Short-Term Medical Missions to Guatemala: The Preparation, Organization, and Execution of STMMs Under the Enduring Influence of Neoliberalism

by

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ABSTRACT

Short-term medical missions (STMMs) are groups of volunteer medical providers who travel to provide health care, including basic services and surgeries, to global low-income populations. STMM organizations present their work as contrary to both public and private systems within Guatemala that do not adequately serve the patient population, though they operate within the same framework as other providers and mirror the same neoliberal ideology in their planning, organization and strategy, and execution. STMMs strive to offer free, high-quality access to surgeries and basic health care services via volunteer medical providers willing to dedicate their time and skill to low-income patients. The patient population of STMMs in Guatemala, who are often rural, indigenous, and low-income, already experience diminishing access to health care due to neoliberal health policies and discrimination within the existing health care landscape, go to great lengths to access quality health care services. This research investigates the planning, organization and strategy, and execution of STMMs through the lens of the enduring influence of neoliberal health ideologies on volunteer medical providers and existing health resources in Guatemala. Organizational strategies that prioritize the ease of travel for volunteer medical providers mirror the geographical lack of health care access, neglect of indigenous language services in the health care context, and urban focus already existing in the country's public health care system. The patient population experiences heightened vulnerability exacerbated by STMMs when seeking care because of their low adherence to Guatemalan law surrounding registration requirements for foreign medical providers and poor institutional accountability, burdening patients, who lack legal literacy and financial resources, with denouncing malpractice or post-operative problems. Finally, STMM providers expect patients to both demonstrate passivity, humility, and material deficiency and show that they can be ‘good’ patients—able to understand and abide by the authority of the medical providers, know what information to provide, and communicate effectively—essentially, to be good health consumers. Ultimately, this research demonstrates how neoliberal health ideologies remain deeply engrained in the psyche of STMM organizations, despite their targeted approach to deliver health care to patients struggling to access services in Guatemala’s chaotic health care landscape.

DEDICATION

I would like to first thank my parents, Marylaine and Steven Driese for the years of love and support while in my undergraduate and graduate studies. Thank you for raising me to be curious about the world. I am so lucky to have two parents that supported me first in studying abroad to Guatemala, then moving there to live and carry out my dissertation research. Thank you, Mom, for teaching me to look at all of life (the good and the bad) as part of the adventure. Dad, you were the first person to earn a Ph.D. in the family, and thanks to your love of education and desire to constantly learn, you certainly will not be the last. I want to thank my brother, Nathan, for encouraging me to read as much as possible and always believe that the mind is a limitless place—a place to keep memories, a place to explore, and a place to solve many of life's problems. To my brother Trevor: your kindness and acceptance of others has always guided me. You treat people fairly but never compromise your own internal code of ethics, and that's what makes you a wonderful older brother, husband to Lindsay, father to the twins, and role model for everyone you meet. Thank you for leading the family by example.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

INTRODUCTION

Living anywhere new, your perspective changes the more you get to know the place. Every place has its rhythm, its own beauty, frustrations particular to living there, and deeper problems that you are exposed to over time. Guatemala has plenty of beauty and plenty of profound social and economic problems, and I have always wondered how much of this the foreign volunteers could see in the week or so that they spent in the country during the short-term medical missions (STMMs) I observed.

Most of the time, I traveled with the volunteer medical teams, spending as much time with them as possible to build rapport, complaining with them about the traffic or dangerously speedy chicken buses whooshing past us. Sometimes I traveled alone to meet up with them where they were to deliver care, immersed in the countryside. On the way home, through the windows I would see *milpa*[1], *milpa*, and more *milpa* making my eyes hazy and tired, especially after a long day standing in the clinic. During the year of my dissertation research, I traveled at least one week of the month to another part of the country and my life felt defined by the constant movement and constant exposure to the variety of landscapes and people that Guatemala would show me.

In and out of Antigua, Guatemala's former colonial capital, tourism hub, and my home base, I transitioned between the two identities many foreigners find themselves in: the bright-eyed, excited newcomer and the cranky *antigüeño* (the demonym for residents of Antigua) resentful of the many tourists who come on the weekends. Antigua first felt like home after the spring I spent there in 2019, right after Holy Week. Thousands of

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[1] The *milpa* is a Guatemalan family's (often large) plot of land, consisting of corn, black beans, and other vegetables that traditionally allowed indigenous families to engage in subsistence agriculture.

tourists from all over the world flocked to the city to see the processions during the week, then by Sunday, they had gone home. I remember walking to the gym the Monday morning after Holy Week was over, kicking past the trash littered in the streets of my adopted home.

Three years later, I reflect on how necessary experiencing both insider and outsider identities. I could relate to the volunteer medical teams because the awe I feel is sincere—I never got over how beautiful Guatemala is, nor will I ever. But, as a resident of one of the most popular tourist destinations in Central America, I also understand how colonized, how *extractive* the tourism industry can feel for people living in it. However, I resent the platitude many people have repeated to me: “Antigua isn’t the *real* Guatemala. It’s so touristy.” Antigua is Guatemala, too. The touristy, comfortable, and convenient town is like the set of a play.

The view from the front is picturesque and relatively orderly city; from the view backstage, there’s thousands of people living in the nearby towns hired by the municipality cleaning the streets, painting buildings, serving tourists in restaurants, and selling artisan items in the park for much less than the time people usually spend to create them. Many people who work in Antigua live in the communities outside of town because of the cost of living in Antigua. Prestigious families who own property in Antigua-proper, even those that inherited money from their wealthy colonial ancestors, often find it difficult to afford living in the town, especially after generations of inherited wealth start to divide and dwindle.

Guatemala City, where I also spent a significant amount of time in my research, is just as real, but raw. While most of Guatemala City does not boast the beautiful façades of Antigua, it is certainly an example of the shocking wealth divide in the country. Many of the providers of the medical missions that passed through Guatemala City in the daytime or stayed there while they provided surgeries in the hospitals remarked how shocked they were to see expensive cars or impeccably dressed city-dwellers. What is interesting about Guatemala is the juxtaposition of so much wealth with so much poverty. It is not the lack of money—in fact, Guatemala is designated as a middle-income country—it is how few people have so much, and how so many people do not seem to have anything at all.

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Guatemala has long been a source of fascination for U.S.-based academics. From the archaeologists and anthropologists who first came to study ancient Maya architecture and culture in the 19th century to academics across many disciplines today, scholars, often from the United States, have long questioned the paradoxes Guatemala offers. We are perplexed by the vast natural resources but poor economic development, by the sociability and family-orientedness and simultaneous high rates of interpersonal violence. Personally, I have been fascinated by the striking number of organizations and foreign aid that comes to Guatemala dedicated to healthcare—and what little effect these efforts seem to have on population health.

This question guides the work of many academics who conduct health-related research in Guatemala, including my own. One of the answers provided by previous scholars, and a position that I share, is that poor health is directly tied to neoliberal health care policies, which brought about a global re-orientation of governments' responsibility to their citizens vis-à-vis healthcare, a re-orientation of providers to their patients, and the widening of the inequality gap we hoped to close.

Developed starting in the 1990s, but made to flourish starting in the early 2000s, neoliberalism has exacerbated the racial, class, and economic inequalities that were born in European monarchies and baptized during the colonization of the Americas. Despite the independence movement to separate from Spain, governance aimed to modernize the economy, a socialist revolution, ten years of progressive policies, and an internal armed conflict, inequalities persist.

Neoliberalism asks Guatemalans to ignore racial and ethnic inequality, just as it does in the United States. As if by speaking the words 'everyone is equal,' we magically were. Neoliberal health care policies in Guatemala assume an erroneous orientation of health care consumers to their providers and to the state. Pretending that all people have equal opportunities, equal access to information, and equal health literacy does not make it so, nor does it justify the poor quality of care that Guatemala's historically marginalized populations receive. Furthermore, economic theories applied to health and manifested as a commitment to uphold capitalism weakens any claim to uphold health as a human right. In Guatemala, health care is a right – if one can pay for it.

As such, a market-driven health care system fails to meet the needs of the most vulnerable populations, such as indigenous, rural, and low-income populations. This exclusion creates space for non-government organizations (NGOs) and short-term medical missions to enter the landscape. However, even these alternate health care providers are subject to the same systemic pressures of the market, using quantitative metrics to garner financial support (often from U.S. donors), publishing success stories of patients, and utilizing other methods to prove the economic value of their work.

NGOs and STMMs that provide health care to the population position themselves as alternatives to the above system, and to their credit, often are recognizably and intentionally anti-racist. However, with an estimated 15,000 NGOs in the country, at least 775 organizations dedicated to health care (Pionero Philanthropy, 2021), millions of dollars in aid for health care from the United States and other countries (U.S. Embassy, 2020), and hundreds of STMMs arriving to provide basic health services and surgeries each year, the variety of approaches by which many organizations operate have not collectively resulted in much change.

In this dissertation, I will show how, despite the aim to bring health care access to populations not reached by brick-and-mortar NGOs or provide care to populations not generally respected within public health care institutions, they operate within the same neoliberal framework. By adopting this framework (even unintentionally), STMMs replicate certain structural problems in their health care delivery. In Chapter 1, I will explain the origins of the non-profit health care landscape in Guatemala, how it was shaped by neoliberalism, and the space alternate health care institutions occupy to work towards bettering health care access in Guatemala. In Chapter 2, the global background of STMMs and how they fit inside this framework as providers in the specific Guatemalan context, meeting certain needs in the health care landscape but also exposing the weaknesses of the STMM as a strategy to provide health care.

Chapter 3 shows the research methodology used to answers the questions specific to the dissertation as well as the factors that led to the research participants' acceptance of me as a researcher and member of their teams as they executed the medical missions studied. As a direct result of my participant observation and interviews with medical mission coordinators, I formed typologies of STMMs in Guatemala in Chapter 4, which is intended to guide the categorization and distribution of medical missions within the study and serve as a point of departure for analysis of the relationship between neoliberalism and the structures it promotes. It will also serve as a resource to members of the health care service delivery community in Guatemala seeking to know the variety of ways in which STMMs are observed to be organized and executed.

One of my goals for this dissertation is to address one of the most important topics about STMMs in Guatemala that previously has only been superficially addressed—the triangulation of Guatemalan laws vis-à-vis foreign health care providers, the state of patient rights in Guatemala, and STMM organizational policies that disengage patients from meaningful ways of advocating for themselves and in fact, leave them more vulnerable. In Chapter 5, I show how these policies reflect neoliberal ideals applied to health care and how they are a blind spot for organizations and STMMs who hope to fully commit to the well-being of their patients.

Finally, I address the ways in which the values characteristic of a neoliberal state has permeated health care delivery in the STMM context in Chapter 6. From coordinator interviews, participant observation, and direct observations, I will juxtapose the provider expectations of patient behavior in the clinical environment with the reality of treating marginalized patient populations and show how this ties to a larger concept of cultural health capital and who is the ideal health care consumer. What many STMM volunteers seem to find in Guatemala is not the perfect, amiable, and compliant patient, but real people who hope to be healthy but struggle under social and economic pressures to survive in a deeply discriminatory neoliberal state. In the conclusion, I will look towards the future and offer insight regarding the ways the operation of STMMs in Guatemala could be improved via planning, ethical considerations, and implementation.

CHAPTER 1

THE HEALTHCARE LANDSCAPE OF GUATEMALA

I had to jump through many bureaucratic hoops to get into the National Hospital in San Felipe for participant observation. The National Hospital system in Guatemala is a network of publicly-accessible regional hospitals, normally distributed one per department—the Guatemalan equivalent of U.S. states. Paperwork, several meetings with the hospital director, and a note from my advisor confirming my research preceded this opportunity. While the day prior I had arrived at the National Hospital to deliver consent forms to the fifteen or so providers and volunteers that would be working with the orthopedic patients in recovery, and the five on the first floor putting patients under anesthesia and performing the surgeries, the next day I was finally permitted to take a tour of the hospital wing the short-term medical mission (STMM) took over during their ten days of work there. I had never been inside a National Hospital before, though I had heard many stories about it—usually involving the theft of limbs or eyes--that hopefully were exaggerated.

I walked towards the back of the National Hospital, the odd architectural child of a Mediterranean mother and California modern father. This is where the volunteers and hospital staff entered each morning. I showed the guard at the gate my license, my university ID, and the letter from the hospital director allowing me to conduct my research in the facility under his supervision. I passed through another round of security, though they only checked that hospital employees were not transporting any items *out* of the hospital unsupervised. They waved me in, not even checking my backpack.

I walked up the four flights of stairs, centrally located in the building; at each floor, one could look in three directions to see large concrete railings, bland brown interior walls, and beige accents, with a long rectangular administrative desk populated with nurses and medical students. I arrived at the fourth floor and was ushered down a dark hallway to a corner room filled to the brim with donated orthopedic rehabilitation supplies such as crutches and boots, medications, and anesthesia. The quantity of supplies brought by the volunteer medical team (VMT) contrasted to the scarcity in the rest of the hospital. On the wall was a 'storyboard,' the team's term for the cork board filled with post-it notes of the surgeries to be performed that week, carefully placed below the assigned day with the patient's name, their age, and the surgery they would be receiving.

That day, I was permitted to shadow the pharmacist. He was one of the team leaders, a long-time volunteer, and most importantly, an enthusiastic presence among many tired surgeons and nurses. We walked to the convalescent room, shepherded by 24-hour nursing staff from both the STMM and the hospital. When it was time for the physical therapists to conduct rehabilitation and therapy with the patients, the halls were filled with the shuffling of nervous feet attached to newly replaced knees and hips. Then—praise. "*Muy bien*!"

I was released for a few minutes, allowed to roam the floor alone. I wandered through an unlit corridor, surprised to see patients convalescing on gurneys, many of them asleep, pressed against the walls. The image reminded me of the final ocean scenes of the movie *Titanic*; the gurneys were driftwood, silently and peacefully floating through the hallway, yet simultaneously seeming completely out-of-place. I felt awkward having invaded the patients' space, not knowing if I should walk away quietly or to disturb their ghostly peace by greeting them.

Turning to the right, I entered to use the bathroom. Only one of the four stalls had a door, and there was no toilet paper to be found. Thankfully, I had spent enough time conducting fieldwork to always carry my own toilet paper, having experienced one unfortunate roadside incident that involved a bathroom at a bus stop that doubled as a chicken coop (or was it a chicken coop that doubled as a bathroom?), using the bathroom with twelve pairs of chicken eyes fixed upon me. I rinsed my hands in the sink. A thought popped into my mind: while I knew that that surgeries in government facilities often had hidden costs, such as the purchase of syringes or scalpels for the patients' procedures, I did not realize that patients at this government-run hospital must buy and bring their own toilet paper. That's the 'free' hospital care I had read so much about.

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I. Introduction

Short-term trips, often for less than two weeks, made by volunteer medical teams (VMTs) to lower-to-middle income countries to deliver health care services and surgeries define short-term medical missions. Although many researchers have studied how STMMs are run, how they are funded, and the ethical concerns surrounding them, the connection of short-term medical missions to international development, including bilateral aid and non-government organization participation, has not been adequately addressed. Different health care providers distributed across various institutions make up the health care landscape in Guatemala, but short-term medical missions (STMMs) and volunteer medical teams (VMTs) are not included in assessments by the government or organizations such as USAID. Additionally, due to the transient nature of VMTs and at times, ignorance of the regulations surrounding their execution in the country, many teams enter and leave the country without oversight—and without ever entering official reports or analyses categorizing them as health care providers. The Guatemalan Board of Physicians estimates about 100-150 STMMs enter the country annually, based on their monitoring (Personal communication, 2019). However, this number is likely undercounted due to the limitations of that monitoring.

How did Guatemalan public health care become so limited in its health care coverage, despite so much aid, financial intervention, and initiatives by non-governmental actors? And how did that create spaces for non-governmental actors to provide services? In this chapter, Guatemala serves as a case study for how the developmental trajectory of a low-to-middle income country (LMIC) has evolved over time, and how interventions from international political and economic entities such as international financial institutions (IFIs), foreign governments, and foreign philanthropic organizations have influenced the development of the health care landscape.

The first section of this chapter will outline the political history of Guatemala, focusing on the effects of national politics on health. The second section will include a discussion of the political and economic forces acting at the international level between the 1960s and 2000s, which had visible effects on health care. Finally, I will analyze the results of these impacts on health over the past sixty years, focusing on the structure of the health care system and the health effects on the population that follow. By exploring this context, it becomes clear how the spaces have been carved out for substantial intervention by non-government organizations, local nonprofits, and most recently, short-term medical missions.

The current era of the evolution of Guatemala's political, economic, and health system development began with a socialist revolution and transition to democracy in 1944, which ushered in legislative changes slated to design a Guatemalan welfare state. These changes were halted in 1954, when the military, in a U.S.-led coup, overthrew the new government. This started a long period of violence[2] that cost Guatemala hundreds of thousands of lives until the Peace Accords of 1996. During the time of the armed conflict, the international stage was also changing; Cold War tensions heavily influenced what were considered appropriate models of international development. These were capitalist models with an emphasis on lending from International Financial Institutions such as the World Bank, Inter-American Development Bank, and the International Monetary Fund.

A focus on neoliberal health reforms ultimately shows how a space has been created for entities engaged in the provision of health care apart from that of the government, such as private physicians, non-government organizations (NGOs), and short-term medical missions. Of particular interest is the impact of the Debt Crisis of the 1980s and the subsequent neoliberal reforms leading to the partial privatization of the Guatemalan health care system. This 'partial' privatization in Guatemala is not strictly defined as the replacement of state providers with private providers, but rather initiated the development of a pluralistic set of health care deliverers within the Guatemalan health care landscape (Chary & Rohloff, 2015). Both privatization and public-private

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[2] In Guatemala, there are several ways of discussing the violence that occurred between 1954 and 1996, the most intense of which occurred in the 1980s. These terms include *La Violencia* (the violence), *el conflicto armado* (the armed conflict), and *la guerra civil* or civil war. I will use "the armed conflict."

partnerships have emerged in the time since the Peace Accords of 1996. The initiation of contracting between the government and NGOs and their integration into the government health care system both informally and formally through the comprehensive health system/PEC (Programa de Extensión de Cobertura) decreased the role of the state in health care delivery (Lao-Peña, 2013), though its role regulating and agenda-setting increased (Maupin, 2009).

Secondly, privatization occurred through a decrease in overall financial investment from the Guatemalan government in health care, leaving patients to seek other health care providers, such as private physicians. In Guatemala, the lack of publicly provided health services coupled with the population increase provides space for health care providers such as short-term medical missions to emerge. The term "privatization through attrition" (Fielder, 1985; Fort, Mercer, and Gish, 2004, p. 59) regularly echoes among social scientists studying health care in nations with neoliberal health policies, due to the observed increase in private medical care in lieu of the state funded and provided care for the population. Development efforts of the second half of the 20th century and an increase in the desire to volunteer abroad have thus contributed to the introduction of new health care providers such as short-term medical missions.

Short-term medical missions have become increasingly visible and are commonly seen as part of the Guatemalan health care landscape. Caldron and colleagues estimate that physician participation in STMMs overall has increased three-fold since 1993, though no data exist describing the trend specifically for Guatemala (Caldron, Impens, Pavlova, & Groot, 2016). Several NGOs in Guatemala now include the coordination of STMMs with local providers as part of their organizations' main operations and goals. The practice of

American doctors arriving in Guatemala to perform medical procedures is formally recognized, as these physicians are obligated to send their credentials to the Guatemalan College of Surgeons and Physicians before providing surgeries or medical care (Berry, 2014). However, national surveys provided by the Guatemalan government have not yet included short-term medical missions as health providers when asking how Guatemalans receive their care (Makinen et al., 2000; Flores, 2008; INE, 2015; Avila et al., 2015). Because of this, we know very little about the quality, efficacy, and patient load of short-term medical missions overall. Additionally, it is unclear how these providers collaborate with existing health care providers, and the variety of ways in which medical mission teams execute their medical services for Guatemalan patients has been underexplored.

Rarely are short-term medical missions understood as part of international development. Nor are they frequently associated with the neoliberal health policies enacted in the past two decades, despite the fact that STMMs treat patients who exist within the poorly-resourced health care environments shaped by policies characteristic of neoliberalism such privatization and austerity measures. I argue that the increased popularity and ubiquity of STMMs in Guatemala is a result of the evolution of overall neoliberal health care policies and the continued weakening of state health services (in quality and distribution) and simultaneous expansion of the nonprofit sector.

II. The Political History of Guatemala in Relation to Health Care

Health Care Before and During the Ten Years of Spring

The recent history of the Guatemalan health system begins with a period of time known as the Ten Years of Spring, which lasted from 1944-1954. Prior to this time of socialist reform, health care was largely a decentralized, private matter. Debts were often accrued by indigenous Guatemalans who worked on *latifundias* (large plantations or estates owned by the *ladino*, or Spanish-descended, segment of the Guatemalan population). The workers would incur debt through systems of credit, which could be used to pay for "church-related exactions, marriage expenses, health care, or release from the town jail" (Reeves, 2006, p. 77). In modern terms, health care was always a costly out-of-pocket expense for low-income Guatemalans, which was not uncommon for the post-colonial, pre-industrial period. During the late 19th century, Puerto Barrios, an Eastern port town that often imported workers from the Caribbean, created its first hospital in order to maintain the health of the local railroad workers (Opie, 2004). This indicates that public health functioned specifically to maintain the labor force – contrary to many current public health systems which in theory aim to sustain the health of all members of a population.

In 1944, a revolution and the election of a university professor named Juan Jose Arévalo inaugurated what is known as the Ten Years of Spring. Handy describes the revolution as simultaneously nationalist, pursuing a modern capitalist economy, and pursuing a democratic political system, though the policies implemented during the Ten Years of Spring are also considered redistributive (Handy, 1984). Arévalo enacted reforms in labor rights, education, and land ownership, which laid the foundation for the next progressive leader (Lawton, 2015). What he is less known for, but is most pertinent to the health of Guatemalans, was his formation of the Ministry of Public Health and Social Welfare (MSPAS) and the Guatemalan Social Security Institute (IGSS) which still exist today.

Jacobo Arbenz, elected in 1951, continued the land reform and redistribution efforts of his predecessor, for which he was most reviled by the wealthy landowning class at the time and is best known now. He was viewed with suspicion by the elite landowning class because his policies promoted upward mobilization of the indigenous and poor populations and the promotion of land ownership by those historically disenfranchised groups. Additionally, landowners had slowly taken more and more land away from the indigenous population over the last three hundred years, and were reluctant to give up the land they had acquired. In 1952, the Guatemalan Congress passed Decree 900, which called for expropriation of uncultivated land from the largest *fincas* in an effort to increase agricultural production (Handy, 1984).

A centralized health care system was created for the first time in Guatemalan history during the Ten Years of Spring (1945-1954). The MSPAS was instituted as a healthcare provider for all Guatemalans in 1946, regardless of whether or not they work in the formal employment sector. MSPAS delivers care through health posts, clinics, and hospitals paid for through taxpayer money. IGSS, also founded in 1946, is an independent institution that provides private insurance and access to care through formal employment – businesses with five or more employees on the payroll. Those in the Guatemalan military receive health care services through the military. These reforms contributed to one of the ultimate goals of Arévalo, which was the creation of a modern welfare state (Verdugo, 2000).

During the Ten Years of Spring, the Arévalo and Arbenz administrations primarily combatted sanitation and malnutrition. Arévalo established rural health clinics and sanitation systems in areas without potable water, and when combined with higher income levels for Guatemalans at this time, led to a reduction in the mortality rate by 2.5% between 1945 and 1954 (Handy, 1984, p. 107). Though these efforts were made, only 19.1% of Guatemalans had access to sanitary water systems by 1960 (PAHO, 1962, p.84). The prestigious Hospital Roosevelt was constructed between 1944-1955, with the contribution of $1 million from the U.S. Government for its construction (Prensa Libre, 2015).

According to a 1952 Pan-American Sanitary Bureau[3] report, the main causes of death were "diarrhea and gastroenteritis, Bronchitis and pneumonia, Malaria, Whooping cough, [and] Diseases due to helminths"—indicating that at this time efforts to control infectious disease were still most important (Pan-American Sanitary Bureau, 1956). The ratio of physicians to inhabitants in 1957 was 543 physicians per 10,000 Guatemalans; however, only 8.1% of those physicians were employed by institutional health services and most were located in urban areas (Pan-American Sanitation Bureau, 1958, p. 80-81). At this time, the MSPAS spent $0.61 USD per inhabitant each year for health services (Ibid.). By 1960, there were 58 hospitals (including one mental health hospital), 24 clinics, and 12 public health laboratories, which offered serology, parasitology, and bacteriology services (PAHO, 1962, p. 66-69). Though the agenda had been set forth by the Arévalo and Arbenz administrations to prioritize social services, the reports offered by PAHO at the time indicate that the allocation of resources to public health care was still quite minimal.

The unpopularity of Arbenz's land reform measures from elite Guatemalans resulted in an American CIA-backed coup in 1954 known as PBSUCCESS. Following

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[3] Now the Pan-American Health Organization

the coup, Carlos Castillo Armas succeeded Arbenz—an army man approved by the U.S. government, who played a chief role in the transition of power (Handy, 1984). Supporters of the revolution were quickly punished by the new government and the period of the armed conflict began.

Health Care During the Armed Conflict

Population health did improve between 1940 and 1960, due to "advances in medical know-how" such as "antibiotics, vaccines, drugs, insecticides… and basic sanitation services" that were occurring all over Latin America (Fielder, 1985, p. 277). However, the coup of 1954 ushered in political instability and violence that came in waves until the Peace Accords in 1996. Military control of the central government characterized the 1960s, as various military officers rose to power and just as quickly were deposed by their rivals (Handy, 1984).

Economic stagnation characterized the 1950s through the 1980s. Agricultural production was low due to the destruction of indigenous community life, which was an integral part of the agrarian economy. Davis and Hodson describe how the economy was altered by the violence:

> "People are afraid to plant their fields, for fear of being accused of supplying the guerrillas; fertilizers are in short supply; women must handle production alone because men must go into hiding; productive lands have been burned and bombed" (Davis & Hodson, 1982, p. 19).

Additionally, the violence led to the flight of foreign capital, a near-collapse of the tourist industry, and the exit of wealthy Guatemalans to other countries (Handy, 1984).

Physicians educated in urban contexts (the majority of physicians at the time) often focused on Western disease etiologies and biomedical treatments, becoming licensed in specialized fields rather than practicing general medicine or including traditional Maya medicine in their practices. This caused a major decline in general practitioners (GPs) in the 1970s (Fielder, 1985). A concentration of physicians in urbanized areas of the country contributed to the access issues faced by rural and low-income Guatemalans (Annis, 1981); today, this is still largely true, with 71% of the nation's doctors and biomedical staff concentrated in urban areas (Becerril-Montekio & Lopez-Davila, 2011).

Rural Health Technicians and health promoters, collectively known as community health workers (CHWs) were introduced into government health services 1971 by the Ministry of Health to act as liaisons between rural isolated communities and health care centers in more populous areas (Colburn, 1981). Steltzer describes the rural health promoters (*promotores de salud)* working in the Berhorst Clinic in Chimaltenango and their efforts to bring basic health care to rural indigenous communities despite the threat of the government growing in the region at the end of the 1970s and early 1980s (1983). Overall, access to health care was still inadequate through the 1970s, at which point two thirds of Guatemalans still did not have access to health services (Green, 1989, p. 249).

In 1973, the Ten Year Health Plan for the Americas was drafted by the Latin American Ministers of Health. In this plan, the promotion of primary health care was emphasized and was to be carried out through such measures as restructuring the health care system to reduce redundancies, improve administration through the many levels of health care planning and delivery, and implementing regional referral systems through a hierarchy of care provision—among many other measures (Fielder, 1985, p. 287). Finally, the 1970s was a time of investment in Guatemala's health care system by the Inter-American Development Bank; the IADB and USAID have "provided technical assistance, and major funding for a variety of infrastructural development projects" amounting to a total of $15,874,690 for health loans (Fielder, 1985, p. 288).

During the 1970s, institutional modifications to the health system were more or less confined to bureaucratic changes engineered to better organize the provision of care. These included the division of the country into new administrative divisions in 1976, and the organization of primary, secondary, and tertiary levels of healthcare in 1980. These measures established health posts designed to reach rural and underserved areas, health centers, and regional hospitals (MSPAS, 2016).

After the 1970 election of Carlos Arana Osorio, political dissenters from the left were placed on death lists and forced to exit the country; at this time, the focus of government retribution was still on left-leaning political parties rather than along ethnic lines (Ibid.). A brief reprieve from violence occurred during the government of Kjell Eugenio Laugerud; during his tenure, he supported the cooperative movement and rural development (Green, 1989). However, the momentary peace did not last for more than a few years. The period of time between 1978-1983 saw an escalation in violence towards suspected subversives under the leadership of Lucas García from 1978-1982 and Efraín Ríos Montt from 1982-1983. Rios Montt enacted a "scorched earth" policy aimed to destroy communities and the agricultural basis of their livelihoods, which consisted of terrorizing rural communities in primarily indigenous areas of the country, burning their homes, destroying their crops, and engaging in sexual and physical violence against the population. At this time, the identity of political subversives was extended to “trade unionists, students, teachers, lawyers, [and] journalists” in addition to opposition politicians (Handy, 1984, p. 176). Community health workers and health promoters were also targeted (Maupin, 2011).

During the most violent years of the armed conflict (1978-1982), the political focus remained pointed at suspected political subversives and guerrillas, who responded to the “profound exclusion, antagonism and conflict” of the colonial and post-colonial eras of Guatemalan history with Marxist ideology and action (CEH, 1999). This was seen as justification by the Guatemalan military for targeted repression and persecution of indigenous Guatemalans, some of whom were allied with the guerrillas hiding in the highlands, some of whom were completely outside of politics but were nevertheless characterized as guerrillas because of their ethnic identity and membership in indigenous communities, thought of as ‘base camps’ for the guerrillas. In total, it is estimated that over 200,000 people were killed or disappeared during the Armed Conflict and that 83% of those killed or disappeared were indigenous (CEH, 1999). Thus, many critics and human rights activists have claimed ethnocide occurred against Maya Guatemalans.

As of 1981, the top five causes of death were intestinal illness (1), pneumonia and influenza (2), homicide, legal interventions, and war (3), accidents (4), and “certain conditions originating in the perinatal period (5) (USAID, 1990, p. 126). Health and education were affected by the violence, described as the “dismantling of rural healthcare centers and schools and the killing of nurses, doctors, and teachers" (Davis & Hodson, 1982, p. 21). Fear kept many from seeking health care, since the staff for health facilities often felt stuck between wanting to provide care to communities but not seem sympathetic to subversives (Ibid.). Verdugo (2004) describes the health sector during the period from 1954-the mid 1980s as "essentially abandoned" (p. 59). By the time both sides of the armed conflict reached peace brokerage, the country's health care system had been set aside as a priority. Bruce Barrett described the Guatemalan Ministry of Health to be as a whole "professional, biomedical, and disparate" (Barrett, 1996, p. 77).

The healthcare system went under a major "reorganization" in 1987, mainly focused on decentralization and funded through the Social Investment Fund (Hernandez Mack, 2010). The management of the MSPAS was divided into one sector for political direction, one sector for the direction of delivery of service and technical execution, and one sector for the provision of services and management of the hospital system (Ibid.). This is also when the hierarchical model of administration (Hospital Nacional-Hospital Regional-Centro de Salud-Puesto de Salud) was refined, though unfortunately this system has never allowed for funds to reach the lowest 'primary care' level or these entities receive the lower-quality, cheapest resources and supplies (Calderón Pinzón, 2020).

Non-government Organizations

The health care system was long separated from the care provided by NGOs. The introduction of non-government organizations (NGOs) before and during the armed conflict produced changes that have permanently altered the health care landscape in Guatemala. Significantly, the earliest missionaries recorded to have provided health care in Guatemala came to maintain the workforce and push the population towards the economic goals for development. The missionaries were from the American Rockefeller Foundation, who came to Guatemala in 1919 to provide care for members of the workforce suffering from yellow fever, malaria, and hookworm (Rockefeller Foundation, 1919). After this point, more missionaries from both Protestant and Catholic churches established themselves in Guatemala as providers of health care and the introduction of biomedicine to an indigenous population with their own traditional methods of health care.

The evolution of NGOs in the Guatemalan health sector is meticulously documented by Alberto Cardelle in his work *Health Care Reform in Central America: NGO-Government Collaboration in Guatemala and El Salvador* (2003). He states that the first generation of NGOs in Guatemala appeared primarily in the Depression-era and were mainly concerned with providing relief and welfare services. The Catholic Church was especially active during this period, forming a “social participation organization” called Acción Católica (Catholic Action) and regional NGO, Caritas (Cardelle, 2003, p. 14). A second generation starting in the 1960s focused on providing technical solutions to problems and encouraged economic and social development, in vogue with the modernization theory that was driving global development efforts during the 1960s and 1970s.

In 1978, the Declaration of Alma Ata called for a re-focus of global health improvement efforts; instead of promoting curative methods for disease, governments and health systems were encouraged to focus on preventative measures to combat disease and illness. This set of principles is known as Primary Health Care (PHC). Community health efforts to combat the myriad health problems endemic to Guatemala and exacerbated by poverty through PHC methods were met with violence from the military, and were often viewed as sympathetic to Marxist ideology (Green, 1989). Heggenhougen describes "elimination," threats and murder of family members, and disappearance as consequences for participation in these community health initiatives (1984).

Understandably, the high cost of participation in community health endeavors (among other development and relief efforts) frustrated those in Guatemala interested in improving health. In 1980, "a number of [NGOs] found their Guatemalan staff members on death lists, and many were forced to abandon or reduce their programs" (Davis and Hodson, 1982, p. 15). The number of rural assistance programs, including NGOs, was reduced by 46.2%, either by substantial reduction in program operation or by termination. (Ibid.)

The final generation of NGOs that Cardelle describes emerged in the 1980s. The "liberationist NGOs," as Cardelle terms them, regarded social change as the necessary catalyst to achieve (in the case of health-care delivering NGOs) better health care for all (2003, p. 16). Most importantly, this third generation distanced itself from government institutions because the governments of Guatemala and El Salvador were the most visible promoters of violence towards their own citizens through right-wing militaries in the period of the 1970s-1990s (Ibid.). That, and the shift towards neoliberalism, distanced NGOs from the state for many years, until the institution of PEC/SIAS. The third generation of NGOs ran parallel to the Catholic Church's transformation after Vatican II, which called for greater attention to the suffering of the poor and social injustice (Ibid., p. 14).

The 1980s Through the Peace Accords of 1996

In 1984, the health care expenditure as a percentage of the GDP was a mere 3.7%, or per capita $4 USD (USAID, 1990). Fielder posits that government's commitment to seeking outside loans during the 1970s contributed to a "shortfall of operating funds" from the government itself (Fielder, 1985, p. 289). Green contends that plenty of facilities were available in theory, but in practice were poorly maintained and under-supplied (Green, 1989). PAHO reported the bed-to-population ratio as 1.7 beds per 1,000 inhabitants in the years between 1981-1984, but that both the public and private hospital beds were mainly concentrated in Guatemala City—excluding the rural part of the population (PAHO, 1986). Fielder contends that rather than actually implementing programs based on the primary health care approach, the government simply paid lip service to the idea (Fielder, 1985), though certain aspects of primary health were certainly pursued, such as vaccination. He concludes that "the structure of Guatemala's dependent-development conditioned, health care delivery system remains essentially the same, as do the abysmal health conditions of Guatemala" at the time of publication (1985, p. 295), even after attempts at reform had been made.

In 1990, the first phase of the peace process was initiated by the *Comisión Nacional de Reconciliación* (National Reconciliation Commission, or CNR), which successfully brought some of the many opposing forces together to set an agenda for peace (Short, 2007, p. 72). Six years later, members of these opposing forces signed the Peace Accords, which among other measures, legitimized the guerrilla groups into political parties, reformed the military, and guaranteed some basic socioeconomic rights to all citizens. Most notably, the Peace Accords (though never ratified) reiterated the set of guarantees to the population outlined in the Constitution of 1985, which included a right to universal healthcare.

However, the successful delivery of this universal health care remains a multi-faceted problem. International economic and health care policies tremendously influenced the domestic health care policies that Guatemala has been able to implement. In the following sections, I describe how neoliberal health care reforms came about as an international policy initiative, how they applied to Guatemala specifically, and how they altered the course of Guatemala's health care policy development as a whole. Then I will focus more directly on the development of the state-run health care system through its policies over time.

III. Health Policy Reforms Guided by Neoliberal Ideology

In examining its influences on health care in the developing world, neoliberalism can be characterized as an economic, political, and social ideology that promotes the privatization of social services, trade liberalization, and the diminished role of the state in providing social services (Armada and Muntaner, 2004). Understanding the processes that led to the introduction of these reforms across much of the developing world in the latter quarter of the twentieth century aids social scientists in their ability to distinguish the short and long-term consequences of these reforms on the health systems of developing nations. This section outlines the genesis of international financial institutions, the general trends they followed (and created), the ways in which IFIs influence health policy in Guatemala, and what some of the effects of the neoliberal health reform policies were.

International financial institutions (IFIs) played a significant role in the development of Central and South American economies in the period after World War II. The "Third World" nations were characterized as backward due to their relative lack of industrialization and economic might compared to the Allied nations involved in World War II, such as the United Kingdom and the United States. Two of the largest financial institutions, the World Bank and the International Monetary Fund (IMF), were formed out of the Bretton Woods conference in July of 1944 (Kim, Millen, Irwin, & Gershman, 2000). The IMF was designed to bring back economic stability to the countries ravaged by World War II, while the World Bank served to aid in the rebuilding of infrastructure in those countries; however, by 1948, the IFIs had started loaning money to developing nations outside of Europe (Ibid.). This international "embedded liberalism" served to encourage free trade and maintain stable markets, which in turn was supposed to prevent newly de-colonized countries from pursuing socialist or communist government structures and non-capitalist economies in the post-War period (Kim, Millen, Irwin, & Gershman, 2000, p. 19).

Guatemala first received a loan from the International Bank for Reconstruction and Development (IBRD), a branch of the World Bank, in 1971 (World Bank, 2016). The loan amounts steadily increased to their highest points in 1988 and 1992 (at $104 million and $120 million, respectively) with the loan commitment amounts defined as "the sum of new commitments on public and publicly guaranteed loans from the International Bank for Reconstruction and Development (IBRD)… in current U.S. dollars" (World Bank, 2016). The Inter-American Development Bank was an additional lender starting in 1991, and was the main proponent of the austerity health policy reform that characterized the mid-1990s through the 2000s (Verdugo, 2004). A summary of the total external debt stocks in the period before the Debt Crisis of the 1980s is below, illustrating that Guatemala was a typical borrowing country in this period of time. With the external debt stocks valuing at over 26% of Guatemala's GDP in 1984, it is easy to see how the country was considered to be in a "Debt Crisis."

Table 1.1. Total External Debt Stocks as Percentage of GDP, 1975-1984

Year	**1975**	**1976**	**1977**	**1978**	**1979**
External Debt Stocks ($USD)	396,868,000	465,475,000	744,635,000	909,888,000	1,142,000,000
As % of GDP	10.89%	10.66%	13.59%	14.99%	16.54%
Year	**1980**	**1981**	**1982**	**1983**	**1984**
External Debt Stocks ($USD)	1,270,000,000	1,369,000,000	1,654,000,000	1,926,000,000	2,486,000,000
As % of GDP	16.12%	15.90%	18.97%	21.28%	26.25%

Source: World Bank, 2016

This lending by institutions such as the IBRD and the inability of the borrowing countries to pay back the loans contributed significantly to the Debt Crisis of the 1980s. This engendered panic among the commercial lending institutions in wealthier countries, and they came up with structural adjustment programs—programs designed by commercial lending institutions to help loan-receiving countries pay off their debt. Although Guatemala was by no means the most heavily indebted country, as Mexico and Brazil were clearly hit the hardest by the Debt Crisis (Escobar, 1995), the country was still subject to structural adjustment measures. An additional factor that contributed to the proliferation of neoliberal reforms in Guatemala was the internal and external pressures to combat the popularity of Marxist ideology among political subversives, mentioned earlier. Verdugo suggests that the lenders' interests were allied more with those of the nascent government of the 1990s, which still emphasized "law and order" more than the interests of the population whose health the loans were designed to improve:

> "… these structural adjustments can be characterized as unbalanced or asymmetrical, as progress occurs only in relation to aspects that do not compromise the interests of the dominant economic sectors. In this sense, liberalization, openness, and economic transformation occur slowly and intermittently, while privatization and social reforms move forward without resistance, due to the absence of social or political power that would maintain a greater balance within, enrich, or halt government measures" (2000, p. 280).

When a loan is implemented to a country from an IFI, a series of conditions are agreed upon by both the lessee and lender. If a country defaults completely on a loan from an IFI, it is unlikely that other nations will lend to it in the future—essentially cutting off ties from money necessary for big projects unaffordable through the collection and funding of national taxes alone.

Structural adjustment follows the logic that "fixing the "structural" causes of macroeconomic imbalances—through "stabilization," "liberalization," and "privatization" of economies—would lead to growth and development" (Keshavjee, 2014, p. 94). Privatization assumes that government-run state enterprises are less efficient and of lower quality, and that market forces can better regulate this efficiency, though the relevant literature fails to conclusively support these assumptions (Armada and Muntaner, 2004). Liberalization attracts foreign and domestic investment by no longer allowing for price controls on certain goods, thus allowing a “free”-flowing market to flourish (Kim, Millen, Irwin, & Gershman, 2000, p. 23). Finally, deregulation is the overall loosening of state control over “capital, goods, services, and, increasingly, domestic labor markets” (Ibid.), which creates room for private industry to expand.

Structural adjustment measures are first and foremost an expression of the perpetual power of the core in comparison to the semi-periphery and periphery countries, to use world systems theory terminology (Patterson, 1999). Because of European and the United States’ financial power dating back to colonialism and the wealth gained from the extraction of resources, labor (forced or paid), and capital from colonized nations, European nations and the United States were able to provide much of the pooled capital for the IMF and World Bank. This reinforces global inequality, as “rich countries have far greater voting power formally calibrated to the size of their economies” (Pfeiffer and Chapman, 2010).

Developing nations such as Guatemala take out loans from the pooled capital. These loans constitute *official debt*, which also gives the IMF and World Bank (and their largest contributors, known as creditor governments) the power to exact political and economic reforms from these developing nations that in turn liberate capital to be paid back to IMF and World Bank. *Commercial debt* is owed to private banks and it is significantly more difficult to demand a country pay back those loans (Kim, Millen, Irwin, & Gershman, 2000). Because developing nations were unable to pay back their official debts in the 1980s, the IFIs could create conditions upon which debt restructuring support would be granted – structural adjustment programs (Pfeiffer and Chapman, 2010). Structural adjustment can apply to sectors outside of health, but the policy reforms enacted within structural adjustment frameworks that I am focusing on will be referred to as "neoliberal health policy reform."

Juan Carlos Verdugo, in his assessment of health sector reform, describes two reform trends in Guatemala. The first is health sector reform that occurred between 1986 and 1990, during a period of civil government control (2000). These reforms included an emphasis on the government as a provider of health care, and at this point during the armed conflict, a stabilizing force during a time of conflict and uncertainty. The specific reform the government implemented was a Health Council (Cápsula Distrital) whose plan included "vertical mechanisms for the integration of health workers that limited the participation of these human resources to the coordination and delivery of health services, while excluding them from taking part in decision-making" (Verdugo, 2000, p. 280). The Guatemalan government saw the delivery of health care as an opportunity to promote the growth of a bureaucratic, complex state. Through continuing to provide health services, the government used health care as a tool to curb the radicalization of the populace during the pivotal years between 1986-1990, before the Peace Accords were signed.

The privatization of health services is the central tenet upon which structural adjustment programming in Guatemala is based. This is designed to, among other things, reduce external debt, attract foreign investment, increase competition, and reduce the role of the state in the economy (Lieberman, 1993). The World Bank's suggestions for this privatization included the implementation of user fees for government facilities, the encouragement of non-government organizations and private physicians to provide services, and the decentralization of government health care services (Pfeiffer and Chapman, 2010). "Decentralization" in the context of user fees suggested that health systems would function better if patients were paying into the very facilities serving them and not into “government coffers” (Keshavjee, 2014, p. 98), indicating the mistrust felt between international financial institutions and the countries accepting loans—often newly decolonized, constituted of people of color, or countries who previously associated with the former USSR and communism. The shift in responsibility for the delivery of care was the most far-reaching of these suggestions realized by the Guatemalan government.

Verdugo asserts that the government health system pivoted towards the neoliberal health model in 1991-1992 (2000, p. 280). In 1995, negotiations were begun between the Guatemalan government and the Inter-American Development Bank (IADB). The IADB funded health sector reform, which largely focused on redefining the role of the government in the delivery of health care. Verdugo states: “Starting in 1997, the government transferred its administration and delivery of primary health care services to private entities through signed agreements (*convenios*)” (2004, p. 60). This transferred much of the responsibility of health care delivery from the state to non-government entities such as “NGOs, faith-based organizations, private companies, cooperatives, and municipal governments” (Ibid.).

As the history of international lending has shown, countries, especially those governed by people of color, that were former colonies, or former communist/communist leaning, are met with suspicion of their governance practices. Lending institutions from predominantly white, formerly colonizing countries are understood to be acting in the best interests of countries who are being ‘structurally adjusted’ (Henderson, 2013; Gallagher, 2014). NGOs, faith-based organizations, and other non-state actors as mentioned above represent a palatable, seemingly non-racist, non-corrupt, and non-colonialist mode (Hobson, 2014) for international development initiatives often based on neoliberal values to be implemented.

For the MSPAS in Guatemala, reforms aimed at privatization at the first level of care included “privatized delivery and management of health care services,” at the second level “budgetary management and allocation based on production, efficiency, and effectiveness; inclusion of basic packages for each level, to be financed with public and private funds” and at the third level user fees for services[4], especially for ophthalmological and cardiovascular surgery (Verdugo, 2000, p. 283). These reforms would place the burden on the consumer to choose their health provider from a “chaotic health care landscape”, often based on the ability to pay rather than the quality of services or geographic proximity to the patient (Rohloff, Diaz, & Dasgupta, 2011, p. 429). This is further representative of the neoliberal health care model wherein the consumer is responsible for navigating the healthcare ‘market’ and making rational choices, despite the level of mastery the consumer may or may not have of the information to make such a decision.

The Comprehensive Health System, or SIAS (Sistema Integral de Atención en Salud) was the most notable health reform in the form of a public-private partnership, which Verdugo describes as “neoliberal state modernization” and was required through loan negotiations with the Inter-American Development Bank between 1991 and 1998 (2000, p. 280-281). Civil society and non-government organizations would be

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[4] User fees were implemented, but the Health Code was amended in 2008 to abolish user fees (Avila et al., 2015).

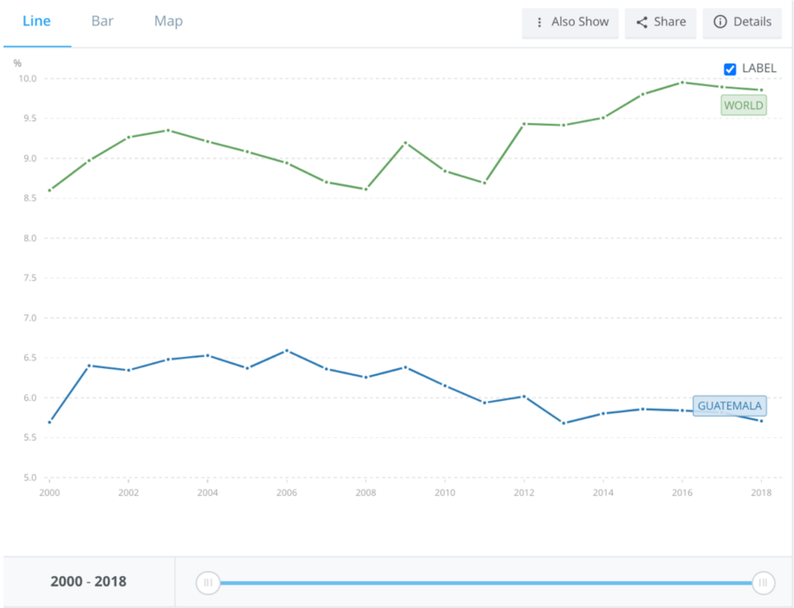
responsible for care provision through government-organized districts of 10,000 people. Basic health packages would be budgeted between Q28 and Q32 (around $5 USD) per person in each health district, though the source of these funds was supposed to be a combination of public (government) and private (NGO, international subsidized, etc.) investment into the system (Verdugo, 2000). SIAS fit the overall goals of the IFIs. While the government still created and administered these divisions for the provision of care (emphasized by the IFIs—"steering role" of the state), the actual provision of care was left to the contracted NGOs. The name of this program was later changed to the Programa de Extensión de Cobertura (Extension of Coverage Program, or PEC). Privatization was then achieved via the transfer of the responsibility of health care delivery from government providers to non-government providers (NGOs).

One of the effects of privatization is the transformation of the citizen into a consumer in the realm of health care—a consumer who, despite their level of poverty, is wholly responsible for their health care (Keshavjee, 2014). In theory, the permission of the free market to dictate most aspects of health care (such as price, availability, and the form in which it is presented to the patient) should allow for only the highest quality care. The market would eliminate low-quality care because it is not worth paying for. This is what Abel and Lloyd-Sherlock say is a "retreat from a notion of healthcare as an entitlement of citizenship rather than a privilege or commodity" (1997, p. 12-13). In practice, this means that social services can be made more expensive or disappear altogether; *basic* services are provided free of cost up to a point—beyond that, the patient must bear the burden to seek care elsewhere and pay for the service themselves (Flores, 2008; Lao-Peña, 2013). The ability of the poor to reliably reach health services is reduced when controls are not placed on the cost of health care, and state and public funds are reduced so many of those who could not pay in the first place simply cannot access health services at all (Armada and Muntaner, 2004).

Below is a chart from the World Bank showing the public health care expenditure as a percentage of its gross domestic product (GDP). Public health expenditure includes "recurrent and capital spending from government (central and local) budgets, external borrowings and grants (including donations from international agencies and nongovernmental organizations), and social (or compulsory) health insurance funds" (Index Mundi, 2016). The government health expenditure as a percentage of Guatemala's GDP rose steadily from 1.5% in 1996 (not shown in the chart) to a height of 6.59% in 2006 (World Bank, 2016). In contrast, the global expenditure on health as a percentage of GDP dropped from 2001 to 2008, and since then has rose somewhat steadily (World Bank, 2022). Guatemala's health expenditure as a percentage of GDP, as of 2018, is little more than half the global average, and in the last fifteen years has reduced spending while globally, governments have invested more in health care. This indicates that Guatemala spends very little on health services for its citizens compared to other countries— perhaps a result of the push for privatization from IFIs. In other words, this difference shows a decrease in public spending in accordance with the implemented austerity measures.

The most impactful indication of the World Bank neoliberal health reforms' influence on the Guatemalan government is the study of health care expenditures by Makinen and colleagues, entitled "Inequalities in health care use and expenditures: empirical data from eight developing countries and countries in transition" (2000).

Figure 1.1. Current Health Expenditure as a Percentage of GDP, Global and Guatemala Data, 2000-2018



Source: World Bank, 2022.

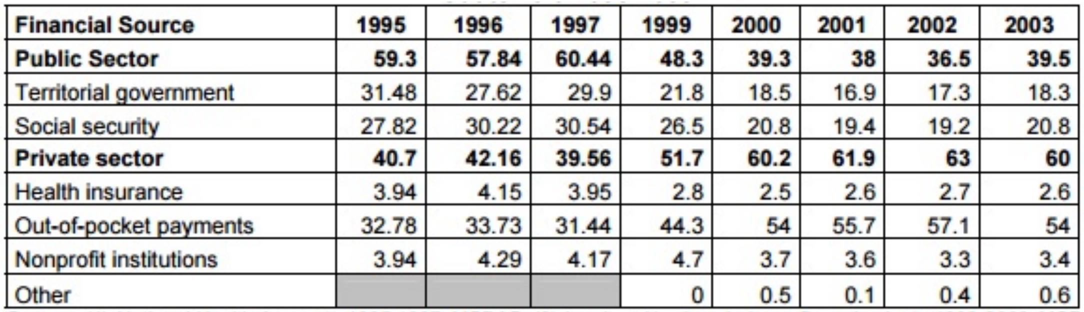
Although the study was conducted on an array of developing countries, Guatemala stood out because of its implementation of privatized health care (even in the presence of a government health care system) and its clearly corresponding inequality. The privatized health care use is a response to the retreat of the public sector as a provider of health care. This retreat was partially due to the neglect of the public health sector and the growth of the for-profit health sector "to the point that the relatively small middle- and upper-class population could sustain it" (Verdugo, 2004, p. 59).

In this study, several trends in health-seeking behaviors came to light. Firstly, wealthier Guatemalans are more likely to receive care in a private hospital. Secondly, wealthier individuals are more likely to use the private sector. And finally, health care spending was dramatically different between the poorest and richest quintiles measured by the study, and that this spending may indicate an "opting out" of the wealthiest

Guatemalans from the government health care system (Makinen et al., 2000). The authors conclude that in Guatemala, "health care would appear to be a luxury good, especially for the richest quintile" and that wealthier households are more likely to use privately provided health care (Ibid., p. 78). The data also suggested that the wealthiest are also most likely to seek care in a hospital, unsurprising, given the many private hospitals in Guatemala City.

Health care expenditure inequality is related to overall health disparities. The ratio of health expenditures by household for rich to poor Guatemalans is 10:1, which indicates at least some degree of income inequality; this is echoed by the country's Gini coefficient, which is 52.4 on a scale of 0-100, with a score of 100 representing perfect inequality (World Bank, 2016). The average household health expenditure at the time was $58.00, while the government contributed around $12 per person annually for health expenses (Makinen et al., 2000, p. 61). PAHO confirmed the finding that the state-funded healthcare is on the retreat by showing the country's health expenditure by sub-sector and function from 1995-2003. Overall, one can see that public sector spending is on the decline, and private sector spending is increasing (2007).

Table 1.2. Health Expenditure by Sub-Sector and Function (in US$)
Guatemala 1995-2003



Financial Source	**1995**	**1996**	**1997**	**1999**	**2000**	**2001**	**2002**	**2003**
Public Sector	**59.3**	**57.84**	**60.44**	**48.3**	**39.3**	**38**	**36.5**	**39.5**
Territorial government	31.48	27.62	29.9	21.8	18.5	16.9	17.3	18.3
Social security	27.82	30.22	30.54	26.5	20.8	19.4	19.2	20.8
Private sector	**40.7**	**42.16**	**39.56**	**51.7**	**60.2**	**61.9**	**63**	**60**
Health insurance	3.94	4.15	3.95	2.8	2.5	2.6	2.7	2.6
Out-of-pocket payments	32.78	33.73	31.44	44.3	54	55.7	57.1	54
Nonprofit institutions	3.94	4.29	4.17	4.7	3.7	3.6	3.3	3.4
Other				0	0.5	0.1	0.4	0.6

Source: (1) National Health Accounts 1995.1997; MSPAS; (2) *La situación de salud y su financiamiento 1999-2003*, MSPAS.

If the Guatemalan government was providing so little per person, and only the wealthy seemed to be able to afford private health care, therein lies a partial explanation for the prevalent and severe health problems that primarily affect the poor in Guatemala: the more financially vulnerable get and stay sicker without being able to pay for care (PAHO, 2007). Neoliberal health reforms have delivered as promised, but only to a certain extent. The PEC ultimately increased coverage to health care substantially, allowing for 85.5% of Guatemalans to at the least have the minimal level of care (a health post) within 5 km of their homes through the extension of coverage in the jurisdictions of health teams (Avila et al., 2015, p. 68). It also brought a basic package of services to many Guatemalans (pre-natal care, immunizations, tropical illness, vector control, and water quality, among others) though care for complicated medical issues was often out of reach (Lao-Peña, 2013). Flores specifies several areas of health care not accessible to patients through PEC, including “attention to chronic and degenerative illnesses, occupational health issues, geriatric care” (Flores, 2008, p. 54). Abel and Lloyd-Sherlock echo this criticism, saying “entitlement and access to healthcare in most Latin American countries mirror the stratification and inequity of their societies rather than mitigating social divides” (1997, p.8).

PEC also heavily impacted the multitude of NGOs in Guatemala. Cardelle’s outline of the types of NGOs includes both those who had been present for decades before the armed conflict and “Astroturf NGOs” believed to participate in PEC to make money (Cardelle, 2003, Maupin, 2009). Rohloff and colleagues state that the diminishing pool of donor funds for development projects (rural, health and otherwise) due to the economic crisis of 2008 and the increasing number of NGOs causes competition between

NGOs (Rohloff, Diaz, & Dasgupta, 2011). Competition for a place within communities can also lead to confusion among potential patients of these NGOs—certainly not creating the desired intuitive and usable health care landscape (Ibid.).

This section has explained what motivated the neoliberal health reforms, how they were enacted in Guatemala, and what their effects were on the Guatemalan health care system. It is important to note that though the Debt Crisis occurred in the late 1980s, much of the neoliberal reforms were not enacted until later – in fact, one could argue that the austerity measures put in place in the 2000s were even part of this same trend. The slow evolution of the Ministry of Health in Guatemala, the introduction of PEC, and the changes in the types of NGOs present in the country in the next section connect to neoliberal reforms in a clear way: privatization meant that *anyone* besides the state, including non-government organizations, were popularized as providers of care. Chary and Rohloff comment on the unique privatization scheme in their edited volume, stating that "…privatization has not necessarily introduced widespread social inequalities in access to public healthcare. Rather, the social inequalities resulting from privatization in Guatemala are of a different sort and scale, because among the poor, privatization offers apertures for obtaining care to some health seekers, but not to others" (2016, p. xxviii).

IV. Characteristics of the Health Care Landscape Since 1996

The Contemporary Guatemalan Public Health Care System

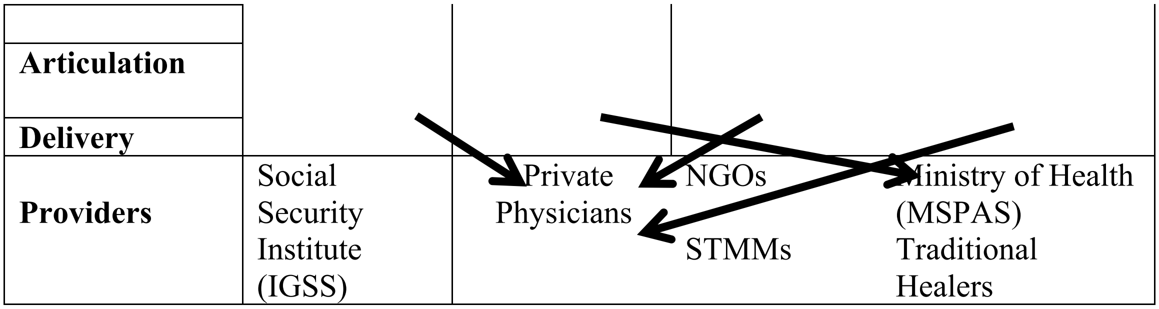
The signing of the Peace Accords ignited a period of changes between 1996 and the present which have been enacted, redacted, and implemented with varying success. The culmination of the developing role of NGOs as a major provider of health care resulted in the SIAS/PEC (discussed in the previous section) which permitted NGOs to contract with the Guatemalan government. This signaled both collaboration and the complication of relationships between the health care system, NGOs, and private providers of care. Within this system, NGOs could compete for government contracts and even potentially earn profits from their provision of health care. The proliferation of NGOs has been credited to the introduction of PEC, as well as the “tourism effect” detailed by Rohloff and colleagues. They describe a “tourist-volunteer-development worker spectrum,” which heavily relies on the indigeneity of the poor, a desire of foreigners to help with local problems, and a fluidity between the tourism and development domains (Rohloff, Diaz, & Dasgupta, 2011, p. 432). Medical mission teams certainly fall onto this spectrum, but where and how exactly demands further research.

PEC, which extended coverage to many people in poor, rural areas, has been reviewed with mixed results (Maupin, 2009). Verdugo critiques PEC from the perspective of emphasizing the state’s responsibility in the health care of its citizens, saying “In addition to using volunteers to keep spending low, the SIAS health care model formally exploits the self-care strategies of families and self-sufficiency of communities” (Verdugo, 2004, p. 67). Even though the PEC ultimately increased coverage to health care substantially, allowing for 85.5% of Guatemalans to at least hypothetically have a health post within 5 km of their homes, the program was not renewed in 2015 (Avila et al., 2015, p. 68). Now, close to 1.7 million Guatemalans must travel further for their basic health needs (Ibid.). Rural Guatemalans who had previously been able to access primary care—some prenatal care, vaccinations, and other preventative medicine—were now left with nothing close to them, as there was no replacement program implemented. Access to preventative medicine for rural populations was thus reduced.

Many scholars, activists, journalists, and politicians recognize that not enough Guatemalans have been adequately covered by state-provided health care, and that those who suffer the most from the lack of health care are the rural poor (MSPAS, 2008). The inequality and privatization discussed in Section II have engendered what Londoño and Frenk call a “segmented model of health” (1997). In this model applied to Guatemala, the poor and the rich within the society receive differing qualities of care through separate avenues. Different groups are not “integrated” in the sense that they all have equal access to every institution in a health system (Ibid., p. 29, but all of the institutions theoretically carry out the same functions. Applied to Guatemala, this articulates according to the model and mirrors the almost-equivalence of poor to non-poor in Guatemalan society; in 2011, Guatemalans in poverty made up 54% of the total population (World Bank, 2016). This diagram, adapted from the original in Londoño and Frenk’s book chapter entitled “Structured Pluralism, Towards an Innovative Model for Health System Reform in Latin America” (1997), was altered slightly to illustrate the segmented model according to poverty demographics specific to Guatemala.

Table 1.3. A Segmented Model of Health: Guatemala

Functions	**Social Groups**		
	Non-poor		**Poor**
Insurance	Socially Insured	Privately Insured, Self-Insured	Uninsured
Modulation	↓	↓	↓ ↓
Financing			



Articulation				
Delivery				
Providers	Social Security Institute (IGSS)	Private Physicians	NGOs STMMs	Ministry of Health (MSPAS) Traditional Healers

Diagram adapted from Londoño and Frenk (1997, p. 33).

Londoño and Frenk outline the four primary functions of providing health services to a population: modulation, financing, articulation, and delivery, briefly outlined here. Modulation refers to "setting, implementing, and monitoring the rules of the game for the health system, as well as providing it with strategic direction" (Ibid., p. 28). Financing is the collection of fiscal resources by the government, then their redistribution to the appropriate entities that pay for services to be delivered to populations utilizing health services – the delivery function (Londoño and Frenk, 1997). Articulation is meant to "pull together and give coherence to various components of healthcare [and] allow financial resources to flow to the production and consumption of healthcare" (Ibid., p. 28).

Segmented health systems are characterized by their lack of integration across social groups and vertical integration. In other words, as shown by the diagram above, the poor have access to Ministry of Health facilities but cannot become part of the social security institute because of their lack of employment in the formal labor sector. Though this in theory does not signal outright discrimination, the quality and availability of services (i.e., complex health care needs) within the Ministry of Health is not equivalent to those of the IGSS or private physicians whom the wealthy can afford to see. Often, the quality of the care received or the ability to receive care at all depends very much on the ethnicity and socioeconomic status of the individual asking for it (Chary, 2015). It is easy to see how short-term medical missions can potentially solve a need for health care for Guatemalans who otherwise might fall through the cracks—either because of their geographic location or because of the cost of more complicated medical procedures and care. And as argued further below, this absolves the state of the financial and political burden of bettering its quality of care, distribution, and health care delivery.

The Contemporary Health Care Landscape

Universal health care was granted to the entire population at the time of the signing of the 1996 Peace Accords after the four-decade long civil war (MINIGUA, 1998). In theory, all citizens qualify for the national health care program through the Ministerio de Salud Pública Asistencia Social (MSPAS) and citizens have the ability to opt out and seek other methods of health care if they wish. This "opting out" and completely using private health care providers as evidenced by the statistics on private health care usage provided in the previous section through the work of Makinen and colleagues (2000) is generally available only to the wealthier members of Guatemalan society. With 80% of health care expenditures funded privately, Guatemala has the "lowest ratio of public to private healthcare expenditures in Central America" (Chary & Rohloff, 2015, p. xvii).

According to the Instituto Nacional de Estadísticas (INE), which publishes reports such as ENCOVI—a national survey describing the living conditions of Guatemalans—only 40.1% of the whole population went to the doctor for an illness, accident, or check-up in 2014. For indigenous Guatemalans, the rate was even lower—29.1% (INE, 2015).

When divided into quintiles, the INE shows that 60.4% of the richest quintile went to the doctor in 2014; 23.4% and 29.1% of the lowest two quintiles, respectively, went to the doctor that year (Ibid.). That same year, 27% of the population that did seek medical care went to a *centro* or *puesto de salud* and 22.3% of the population went to a private clinic (Ibid.). Finally, there has been a 24% increase in the percentage of the population who do not seek medical care because of financial barriers between 2000 and 2014[5] (INE, 2015). This indicates that medical care is becoming out of reach for the poor population and that they are getting medical care less, though there are other factors to consider, such as less use due to poor evaluations of the quality of care in public health care settings (Rohloff, Diaz, & Dasgupta, 2011; Chary, 2015).

MSPAS is reputed among Guatemalans to promise but not execute its ability to cover a large portion of the Guatemalan population who do not work in the formal employment sector. Austerity measures aimed at cutting social services expenditures and rampant systemic corruption mean that the MSPAS is often stretched very thin and cannot cover its assigned population, often due to shortages in supplies or pay for workers; the health worker density in 2013 was found to be 12.5 workers per population of 100,000—the "bare minimum for a functioning health system" (Avila et al., 2015, p. 78). Other means of obtaining health care includes private physicians, health care-providing non-government organizations, the *Instituto Guatemalteco de Seguridad Social* (for government workers/those working in the formal sector) known as IGSS, and short-

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[5] It should be noted however, that this data does not differentiate between preventative care and curative care.

term medical missions which come to Guatemala semi-regularly but are also generally aimed to provide care to the poor.

Figure 1.2. Health Provider Coverage Percentages, Guatemala.

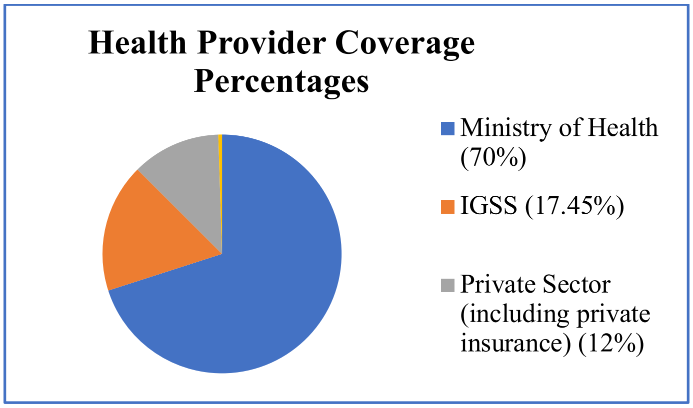

Chart adapted from information in Becerril-Montekio (2011)

The public health care system, MSPAS, is composed of three levels of care. These levels and their current number of facilities are: primary, which is made up of 1,302 health posts at the primary level, 923 health centers at the secondary level (plus 379 mobile clinics), and 51 hospitals at the tertiary level of care (Avila et al., 2015). Even though equal financing is supposed to be allocated to all three levels equally, “the third-level of care still receives over 50% of total financing” (PAHO, 2007, sec. 2.1.5.). Tertiary care, which is more expensive to provide, is available primarily in the heavily urban areas of Guatemala—leaving rural areas in need. Additionally, tertiary care is often not a “free” social service; at the level of providing surgeries, “patients must pay for medications and clinical tests; supplemental food if they are admitted for overnight stays; and materials for procedures, such as gloves and surgical suture” (Chary et al., 2016). The ENCOVI published in 2015 showed that 27% of the population in 2014 who had an accident, illness, or health complaint went to a health center or health post. Private clinics saw 22.3% of visits, and 18.2% went to a public hospital (INE, 2015).

The *Instituto Guatemalteco de Seguro Social* (IGSS) serves the percentage of the population engaged in the formal economy. IGSS covers Guatemalan citizens due to a job in the formal economy, being a spouse of someone with a job in the formal economy, being a child under 7 years old of an employee, disability due to an accident, and old age, among other factors (MSPAS., 2012, p. 13). IGSS operates a different, smaller set of facilities from the Ministry of Health. IGSS, as a private insurer, spends significantly more on those who buy into the insurance scheme than the MSPAS does on each citizen. In 2005, "the Ministry of Health spent US $32.22 per inhabitant and IGSS spent US $298" (PAHO, 2007, sec. 2.2.1.). According to the INE, 89.2% of the Guatemalan population does not have access to health insurance, and 9.2% of the remaining 10.8% of Guatemalans that do get their insurance from IGSS (INE, 2015).

Private health care is an additional avenue through which Guatemalans receive their health care, although many providers work both in the national hospitals and health centers and in their private practices. Between 2000 and 2010, there was a 107% increase in the per capita yearly expense on health (MSPAS, 2012). This demonstrates that the push for privatization by entities such as the World Bank and Inter-American Development Bank garnered results. Private spending in health as a percentage of total expenditures was 43% from 1995-1999, 54% from 2000-2005, and was recorded at 62% in 2015 – a 44% increase (PAHO, 2007; Avila et al., 2015). Guatemalans increased spending of their total income on private health care in that 10-year period; however, between 2000 and 2014, the percentage of Guatemalans who did not seek care due to financial barriers[6] also rose from 29.2% to 36.2%.

Health Care Demographics and Disparities

As of the census in 2018, the population totals 17.92 million Guatemalans. The country still has one of the highest total fertility rates in the Latin American and Caribbean (LAC) region – 3.8 births per woman. Guatemala has a balanced rural to urban population ratio, with the urban population making up 49.3% of the total population. Guatemala is a country of young people, with those under 14 years old composing 40.4% of the total population. The most current top 5 causes of death are lower respiratory illness (1), interpersonal violence (2), cancer (3), ischemic heart disease (4), and diabetes (5) (CDC, 2013). In sum, many of the causes of death are similar to those in the years preceding health care reform – respiratory illness and interpersonal violence. Other causes of death match international trends; globally, non-communicable diseases are replacing communicable disease as leading causes of death. This indicates that some of the diseases historically endemic to Guatemala are decreasing, but are also being replaced by chronic illness.

The following demographics of Guatemala from the Pan-American Health Organization detail the disparities in health care access and coverage. Fifty-six percent of the population is poor, while 21.5% of those in poverty are in extreme poverty. Of those

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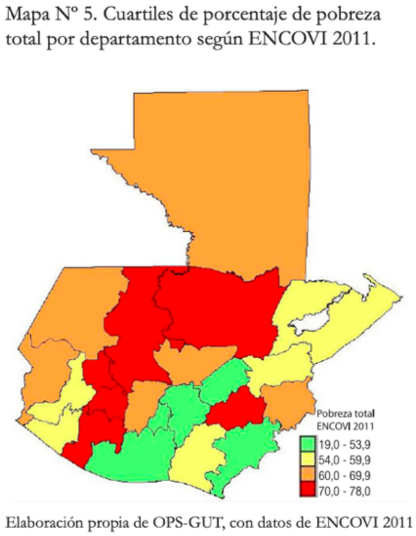
[6] In ENCOVI "*por falta de dinero*," literally "lack of money."

56% in poverty, 76% are indigenous. Although there are several means of obtaining health care, they are still inaccessible to many Guatemalans.

As seen in the PAHO image below, Figure 1.3, the concentration of poverty is highest in the north and northwest departments of the country, including the departments of Alta Verapaz, Quiché, Totonicapán, Sololá, and Retalhuleu—areas overlapping with percentage indigenous population and sites of ethnic violence during the armed conflict. Departments on both coasts (Escuintla to the west, Izabal to the east) host the primary shipping ports, providing economic stimulation in those areas.

Figure 1.3. "Quartiles of the total percentage of poverty per department, according to ENCOVI, 2011"

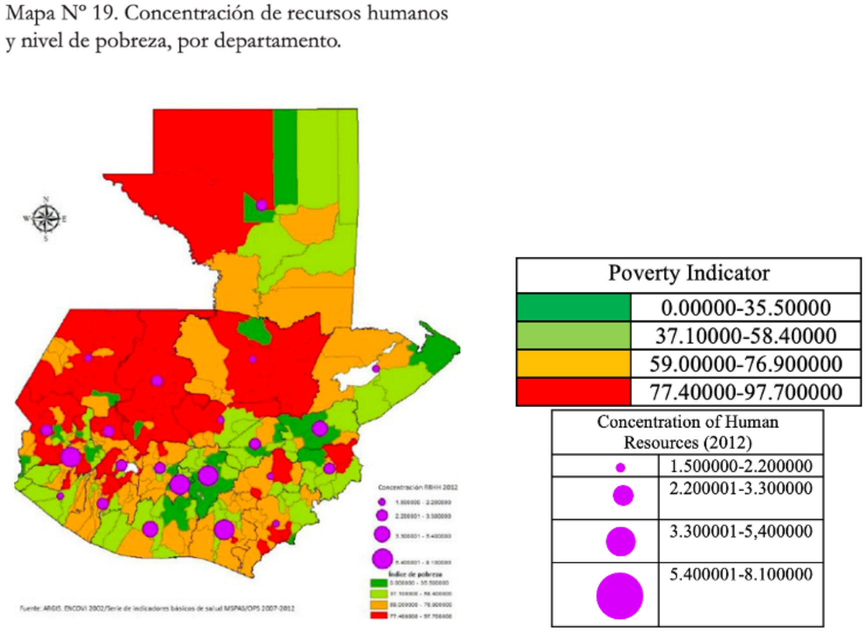


Source: PAHO (2016)

There are health disparities within the country that follow a rural-urban distribution. Infrastructurally, there are national hospitals distributed in each different department, with three additional hospitals concentrated in Guatemala City. While these national and regional hospitals often have dedicated staff and providers, they suffer a lack of resources (human and material) that make for what is often characterized as subpar attention to patients and the hospitals are seen a "places to die" (Berry, 2014).

As illustrated in Figure 1.4 below, the areas with the most poverty are the areas with the least human resources dedicated to health care. Human resources are concentrated in urban, more affluent areas (in green), while the areas (in red) characterized by the most poverty and the highest percentage indigenous population, have very few human resources available to them.

Figure 1.4. "Concentration of human resources and level of poverty, per department"



Source: PAHO (2016)

In a personal observation of one national hospital, patients were recuperating on rusted gurneys in the hallways, in front of any passerby, and patients (or visitors) had to bring their own toilet paper to use the bathroom—what would seem a risk to hygiene and cleanliness in any hospital. Technology and medical devices, in good faith donated to some of the institutions, have by more than one account been "re-appropriated" by hospital personnel or physicians with private practices they operate on the side. In a report by the Pan-American Health Organization, the researchers concluded that "the material and human resources to provide health care are found unequally distributed in the national territory and a lesser concentration of those resources is observed in the territories with the most poverty" (2016).

Regarding maternal mortality ratios, one of the key indicators often utilized to evaluate general health status and health disparities, the USAID report published in 2016 states that there are "vast inequalities between poorer, rural, and predominantly indigenous departments… compared to urban departments" (Avila et al., 2016, p. 65). The ratio is more than 225 deaths per 100,000 live births in the department of Huehuetenango, and less than 50 maternal deaths per 100,000 live births in the department of Guatemala (Ibid.). This is just one example of the typical rural-urban health disparities access to health care characteristic of the country.

Criticisms and Concerns of Public Health Care Provision

The Guatemalan government's national health care system has been heavily criticized in recent years, due to its poor quality of care delivery and corruption scandals. Based on a limited set of interviews done in 2015 by the author, some Guatemalans seem to see the national hospitals as places to give birth (in the case of Caesarean delivery) and to die. Some of the inefficiencies in the national health care system include, "'leaks' in the system (losses, fraud, and corruption), inadequate budgets, low use of innovative medications or high-quality generics, overestimated earnings [e.g., from taxes], a culture of lateness and inefficiency, lack of personnel in rural areas," among other criticisms

(Calderón Pinzón, 2019). Calderón Pinzón also notes that institutional corruption within the MSPAS negatively impacts poor and rural populations disproportionately (Ibid.)—as mentioned previously, those with the economic means often go to private providers rather than to public health facilities.

Many health professionals believe that working in the national health care system is not fulfilling work, either. The Prensa Libre reported in November 15th that doctors were protesting their lack of pay in national hospitals (Prensa Libre, 2015). During the outbreak of Covid-19 in 2020, health care workers protested in December after months of not receiving pay, despite being the most at-risk populating for contracting the disease (Román, 2020). In Chary's account, she observed that doctors working in the national hospital routinely left at noon to work in their private practices, due to the low pay and lack of resources in national facilities. Finally, time is not spent on adequately explaining medical testing, diagnoses, and procedures either because the patient is illiterate and cannot read signs and forms or is a monolingual Maya language speaker and does not speak the country's language of business and politics, Spanish—despite the promise of care made in the Peace Accords (Chary et al., 2016).

In 2014 *the Comisión Legislativa de Salud y la Comisión Presidencial contra la Discriminación y Racismo (COMISRA)*, or the Legislative Health Commission and Presidential Commission against Discrimination and Racism presented *denuncias*[7] in front of the Office of Human Rights. The *denuncia*s included complaints of ambulances being used for personal meetings and not available in emergencies, indigenous languages

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[7] A *denuncia* is a formal complaint, often against a government or official entity. It is a common way in Guatemala to publicly shame an individual or organization.

not being spoken when it is necessary, lack of sterilization of tools in hospitals in Coban,[8] Caesarean sections performed on women under 14 years old without their consent, and other issues of patient rights (Prensa Libre, 2015). Clearly, there is still much progress to be made when focusing on the improvement of the quality of care, access, and delivery of health care in the public context.

Dr. Mario Calderón Pinzón, a physician and professor at the National University of San Carlos, wrote a series of articles criticizing the health care system and proposing ways in which to 'revolutionize' it. One of the specific criticisms he raised about the health care system is specifically of physicians, especially those at the leadership level; once they reach "011" (the equivalent of tenured) status, many stop valuing their work, take their pay, and do little to serve others (Calderón Pinzón, 2020). Additionally, he identified nepotism, poor leadership skills, and clientelism as systematic flaws of the MSPAS (Ibid.).

Barriers to Care for Patients and Ancillary Costs

Anxieties about the quality of care that patients receive in publicly funded hospitals and clinics by indigenous Maya patients appear frequently in the literature. Chary and colleagues highlight the difficulty of indigenous patients who have complex health care needs and must be referred to multiple health providers for resolution of a health care problem: "referrals remain exclusively the responsibility of the patient, who must overcome economic, transportation, language, and cultural barriers to access higher levels of public sector care. Journeys from rural areas to urban hospitals in the capital

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[8] Coban is a city in the department of Alta Verapaz, in rural north central Guatemala.

often take many hours-even days for those from remote villages-and are very expensive, even utilizing public transportation" (Chary et al., 2016, p. 307).

Nicole Berry, in her study of indigenous perceptions of quality of care in hospital settings in the department of Sololá (a majority indigenous department of the country), found that many indigenous Guatemalans who went to the hospital for care felt they were not attended to—that despite the effort they made to get to the hospital, the staff were apathetic towards them (2008). Additionally, Berry's work outlined the costs paid by families for a visit to the hospital; despite the free care delivered by the hospital staff, the medication and tools needed for the procedures are not (Ibid.) The idea that MSPAS health care is "universal," "public," and synonymous with "free", is a false one. Chary observed cancer patients being asked buy medications, IVs, and syringes for themselves from the pharmacy – the hospital did not have them readily available for patients (Chary, 2015). Ironically, this observation of there being few necessary pieces of medical equipment available is no different from over thirty years earlier when Sheldon Annis said, "in fact, about the only medical items that are really in adequate supply are syringes, wooden tongue depressors, thermometers, and cotton swabs" (1981, p. 522). This clearly undesirable characteristic of the sites of health services has persevered, despite the many changes undergone by the country since 1981.

Patients have stated that one of the reasons surgeries within medical missions are particularly sought after is because they occur on a reasonable timeline, as noted by patients who participated in this research. One medical director, a Guatemalan physician, explained the complex referral system and requirements in order to receive a surgery from a national health facility. A patient must begin at their local Centro de Salud, obtain a referral from a physician at the Centro de Salud to get diagnostic testing done (e.g. ultrasound showing gallstones of a considerable size) along with a consultation and physical examination (e.g., showing Murphy's Sign, where patient is pained/distressed by a tap to the area where the gallbladder is located). They are then referred to one of the regional hospitals that corresponds with the area they live in. If a surgery is not available at the regional hospital, they still must meet and be given an additional referral by a physician in the regional hospital after reviewing the patient and their laboratory/imaging results.

Finally, the patient is allowed to travel to a regional hospital (if available) or one of the national hospitals in Guatemala City to receive their surgery, though many must wait six months to a year for their surgery date. This lengthy process applies to cancer patients as well. The physician commented that even a cancer patient cannot simply arrive at INCAN (the National Cancer Institute) to be treated at no/low cost as supported by MSPAS—they must go through the referral process, which includes biopsies and substantial laboratory testing, often still at a cost to the patient, or elect to enter as a "private patient" and pay the full cost of treatment. Thus, what are at the least, painful conditions that need surgery (such as gallstones) or at the most, life-threatening and time sensitive illnesses (such as cancer), often become lengthy processes to achieve proper treatment.

NGO and Short-Term Medical Mission Care as an Alternative

While non-government organizations have long been participants in the wide variety of health care providers in Guatemala, the period in which the government pursued PEC as a viable option for extending health care coverage to the country—and creating contracts with NGOs to execute it—primed the country for further non-government interventions, as detailed in previous sections of this chapter (Maupin, 2009; USAID, 2015). PEC was cancelled in 2014, following a law the government passed the year prior (2013) prohibiting government entities from subcontracting with NGOs to provide MSPAS services, as the government struggled to pay the contracts (USAID, 2015, p. 64). This created a literal division between non-government health care providers and public health, where before there had been space for collaboration and contracting.

The number of NGOs within the country has grown, with estimates ranging from around 700 in the 1990s, to now over 10,000-15,000 estimated as of 2007 (Chary & Rohloff, 2015), reflecting world trends thought to explain the global boom in NGOs, such as war (Guatemala's armed conflict), globalization, and poverty (and its ensuing problems to be resolved) (Turner, 2010). In the health sector in Guatemala, it is obvious that the state has slowly been retreating as a reliable, cheap, and public provider of health care, and NGOs and other non-government health care providers have found their place in the health care landscape (Chary & Rohloff, 2015). One such health care provider is the volunteer medical team in the context of short-term medical missions, which will be discussed further in Chapter 2.

Health care delivered at low-or-no cost by non-government organizations (which includes providers in U.S.-based or Guatemalan NGOs and short-term medical missions) has become a reasonable third alternative for many Guatemalans, often arriving in the middle of the spectrum in terms of cost and wait time to receive medical care. Short-term medical missions, while plagued by their own set of systemic issues they must overcome (e.g., patient follow-up, local regulations, importation of medications, and language differences, etc.), offer an even more attractive alternative because, for the patients, it is often a matter of who arrives earliest to wait outside of the clinic—not how much they need to pay or their ethnic identity (Roche et al., 2018). This is not to say that short-term medical missions offer some sort of utopian solution vis-à-vis the MSPAS, but they do seem to provide a workaround for what many people believe are unchangeable personal barriers to getting healthy—poverty and indigeneity. While idealists and academics might hope that structural inequality, poverty, and discrimination in Guatemala will change in the next few decades, many Guatemalans remain stuck in a cycle that seems impossible to escape.

As discovered in the fieldwork for this dissertation, healthcare NGOs that coordinate short-term medical mission care tend to charge between Q0 and Q800 for surgeries and between Q0 and Q50 for consultations, which most often do include medications. In contrast, at the least expensive, private surgeries (e.g., surgeries provided by a private surgeon) often start around Q4000, and can cost upwards of Q50,000, while consultations at the minimum cost around Q150-200. The organizations that provide surgeries are constantly managing large rosters of patients in coordination with the types of surgeries different teams are offering in the calendar year, trying to match the appropriate patient with the right provider. While many patients still must wait for their surgery, the process includes a single referral and, if organized efficiently, one point-person who notifies the patient of their opportunity to receive a surgery.

Interestingly, while Guatemalans are well aware of the presence of medical missions, the missions themselves are often unaware of local providers. Roche and colleagues, in their systematic analysis of short-term medical mission literature, identified a dearth of acknowledgement by STMMs that there are health services potentially available to patients (2016). They attribute the lack of referrals to the idea that volunteer medical teams are the single option for patients needing care, rather than being one of many providers theoretically available to patients, following the medical pluralism concept offered by Chary and Rohloff (2016). Patients who see STMMs and are successfully referred to a local provider could see beneficial outcomes—but only if the STMMs are aware of local resources (Roche, Ketheeswaran, and Wirtz, 2016). Short-term medical missions are thus simultaneously a valuable resource for low-income Guatemalans and a potential risk if there is inadequate triage between STMMs and local providers.

V. Conclusion

In the past century, Guatemala has changed in dramatic ways, one of which being the constant evolution of the health care system. Prior to the revolution in 1945, there was no insurance and no publicly provided medical care. During the Ten Years of Spring, a universal system of medical care was introduced as part of a general welfare system that was introduced to the country by Juan José Arévalo. The health system was modified during the years of the armed conflict (1954-1996), but modifications were mainly organizational or bureaucratic and did little to improve population health. During the 1980s, when Guatemala's economy suffered the most, structural adjustments were required by the Inter-American Development Bank and the International Monetary Fund to maintain Guatemala's financial status with those lending institutions. Guatemala had to work towards privatization after this time, reducing the role of the state in the provision of social services through divestment in the health sector and the transfer of responsibility to non-government entities and individuals.

Significant structural changes emerged after the Peace Accords were signed in 1996 – the Peace Accords reiterated that the right to health was one of the fundamental rights that Guatemalans are afforded. After the conflict, many people were left in communities without health care resources. SIAS/PEC was created in order to remedy that coverage issue while still maintaining a role for the state as a regulatory agent and agenda-setter. PEC allowed for NGOs to accept government contracts in exchange for the provision of health care services to low-covered rural areas of the country. During this time, NGOs flourished in Guatemala and continued to bring in foreigners as volunteers and employees.

Today, the "health care landscape" is a fractured set of health care providers who often provide the same types of care for different costs at varying levels of quality and do not always communicate with one another to achieve a shared goal. The MSPAS provides a basic health care package, but the quality and availability of health care provided is known to vary. NGOs are still a major provider of care in the country but also include some variability and coverage issues. IGSS is a reliable means of obtaining health care, but meeting the formal qualifications through employment can be difficult. Private physicians offer specialization that sometimes cannot be offered through the basic health care package, and is financially not feasible for sustainable health care for most

Guatemalans. SIAS/PEC was not renewed by Guatemala's president in 2015, which meant a reduction of primary health care coverage in rural areas.

Finally, among the many providers of care are also American doctors working in short-term medical missions, the most recent addition to this pantheon of health care providers. Short-term medical missions satisfy the desire of volunteer medical providers who want to travel and engage in humanitarian work (the push) as well as satisfy two prominent needs within health care in Guatemala—low-or-no cost surgeries and access to free consultations that often include the prescription of low-or-no medication.

STMMs represent another facet of the neoliberal health care model, absolving the state of the responsibility but often leaving the labor of finding STMMs and arriving to their locations to patients, further discussed in the following chapters. STMMs remedy the state's problem of tertiary care/surgical care, which is heavily distributed in urban areas and encourages a surgical care model that depends largely on the ability of patients to navigate and finance their own care, or 'resource shop' in a similar way as done within the NGO context (Rohloff, Diaz, & Dasgupta, 2011). STMMs often coordinate with local NGOs to have a place to conduct examinations and surgeries but are not officially part of the NGOs. These entities are the least institutionalized of all the aforementioned providers of care; however, STMMs are numerous and ubiquitous in Guatemala, especially the regions that receive the bulk of U.S. tourism. The history and nature of these missions will be explored in the following chapter.

CHAPTER 2

THE GLOBAL SCOPE OF MEDICAL MISSIONS

“Screw OSHA[9].”

I looked around to see if anyone else reacted the way that I did, wide-eyed and a bit incredulous. I was with a group of twenty medical mission volunteers, many of whom were nursing students earning practice hours under the supervision of an older nursing faculty at a small university in Texas. The others were anesthesiologists and obstetric and gynecological providers. The veteran providers decided to forgo the tour and instead rest up for the five days of hysterectomies and uterine prolapse repairs ahead. We toured the private hospital facility run by a committee comprised of members of the community, a local physician, and members of a church in Texas who had founded the STMM and made the initial investment to construct the hospital. The director of the hospital, an elderly surgeon from the United States, made his distaste for bureaucracy more than apparent.

“It’s that we waste so much stuff in the U.S. because of laws like OSHA. So, here, if it can be sanitized and used again, do not throw it away. And make sure you really need it if you’re gonna use something on a patient.” We were all standing in the long operating room and continued to listen to the director’s sermon. Finally, we walked through the corridor into the convalescence room. He told us that patients were to spend

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[9] “With the Occupational Safety and Health Act of 1970, Congress created the Occupational Safety and Health Administration (OSHA) to ensure safe and healthful working conditions for workers by setting and enforcing standards and by providing training, outreach, education and assistance.” (https://www.osha.gov/aboutosha).

the time needed for their anesthesia to wear off in this room, directing the nurses to keep blankets on hand because "Guatemalans tend to get cold."

The group nodded. We followed him as he veered to the right into a large space. "This used to be the chapel, but we made it into the orthopedic OR [operating room]." The room had a small stained-glass window with a cross, letting a small bit of light in. There was something funny about the chapel of a hospital built by Bible Belt Christians later being converted into such a practical and unceremonious space by the same group.

We followed the hospital director into a second convalescent space with more beds. He explained that unless there were complications, most patients did not spend more than 48 hours past their operation in the hospital. Patients enter the hospital, go to intake, where their vital signs are measured, and they explain the reason for their arrival in the hospital. After a first consultation (at least in the case of surgery), the patients go in for surgery often that day or the day after, a shockingly quick turnaround for people used to waiting between six and twelve months for surgeries in national hospitals.

He explained the flow of patients at the end of their stay: once they were able to walk and make it to a vehicle, they would be instructed to go to the front entrance of the hospital and pay for their surgery. If they said they could not pay, they would sit and talk with the social worker, who would determine their ability to pay by asking them questions about the size of their family, their income, and their occupation, among other questions. To me, this process seemed incredibly murky and based on many false assumptions about how people in poverty live, though the surgeries rarely cost over Q1000, or $125 USD.

Once the financial aspect had been resolved, they were released to their fate. I was always worried about the elderly female patients in medical missions, especially because of all patients, they were less likely to be able to read, less likely to be able to understand Spanish if they had an emergency, and the least educated demographic. When I watched their tiny bodies walk away, often accompanied by their husbands or sons, I wondered what would happen to them. They were not given paperwork to show to their primary physician, so I imagined the next time they went to the Centro de Salud, explaining what they could remember about their procedure and patching together the geography of all their bodies have been through with their doctor.

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I. Introduction

In the last twenty years, drastic changes to the health care landscape in Guatemala have impacted the ways in which people can obtain medical care. These changes were outlined in the previous chapter—most notably, the deterioration of the state as a provider of health care due to underfunding, corruption, and lack of accessibility (Calderón Pinzón, 2020) has allowed for new providers of care to enter the health care landscape—including medical missions that use various strategies to provide basic health services to populations as well as mitigate the prohibitive cost of timely surgeries (Chary & Rohloff, 2015; Roche et al., 2018). Short-term medical missions are one of these providers that deliver care in a context of limited time, limited manpower, and cultural barriers—thus introducing specific concerns. In this chapter, I focus on the origins of medical missions globally, then situate them more specifically to the Guatemalan context and discuss the applicability of cultural competence in this context, where the differences between provider and patient are not only expected, but are also the main point of interest for many volunteers in the STMM context.

Short-term medical missions (STMMs) are defined as small groups of foreign physicians, nurses, surgeons, and other similarly qualified providers who travel to other countries for short periods, often up to two weeks, to provide health care (including consultations, writing prescriptions, and performing surgeries) to the local population (Montgomery, 1993; Priest & Priest, 2008). The National Library of Medicine definition specifically excludes "missions and missionaries which covers permanent medical establishments and personnel maintained by religious organizations" (NLM, 2011). "Short-term" medical missions are defined differently in the literature, ranging from less than one week (Caldron, Impens, Pavlova, & Groot, 2016) to one or several months (Maki et al., 2008), or even two years (Martiniuk, Manouchehrian, Negin, & Zwi, 2012). In the background research conducted while recruiting teams for the dissertation research, no single medical mission trip to Guatemala was identified as lasting longer than 8 days. In the literature, STMMs to Guatemala specifically also appear to be limited by such a time frame.

This chapter will first focus on the role of all STMM physicians globally and what constitutes medical mission care. The range of "short-term medical mission care" varies from military and NGO interventions in disaster zones, to surgical missions, to those that provide more basic health services, all with differing care settings and engagement with local health care systems. How did the practice of delivering short-term care begin, and how has it impacted health care systems in which this practice is common? The difficulty of measuring and observing this phenomenon will also be addressed, as well as both the positive and negative implications of offering short-term medical care to what are often low-income populations unable to afford high-quality care from other providers. One of the few studies attempting to establish how many STMMs leave the United States each year counted over 500 medical mission organizations and 6000 missions to foreign countries (Snyder, Dharamsi, & Crooks, 2011).

The primary case studies of this chapter are 1) medical missions conducted by Medicins San Frontiéres, which offer an excellent case study of global medical humanitarianism due to their ubiquity as a global medical mission, though they tend to operate within a longer timeframe and 2) shorter missions (often up to two weeks) executed in Guatemala to contextualize the dissertation research. The time frame of two weeks or less was chosen given that the transient nature of the medical providers (exclusive of the organizations with which they collaborate) as a defining feature of their role in the health care landscape. These case studies also serve to demonstrate the desire for medical missions (of any type) to be identified as socially, economically, and politically neutral parties—when in fact, the histories of colonization in the places receiving medical missions makes neutrality impossible within the realm of international aid and development. Denying the ideological underpinnings of STMMs, such as neoliberalism, may actually hinder the honest evaluations necessary to improve the access to and quality of the care provided.

Three common methods of providing care characterize medical missions. Medical missions often aim to serve a specific need for communities in which they work, such as eye surgeries, cleft palate surgeries, or cardiovascular care; in other words, they find patients with particular ailments to treat. These are known as surgical-dental teams, who use in-country facilities or non-traditional facilities such as ships or planes (Bajkiewiecz, 2009). In contrast, other medical missions go to a particular location and take patients on a case-by-case basis. Basic care and consultations are routinely provided to patients within the target communities of STMMs—these are known as mobile clinics, which provide non-invasive procedures (Ibid.). Finally, relief care is provided in "complex humanitarian emergencies," often through organizations such as Medicins san Frontiéres (MSF), also known as Doctors without Borders (Ibid., p. 111). Relief care is not a focus of this study, but the section of this chapter dedicated to the study of MSF contextualizes some of the crucial elements of collaboration between volunteer medical teams and the countries to which they provide humanitarian aid.

Cultural competence is a concept in health care gaining traction in the United States, and one I hoped to examine through the lens of short-term medical missions. There are several uses of the term 'cultural competence'—as a skill, a philosophy, or an approach to health care delivery. While these orientations towards cultural competence bring important attention to the fact that there are cultural differences between providers and patients, later anthropological critiques of cultural competence primarily encompass the way that culture is constructed in these discussions: static, memorizable, and not intersecting with other important factors such as gender or socioeconomic status. STMMs lay bare the differences between patients and physicians, most importantly on the axes of ethnicity, education, and socioeconomic status in many environments in which STMMs work. While I prepared a survey to measure cultural competence within the provider population that participated in the research, my qualitative research led me to the conclusion that structural issues dominate STMM care and supersede the individual focus that implementing cultural competence skills demands.

Finally, issues pertinent to short-term medical missions in Guatemala will conclude this paper. This includes the reasons many short-term medical missions visit Guatemala, how they coordinate with existing medical providers, and how they have been evaluated by scholars in the past. Measures are taken by the Guatemalan College of Physicians and Surgeons to register foreign physicians before they perform medical care in the country, but the efficacy of these efforts has not been studied. One of the issues specific to Guatemala is the country's popularity as a tourist destination and how this impacts short-term medical mission work.

One of the popular reasons for tourism to Guatemala—the vibrancy of indigenous Maya culture—juxtaposed with the poverty many indigenous Guatemalans face, can potentially lead to what some scholars coin "poverty tourism" (Rolfes, 2010). The term was originally applied to tours in urban slums in Brazil known as *favelas* that allowed tourists to see poverty up close—neglecting the dignity of the poor. In Guatemala, the Maya are offered to tourists as an example of living history, indigenous culture, or as bodies for the *típica* textiles to clothe. However, the Guatemalan government and INGUAT (Instituto Guatemalteco del Turismo) incorporate few to no mechanisms for the protection of the Maya culturally through intellectual property of textile manufacture or through efforts to alleviate structural inequalities (Little, 2004).

These factors, including the attitudes of the Guatemalan government, tourists, and expatriates towards the Maya (whether discriminatory or exoticizing) in turn influence the experience that this marginalized set of ethnic groups have while in the short-term medical mission setting. Volunteer physicians may see the Maya less as individuals and more as bodies to be acted upon in order to achieve an idealized medical mission experience. While cultural competence, thought to better the quality of patient care, might play a helpful role in facilitating individual interactions between providers and patients, it cannot mediate structural inequality or structural failures in STMM planning.

II. Short-Term Medical Missions & Medical Humanitarianism

Medical Humanitarianism

Medical humanitarianism is an offshoot of humanitarianism—"relief in times of crisis" that focuses on health; in particular, this health care is delivered by visiting providers often facilitated by international organizations and emphasizing a pathological notion of human suffering redeemable by biomedical intervention (Beshar & Stellmach, 2017, p. 4). The history of general humanitarianism and philanthropy informs medical humanitarianism. Barnett (2011: 50) contends that the profound cultural shift in the eighteenth century from a "puritan pessimism" about human nature towards a sympathetic view of humankind signaled the beginning of humanitarianism in Western society. Other contributions to this shift were the belief in the natural rights of man (not yet for women), technological advancements such as the widespread use of the printing press that allowed awareness of the suffering of others, and the embrace of humanitarianism by clergy who saw this evolution "as consistent with and nurturing Christian notions of love, compassion, and charity" (Ibid., p. 51).

Evangelism and religious 'awakenings' also contributed to the rise of the welfare state and beliefs about a responsibility of the wealthy or financially stable to those less fortunate, often called ‘charity’ (Ibid.). However, historically, local cultures were seen as impediments to progress and prosperity by political and religious leaders, namely in colonized nations. Mexico, the United States, and Guatemala are all familiar and salient examples of this attitude towards their indigenous populations. The shift towards a more sympathetic view of humankind emerged in the context of colonialism—offering charity was inherently rooted in systems of racial, gender, and political inequality that situated white Western European men as givers and women, indigenous populations, people of color, slaves, and the politically disenfranchised as receivers. This view also reflected ideas of paternalism; it was thought that local populations in colonized countries simply could not be trusted to take care of themselves and necessitated interventions by those deemed qualified to do so.

Henry Dunant, a Genevese businessman, wrote *Un souvenir de Solferino*, a work concerned with the ugliness of war, focusing on the meager medical services available to men on the battlefield on both sides (1862). Describing the work of Dunant, Barnett states, “after juxtaposing the inadequate medical corps, the thousands of soldiers left to suffer, and the heroic but overwhelmed townspeople, Dunant recommended that European elites form charitable societies to march into battle to help the wounded,” the first modern concept of an organized effort to provide medical care in a time of devastation and distress (Barnett, 2011, p. 78). His efforts eventually led to the foundation of the International Committee of the Red Cross. While the ICRC sought to include European nations and the Ottoman Empire as equals in their Christian mission[10],

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[10] The Ottoman Empire refused to use the red cross as their symbol, instead using a red crescent on their emblems for the ICRC.

they included members such as Japan—mostly as a measure of 'civilizing' the perceived-to-be inferior state (Barnett, 2011).

Social scientists who study the field of medical humanitarianism date its birth in the 19th century, stating that its early goal was "direct spiritual and physical support" (Abramawitz & Panter-Brick, 2015, p. 4). One of the most popular figures in the history of medical humanitarianism, and most recognizable, is Florence Nightingale. She both aided in the establishment of the field of nursing and of medical humanitarianism, traveling to modern-day Turkey during the British Crimean War (1853-1856) to tend to the wounds of British soldiers, leaving behind supplies for the military station when she departed back to England (Gunn, 2008). This ushered in other efforts to 'humanize' war and allow non-military participation in war efforts (Barnett, 2011).

After World War I, humanitarian organizations focused on helping those who shared a similar identity above simply helping those in need. British and American relief went to their allies during the War, but they specifically excluded Germans. Some German-American organizations attempted to send aid to Germany during this time because of the high rate of malnutrition among children, but were rebuked by other Americans for aiding the 'enemy' (Barnett, 2011, p. 83). This led to Eglantyne Jebb's founding of Save the Children, promoting the idea of need-based aid, the role of children as "innocent representatives of humanity," and the belief that the unification of former enemies through care for children could promote peace (Ibid., p. 87). Finally, post-WWI aid became further organized by the state and not by charity, some of which included giving aid, and some of which aided the United States in a subtle public relations campaign to improve their image in places ripe for Communism to take hold such as the Balkans (Barnett, 2011).

The Bolshevik Revolution of 1917 overhauled the Russian political sphere and carried important implications for Christianity; Christianity and the Russian Orthodox Church were closely associated with the czarist monarchy and were declared unacceptable by the new Communist government. World War I brought tremendous destruction, disease, and famine to Western Russia and many countries were reluctant to give humanitarian aid to a country that disrupted the status quo with revolution and reorganization of the social hierarchies still comfortably in place in Europe (Cabanes, 2014). Humanitarian organizations were forced to decide whether the severity of the famine in Russia or the perceived evil of Communism was most important to address through action or inaction. Herbert Hoover, then the head of the American Relief Administration in the United States, decided that the U.S. would participate in relief efforts for Russia; he "hoped to demonstrate the negligence of Communist authorities and the generosity of American capitalists" (Cabanes, 2014, p. 195). This amounted to one of the first examples of humanitarian relief transecting political alliances and the genesis of the false notion that humanitarian aid could be apolitical despite clear political stances by the sending and receiving nations.

Ruth Young, a medical missionary who practiced in India in the early 20th century recorded her observations of medical mission practices during that time and suggested a shift from curative to preventative care (Young, 1927). While the author suggested primary health care as a medical mission practice long before the World Health Organization identified such an orientation to health care, Young did so with a paternalistic and racist attitude, saying that prevention is “foreign to the fatalistic and *laissez-faire* temperament of the East” and that local populations have “practically no public opinion on the subject of prevention or health” (Young, 1927, p. 558). Moorshead also addressed the primacy of biomedicine, noting that medical mission work “adds the weapon of scientific truth to the armoury of the Christian Missionary… It can weaken faith in the superstition of a “Medicine Man,” and lead in turn to the patient being prepared to listen to, and receive, the Christian Message” (Moorshead, 1926, p. 58). Language such as this would not likely be used today, but the sentiments behind it are still common—the idea that non-Western cultures are a blank slate without their own medical practices, incorrect medical practices, or the idea that if people from these cultures would just commit to biomedicine, their problems would be solved.

Often the ‘Christianization’ of colonized nations after World War I meant making colonies ripe for British intervention and development. Dr. R. Fletcher Moorshead was a physician who reflected deeply on his time as a medical missionary in the book *The Way of the Doctor*, published in 1926. As many colonies were still under British rule and remained unexplored or undeveloped by their colonizers, he described the medical mission as a “pioneer agency” that would serve as a means to “break down barriers… attract reluctant and suspicious populations… open whole regions, [and] capture entire villages and tribes” (Moorshead, 1926, p. 48). Although his book details individual cases of curing illness and disease, Moorshead viewed his medical practice in British colonies as integral to an overall ‘civilizing’ goal.

World War II significantly impacted the field of humanitarianism; wars were fought in a greater range than in the first World War—war raged in the South Pacific, East Asia and Indochina, North Africa, Western Europe, and Eastern Europe. Subsequent diplomatic agreements such as the formation of the United Nations and independence movements rapidly changed the dynamic between nations that had previously been at war, been allies (most notably, the United States and Russia became enemies after the war ended), or had been colonies. Many of the most prominent international aid organizations began their efforts at this time: the World Health Organization, international financial institutions such as the World Bank (discussed at length in the previous chapter), Catholic Relief Services, the International Relief Organization, Oxfam, among many others.

Barnett contends that the myriad interventions, both overt and covert, executed after World War II in recently independent nations was due to the clear tie policymakers and politicians in the United States saw between economic development and American "security" interests in many regions, including Latin America (2011). If the United States helped these new nations develop after the devastation of World War II and helped solve problems such as widespread hunger, they might be less susceptible to adopting Marxist ideology.

Barnett traces the shifting relationship between humanitarianism and political ideology; he claims that persistent interventions by former colonizers, while using the guise of humanitarian aid and development, amounted to neocolonialism. Of this, he states:

> "Neocolonialism had a soulmate in Neo-Humanitarianism. Humanitarianism's emerging principles of humanity, impartiality, independence, and neutrality were crafted to lift humanitarianism from the muck of politics and power in much the

> same way that international policymakers tossed around sovereign equality. But humanitarianism had little chance of escape." (Barnett, 2011, p. 104).

These ideas—that humanitarianism is and should be transcendent of both local and international politics—did not mean that international politics and history had a limited role in the relationships between humanitarians and the objects of their efforts (Barnett 2011). Those on the receiving end were treated as objects; only much later in the trajectory of humanitarianism were local populations recognized as equal and integral parts of successful health, social, and economic interventions—often assisted through international non-government organizations (Quelch and Laidler-Kylander, 2005, p. 143-172; Ronalds, 2012).

Medical Humanitarianism and Christianity

Protestant missionaries initially became concerned with health and hygiene in the eighteenth century, perceiving that Western medicine was superior to some medical techniques in colonized areas and only then enveloping doctors into the fold of their missionary activities (Hardiman, 2006). Medicine became a tool for conversion, especially in contexts where colonial activities had severely weakened traditional agriculture and industry—or if the colonizers had enslaved the local population. Barnett describes a "parent-child" paternalism characteristic of Christian humanitarian work (2011).

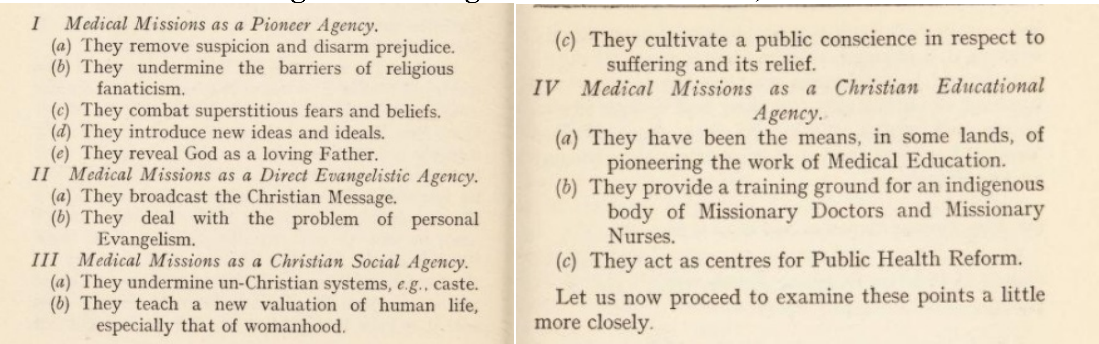
This paternalism was exacerbated by the colonial relationships that delineated primarily Christian colonists from the colonized who had their own religious belief systems. Converting indigenous populations to Catholicism was one of the central goals of colonization and subjugation in the New World, including Guatemala and other locations in Latin America; certain monastic orders have historically concerned themselves with social welfare, such as the Jesuit friars and Carmelite nuns, with missionary work supported by congregations such as Sacred Congregation for the Propagation of the Faith or the Propaganda Fide since 1622 (The Vatican, n.d.). However, the overall power of the Catholic Church (and its ability to realize missionary activities) was challenged for much of the latter half of the 19th century in Latin America by liberal governments seeking to wrest political power from the Catholic Church to strengthen the power of the state (Lynch, 2012).

Thaut outlines some of the key evangelical Christian tenets that motivate modern humanitarian work: first, they take seriously the call to go into the world and preach the 'good news'; second, Protestants take seriously a sense of duty, through charity; finally, the parable of the Good Samaritan has been "perhaps the foundation of twentieth century philanthropy and aid" (Thaut, 2009, p. 322). The orientation of white Protestants towards the generally non-white recipients of their colonizing and mission efforts set up the perfect stage for neoliberalism to take hold much later: those who did participate in the colonial or missionary-sanctioned ways of living, producing, behaving, and believing were perceived to be incapable and needing help or intervention from colonizers and missionaries rather than perhaps simply not subscribing to non-Western values or the seeds of global capitalism missionaries busily planted (Meyer, 2007). Furthermore, evangelicalism in Latin America embraced the Protestant work ethic and prosperity gospel—that economic prosperity is a blessing from God and sign of God's favor—wholeheartedly (Chesnut, 2003).

Humanitarianism and evangelical Christianity have long been bedfellows, but the secularization and professionalization of Christian humanitarian efforts (missionary efforts) have characterized the 'modernization' of Christian humanitarianism. Hardiman describes a marked difference between secular humanitarians and religious humanitarians; population-level problems and solutions were the focus of secular physicians, but "mission doctors focused on healing individuals and inculcating a belief amongst their patients that ill health was caused as much as anything through their own moral failings" (2006, p. 6-7). Poor health framed as a moral, individual failing absolves the familial, community, or state responsibility towards population health.

By the 1870s, Protestant evangelist missionaries and medical missionaries were distinguished from each other due to the growing professionalization of the work of doctors and differentiation within the mission context, though they still worked in tandem (Hardiman, 2006). The shift towards a professionalization of missionaries, even in the context of Christian missions, began after World War I. Missionary doctors were no longer expected to devote much of their time to direct evangelizing because of the demand for their professional expertise—there were plenty of local Christians eager to handle the evangelizing role in their stead (Hardiman, 2006). Rather the approach was to practice medical care and view it as an embodiment of 'holy work'—by virtue of Christians providing the medical care, the receivers would want to become Christian or lead Christian lives. *The Way of the Doctor* detailed the direct and indirect ways in which medical missions forwarded Christian ideals throughout the world:

Figure 2.1. Original Moorshead text, 1926.



I Medical Missions as a Pioneer Agency.
  (*a*) They remove suspicion and disarm prejudice.
  (*b*) They undermine the barriers of religious fanaticism.
  (*c*) They combat superstitious fears and beliefs.
  (*d*) They introduce new ideas and ideals.
  (*e*) They reveal God as a loving Father.
II Medical Missions as a Direct Evangelistic Agency.
  (*a*) They broadcast the Christian Message.
  (*b*) They deal with the problem of personal Evangelism.
III Medical Missions as a Christian Social Agency.
  (*a*) They undermine un-Christian systems, *e.g.*, caste.
  (*b*) They teach a new valuation of human life, especially that of womanhood.
  (*c*) They cultivate a public conscience in respect to suffering and its relief.
IV Medical Missions as a Christian Educational Agency.
  (*a*) They have been the means, in some lands, of pioneering the work of Medical Education.
  (*b*) They provide a training ground for an indigenous body of Missionary Doctors and Missionary Nurses.
  (*c*) They act as centres for Public Health Reform.

Let us now proceed to examine these points a little more closely.

(Moorshead, 1926, p. 46-47).

The conquest and subjugation aims were discussed earlier, but clearly British medical missions' activities were also supposed to communicate Christian values and norms—norms such as the supremacy of the Christian God, monotheism, the Protestant work ethic, and a British national identity that was bound to Christianity, especially in the face of strong religious and cultural systems such as Hinduism and the caste system (Ibid.). He succinctly summed up the potential of missions, saying

> "We have yet to fathom all the Divine potency of that is wrapped up in the revealing Ministry of Medical Missions. They give an exposition of Christianity which is at once an apologetic and an appeal, and it does not need much reflection to appreciate the inherent usefulness of a form of evangelism which interprets its spirit by a deed, and which commands its message by an act of mercy."
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> (Moorshead, 1926, p. 67).

After World War II, many nations were nursing independence movements or exploring non-capitalist economic and social structures and became skeptical of missionary activity (even the delivery of medical care); because the social hierarchies in colonial societies were often based on race, local populations associated white missionaries with capitalism. Hardiman notes that over time, different denominations responded to local contexts differently and possessed differing enthusiasm and strategies for their work (2006).

Turning towards modern missions, religious motivations can be a significant component to a modern medical mission as well. Clearly a history of evangelizing tied to foreign health care delivery (as outlined above) impacted the evolution of humanitarian missions abroad. Unique to Guatemala's history, evangelical Christianity became a particularly powerful force in the survival of indigenous Guatemalans during the armed conflict (1960-1996). Abandonment of Catholicism and syncretic Maya religious beliefs and affiliation with an evangelical church in the years of Rios Montt's presidency, especially in majority indigenous communities, was thought to reduce suspicion of subversive activities due to Rios Montt's conversion to and promotion of fundamentalist Christianity (Burnett, 2010). While the link between Guatemala's history with Protestant conversion and the proliferation of medical missions deserves its own study, evangelical Christianity and medical missions are at the least, symbiotic.

Today, besides a few notable exceptions, most medical missions with a religious component have pivoted towards providing technically sound medical care. While missionaries ventured to colonies for hundreds of years with the aim of saving souls, organizations such as World Vision International began to phase out the religion-forward model of giving aid after the 1980s and began to favor professionalized humanitarian work (Barnett, 2011). The needs of communities in war-ravaged Eastern Europe, North Africa, and Asia demanded technically sophisticated universally-applicable efforts envisaged by Westerners to save lives. Barnett summarizes, "technocratic authority replaced religious authority" (Ibid., p. 131). While "technocratic authority" dominates the execution of medical missions, there are certainly exceptions to this norm and some teams use religious authority as a gray space to justify actions that would be unacceptable in their home country.

Critical Medical Humanitarianism and Medical Missions

Ticktin, in her analysis of anthropology's engagement with 'transnational humanitarianism,' writes that medical anthropology aimed to study what Barnett identifies—the "muck of politics and power." She frames this shift as a sea change from work focused on cross-cultural experiences of disease and illness to a focus on "universal suffering" (Ticktin, 2014, p. 275). She describes the self-reflection and acknowledgement of the discipline's contributions to colonization and subjugation as a catalyst for a reinvigorated desire for anthropologists to delicately balance a "moralized connection to one's research subjects" with a critical lens appropriate to a scientific discipline (Ticktin, 2014, p. 277).

Modern humanitarians often describe their work in terms of emergencies, still the modern distinguishing factor between medical humanitarian missions and international development focused on health. Good and colleagues define medical humanitarianism as "the delivery of health-related services in settings of crisis," which notably does not include a time component (Good, Good, Abramowitz, Kleinman, & Panter-Brick, 2014, p. 311). "Humanitarian practitioners often maintain that the purpose of humanitarian action is to address immediate needs, while initiatives to resolve crises or rebuild after disasters must be taken at the political level" (Abramowitz & Panter-Brick, 2015, p. 8). While addressing immediate needs remains a worthwhile endeavor, short-term medical missions' timelines operate between humanitarian emergencies and long-term development projects. One of the key differences between humanitarian emergency efforts and STMM efforts is the peripheral or repeat nature of STMMs—they will often return to a site many times over many years, rather than departing permanently when the situation is determined to be resolved. While many STMM teams voice a concern to "make a lasting impact" and reduce reliance on medical mission teams, there are often few efforts to increase the autonomy of the patients or communities served. As long as there is a perceived need by the STMM, they may never truly leave.

Moral humanitarianism is the field developed primarily by Didier Fassin. The anthropologist critically examines both the structures and policies that claim humanitarian goals but that are engendered with problematic assumptions. In his book *Humanitarian Reason: A Moral History of the Present*, Fassin questions the essential premises of compassion from the standpoint of governments. He explains that compassion is bidirectional, but that it assumes a power structure—for "the most vulnerable individuals... the politics of compassion is a politics of inequality" (Fassin, 2012, p. 3). Those that are the givers of humanitarian aid assume an obligation from the receivers, often in the form of the rights, more or less, to a person's story of suffering or the form of expected gratitude. Indeed, it is common to see on the websites of medical missions the photos of individuals who have suffered from a disease and needed surgery with a short commentary on their experience and gratitude; it is unclear how and in what circumstances consent was given by these individuals to publish their stories online—or if the consent was merely assumed.

Short-term medical missions fall under the umbrella of medical humanitarianism but inhabit a unique space in which they mostly address pressing but non-emergency health issues—all of the many medical needs a population might have but that forego address because of local systematic problems with health care delivery. For example, because of the waiting times in regional and national hospitals, many people must wait months or up to a year for surgeries such as cholecystectomies (the removal of the gallbladder), a common issue in Guatemala. While a person might not die due to the malfunction of their gallbladder, they still withstand significant pain while waiting for their surgery date. So, those receiving care from short-term medical missions are in need of services that are inadequately addressed by the health care system, especially for some of the more common procedures performed by STMMs, such as cleft palate surgeries, restoring one's eyesight, or health care for young children. Occasionally, if the timing is right, STMM surgical teams do receive patients who are candidates for emergency surgery.

One of the reasons STMMs seem to defy categorization is the dramatic variation in the goals and capabilities of different groups—at their most simplistic, they bring medications and vitamins to dole out to communities; at their most complex, they deliver highly specialized surgeries to vetted candidates with plans for coordinated follow-up care. Technocratic approaches are often favored in the STMM context because of both the perceived universality of biomedical care and the fact that pinpointed, specific medical procedures are all that can be offered in a short period of time. The medical aid STMMs provide is certainly valuable but does not challenge systematic failures within the local health care system or prevailing structural inequalities that maintain poor population health. The case study below of Medicins San Frontiéres engages with many of the tensions present in the medical mission setting, though MSF is not considered a “short-term” medical mission due to the widely varying timelines of its humanitarian interventions.

Medicins San Frontiéres: The Most Widely Recognized Medical Mission

While this organization often requires long-term commitment from volunteers, Medicins San Frontiéres provides an excellent case study to examine the dynamic between medical missions and the contexts in which medical volunteers work. Medicins San Frontiéres (MSF), also known as Doctors Without Borders, was founded during the global political upheaval of post-independence former colonies; specifically in response to the failed state formation of Biafra in 1971 and subsequent famine (Medicins San Frontiéres, 2017). In the following four-and-a-half decades since its creation, MSF has molded itself into the role of the medical first responder for global humanitarian crises: war, famine, epidemics, refugee crises, and natural disasters. Some of the notable events to which MSF members have contributed their skills and lives are the destruction created by Hurricane Fifi in Honduras in 1974, the Cambodian refugee crisis of 1975, the civil war in Sudan between 1983 and 2005, the Bosnian War in 1993, the 2010 earthquake in Haiti, and recently, the conflict in Syria (MSF, 2017).

While the organization describes itself as “fiercely independent of both governments and institutions” and diplomatically neutral (MSF, 2017), scholars have noted that it is impossible to adhere to this policy completely, precisely because humanitarian crises necessitate dialogue with political and legal actors (Ticktin, 2006).

Notably, the MSF was founded in a dominant European world power, but often operated in former colonies of other European nations. The organizational branches to follow MSF France in 1971 were MSF Belgium founded in 1980, MSF Switzerland founded in 1980 (the exception with no colonies), and MSF Holland, also founded in 1984 (Fox, 2014). These relationships are not lost on authors Shevchenko and Fox, who interrogated the impetuses of MSF members within such organizations as MSF Belgium and MSF United Kingdom, who cited a fascination and concern with Africa that at the least, they consider paternalist (2008).

Figure 2.2. "Where We Work"

Doctors Without Borders, 2017.

Over time the organization has increased in size, as well as evolved from a decentralized organization towards a hierarchical, formal, bureaucratic one (Fox, 2014). Today the organization directs interventions in situations of crisis and "turns over" the health care back to local communities once the crisis is deemed to have subsided (Ibid., p. 33). This process demonstrates the directorial role the organization takes in health care in local contexts, potentially subordinating the role of local leaders or health care providers. Redfield furthers this point, noting that MSF has two distinct categories of personnel:

'international volunteers' and 'national staff' hired in support roles at specific project sites" (2012, p. 360). It is difficult then to describe MSF as either a short-term medical mission or a permanent fixture. The MSF website states that is now has offices in 28 countries—but in some cases, such as the conflict in Syria, the MSF operated no offices within the country but coordinated with local medical facilities to provide care to the victims of the endless bombing (MSF, 2017).

In a study of the division between national and expatriate staff in MSF Belgium's operation in Russia, Shevchenko and Fox found that the upper tier of management and administrative positions were run predominantly by expatriates, while much of the lower-skill labor and service provision were provided by Russian nationals (Shevchenko & Fox, 2008). The logic offered by MSF dictates that too close "proximity" by the "Head of Mission" position in each country would contradict the organizations' desire for impartiality (Ibid., p. 116). Whatever claim to political neutrality MSF may make, the personnel whom the organization hires within-country for support and to whom the organization turns over health operations once MSF departs are likely not politically neutral actors—logistics must be arranged for MSF to enter an area, including the approval of an area's political or military leader, even if such leadership is not permanent.

Anthropologist and sociologist Didier Fassin spent four years on the board of MSF France and writes prolifically in the disciplines of moral anthropology and humanitarianism, among others. Fassin introduces the "politics of life" as a distinct but complementary term to Foucault's idea of biopolitics (2007, p. 500). In contrast to biopolitics, a term Foucault uses to describe the governance and the regulation of populations through technology (2008), Fassin's term describes the evaluation of human life and the meaning of human beings' existence (2007). Fassin exemplifies "politics of life" through issues pertinent to MSF in three primary ways: within humanitarian endeavors, there are those who must be saved and those who can be sacrificed; he criticizes the division of higher value lives (expatriate MSF) and lower value lives (local employees); and finally, those who in crisis speak for themselves and narrate their own experiences and those who are the objects of interventions, depicted as voiceless and helpless in the third person (2007). These problems are reflected throughout humanitarian efforts globally, a key point of reflection given the conclusion of Fassin that local populations, especially in war zones, are the last lives considered sacred and the last people asked about their experiences through testimony.

In her analysis of MSF blogs in 2014, Renee Fox examined the motivations for participation in the organization from expatriate participants. She wrote,

> "Their motives, they agree, are complex and mixed. Among them are idealism, altruism, moral indignation, a commitment to social justice, a sense of adventure, the desire to 'escape an uncomfortable situation at home,' or to 'put the past behind' one, a search for self-fulfillment, a need to test one's self, and a 'because we can' spirit of pragmatism" (Fox, 2014, p. 19).

Some of the motivations for MSF participation are certainly problematic—only someone from a stable nation who is well educated and relatively wealthy would categorize a natural disaster or social and political upheaval as 'an adventure.' These motivations also underscore the victimhood that is ascribed to the local population by the MSF. Ticktin notes that recipients of aid from organizations such as MSF often must recall their suffering (physically, mentally, and emotionally) to demonstrate their "moral legitimacy" in order to receive care from physicians or psychologists or immigration assistance (Ticktin, 2014, p. 279).

Local attachment and culture are two additional facets of MSF that merit thoughtful reflection. While the organization historically celebrated the mobility and transience of its employed population, this mobility causes distinct problems as well (Redfield, 2012). Most notably, the MSF expatriate employees have the privilege of foreign, often powerful passports; if the situation becomes too hazardous, they have the diplomatic privilege of being able to go home (Ibid.). While expatriate MSF employees clearly make the commitment to immerse themselves in nations in a state of emergency, their nationality and ability to return to a safe place transcend any notion of equality they might feel compared to national MSF employees.

Negotiation with local culture is another concern. Shevchenko and Fox state, “The universalistic convictions on which MSF is founded underlie a tendency throughout the organization to suppose that playing down cultural differences, overlooking them and, if possible, overcoming or dispelling them, constitute desirable modes of surmounting ‘cultural borders’” (2008, p. 117). The authors continue, saying that MSF physicians view themselves as impartial “because they come from “elsewhere,” [and] are not encumbered by cultural values and beliefs that affect the objectivity of their in-situ perspective and judgment,” (Ibid.) and reflect Kleinman’s critique of physicians who view themselves as providing “culture-free” biomedical care (Kleinman, 1980). The health care environments are a blank slate for providers because of the perceived objectivity and neutrality ascribed to biomedicine. MSF physicians are encouraged to bring their professional expertise to the field but often do not acknowledge the cultural competence they lack (Shevchenko & Fox, 2008). Considering the international media attention MSF receives, it is easy to estimate the effect an ideology such as this has on other physicians with intent to practice medicine abroad.

III. Profile & Critique of Global Short-Term Medical Missions

Until recently, little data have been collected concerning short-term medical missions, and even less have appeared in peer-reviewed journals. Four systematic reviews have been published as of 2016, the results of which I will summarize (Martiniuk et al., 2012; Sykes, 2014; Shrime, Sleemi, & Ravilla, 2014; Caldron, Impens, Pavlova, & Groot, 2016). Caldron and colleagues established 41 unique articles in their literature review that both considered the substance of prior literature reviews and extended the timeline used by those previous authors to establish the knowledge generated of STMMs over time. Three articles included in the review were published between 1981-2000, six between 2001-2005, fourteen between 2006-2010, and eighteen between 2011-2014 (Caldron, Impens, Pavlova, & Groot, 2016). This establishes the relative newness of the study of STMMs and the dearth of knowledge produced prior to the year 2000. Another systematic review focused on the norms within the field, asking how the literature characterizes best practices for STMMs, further examined in the discussion of ethics specific to short-term medical missions (Roche, Keetheswaran, & Wirtz, 2016).

Demography of Short-Term Medical Mission Participants

Using data from the Physicians Giving Back (PGB) Survey, Caldron and colleagues established a demographic profile of physicians participating in STMMs.

Caldron and colleagues define medical missions as "the activity whereby physicians who are gainfully engage in medical or surgical practice in their home countries spend short periods away in lower- and middle-income countries (LMICs), without pay, to provide services directly to the ostensibly poor" (2015, p. 1). This rich profile answers several questions about STMMs previously not interrogated in the literature, such as demographics, religiosity, and locations of the missions in which they work. Their study disseminated into the four primary regions of the United States included 601 physician participants recruited through an online survey Physicians Giving Back, 192 of whom had participated in a short-term medical mission (Caldron, Impens, Pavlova, & Groot, 2015). Their demographic profile included information about age, gender, race, Hispanic ethnicity, naturalization, medical training, marital status, religion, regional location within the United States, children, and years in practice, among their sample of U.S. physicians gathered using a proprietary email database of Healthcare Data Solutions for recruitment (Caldron, Impens, Pavlova, & Groot, 2016, p. 3).

Regarding age, only 3% of STMM volunteer physicians were between the ages of 25-39 years, while 25% were between ages 40-55 and 72% were between 56-73 years of age (Caldron, Impens, Pavlova, & Groot, 2016, p. 3). This indicates that physicians are more active as STMM participants later in life. A large majority of STMM physicians are male (64%). Finally, 79% of STMM physicians were White, 12% Asian, 6% Black or African-American, and 5% Native Hawaiian/Pacific Islander, or another ethnicity; Native Americans were not identified in Caldron and colleagues' data set. Five percent of STMM physicians identified as Hispanic (Ibid.), which is interesting considering the popularity of Latin America amongst all medical missions. Notably, the demographics of

STMM participants resemble the medical field overall. According to the Association of American Medical Colleges, of all U.S. physicians in their study of diversity, "4.1% were Black or African American, 4.4% were Hispanic or Latino, 0.4% were American Indian or Alaska Native, 11.7% were Asian, and 48.9% were White," though there remained a 30.5% category of "other" or "unknown" responses (AAMC, 2013). The lack of representation among STMM physicians has implications both for the inclusion of people of color in short-term medical missions as well as implications for the people being treated—at least in Guatemala, it seems relatively unlikely that a Guatemalan will receive STMM care from someone of their same ethnicity or socioeconomic background.

Religiousness was apparent in the Physicians Giving Back Survey. While the survey did not identify whether or not the mission itself was religiously oriented or sponsored, the majority of physicians in the survey were religious: 80%. Broken down, 53% of respondents were Christian, 16% Jewish, and 11% other, which included Buddhism, Hinduism, and Islam (Caldron, Impens, Pavlova, & Groot, 2016, p. 3). Religious motivations for participation need to be studied further, especially with regard to sponsorship and organizational structure of medical mission groups.

The majority of missions identified by survey respondents were located in Latin America (60%) likely due to its American sample population. STMMs in Africa (14%), Southeast Asia (11%), the Indian subcontinent (9%), Eastern Europe (2%), Pacific Islands (2%), the Middle East (1%), and Central Asia (1%) made up the remainder of locations to which the identified STMMs traveled (Caldron, Impens, Pavlova, & Groot, 2016, p. 6). Clearly, Latin America is the most popular place for STMMs, likely due to the relative ease of language acquisition (in most places, Spanish) and the proximity to the United States—at least for this study of American physicians. As evidenced by Figure 1 above, Medicins San Frontiéres, which draws much of its financing, human resources, and derives its history from Western Europe, mainly operates in countries that were formerly colonies of European nations. Volunteers retrace the steps of their colonial predecessors while delivering care through medical missions, though the political relationship between the sending and receiving nations is theoretically quite different.

Martiniuk and colleagues reviewed the literature on short-term medical missions in 2012, providing important knowledge about the global extent of STMMs. The top four sending countries of STMMs were The United States, Canada, The United Kingdom, and Australia (2012). Of the overall global receiving regions, they reported that Central America was the second most-visited region for STMMs, with Africa being the most popular; the top destinations for medical missions from the United States were Honduras, Costa Rica, and Mexico, though these data were the result of a meta-analysis of literature and not a direct sampling of STMM participants (Martiniuk, Manouchehrian, Negin, & Zwi., 2012, p. 4). The top five health issues addressed by STMMs were cleft lip/palate, oral and dental health, vaginal fistula, congenital heart disease, and cardiovascular disease (Ibid., p. 6). They recognized the social and political ties between sending and receiving nations, restating a "strong correlation between colonial status and the amount of foreign aid received" from one of their reviewed articles (Ibid., p. 6).

Ethical Concerns of Short-Term Medical Missions

The literature illustrates the ways in which short-term medical mission care can unintentionally cause problems for the very people the care is intended to help. One systematic review specifically addressed the recommended practices for STMMs in contrast to the other systematic reviews that concentrated on aggregating general information. Roche, Ketheeswaran, and Wirtz selected 92 articles that recommended at least one practice for short-term medical missions, emphasizing in their findings the practices related to coordination with local providers (2016). The subsequent subthemes identified by the authors are pervasive throughout the STMM literature, often characterized as "problem areas" when describing the ethical and practical problems confronted by STMMs working in the developing world. The authors list these as "Patient safety and quality of care…patient autonomy…continuity of care…minimizing impact on local service delivery…integration with local health services and sustainability" (Ibid.).

The authors identify certain issues that were *not* generally agreed upon which deserve separate mention. Four primary issues were identified. First, a standard of care that is not agreed upon or enforceable (discussed in the following section); second, patient selection pertinent to the strategy of the STMM (e.g., STMMs finding patients to match their skill set or STMMs trying to meet patient concerns and local needs); third, strategies for referral if the STMM cannot meet patient needs (Roche, Ketheeswaran, & Wirtz, 2016). Finally, the authors addressed the variation in ways to obtain informed consent, especially in consideration of language barriers between provider and patient; while no global standard exists, the authors suggested guidelines for their creation (2016). A more detailed analysis of critiques begins below, organized according to the ways in which patients can be negatively impacted.

Personal Motivations and Altruism

Finally, physician intent is the most intractable of ethical issues to determine and confront. Few venture to critique the motivations of medical volunteers, often because of both the good intent with which volunteers go into the world to solve problems and, in the case of physicians, the historical high status that physicians have in society—especially so if they are white physicians in a foreign context (Parsons, 1951; Berry, 2014; Green, Green, Scandlyn, & Kestler, 2008; Priest and Priest, 2008). Of these authors, Berry offers the most detailed discussion of altruism and selfishness, the key constructs with which she analyzes the attitudes of short-term medical missions.

"Any care is better than no care" is a pervasive and damaging attitude prevalent among medical volunteers suggested in the literature, which is often used to justify medical standards and practices discordant with what a provider might offer to patients in their own country (Berry, 2014; Roche, Ketheeswaran, & Wirtz, 2016). DeCamp describes this attitude in terms of ethics, naming it "The Myth of Mere Charity" where ethicality goes unexamined because of the intentions of the volunteers on medical missions (2011, p. 95). Berry critically examines motivations for participation from the perspective of selfishness and altruism; she concludes that many physicians do medical volunteer work in order to feel good about themselves or to feel appreciation from the patients, intensified by the patients' level of poverty (Berry, 2014). Priest and Priest echo this sentiment in their publication about Christian missions to the developing world, saying people volunteer to cultivate a "desired self-image, an image of the self-loving and serving those in need" (2008, p. 61).

While focusing on charitable medical work in the United States, Rivkin-Fish discusses the characterization of Medicaid patients in the United States who frequent mobile dental clinics and receive care from dentistry students. Patients are expected to show gratitude according to what Rivkin-Fish describes as a “moral economy of commodified health care”:

> “Persons who do not pay for care (failed consumers) have few entitlements; if they become the fortunate recipients of charity, then they are expected to demonstrate their gratitude for whatever they receive, fulfilling their debt to volunteers by helping forge the sense of satisfaction that derives from helping deserving others” (2011, p. 192).

Though this hypothesis has not been tested, it is not unreasonable to conjecture that this attitude towards patients is not exclusive to dental care volunteers and is similar to that described by Berry (2014). Huschke noted the attitudes of physicians working in a volunteer clinic in Germany; some of the physicians became annoyed or irritated when patients with nonlife-threating or ‘trivial’ health problems sought help from the clinic. Other physicians commented that patients did not look “poor enough” to receive care, clearly keeping in mind an image of the proper recipient of free medical care (2014, p. 355). Huschke’s findings echoed those of Rivkin-Fish regarding gratitude and entitlement of patients: patients who demanded too much in the eyes of the physicians were often discharged early or treated coldly by the staff and those patients who recognized this dynamic often asked for less than they needed because they did not want to be perceived as difficult patients (2014).

In the study of a short-term medical mission to Honduras, Bonner and colleagues studied both the rationale for participation on the part of the volunteers and the assessment of the quality of care from the patients. The top reasons for participating in a medical brigade were "personal enrichment, an opportunity to help the underserved and volunteer, convenient timing and scheduling, and to learn about another cultural and health care systems" (Bonner, Hopper, Gore Martin, & Caldwell, 2013, p. 93). Asgary and Lawrence studied the motivations of humanitarian workers, who indicated that their motivations for participating in international relief work became more nuanced or changed over time ("my motivations in the 90s were quite different from my motivations now") though the respondents did not indicate how the motivations changed even in the article's index; this indicates that time spent in STMMs influences motivations for continued participation (2014, p. 4). In other literature, social scientists have noted reasons such as practicing surgical skills, wanting to travel, and wanting to cultivate cultural awareness (Snyder et al., 2011; Taub & Jarrahy, 2016). Many of these reasons seem to indicate a desire on the part of the part of the volunteers to benefit themselves; though volunteer medical work can obviously be mutually beneficial (and ideally would be so), this study indicates physician-centered motivations for providing care in this context.

Others have taken notice of what is known as the "White Savior Industrial Complex," most notably the Nigerian-American author Teju Cole. "The White Savior

Industrial Complex is not about justice. It is about having a big emotional experience that validates privilege" (Cole, 2012). Of Kony 2012,[11] Cole writes,

> "Africa has provided a space onto which white egos can conveniently be projected. It is a liberated space in which the usual rules do not apply: a nobody from America or Europe can go to Africa and become a godlike savior or, at the very least, have his or her emotional needs satisfied" (Cole, 2012).

These sentiments, expressed in an opinion article in *The Atlantic*, mirror the data and conclusions gently introduced in academic articles. While the author certainly speaks in reference to a particular event in Uganda, his words demonstrate the degree to which the white provider/brown patient dynamic has permeated the collective thought surrounding humanitarian missions abroad. In the case of Renee Bach, a missionary with no medical training who opened a clinic in Uganda, the desire to provide a perceived need (despite having no authority as a medical practitioner) and belief that the regulations did not apply to her in Uganda by virtue of her whiteness, ultimately led to actions that caused the death of several children, (Aizenman, 2020).

Wall explores objectification of patients with obstetric fistulas. The author explains overhearing doctors discussing a pre-surgery kit sent with them on their medical mission to "try out" on the local population "before using them on their patients back home" (Wall, 2011, p. 119). This is explained to be a "personal benefit" of participating in short-term medical missions. This is especially problematic given the power dynamic

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[11] Kony 2012 was a film and subsequent social movement promoted by Invisible Children, Inc. that sought to elucidate the crimes of Ugandan president Joseph Kony.

inherent in the short-term medical mission schema and the lack of mechanisms for provider accountability, which will be discussed in Chapter 5.

Though “biomedicine has only recently been understood as located in and constituted by relations of power” (Shaw & Armin, 2011), many of the patients in the foreign contexts in which STMMs work must work against the power relations of wealthier nations/LMICs, former colonies/former colonizers, and white majority/brown majority relationships. This makes it ever more important for physicians to truly listen to their patients in the foreign context and try to understand their perspectives. Shaw and Armin call for an “ethical self-fashioning” in which providers self-assess their own worldviews and identity, conscious of how this might affect their understanding, interpreting and framing of problems (2011, p. 244).

Knowledge of Foreign Medical Context

Knowledge of the local context is imperative to providing good medical care—even more important if providing a surgery, despite the allure of the perceived ‘culture-free’ Western biomedical care environment (Kleinman, 1980) or the “pure surgery” environment described by respondents in a 2021 study in Guatemala as the “absence of preoperative/postoperative care and freedom from documentation” (Coughran et al., 2021). Without knowledge of endemic disease or risk factors for local populations, the decision of a surgeon to perform a surgery on a patient may be based in inaccurate information. Shrime, Sleemi, and Ravilla emphasize the importance of the complexity of surgery being balanced for the context; they reiterate that organizations that execute complex surgeries in a ‘camp,’ ‘blitz’, or ‘safari’ context (e.g., short-term missions), "tend to suffer from higher mortality and complication rates while producing mixed results" (2015). Moreover, in a study of patient perceptions of itinerant orthopedic surgery in Guatemala and Nicaragua, the patients were in fact very concerned about issues such as the danger of their surgery and follow-up (Kavolus et al., 2016), suggesting that the pre-surgery consultations between patients and surgeons (a wholly social interaction, as opposed to performing a surgery on an anesthetized, isolated body) are of critical importance.

While screening patients is a separate issue, knowing what to look for in a foreign patient population is integral to providing proper care; providers must have a solid grasp of endemic disease and illness for the health care context even if this necessitates independent or group learning prior to departure. Huijing and colleagues identified this issue in their study of facial reconstructions in Ethiopia; they contended that patients might come in for a surgery being severely malnourished and afflicted with diseases not encountered in Europe and North America, then convalescing in less sanitary environments. These are all factors that need to be considered when deciding to operate (2011). This is echoed by other authors as well; Jesus notes this in his case study of Ghana, where Ghanaian traditional medicine is extremely popular and could potentially interfere with a prescribed drug regimen (2010). McClenaghan and colleagues wrote, "Adaptation to management have to be made for operations in Africa. Patients are malnourished, underweight, and small for age. Many carry endemic infections (helminths, malaria) and have reduced physiological reserve" (2013, p. 1589). In Guatemala, anemia is common from poor nutrition (Sykes et al., 2012).

Patient Selection

Patient selection is another concern when providing short-term medical mission care. STMMs are either focused on the skill set of the physicians (e.g., ophthalmologists) and the coordinating NGO will seek out people with specific health care needs to bring to the physicians, or the team is more varied in skill set and offers a 'first come first served' basis for care. Surgical missions seem to favor the former so as to avoid arriving in a foreign country with no surgeries to perform or no adequate spaces in which to do so. Dupuis recommends truly respecting local colleagues and allowing them to choose patients; colleagues in the context of Guatemala are surgeons working most often as public providers, in private practices, or as in-house physicians for local NGOs (Dupuis, 2004; Green, Green Scandlyn, & Kestler, 2009). Woflberg notes that complications for patients often are attributed to inadequate screening of patients before surgery and/or inadequate follow-up care post-operation (2006). Langoswki and Iltis recommend consultation with the local community to plan and implement interventions suitable to them (2011). Leeds and colleagues reported a successful STMM to Haiti; one of the essential elements to the success of this project was the use of "multiple pre-trip needs assessments" by in-country staff at the local hospital and the evaluation of all patients by both the visiting team and local surgeons (2011, p. 2).

Issues of Accountability

A related issue to this is the inadequate bureaucratic infrastructure in the places in which STMMs work. There is not always a way for physicians to register themselves locally, providing their qualification for review to a local regulatory entity (Dupuis, 2004). In Guatemala, the College of Physicians and Surgeons requires physicians to register before providing care, but numerous anecdotal accounts of Guatemalan providers and administrators note inconsistency in this practice—and at the worst, willful ignorance from foreign practitioners (Green, Green, Scandlyn, & Kestler, 2009; Berry, 2014). Patients dissatisfied with care or families of patients who die from complications may not have recourse if the physician was never registered and did not leave contact information. For the physicians, this inhibits their own learning as well because they may never discover their own errors or ways to have improved the patient experience.

Though patients in foreign contexts should not be used as "experimental fodder" (Dupuis, 2004, p. 434), the physicians are theoretically supposed to be learning from the STMM experience in addition to providing a service to patients. A contrasting view of accountability was recently published by a "veteran mission surgeon" who argued against oversight and outcome research because of the fundamental flaw in American medicine: "Corporate avarice teamed with Big Brother-like insurance and governmental oversight and mandates have robbed the average physician of their sense of vocation and purpose" (Cicchinelli, 2017, p. 1). While those are certainly real concerns for physicians in the United States, it would be unethical to assume that vulnerable foreign populations are merely vessels for the regeneration of physicians' feelings of personal satisfaction in their work.

Several social scientists critique the STMM models in which medical (or undergraduate) students are included in the provision of care through STMMs, sometimes performing tasks above their level of training (Ackerman, 2010; Langowski & Iltis, 2011; Berry, 2014). Dupuis criticizes the practice of some physicians or medical residents to provide care for which they are not trained—in his case, he has seen a hand surgeon try to complete a cleft palate surgery (2004).

“Fistula tourism,” described by Wall, was coined after seeing so many surgeons visit areas in which women suffer the painful affliction of obstetric fistulas and operate without “adequate personal skill or the institutional capacity to provide minimum levels of safe and appropriate surgical care” (Wall, 2011, p. 124). The suffering of these women attracts physicians with good intentions and a desire to treat such an “exotic” condition (Ibid., p. 122), but the experience of those physicians with obstetric fistulas may only begin with their arrival in the country to operate; even if they do have experience with obstetric fistulas, they might not have operated in the context of poor country (2011). Wall continues, advocating for self-reflection of surgeons and the meeting of minimum ethical requirements, which is to provide just, fair care and not to treat a foreign patient differently than their own at home (2011). This introduces a discussion of physician perceptions of quality of care, detailed later in this section.

Follow-Up Care or Continuity of Care

The most pressing ethical issue pertaining to short-term medical missions is follow-up care. Though many short-term medical missions are often conscious of this problem and seek to remedy it through coordination with local providers, worldwide this remains an issue of both determining patient outcomes and organizational accountability (Zitzman, Berkley, and Jindal, 2018). C.C. Dupuis, a physician, provides an overall critique of missions, citing a “body count mentality” wherein volunteers try to perform as many surgeries as possible, ostensibly to report success back home but to the detriment of properly keeping track of postoperative patients (2004, p. 433).

Roche and Hall-Clifford note that distance traveled between a patient's home and the medical mission site can impede proper follow-up care for patients in Guatemala, especially given the distribution of surgical centers mainly in urban areas, while patients are often recruited from rural areas (2015). Other patients have expressed concern and disappointment when follow-up appointments to surgery were not realized after a STMM surgery (Roche et al., 2018). Some surgical teams have experimented with different methods and technology in order to properly follow up with surgical patients and assure full rehabilitation from surgery, most often using smartphone follow-up (Rapp et al., 2018; Wes et al., 2018; Bradley et al., 2021).

Medical mission surgery recipients *do* risk their lives when receiving surgeries; DuPuis reports the deaths of two children who died after a cleft palate operation in Asia undertaken despite the children's malnutrition—he states, "there the excuse was that there was no proper intensive care unit" which should have been foreseen by the surgeons, in addition to the children's health status (2004, p. 433).

Wolfberg similarly reflects on a failed operation in Guatemala: "Complications that do occur are often attributable to insufficient screening of patients or inadequate follow-up… although the complication rate associated with facial-cleft surgery was similar to rates in developed countries, the brevity of missions may contribute to avoidable illness and death" (2006, p. 443). He continues, recalling the death of a young boy who, while undergoing a preoperative workup, "developed flash pulmonary edema," was kept in a makeshift intensive care unit, and died the next day in a Guatemala City hospital (Ibid.). While the team was not sure why the boy developed this issue so suddenly, they concluded that their preoperative work had pushed him over the edge. Perhaps a quicker response to the problem and transfer to a full hospital facility would have produced a different outcome—a plan to be set in place in advance of beginning the medical mission.

IV. Cultural Competence

‘Cultural competence’ is defined in various ways in the literature. Flores defines cultural competence as the “recognition of and appropriate response to key cultural features that affect clinical care” (2000). There are several different approaches to cultural competence, depending on how the term is defined and the function cultural competence is supposed to play in clinical interactions. Initial efforts to implement cultural competence into medical education followed a “knowledge-based” approach, wherein medical practitioners learn about different racial or ethnic groups and their relevant cultural information that helps them know more about their patients; that is, “culture” was seen as an obstacle to overcome. This is described by Betancourt as the “multicultural/categorical” approach and mirrors the early research and theory surrounding cultural competence. Critiques of this approach appear in the following section.

Some authors conceptualize cultural competence as a skill to be acquired. According to this view, cultural competence focuses “on communication skills and train[s] learners to be aware of certain cross-cutting cultural issues, social issues, and health beliefs while providing methods to deal with information clinically once it is obtained" (Betancourt, 2003, p. 562). Betancourt describes this conceptual approach as the "cross-cultural" approach that emphasizes practitioner skill (2003). This use of the term stems from the Institute of Medicine report in 2002 *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, which highlighted the ways in which non-white Americans receive poorer treatment within the health care system than their white counterparts and how cultural competence could be developed as a skill among practitioners (Nelson, Stith, & Smedley, 2002).

Within this same application of the term, health care environments can aspire to be "culturally competent," such as in the Commonwealth Fund's report (Betancourt, 2006). Upon consideration of the racial disparities in health care and six points of improvement from the publication *Crossing the Quality Chasm*, says the report, health care environments can become culturally competent by implementing techniques aimed to foster the inclusion of minorities. The six points are "patient-centered care, patient safety, timeliness or responsive care, efficient care, effective care, and equitable care" (Ibid.). The large population-level problem of the 'quality chasm' is thought to be mediated by individual practitioners' efforts, though the data do not necessarily mirror this (Lie, Lee-Rey, Gomez, Bereknyei, & Braddock, 2011).

Another proponent of a skills-based approach, Kleinman advocates for a 'mini-ethnography' definition of cultural competence; that is, a care provider needs to experience and seek to understand norms and practices from a certain cultural context to make culturally-specific conclusions informing how to confront a medical problem. Theoretically, this is thought to improve patient outcomes through better compliance of patients, less unnecessary testing, and less delays obtaining informed consent from patients (Kleinman, 1980, Kleinman, 2006; Betancourt, 2006). Betancourt named this approach the “manual” approach which means that clinicians execute a tailored treatment of each patient, looking to consider both the wider cultural features that apply to the person, and those features that pertain to the individual, which might not follow a cultural pattern. While helpful in some situations, this still can leave room for oversimplification (Betancourt, 2006).

Finally, authors Gregg and Saha promote an interpretation of cultural competence in which physicians and care providers seek out knowledge of the social, economic, and ethnic contexts of their patient population and pair it with sensitivity to individual lived experiences of their patients (2006). Betancourt classifies this approach as the “awareness/sensitivity approach” that focuses on provider attitudes (2003). This is similar to other constructs such as cultural humility that emphasize the amount of work physicians and care providers must dedicate to truly understand patients dissimilar from themselves and to recognize their own biases. In other words, cultural competence from this perspective cannot be learned in a short amount of time nor through taking shortcuts such as reliance on cultural stereotypes to deliver care. Cultural humility and cultural empathy, additional approaches to cultural competence, will be further explored at the end of this section.

Early Cultural Competence Discourse

Beginning in the 1960s, researchers began to recognize cultural barriers as the responsibility of the visitor to a foreign country to overcome, first seeking to use strategies such as the cultural assimilator (Fielder, Mitchell, & Triandis, 1971). The cultural assimilator was “a programmed learning experience designed to expose members of one culture to some of the basic concepts, attitudes, role perceptions, customs, and values of another culture” designed to facilitate intercultural understanding between Americans and their counterparts on overseas government assignments (Ibid., p. 95). Fielder and colleagues continued to study the assimilator as case studies, detailing cultural assimilators entitled ‘Arab Assimilator,’ ‘Thai Culture Assimilator, ‘Honduras Culture Assimilator,’ and ‘Greek Assimilator’ in their field studies (1971). These are what Betancourt refers to when he describes the “multicultural categorical approach” to cultural competence (2006).

The cultural assimilator was first implemented in the health care environment in Honduras and Guatemala with funding from the U.S. Army in 1971. The criteria for evaluation were team performance, productivity, and adjustment—all focused on the members of *Los Amigos de las Americas*, groups of teens sent to Central America on their summer breaks from school “to operate public health clinics and perform community development work” (O-Brian, Fielder, & Hewett, 1971, p. 210). The cultural assimilator was tested on the teens because they were “not psychologically ready to live among people who speak a different language and whose customs and traditions differ so markedly from their own” (Ibid., p. 210-211). The students exposed to the cultural assimilators tested better than their peers who were not exposed to the cultural assimilator.

Arthur Kleinman lamented the “tendency of clinicians to treat healing as if it were a totally independent, timeless, culture-free process” in 1980 in *Patients and Healers in the Context of Culture* (p. 33). In this work, he advocated for the study and understanding of unfamiliar health care systems according to the *explanatory models* of the cultures from whence the unfamiliar health system originates; a physician creating an explanatory model for a patient is to ask and understand what factors are most important in the patient's health, illness, and care. Mutual understanding and respect for the patient's explanatory model along with the physician's accommodations to it, thus should result in better outcomes and satisfaction. In the book's case study, Kleinman focused on the Chinese explanatory model of health (Kleinman, 1980). Though short-term medical missions tend to focus on the curing process and not the healing process, different explanatory models of the same complaint, and its treatment, might result in the overall conclusion by either the physician or the Guatemalan patient that the health problem, including its full cultural context, was not resolved.

Between 1980 and 2000, scientists and physicians further developed the ways in which cultural competence was understood and measured. Sue and Sue created and applied a cultural competence model to cross-cultural counseling (1990). Their model is characterized by the application of a 3x3x3 model of racially and culturally specific attributes, foci of culturally specific services (individual, program, and organizational/administrative levels), and core elements of cultural competence. The core elements are cultural awareness, cultural knowledge, cultural knowledge of behavioral health, and cultural skill development. Kumas-Tan and colleagues note that while these factors are crucial to consider, the real development lies somewhere between figuring out as a physician what to do about racial and ethnic disparities and the implementation of such critical thinking into patient care (2007). Sue and Sue's model has been used and adapted for over twenty years, and several scales have been created for measurement reliant upon this model (Kumas-Tan et al., 2007).

A second model of cultural competence, known as The Process of Cultural Competence in the Delivery of Healthcare Services by Josepha Campinha-Bacote, contains some of the same constructs as the Sue and Sue model. The foci of this model are cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire (a want of the provider to become culturally competent) (2002). She conceptualizes cultural competence as a process, stating that the intersection of the above constructs overlap: “As the area of intersection of the constructs becomes larger, health care providers more deeply internalize the constructs on which cultural competence is based” (p. 183). This allows for flexibility between the constructs—even if a health care provider has cultural knowledge, they may not participate in cultural encounters, and vice-versa.

Finally, a third widely cited model of cultural competence is Cross’s Cultural Competence Model. The framework follows a spectrum of cultural destructiveness, incapacity, blindness, cultural pre-competence, and cultural proficiency (1989). Cross describes a culturally competent medical system: “A culturally competent system of care acknowledges and incorporates--at all levels--the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs” (1989, p. 28). This allows for an individual or organization to develop positively but also accounts for the consequence of policies or behaviors that might lessen the inclusivity of people of color or other social minority groups.

J.L. Mason developed the Cultural Competency Self-Assessment Questionnaire (CCSAQ) in 1995 modeled off of Cross's Cultural Competence Model, originally designed for use in children with disabilities and modified both for service providers and for administrators. The CCSAQ allows a service provider to measure their own knowledge of communities, service provider personal involvement, local resources and linkages, staffing, organizational policy and procedures, and outreach to local communities. Kumas-Tan and colleagues reviewed ten cultural competence assessment instruments, of which the CCSAQ was one (2007). In their analysis, they showed that the CCSAQ, though based in 1995, had "acceptable reliability, except for the personal involvement subscale" and "validity supported by literature and expert review" (Kumas-Tan et al., 2007, p. 551). Godkin and Savageau used the CCSAQ instrument with modification, testing the cultural competence of preclinical medical students on a global multiculturalism track, also utilizing a pre- and post-experience methodology, though the experience in that case was their global multiculturalism education (2001).

Recent Developments in Cultural Competence

In more recent years, critiques of cultural competence efforts often focus on the ability of cultural competence to fit within patient-centered care, a prescription made by the American Medical Association and the Institute of Medicine in the early 2000s (Institute of Medicine, 2001; Shaller, 2007). Betancourt states:

"Cultural competence is no longer seen as a set of skills necessary for physicians to care for immigrants, foreigners, and others from 'exotic' cultures, but instead as a central tenet of patient-centered care, effective communication, and the need to be responsive and deliver quality care to all patients" (2006, p. 500). Chun echoes the sentiment of Betancourt, stating that "Cultural competence enhances patient-centered care by placing an emphasis on the role culture…plays for a patient" (2010, p. 616). In effect, one cannot be without the other. A clinician must focus on the patient's experience and identity to be culturally competent as well as "patient-centered." While the AMA and physicians can generally agree that this "patient-centeredness" is achievable in the U.S. context, the STMM context is another matter. How can a medical intervention designed by foreigners, implemented as a vacation or travel opportunity for foreigners, and that highlights the medical expertise of the volunteers focus itself on the patients?

In his report for the Commonwealth Fund, Betancourt relates the six points of improvement from the Institute of Medicine's *Crossing the Quality Chasm* (2001) to cultural competence:

Table 2.1. IOM Six Points of Improvement and Their Links to Cultural Competence

Institute of Medicine Point of Improvement	Betancourt (2006) Link to Cultural Competence
Safety	• Use interpreters to avoid misdiagnosis • Improve patient-provider cross-cultural communication to avoid unnecessary risk for patients, better informed consent • Patients participate in clinical process
Effectiveness	• Better detection through stratification of measures by race/ethnicity in consideration of health disparities • Clinical cultural competence for providers to discern patient preferences and values
Patient-Centeredness	• Clinicians learn compassion, empathy, and responsiveness through cultural competence
Timeliness and Efficiency	• Reduce waiting time or harmful delays by having interpreters to communicate efficiently
Equity	• Monitor the quality of care delivered to diverse patient populations through stratification of measures by race/ethnicity

Taken and adapted from Agency for Healthcare Research and Quality (2015) and Betancourt (2006).

Within the culture of medicine, Fox notes that though culture has always been acknowledged by some in the medical establishment, culture is positioned to be a distinct and *non-medical* component of the act of delivering medical care, illustrated by its nomenclature: "social, psychosocial, humanistic, behavioral, non-biomedical, and ethical…" (Fox, 2005, p. 4). While acknowledging that progress has been made in the acceptance of cultural competence as a necessity for providing quality health care, Carpenter-Song and colleagues relay several anthropological critiques of depictions of culture. They assert that culture is often presented as static, there is a conflation of race and ethnicity, within-group differences are overlooked, recognition of cultural differences exacerbates power imbalances, and that biomedicine is not recognized as a cultural system itself (2007, p. 1363).

They suggest that culture be viewed as "a dynamic process of shared meanings," and then used within the paradigm of Kleinman and Benson's "mini-ethnography" whereby clinicians can use anthropological techniques to relate to patients (Ibid., p. 1364; Kleinman & Benson, 2006). Shaw and Armin interpret cultural competence interventions as repositioning physicians; rather than taking the position of the highly educated expert regarding their patients, physicians are repositioned as learners who seek cultural expertise (2011, p. 237). Gregg and Saha warn of the oversimplification of trying to define culture as a discrete phenomenon, and how that disallows the overlap and exchange between cultures (2010). In the U.S. context, it would be virtually impossible to expect such streamlined cultural preservation in the same context that assimilation has for decades been expected of immigrants—especially immigrants of color (Alba & Nee, 2003). In Guatemala, the patient context is plurilingual, pluri-ethnic, and pluri-cultural.

The Limitations of Cultural Competence in the Short-term Medical Mission Context

One of the criteria Kleinman offers to compare cross-cultural care were characteristics of interpersonal interaction, most applicable to the study of short-term medical mission interactions (Figure 2). In Kleinman's terms, the opportunities to develop a "quality of relationship" are markedly different in the STMM environment than even in the United States with a minority patient: etiquette may be difficult to distinguish for physicians since they have the "upper hand" in that power relationship but are in foreign communities in a sovereign foreign nation.

Because of the economic dynamic of STMM care, the social roles enacted by provider and patient might exacerbate emotional distance rather than mitigate that distance due to the aforementioned pressure for beneficiaries of free care to perform gratitude. Finally, medical missions are groups of visitors that offer care distinct from what is offered in Guatemalan communities; surgeries are timely and low-cost, the care is delivered by foreigners, it is often facilitated by speakers of a different language, and it will not be there next week. In this case, STMM care would be "divorced from everyday life" (Kleinman, 1980, p. 207).

Figure 2.3. Characteristics of Interpersonal Interaction

Characteristics of the Interpersonal Interaction	
Number of Participants	#
Time Coordinates	Episodic or continuous, average length of treatment, amount of time in each transaction, time spent in communicating or explaining

Quality of the Relationship	Formal or informal (etiquette), type of social role, emotional distance, restricted or elaborated communicative code, nature of transference and countertransference, whether it is integrated into or divorced from everyday life
Attitudes of the Participants	How patients and practitioners view each other

Figure 2. Adapted from Kleinman, 1980, p. 207.

Furthermore, while individual considerations can be made to improve the quality of the interaction between patient and provider in the STMM context, structural considerations likely cannot be addressed by individual improvements made within an identical neoliberal framework. That is, the emphasis on individual interactions between patients and providers to combat the lived history and systemic racism experienced by a patient of color or STMM patient in Guatemala is as equally flawed as interventions proposed within the neoliberal framework itself. Just as viewing STMM patients within the vacuum of the provider-patient consult accomplishes little vis-à-vis the improvement of population health or the effects poor health has on poverty, focusing on the improvement of individual medical providers' interactions with their patients as a panacea to centuries of racism and discrimination within health care and beyond likely will not create the expected sea change.

Cultural Competence in the Guatemalan Healthcare Context

Many of the aspects of care provision in medical missions are specific to its context: STMMs do not often spend more than two weeks in one location, and not often more than one to two episodes with a single patient. Practitioners may view patients negatively or may arrive with assumptions about indigenous Maya in particular based on cultural stereotypes. By many non-Maya Guatemalans, "historically, *Indios*/Indigenous

Guatemalans have been characterized as traditional, antimodern, and backward," constituting an impediment to modernization and its supposed benefits (Vanthuyne, 2009, p. 207; Connolly-Ahern & Castells, 2010). This characterization is both a cause and an effect of the profound social exclusion the Maya have experienced since the conquest which continues into the 21st century (Vanthuyne, 2009).; discrimination proves a formidable barrier to education and upward economic mobility, yet indigenous Guatemalans are also blamed for their marginalization. From this perspective, physicians with some knowledge of racism towards the Maya may characterize their work in STMMs as a modernizing force in the lives of their patients or in the least, bringing to their patients something they are perceived to not have.

These characterizations help construct the idea of the "typical Guatemalan citizen" for the outsider. People in poverty in Guatemala are blamed for their poor health outcomes by the small but powerful upper class of landowners and employers, who are generally *mestizos* or *ladinos*—Guatemalans with Spanish descendance and an identity based on that descendance rather than indigeneity. This blame is exercised through ethnic narratives about work, rural lifestyle, and rejection of biomedical care by some members of the *ladino* population (Chary et al., 2016; Willett, 2007).

These narratives hearken back to complaints by *ladino* landowners and politicians of indigenous workers' laziness, poor health, and even alcohol addiction actually facilitated by greater structural inequalities and discrimination (Carey, 2012). While American physicians do not share the cultural milieu as wealthy *ladino* Guatemalans who discriminate against poorer and/or indigenous Guatemalans, those physicians occupy an analogous tier in U.S. society that excludes poor individuals and people of color—though more inclusivity in medical education and in the medical provider workforce might change this.

Over half of the Guatemalan population is in poverty; of that half, 75% of the poor are indigenous Maya (INE, 2015). Not coincidentally, the Maya population is more likely to be employed in the informal sector (excluding them from health insurance), more likely to live in a rural area, and more likely to use traditional medicine, for example, seeking out a midwife to assist in prenatal care and birth (INE, 2015; Maupin, 2008, Chary, Diaz, Henderson, & Rohloff, 2013). Research shows that the Maya have difficult experiences when attempting to secure health care for themselves in a system both poorly funded and poorly equipped with delivering health care to non-*ladino* populations (Berry, 2008, Chary, 2016). The Maya remain in a double-bind; even if they do try to "help themselves" (a commonly promoted neoliberal value) by seeking out biomedical care for their health problems, they are often dismissed as difficult or wanting too much upon interaction with those providers, much like the immigrants in Germany described by Huschke (2014; Berry, 2008).

Cultural competence also remains relevant in the short-term medical mission context because of the clear applicability of the concept to aspects of STMM care. The first is the recognition that the same disease pathologies might appear to have different causes in different cultural contexts (Gregg & Saha, 2006). "Patient and physician interpretations of disease are often quite dissimilar and may affect the quality of the care a patient receives" (Ibid., p. 543). The concept of explanatory models of disease is particularly relevant to mobile clinics, who consult with patients about general illness, in contrast to surgical consultations and surgical missions (Kleinman, 1980). In the case of

Guatemala, several cultural constructs of distress (CCDs) are known within the population, so knowledge of non-biomedical explanatory models for illness is of particular use. First, a patient might name their illness whose symptoms are easily recognizable within the cultural context; someone unfamiliar with the illness might not know the symptoms or treatments already being utilized that could affect what medications or treatments are subsequently prescribed. Second, an understanding of culture-bound syndromes could lead to better communication with patients about their overall health, improve trust, and demonstrate respect for the patient.

Jenks warns against the use of cultural competence to reinforce and impose stereotypes on patients, however. She states, “culture cannot be thought of as a bounded object or uniform list of traits and that providers must be careful not to make assumptions about how their patients will think or behave” (Jenks, 2011, p. 217). Theoretically, Jenks ties this to efforts of standardization within biomedical practice—even as applied to culture. Deviations from the norm are a core principle in biomedicine, as they inform diagnoses, but applying the same method of thinking to culture would simply reinforce stereotypes. Since the discussion of cultural competence began, some authors have rightly critiqued the use of culture as a singular construct frozen in time, instead introducing other terms.

“Cultural humility” and “cultural empathy” are closely related to the idea of cultural competence and emphasize this process of understanding as a reflexive exercise rather than a memorization of cultural norms as concrete facts (Tervalon & Murray-Garcia, 1998). Tervalon and Murray-Garcia define cultural humility as incorporating “a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician-patient dynamic, and to developing mutually beneficial non-paternalistic partnerships with communities on behalf of individuals and defined populations" (1998, p. 123). Foronda and colleagues executed a concept analysis of cultural humility and found that the above definition of cultural humility was an effective guiding tool used in the literature to describe the efforts of many different disciplines to provide better care to diverse patient populations (Foronda, Baptiste, Reinholdt, & Ousman, 2016). Foronda, Porter, and Phitwong developed Foronda's Cultural Humility Scale specifically to be utilized among nurses, and their "achievement of cultural humility' (2020).

While cultural competence as a skill or cultural humility and empathy as philosophies are perceived to be attainable for physicians in the American context, the shift between the American context and a foreign context is substantial; therefore, the ways in which cultural competence is manifested as perceived by physicians has implications for the extension of cultural competence theory and application. In the medical mission context, physicians often attend to, at minimum, 100 cases per week or more; this means time-limited interactions between provider and patient take place, as well as linguistic barriers (Dupuis, 2003).

Cultural competence only recently appears in tandem with discussions of STMMs. The previously discussed Cultural Assimilators of the 1960s and 1970s were tools utilized to improve cultural understanding but were not a product of an institutional sea change like the Institute of Medicine's *Unequal Treatment* report. Campbell and colleagues conducted 21 questionnaires with students who had received the Operation Smile Regan Fellowship to perform surgeries abroad and had been exposed to a pre-departure meeting that introduced them to "multidisciplinary care of patients with cleft lip and cleft palate, information on planning and funding of international surgical missions, and insight into the provision of medical services in different economic and cultural settings" (Campbell, Sullivan, Sherman, & Magee, 2010, p. 125). The authors' study served to demonstrate the perceptions of these physicians after exposure to the training—unsurprisingly, most of the questionnaire answers revealed that the physicians believed the information and training was useful (Campbell, Sullivan, Sherman, & Magee, 2010).

The concept of "culture" (and its actively changing nature) is an important aspect of cultural competence to consider in the medical mission context. Firstly, standardization and memorization are critical aspects of medical education and a familiar method of learning for physicians. This means that teaching cultural competence (or at least bridging the topic) also means encouraging a vastly different style of thinking than what medical professionals are exposed to in their training. Secondly, as Gregg and Saha point out, often culture can be studied to help find solutions to epidemiological issues but is not often the cause; the authors contend that class and income disparities perpetuate health inequalities in such a forceful way that studying or considering culture in the operating room or at the hospital will not simply eliminate health problems (2006). Finally, measuring and/or teaching cultural competence could be difficult because it is so easy from the perspective of physicians to conflate *caring* about a group of people with *respecting* that group of people as decision-makers in their own lives.

In the most negative interpretation of the implications of using cultural competence in the STMM context, ultimately, cultural competence may be understood as simply a way to execute the goals of the foreigners reflected onto anonymous brown bodies. More positively, physicians may develop a more sophisticated sense of empathy towards low-income patients if they develop the attitudes promoted through cultural competence—that is, respecting the patient who knows much about how their own body functions and what it needs at the personal level and carefully considering structural problems the individual faces. Impeding such an enlightened outlook towards poor patients are many factors that cannot be unlearned in one medical mission experience: racism, problematic attitudes about poverty, and exoticism, among others.

One final and critical issue of the study and implementation of cultural competence in resource-poor environments is the recognition of the inadequacy of cultural competence as a solution to the ubiquitous problem of unequal health care for populations of color, within and outside of the context of STMM health care in Guatemala. Drevdahl, Canales, and Dorcy contend that in the context of poverty and structural inequality, there is only so much that cultural competence and the individual positive actions of health care providers can accomplish. And at worst, cultural competence distracts from efforts to achieve equitable health care at the institutional level by proposing providers' individual actions will achieve population-level benefits (2008). The negations of neoliberalism continue to echo—asking for any solution besides dedicating economic and material resources or reparations to marginalized populations.

V. Short-Term Medical Missions in Guatemala

Finally, I will focus on the development of short-term medical missions in Guatemala. Christian missions to Guatemala have been occurring for centuries. According to McCleary and Pesina, Presbyterian churches first began to send missions in the late 19th century, Seventh Day Adventist and Lutheran churches in 1952, and others, such as the Southern Baptist Church and Wycliffe Bible Translators, in large numbers in the 1960s and 1970s (McCleary & Pesina, 2012). Roche and Hall-Clifford have detailed the relationship between NGOs and STMMs, an often-symbiotic relationship in which local NGOs might gather appropriate patients for the skill set of the arriving medical team and the STMMs provide care to the patients (2015). It is possible that some STMMs were born out of relationships between American physicians with some experience in or knowledge of Guatemala and acquaintances in Guatemala—though this is just a hypothesis. Priest and Priest found that at the time of publication in 2008, Guatemala was the sixth most popular destination for short-term missions, though this number does not break down the type of short-term mission—health, development, or religiously oriented (2008, p. 63).

Motivations and notions of altruism have been observed in Guatemala. Set against the backdrop of poverty and a long, devastating civil war, Rand Paul exhibited himself as an altruist caring for poor foreigners of color, though political and personal gains were to be had from appearing as such. Rand Paul, prior to his entry in the 2016 U.S. presidential election, was featured on Meet the Press Extra on MSNBC. Dr. Paul brought along a camera crew to this medical mission in the municipality of Salamá, Alta Verapaz—three hours northeast of Guatemala City, and was open about how he hoped that this view of his medical work would be favorable for his campaign (MSNBC, 2014). Though many physicians certainly do not take camera crews into the operating room with hopes of it benefitting their political endeavors, the objectification of patients is a salient issue. This is especially important to consider when the physician is white, wealthy, and male patronizes the patient is an elderly, brown-skinned, blind woman—as he asserts in the video, “she’s so cute” (Ibid.).

Two sets of authors have mentioned the issue of accountability through regulation in their work in Guatemala. The Guatemalan College of Surgeons and Physicians nominally registers the names and qualifications of medical professionals working in Guatemala as volunteers, but the efficacy of this regulation has not been measured. Berry noted that it was “not uncommon to find missions that did not register with the College” (2014, p. 3) in her work in Sololá, Guatemala. Roche and Hall-Clifford also found this to be true, identifying changing policies and unclear registration protocol as part of the problem (2015). A further discussion of this issue will be discussed in Chapter 5.

In 2008, Green and colleagues noted that many of the criticisms of STMMs globally were also applicable to Guatemala. In particular, they emphasized the inability of short-term medical missions to actually address poverty in the host communities; a commonly cited goal of medical missions in their interviews and on their websites is to reduce poverty in Guatemala--one person at a time. Poverty is widely identified as a barrier to the achievement of better health for Guatemalans, especially in the neoliberal ‘health care as free market’ context (Green, Green, Scandlyn, & Kestler, 2008). They cited “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”—all of which cannot be solved by short-term medical work (2008, p. 5). Additionally, STMMs cannot always meet the long-term health needs of the patients they encounter—cancer, for example, cannot be treated in such a way (Berry, 2014). However, this does suggest that patients with certain illnesses, especially those treatable through one round of medication or one surgery, could be good candidates for this type of medical care.

Other factors STMMs must consider are risk for patients and the type of surgery offered. In their study of a tonsillectomy program coordinated with Obras Sociales Santo Hermano Pedro, a busy local hospital in Antigua Guatemala, physicians turned away patients for surgery who had anemia, an endemic health problem tied to poor nutrition. While this STMM might not have had the “body count” from having performed an extensive number of surgeries, the team’s post-operation data showed that only 3 patients out of the 197 patients suffered any complications from their surgery (Sykes, 2012). Consideration of the level of risk the surgery brings to the patients can and should guide decision-making for where, how, and for what patients a surgery is performed; a low-risk surgery such as a tonsillectomy is accomplishable in a shorter time frame than other more invasive surgeries.

Travel time to STMM sites for Guatemalans seeking care can often be a problem. Sykes and colleagues identified this in their study of a tonsillectomy STMM, saying that Casa de Fe (an NGO in Antigua Guatemala) will house limited numbers of patients’ family members who reside more than one hour away who accompany their family members who undergo medical procedures (2012). Many still elect not to get surgeries because of the distance from family, normal food, and expense, although this is a criticism of other medical providers in addition to STMMs (Sykes et al., 2012; Chary, 2015).

Anecdotal evidence shows that STMMs almost always operate in Guatemala City, Antigua Guatemala, Chimaltenango, and near Lake Atitlan—but some of the critical areas most isolated from health care services are rural, far from the airport, and not in possession of U.S. conveniences (Berry, 2014). These areas do possess more technology and infrastructure, including hospital services. To some degree, a STMM that aims to provide surgeries is limited by location, and patients are often bussed or driven to surgery locations if they live remotely. But if STMMs seek to provide care to the most vulnerable, why do they continue to locate patients primarily from the least-rural, most economically well-off areas of the country?

Short-term medical missions don't always assess the local needs of Guatemalan communities. Green interviewed Guatemalan physicians, who indicated that North American physicians tended to assume that everyone is poor, when it would be more helpful to make sure the poorest of the poor were receiving the free care (2008). Maki and colleagues identified needs assessments as lacking in the planning of many STMMs, and was integrated into their standardized quality assessment (2008). One area of focus for future research is how STMMs decide on the location in which they will operate as well as how they coordinate with local organizations to decide upon an appropriate plan for the time the STMM will spend in Guatemala.

Linguistic barriers to care are two-fold. Specific to Guatemala is the language barrier between monolingual Spanish speakers and monolingual Maya language speakers—there are 22 Maya languages throughout Guatemala, often distributed regionally and in accordance with the ethnic group which speaks the language—though internal migration has affected this tendency. Additionally, in the STMM context, there might be an English-Spanish barrier or an English-Spanish-Maya language barrier. Jarrahy and Taub identified language barriers between physicians and patients as a primary problem in the delivery of cleft palate surgeries in a medical mission to Guatemala (2014). This linguistic barrier is distinct from cultural differences between providers and Maya patients—several publications have addressed health disparities between non-Maya providers and Maya patients, addressed in the previous chapter (Chary et al., 2016; Berry 2008).

As the background research demonstrates, several tensions present themselves, which have been summarized categorically as individual experiences, tensions in health paradigms, and institutional approaches and limitations in Figure 2.4. Aspects of these tensions will be further discussed in tandem with the dissertation research in the following chapters, especially considering the role of the medical mission coordinator, who is often the actor in the position of mediating between these tensions as they often seek to meet the expectations of both the patients and the volunteers.

Table 2.3 Tensions of Short-term Medical Mission Care

Guatemala-side	**Tension**	**United States-side**
Patient Experience: • being attended to and getting sufficient time from the physician • being understood [language, cultural context], non-biomedical traditions • delivered a solution to their problem • (often) expectation of receiving medication	Individual Experiences	Physician Experience: • desire to help a high volume of patients • desire to act on exotic bodies • language expectations met [able to operate without Spanish/Maya language knowledge] • assumptions of universality of bodies
Public Health Paradigm: • focus on prevention • primary health care (PHC) stressed by World Health Organization	Health Paradigms	Voluntourism Paradigm: • desire to “cure” • meeting urgent or emergency needs • “make an impact” through works, anecdotal evidence of positive effect

• sustained relationships with long-term care providers • population-level improvements in health metrics		• mission-specific metrics that focus on number of patients assisted • lack of long-term health care outcomes for patients
Guatemalan Health Care Institutions: • Structural adjustment and limited budgets/resources • Guatemalan physician autonomy and respect as professionals • Low incentive to reform health care access • Teams abide by local laws for registration of persons and facilities	Institutional Approaches & Limitations	United States Medical Institution: • Medical missions as part of undergraduate and M.D. learning • Paternalism, assumption that U.S. care is superior • Preference for biomedicine • Dislike of bureaucracy, assumption that regulations can be disregarded

VI. Conclusion

Humanitarianism has diversified significantly since its onset in the eighteenth century. Medical humanitarianism focuses on the health needs of the poor in resource-poor environments. Groups such as the Medicins San Frontiéres, the best-known and largest medical mission organization (known also as Doctors Without Borders) were initiated during the tumultuous 1970s and 1980s and represent the modern technocratic approach to medical humanitarianism, motivated by a desire to contribute to the end of suffering in former colonies of European nations. However, as time wears on, fair critiques of MSF, including the stark difference in privilege and its problematic division of labor between nationals and expatriate physicians have emerged.

But other permutations of medical mission work also exist. Smaller groups of specialized physicians work abroad to conduct surgeries for cleft palate and to restore vision. Other groups arrive in a location, set up a medical camp, and treat the ailments of local populations on a case-by-case basis. These trips often only last for one-to-two weeks, comprising a “short-term medical mission (STMM),” a practice not without its own critiques; follow-up care, quality of care, respect for patient autonomy, coordination with local providers, and physician motivations have all been cited in studies as potential and realized problems for STMMs. Within Guatemala, language barriers and considerations of the local context (endemic illness, malnutrition, and travel barriers) make up the majority of criticisms applied to STMMs.

The STMM context brings to light multiple levels of tension between individual actors, approaches towards health care, and health institutions, which is outlined in Figure 3. Individual experiences of both the patient and the physician can be complementary, such as when a single surgery can provide relief to a cataract patient. However, long-term or terminal health problems are not solvable by a single consultation session and may leave both the patient and the physician disappointed. STMMs operate in the opposite direction of global health initiatives starting in the 1970s—rather than contribute to capacity building within Guatemala, they potentially undermine such goals; one community may have a favorable relationship with a medical mission that comes every year, but there is no evidence of such a uniformity in STMM operation areas and timing that STMMs could be considered a reliable source of health care.

Prevention is rarely stressed in STMMs insofar as their stated mission and remain popular because they offer resolution to individual problems—but not population-level issues of access to surgeries or sustained patient-provider relationships. Finally, while this area of STMMs is understudied, at least one article has mentioned negative assertions of STMMs made by Guatemalan physicians, indicating that the confidence boost that comes from healing a sick individual or resolving a medical issue through surgery for American physicians comes at a cost to faith in or opportunities for local physicians (Green, Green, Scandlyn, & Kestler, 2008). In the future, it will be important to understand how medical missions become institutionalized as part of the medical school experience in the United States and how this impacts local economies and confidence in local health care practitioners.

Many academics and care practitioners conclude that cultural competence can deliver better care to minority populations in the United States because it necessitates an engagement of physicians and health care professionals with unfamiliar cultures. However, the way to 'achieve' cultural competence is not agreed upon, and has evolved from listing and memorization of cultural traits to exercises in interpersonal communication and self-reflection on the part of medical professionals. Short-term medical missions provide an interesting new application for cultural competence research but researchers have not yet implemented this idea into research extensively.

One of the potential avenues to do so is by using the Cultural Competence Self-Assessment Questionnaire, which is aimed exclusively at health care providers (as opposed to patients) to assess their own actions and perceptions of non-white patients in the health care setting. While some surveys engage with ideas of cultural competence and humility (specifically, the time spent with the patient population and efforts to include people of color in operations), the translatability of the CCSAQ is yet to be tested in a foreign environment. If, as those who study cultural humility say, cultural competence and humility can take a lifetime to develop and take serious effort (Foronda, Baptiste, Reinholdt, & Ousman, 2016), significant long-term research must be undertaken to understand the full extent of efforts to develop cultural competence. However, this is a worthwhile avenue of inquiry given the extensive travel and burgeoning trend of medical missions from the United States as well as the rich diversity of the United States that only intensifies and expands every year.

Applying the CCSAQ in Guatemala could help researchers gain insight into several facets of STMMs in Guatemala. First, how prepared the physician volunteers are for providing medical in the Guatemalan context, including factors such as infrastructure, ethnic inequality and discrimination, and endemic health problems. Additionally, the CCSAQ measures knowledge of local providers, imperative to providing quality follow-up care and having adequate knowledge for emergencies. Finally, the study of motivations of physicians will demonstrate the personal and professional orientation of physicians to their patients, a major factor identified in the literature as integral to understanding the STMM phenomenon that has potential ramifications for the quality-of-care patients receive. However, measures of cultural competency do not capture structural or organizational inadequacies and of course, only can be utilized to better cultural competency/cultural competency skills by individuals or populations who are invested.

In the next chapter, I will explain my research methodology and orientation towards my research participants and the context in which I conducted my research. Furthermore, I will discuss research methods that were successful and those that failed, influencing the progression of the study and redirection to the topics that emerged as the most critical due to the qualitative methodology utilized.

CHAPTER 3

RESEARCH METHODOLOGY AND POSITIONALITY AS A RESEARCHER

"Welcome to our home!" the woman said, opening the door and ushering us into an elegant, formal foyer, consisting of a single wooden table with a sculpture on it, the walls filled with paintings. The home was in an upscale neighborhood of Antigua Guatemala, mostly populated by wealthy, white expatriates. I was with the coordinator of a surgical STMM organization, who invited me to a donor's home where the couple was hosting the small volunteer medical team (VMT) for dinner—a nice meal, before heading up to Alta and Baja Verapaz. While I trusted this coordinator and appreciated his interest in my project, I suddenly felt overwhelmed and wondered how I would interact with these people. This was my second mission to a rural area, but I did not anticipate its start to be in splendor.

Guided through the home, I observed each room, filled to the brim with art. The home was a grand, multi-winged colonial beauty at the edge of Antigua Guatemala, where the host and her husband, both former Peace Corps Volunteers, decided to retire. Now, as board members for the Guatemalan organization, they occasionally hosted the volunteers for a meal. The owner showed us through her home, passing a kitchen inhabited by two Guatemalan staff preparing the dinner. "They made most of the food, but I made the meatloaf myself. It's my daughter's favorite," she stated proudly. The two quiet house staff and the STMM coordinator were the only Guatemalans there that night.

I was wearing a black jersey dress with a traditional belt wrapped around my waist. Seeing the grandiosity of the house and its expensive art plastered on every wall, I suddenly felt very casual and doubted my sartorial choices. But then I entered through the

French doors to the garden, where I saw six volunteers wearing sweat-wicking athletic wear, cargo pants, and hiking shoes—I felt relief. The volunteers greeted me, but with some hesitation. The coordinator introduced me and my study, though the physicians had received a brief proposal from me via email a few days before.

One of them, a tall, lanky man in his sixties wearing glasses says, “So, you’re gonna study us?” I laughed nervously and said, “Well, when you boil it all down, I guess that is what I’m doing.” Satisfied with my sincerity, he replied that it was fine, and the other physicians nodded along. I breathed a sigh of relief and began to ask them where they were from—South Carolina. After more small talk, we headed into the dining room, where tables were set for us. I learned that these volunteers all work together in a semi-rural community clinic in South Carolina—a husband-and-wife team of a general practitioner and nurse practitioner, a pediatrician, a rotary club emissary from San Francisco, a pulmonologist, and the latter’s wife, a photographer.

The next day’s journey was a stark contrast to the serenity of the elegant home in Antigua from the night before. We spent a chaotic morning picking up volunteers from Antigua and staff in San Lucas and other various areas in Guatemala City. In this mission, there were many more staff from the STMM than volunteers. We slowly completed the depressing drive through El Progreso, a department whose agricultural yields have fallen significantly due to climate change and its once-fertile land replaced with dust. Traveling then to Baja Verapaz, we observed the immeasurable beauty of the temperate rainforests, the home of the quetzal, the national bird.

The six-hour drive gave me ample opportunity to connect with the volunteers and develop rapport. All of them reminded me of my mother—'liberals’ born and raised in the

South, lamenting their shock at how common decency and concern for others had eroded in the era of U.S. President Trump. And yet, they also seemed comfortable and uncritical of the social and economic privilege that had led the country there. The pediatrician, always accompanied by his *Atlas of Pediatrics in the Tropics*, was unable to read his book due to the threat of carsickness. But he shared with me his encyclopedic knowledge of genetic deformities, which he said were common and due to low genetic drift in the isolated communities of Baja and Alta Verapaz. He had visited Guatemala for ten years and knew the type of patients he would find. He said he always goes on the rural missions, which are oriented towards detecting and referring surgical patients.

We crept along highway 14 until reaching Salamá, where we ate dinner at a small restaurant off the highway. I sat with a few of the health promotors, three women from the Achi' and Poqomchi' areas, and an Ixil male health promotor who primarily works in the region of Ixcán, near the border with Mexico. The table was segregated, as I learned it would be every night. Spanish speakers on one side, English speakers on the other. I sat in the middle, trying to talk to everyone, growing accustomed to always being in the middle of the divide.

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According to a literature review of global STMMS conducted in 2014, of the articles selected for review, most "focused on the implementation of STMMs (66 [43%]), personal experiences of STMMs (36 [24%]), or ethical issues (23 [15%])," with the majority focusing on description rather than critical evaluation (Roche, Ketheeswaran, & Wirtz, 2015). Former patient perspectives can be a valuable area of research when studying medical missions on the interpersonal level or to study the perception of the process by the patients (namely Green, Green, Scandlyn, & Kestler, 2009; Esquivel et al., 2017; Morales et al., 2019) and as I did in my Masters research.

But, it is not the only useful tool for studying the overall process of executing STMMS, the potential risks to patients, or studying their effectiveness. This is because of the structural factors that make medical care so expensive and so inaccessible for Guatemalans, as well as the language difference and power imbalance between researcher and patient. Often, research leads to a rather simplistic evaluation of the care—it's free and perceived to be high quality by many patients (Esquivel et al., 2017; Roche et al., 2018).

When much of the low-income, rural, and indigenous population is barraged with the message by staff in health institutions that it is their fault they are poor, it is their fault they are not educated, and they deserve nothing more than the low quality public health care facilities that attend to them (Cerón et al., 2016; Poder & He, 2015)—they are perhaps not the people to ask to critically evaluate a medical mission. Thus, while I gained valuable experience as a young researcher executing a project on her own, I did not gain as much insight as I had hoped. A few scholars have noted that it would be relatively difficult to get honest assessments of medical missions from the patient pool, as they may feel shy or perceive a potential loss of future opportunities for medical care through missions (Green, Green, Scandlyn, & Kestler, 2009; Roche et al., 2018). While they might perceive the standard of care to be much better in a medical mission than in a national hospital, the structural aspects of the medical mission often contribute to a care environment that is below the standard of care the providers must meet in the United States.

Research dedicated to the standard of care in medical missions necessary if medical mission teams want to have an ethical presence in the health care sphere in Guatemala and in other parts of the world frequently visited by STMMs. This dissertation addresses specific issues pertinent to STMMs in Guatemala, analyzing them through the lens of the ideology of global neoliberalism. In the stage of research design, I wanted to have a clearer sense of the medical mission as a full process—U.S.-side planning, Guatemala-side planning, and how those plans come to fruition. how does such an ambitious project become realized? And how might their preparation and organization contribute to the sometimes-troubling practices they're known to engage in? Much of the existing literature focuses on patient perceptions or on the volunteer medical teams (VMTs) via survey—in my research, I wanted to "study up" in the sense that medical providers hold the knowledge and power valued within the interaction, but also to engage with and observe the experiences of patients through my own lens (Nader, 1972).

The primary goal of the dissertation research was to better understand the variety of ways in which a medical mission can be conducted, their scope, and to highlight particular issues that indisputably must be addressed for the benefit of the population receiving care, including the legal and professional requirements by the Guatemalan government. What I found, however, were ample connections to neoliberal health paradigm both in the structure of STMMs and the assumptions they are based upon and the interpersonal communication between provider and patient. Many of the central assumptions forming the skeleton of the neoliberal health model were unchanged from the health care landscape Guatemalans utilize on a day-to-day basis, and the care offered by volunteer medical teams (VMTs), framed by the teams themselves as distinct or superior.

I. Central Questions of Investigation

Three central questions guided my dissertation research. The first was the nature of preparation that volunteers receive while in the planning process of the medical mission. This not only included the logistical aspects of planning—such as arranging flights, deciding who would carry what medication, lodging arrangements, etc.—but also the cultural preparation that volunteers would (or would not) receive via the coordinators located both in the United States and in Guatemala. Americans receive mixed messages about Guatemala; it is simultaneously an exotic, impoverished, and dangerous place (Travel.gov)[12] *and* a humble paradise full of friendly, smiling indigenous people (Devine, 2016; Harbor & Hunt, 2021). I sought to understand how these two perspectives are reconciled, especially in a space so fraught with expectations, especially expectations of the patients by the medical providers.

As with most mixed messages, they contain elements of both truth and fiction. But what do the coordinators emphasize when preparing the volunteers? I wanted to know specifically if the preparation addressed issues of a) endemic disease and illness to Guatemala (e.g., what providers would expect to treat), b) provider health and safety, c) expected behavior of patients, according to cultural stereotypes or prior knowledge of the population. While there has been considerable and valuable research regarding the

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[12] “Violent crime, such as armed robbery and murder, is common. Gang activity, such as extortion, violent street crime, and narcotics trafficking, is widespread. Local police may lack the resources to respond effectively to serious criminal incidents” (Travel.gov, 2021).

expectations of gratitude and participation in the giver/receiver dynamic (Berry, 2014; Roche et al., 2018), I sought to more deeply explore how the perceptions of indigenous patients by providers might contrast to actually treating them in the clinical environment.

The second, and related research question is how the process functions for American providers, some of whom have never traveled to Latin America or do not speak Spanish, to arrive in Guatemala to serve Guatemalan patients. This involves both U.S.-based coordination efforts, often emphasizing volunteer recruitment and fundraising, and Guatemalan-based coordination efforts, which includes significantly more paperwork, planning, and communication with in-country facilities and human resources. I aimed to understand this process in detail, including the requirements normally completed by the American-based coordinator and those completed by a coordinator or contact in Guatemala.

The final research question was concerned with the execution of medical missions and the appropriateness of the concept of cultural competence in this context. Cultural competence, in whatever form, is the ability of healthcare providers to treat patients of different cultural backgrounds from themselves successfully and with respect for their patients' culture. While most cultural competence literature has focused on American providers (who, for a long time, mostly came from white, socioeconomically advantaged and educated social groups) working with foreign-born or non-white populations within the United States, this research is concerned with those providers working abroad, a relatively understudied context in which to examine cultural competence (Steinke, Riner, & Shieh, 2015; Martin, Parker, & Mugambi, 2019).

I sought to observe this cross-cultural medical provision through a critical lens. Prior literature has established that providers volunteer to provide medical care abroad, armed with expectations of the characteristics of patients as well as their behavior, most notably, an exchange of medical care for gratitude (Berry, 2014; Shaw, 2019). Other authors have conceptualized medical missions at the ultimate patriarchal, neocolonial project onto which white people can regain a sense of control and superiority (Hanchey, 2019). Given the power imbalances, language differences, and different cultural presentations of patients, would the STMM experience be so overshadowed by provider expectations that no room would be left for cultural competence?

Addressing Cultural Competence

While the original concept for the dissertation research included measuring self-assessed cultural competence before and after the medical mission, this became logistically infeasible and conceptually challenging. The Cultural Competence Self-Assessment Questionnaire (CCSAQ) was designed to be taken as a pre- and post-test for volunteers before and after the medical mission trip experience. The CCSAQ was adapted to the Guatemalan context and put online in Qualtrics.

Logistically, it was incredibly difficult to oblige medical practitioners to take the CCSAQ before departure. This was partially due to the recruitment strategy; sometimes I was only granted access to conduct participant and direct observations with a group (and thus get their consent and the opportunity to personally explain the CCSAQ to them) one or two days before the team started their clinical work. In addition, many of the volunteers used their vacation time to go on their trips. So, many volunteers were working before leaving on their trip to Guatemala and then immediately resumed work upon their return, also making it difficult for them to complete it at that time. The success rate in collecting these questionnaires was very low—less than 15%. One other study similarly tried to implement a cultural competence survey into the medical mission context, but yielded no significant results and reported difficulty in executing the study for the same reasons listed above (Martin, Parker, & Mugambi, 2019).

Cultural competence was observationally relevant but yielded null results as a research method with this population. I observed many moments of cultural disconnect as well as empathetic understanding. But what became apparent upon actually conducting the research was how much more important some of the structural components to the execution of medical missions (that also relate to cultural differences) became as well as the observations I made while conducting participant observation, as opposed to focusing on the self-assessments. The cultural competence background was necessary in order to see clearly what individual attempts at cultural negotiation and interaction lacked theoretically and practically. The literature has reflected this turn towards recognizing the limitations of cultural competence and what it can reasonably remedy within systems that are structurally flawed. As said by authors Drevdahl, Canales, and Dorcy, "Viewing disparities from a narrow cultural framework is less intimidating as it ignores the roles of power, discrimination, and class operating within larger societal structures, organizations, and practices" (2008). Thus, I pivoted towards understanding the 'system' of medical missions and where inequalities and disparities are unknowingly reproduced.

While conducting research with the teams, I often came upon some cognitive dissonance; practitioners clearly voiced a desire to understand the patients and demonstrate respect for them as individuals prior to departure for Guatemala or to the site where health care was to take place but fell short of that respect for cultural differences either in the clinical setting or later when expressing culturally-based frustrations about patients or Guatemalan staff, often in settings in which the volunteer medical teams (VMTs) were isolated from patients, such as nightly meetings or lunch breaks.

This cognitive dissonance followed a logical pathway beginning in many of the organizational policies of the teams and became a more stimulating point of departure for data collection and analysis. It illustrates perfectly one of the central tensions of medical anthropology. Straddling the medical literature and cultural anthropology is the spectrum of how to view the problems affecting patient care. The medical tradition tends to place emphasis on individual interactions between doctor and patient and until recently, patient responsibility to adhere to the treatment plan outlined by their physician within the time constraint of one to two weeks. While the medical discipline has come to be more accepting of influences from other disciplines, the focus of many of the medical providers recruited in this study was the individual impact they felt they could make with patients. There was, in fact, considerable variation in the attitudes that providers exhibited towards patients and the strategies that some thoughtfully adopted to communicate with patients and facilitate understanding, which will be discussed in Chapter 6.

Medical anthropology (specifically, the work of Paul Farmer), places emphasis on structural vulnerabilities that patients face that might impede adherence to treatment plans and contribute to the cycle of blame that often is laid upon patients,[13] who live in

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[13] Most notably, his work *Aids and Accusation* (1992), *Infections and Inequalities* (1999), and *Pathologies of Power* (2003)

communities with poor health care infrastructure. The physicians who are not always conscious of the everyday struggles that patients face to even receive a diagnosis or medications for their chronic and acute illnesses. The medical mission context is hyper-focused on individual patients, following a trajectory that mirrors the rise of neoliberalism in the 20th and 21st centuries. The planning, preparation, and structure of medical missions fail to facilitate a holistic understanding of patients' lives or where they fit within existing capitalist structures and the accompanying inequality that follows them, sometimes reproducing those same structures.

While conceptually it might not be difficult for a physician to imagine a patient's reality of poverty, it can be confusing when the patient is in front of them complaining of diabetes symptoms and reporting an intake of several sodas per day and eating a diet full of fat and carbohydrates. This is not unique to medical care in the STMM context; the ability of physicians (often of higher SES and racially privileged, historically) to compassionately serve a poorer patient population has previously been included in research on physician empathy (Hojat et al., 2002; Kim, Kaplowitz, & Johnston, 2004) and in the practice of serving indigent patients (Chirayath, 2006 & 2007).

Which perspective is more valid—the individual/interpersonal behavior perspective, or the structural perspective? The answer is that both are necessary points of view to consider, and thankfully were able to be investigated due to my research design. However, the structural issues I encountered while researching the planning and coordination process within STMMs were what seemed most pertinent to the biggest implications for patients and resulted as the focus of the analysis.

II. Research Scope and Inclusion Criteria

Prior studies of medical missions largely occurred with single medical teams (Werremeyer & Skoy, 2012; Esquivel et al., 2017; Green, Green, Scandlyn, & Kestler, 2009; Davis, Than, & Garten, 2014) and/or took place largely in the ‘voluntourism’ hotspots of Guatemala City, Antigua Guatemala, and the towns surrounding Lake Atitlan, Sololá (Berry, 2014; Sykes et al., 2012; Roche et al., 2018). Roche & Hall-Clifford conducted a qualitative study using the interview data focused on the experiences of 11 different NGOs in their collaboration (or lack thereof) with the government health care system (2015) and Coughran and colleagues performed a comparative study of perceptions of medical missions by both foreign (non-Guatemalan) and Guatemalan physicians (2012). These studies focused on surgical missions.

In my own research, I broadened the inclusion criteria to include both surgical and nonsurgical missions, various sizes of organizations, and additional geographic areas than commonly appear in the literature. Research began in August of 2018 and ended in July of 2019, allowing for 11 ½ months of data collection. I chose to conduct research with multiple teams, including participant observation and direct observation, and to work in diverse settings—some of which included the popular geographic areas and some of which were located outside of those areas. I excluded teams whose *primary* activity was not related to health care (e.g., construction teams).

Choosing a sampling strategy for this group of individuals was difficult. Purposive sampling was chosen following the idea of ethnographic sampling outlined by Werner and Bernard, later used in tandem with snowball sampling—that is, initially using purposive sampling to identify and collaborate with teams, then using snowball sampling to work with contacts of the initial teams (1994).

Because this study focuses on comparing different medical mission organizations and sets of providers, I recruited participants 1) not working just in the voluntourism hotspots between Chimaltenango and Guatemala City, where there are the most resources, the most tertiary care hospitals, and the most logistical and practical conveniences and 2) working in a variety of types of medical missions—that is, those that offer "primary care"[14] or consultations to receive a later surgery, or those performing the surgeries that week. While in the literature the medical missions are often dichotomized as one type or another, in practice, there was some symbiosis or coordination between medical missions of the two kinds—which I would have not discovered had I limited my study to only surgical missions or only basic services missions.

I did not exclude medical missions based on their size or the types of medical care provided—only that they needed to provide some form of medical care. Some groups were as small as just a few providers, while most averaged 18-25 members. It was impossible to balance groups according to ethnicity or gender, as the composition of the group was sometimes unknown to me until the coordinator invited me to conduct my participant observation along with the team. If there were Guatemalan staff (including coordinators or Guatemalan physicians) along the trip as volunteers or paid employees,

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[14] "Basic services mission" is the term I will use throughout to refer to medical mission teams that do not provide surgical services. Instead, they often provide some combination of physical exams, medications (over-the-counter and/or prescriptions), eye exams, eyeglasses, dental services, and medical referrals to receive imaging, further testing, or surgeries.

they were also recruited in order for any conversations with them to be included in my study under the conditions of my Institutional Review Board (IRB) protocol.

III. Research Methodology

Recruitment of Medical Mission Organizations and Participants

Some prior studies of medical missions to Guatemala focus primarily on the patient population, which has certainly contributed valuable knowledge to the area of study focusing on medical missions from the U.S. to Guatemala (Esquivel et al., 2017; Roche et al., 2018), and some scholars have made clear the need to include patient evaluations in overall STMM evaluations (Morales et al., 2019). Others focus on the organizational/healthcare delivery aspects of STMM care, often from the foreign provider perspective or through survey methodology (Berry, 2014; Sykes et al., 2012; Roche et al., 2015; Green, Green, Scandlyn, &Kestler, 2009). Most research on providers and coordinators is conducted through surveys, in stark comparison to my own, focused on the complexities and details gained from in-depth qualitative research. For my study, I chose to focus on the coordinators and providers themselves rather than the patients, though they were certainly included in the form of direct observations and properly consented in that context.

From the beginning, even in the planning stages of this dissertation research, it was evident that access to medical mission teams would prove to be an incredible challenge. Firstly, because medical mission teams are composed of a highly geographically dispersed, mobile population that often works long hours. For the purpose of answering my research questions, the providers were integral to the study for one to two weeks per year while preparing to come to Guatemala and delivering medical care directly to patients in the health care context—that is, it would not be a long-term collaboration. So, my initial plan was to recruit medical mission teams while in the U.S., identified from prior research and through online searches, make sure they were planning to conduct a STMM to Guatemala in 2018 or 2019, then meet with them once in Guatemala, as I planned to live there for the duration of my dissertation.

This strategy worked for only a few medical mission teams that planned far in advance to come to the country and agreed to talk to me before they came. It seems that the sometimes-cavalier attitude with which medical mission teams are thought to come into the country--e.g., providing care without preparation or context (Snyder, Dharamsi, & Crooks, 2011) --was sometimes reflected in their communication with me, a researcher, as well. A few teams agreed to collaborate with me less than a week before the mission began—luckily for me, but also leaving me scrambling to get to their mission site.

In total, I contacted 28 VMTs over the course of the year of research, nineteen with which I was able to at least conduct an interview and thirteen with which I was able to conduct observations. Four teams never responded to me. Two of the teams met with me in person, asked me to write a research proposal, then declined to collaborate with me. Interestingly, one of these organizations was consistently referred to negatively by other coordinators and volunteers. Eight teams agreed to be interviewed, then due to scheduling conflicts (5) or problems with the subject matter (3), I was not able to conduct observations with the teams. On occasion, after interviewing a coordinator via telephone and bringing up certain sensitive interview topics, such as the issue of cultural preparation for team members coming into the country or the importation of medication, the coordinators seemed less inclined to work with me and ignored future communication from me. Other possible reasons included concerns over confidentiality/being identified unintentionally, fear of sensitive information being shared (confirmed in relation to drug importation), and feeling awkward about approaching their teams to work with a graduate student.

What did prove to be more fruitful was a snowball recruitment strategy. Living in Guatemala, one quickly realizes that medical missions are really everywhere, and they do run into one another, utilize the same services (hotels, shuttle rentals, drivers, etc.), and sometimes occupy the same surgical and care facilities. One practically cannot fly into the Guatemala City airport without running into a giant team of volunteer medical providers wearing matching t-shirts to quickly and easily identify one another among the vast sea of travelers, in addition to other volunteers on development missions and church missions as well.

I found the most success speaking to in-country coordinators that were invested daily and directly to their organizations' STMM activities, initially recommended to me from personal contacts or cold-contacting. From there, I worked with them to further recruit other coordinators from other organizations. The first few coordinators based in Guatemala that I spoke to were immensely helpful in reaching out to other coordinators on my behalf or, at the least, providing me the names of other coordinators whom they thought would also be interested in participating in my study. I requested for the contacts or coordinators to send an introductory email on my behalf to the people they mentioned to avoid contacting potential participants who perhaps did not want to be contacted by a stranger with no reference to a colleague or acquaintance. So, some bias certainly was introduced into the study as my sample tended towards being collaborative and interested in self-evaluation or further learning—some coordinators asked me to tell them the ways in which they might improve services after all of my research was complete with their teams.

Table 3.1 below shows the anonymized, basic demographic information about short-term medical missions/mission organizations and the Guatemalan organizations they are affiliated with (or none, if there was no Guatemalan organization), as well as the research activities conducted with the teams. When financial information is available (for 2019), the mission/mission organizations are classified according to GuideStar classifications[15] for the size of organizations. The research is classified as 'I' for semi-structured interview, 'PO' for participant observation, and 'DO' for direct observation, all described below in greater detail. The organization that conducted rural consultations and surgical missions is designated below as well, as distinct teams perform rural duties vs. the surgeries. The team information is from 2018-2019, when the research was conducted.[16]

As shown in Table 3.1 below, I was able to conduct at least one method of research with 21 different VMTs, spread out across 18 short-term medical mission organizations, some affiliated with larger umbrella organizations dedicated to planning and executing medical missions in various parts of the world. Six of the teams conducted

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[15] Grassroots organizations have a revenue of less than $1 million USD per year. 'Small' nonprofits are categorized as generating between $1 million and $5 million per year. 'Mid-size' generate $5.1M-10M, 'Large' generate $10M-50M, with 'Economic Engine' organizations generating $50M-5B. Finally, 'Powerhouse' nonprofits generate over $5 billion USD annually. (GuideStar.org, 2017).

[16] As of 2021, most missions are suspended due to Covid-19.

their work outside of the STMM corridor from Guatemala City to the lake. Three organizations recruited from rural areas outside of that corridor but conducted surgeries in urban hospital settings on the corridor.

The coordinator of the first surgical medical mission organization became my key informant. He went to the United States for his undergraduate degree and became a radiologist, then moved back to Guatemala in his late 20s; he is someone deeply invested in improving health in his country, and having been medically trained outside of Guatemala, has a good idea of the medical context that the visiting providers work in when they are at home. As the director of operations for his organization, he is responsible for organizing the teams, finding locations for them to stay, and overseeing the health promoters that his organization employs in the rural regions where they tend to source surgical patients, among many other responsibilities. He immediately was interested in my project and introduced me to several other coordinators or key people in the medical mission context in Guatemala and was also available to answer my many follow-up questions via WhatsApp.

Snowball sampling was key to the success in recruitment for the research. I continued to cold-contact organizations with contact information listed on their websites as well as use referrals from coordinator to coordinator. Often, because organizations are not always able to fund their own research or know where to begin on self-assessments, they were encouraging of my efforts to study medical missions across varying organizations. At times, they even requested that I share with them any key points or recommendations I had after observing them for a week.

Table 3.1. STMM Recruitment and Basic Team Information

Mission Name	Guatemala-based org	Subtype (Primary first)	Depts served (Primary first)	On STMM Corridor?	Size Classification (GuideStar)	Research Completed	Team Members	Total Trip Length	Average teams/year
Mission A	ORG 1	Basic Care, Vision	Zacapa, Sacatepequez	Sometimes	Grassroots	I	I-only	8 days	7
Mission B	ORG 10	Surgical, Basic Care	Suchitepequez, Retalhuleu, Quiché	No	Small	I	I-only	7 days	14
Mission C	ORG 9	Surgery (General)	Baja Verapaz, Guatemala, Nahualá	Sometimes	Mid-size	I	I-only	7 days	8
Mission D	ORG 2	Basic Care	Guatemala	Always	Not available	I	I-only	5 days	24
Mission E	ORG 3	Neurology	Chimaltenango	Always	Not available	I	I-only	4 days	2
Mission F-Surgical	ORG 4	Surgical (Cleft lip/palate)	Guatemala	Surgeries Only	Grassroots	PO	20	7 days	23
Mission G	ORG 5	Basic Care, Dental, Vision	Nahualá, Quiché, Quetzaltenango	No	Grassroots	I/PO/DO	18	7 days	28
Mission F-Rura	ORG 4	Surgical (Consults)	Alta Verapaz, Baja Verapaz, Guatemala, Huehuetenango, San Marcos	Surgeries Only	Grassroots	I/PO/DO	16	8 days	23
Mission H	ORG 6	Basic Care	Totonicapan, Quetzaltenango	No	Not available	I/PO/DO	17	6 days	
Mission F-Surg	ORG 4	Surgery (General)	Guatemala	Surgeries Only	Grassroots	PO/DO	12	7 days	23
Mission I-1		Basic Care	Chimaltenango	Always	Grassroots	I/PO/DO	16	4 days	4
Mission J		Basic Care	Quetzaltenango	No	Grassroots	I	I-only	7 days	2
Mission K		Basic Care	Sacatepequez, Chimaltenango	Always	Economic Eng	I	I-only	3-7 days	3 or 4
Mission I-2		Basic Care	Chimaltenango	Always	Grassroots	PO/DO	8	4 days	4
Mission L		Surgical (Orthopedics)	Sacatepequez	Always	Not available	I/PO/DO	40	12 days	2
Mission M		Surgical (Cleft lip/palate)	Chimaltenango	Surgeries Only	Grassroots	I/PO	11	7 days	2
Mission N	ORG 7	Surgical (Cleft lip/palate)	Chimaltenango, Sacatepequez	Surgeries Only	Grassroots	I/PO	8	7 days	4
Mission O		Basic Care	Santa Rosa	No	Grassroots	I/PO/DO	29	8 days	2
Mission P		Surgical (Gynecology), Basic Care	Guatemala, Izabal, Suchitepequez	No	Not available	I/PO/DO	29	7 days	13
Mission Q		Dental	Guatemala	Always	Not available	I	I-only	6 days	40
Mission R	ORG 8	Basic Care, Vision	Guatemala, Sacatepequez	Always	Grassroots	PO/DO	26	7 days	2

A few of the medical mission coordinators, in their interviews, mentioned territoriality on the part of medical mission non-government organizations (NGOs) working in Guatemala. Some organizations declined to work with me based upon not wanting to provide information about the importation of medications; in their response to my research proposal, they stated that they preferred not to share any information regarding importations or warehouses, nor did they want the information I gathered shared with the Ministry of Health.

When writing research proposals to work with teams (which often occurred with larger organizations), I always indicated my desire to take down GPS points. One organization, in declining to participate, specifically stated that they did not want to share the names of the communities they visit with me, asking me to guarantee "no exact locations or dates." I interpreted this as some sense of territoriality and an unwillingness to share what geographic area is covered by this organization, despite the fact that this information would be useful to everyone working in this field who aims to not duplicate services. This was the only organization that specifically declined to work with me because of this, but the theme came up frequently in my interviews and conversations with coordinators.

As seen in Table 1 of this chapter, I was not able to conduct all modes of research with all teams. Sometimes, coordinators would agree to interviews, but not to conduct participant observation or direct observations. In the case of cleft lip/palate surgeries, I interviewed the providers and coordinators, but was not able to perform direct observations on children as the primary subjects per my IRB. While I tried to formally interview all teams with which I participated, those marked as PO/DO are teams in which I conducted direct observations and participant observation but conducted informal interviews with team coordinators or leaders. This often occurred in contexts where the process to get in touch with the mission was rather expedited. In one case, I got in touch with a team that was coming to the country two days later—not enough time to sit down with the coordinator who lives in the U.S. and traveled with her team. I was able to furiously scribble field notes during a dinner with a team leader in which she let me ask the interview questions, but she declined to be recorded formally in the moment because she was answering my questions in between her bites of food. Obviously, the ideal situation was one in which I had time to interview the coordinator, then conduct participant and direct observation, but the fast-paced nature of the missions and the little time I sometimes had to get in touch with the team prior to the mission made that difficult.

Semi-Structured Interviews

I conducted semi-structured interviews with 30 medical mission coordinators and team leaders both from the United States and from Guatemala across 18 distinct organizations, both tiny STMM organizations and larger international NGOs; 19 were American, 10 were Guatemalan, and one person was of European origin. A further analysis of the demographics is included in the following chapter and in Table 4.2. This is due to the very common practice of "sister organizations," wherein a U.S.-based organization handles the fundraising and donor engagement aspects of non-profit work and the Guatemala-based organization focuses on the delivery of services. While the organizational design of STMMs differed, and some were standalone teams that came to provide services without a host or affiliate NGO, most depended on structural support from a sister organization. A further analysis of these structures follows this chapter.

When possible, I interviewed both that were coordinating for the same medical mission. The interviews with American medical mission coordinators located in the United States, which were conducted primarily via Zoom and telephone, differed somewhat in their content. This was due to the fact that many of the activities they focus on regard the gathering of funds, human resources, and logistically getting volunteers to

Guatemala. I began by asking them about their position, what is required of them, and their experience within missions or leading them. Then, more specific questions about preparing volunteers, the materials they shared with team members, and how the team members normally adapted to the care environment in Guatemala followed. Sometimes, when I asked them questions about where they were going within Guatemala, they did not know or were clear about that being the responsibility of the coordinating NGO or contacts they had in Guatemala. If this occurred, it usually meant for a shorter interview, or they offered to get me in contact with the coordinator or affiliate in Guatemala, "who might know more."

In contrast, the interviews with Guatemala-based coordinators were much more fruitful to understand on-the-ground operations, the structure of the missions, and what to expect from a standard mission in the case of organizations that send multiple VMTs to Guatemala. The Guatemala-based coordinators tended to have more logistical and leadership responsibilities, and more experience bringing teams into the country. I asked many of the same questions to the Guatemala-based coordinators, but they were able to provide details about the facilities in which care takes place, the indigenous languages patients often speak, and what the typical weekly schedule of a team might look like. These coordinators were sometimes Guatemalan, sometimes American, and a few Europeans that had lived in the country for a long time[17].

Other times, I discovered I was imparting information to coordinators by virtue of the questions I was asking. One example is an interview I conducted with an American

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[17] While the staff of some organizations contained some Europeans, the medical missions included in the study were composed of American medical volunteers.

coordinator before joining her surgical mission. I asked the American coordinator about the process that she goes through to register the surgeons with the College of Physicians and Surgeons. She told me that she gathers all of the necessary paperwork from the surgeons and providers coming down to work in the hospital where her organization offers surgeries. I asked her what typically happens after that. She said that it went to a Guatemalan, who kept the paperwork—but that it never goes to the College of Physicians and Surgeons. She realized, in my asking the question about COLMEDEGUA, that she was missing something. So, she started asking me about the process. I told her, "I have the paperwork from the COLMEDEGUA website with the requirements. Would you like a copy of it?" She nodded and said that she needed to review it.

While this instance of the interview acting more as a dialogue than as a petition for information from researcher to the researched might be subject to critique, being viewed by my coordinator participants as "someone who knew something" was advantageous to me. This speaks not to my being an all-knowing holder of medical mission or policy knowledge, but rather to the difficulty of placing non-Guatemalans in roles where they are expected to comply with national policies despite unfamiliarity with Guatemalan bureaucracy and in some cases, the Spanish language.

Rather than immediately presenting the idea of participant observation with medical teams, I instead adopted the method of interviewing the coordinator first, discussing issues such as team schedules, the locations to which the organizations' teams typically traveled, etc. Then I proceeded to introduce the idea of traveling with the team and explained the value of the information I thought participating with the teams themselves would bring. Sometimes I had to decline invitations to conduct participant observation work, due to overlapping schedules of different missions or other responsibilities, such as the field school that I helped conduct in the summer of 2019. But thankfully, through most of 2018-2019, I developed a rhythm of getting in touch with the coordinators, conducting interviews, then scheduling to travel with them for observation.

Participant Observation

Participant observation is a classical anthropological field method designed to both, as the name suggests, participate in the activity being studied as the focus of the research to understand the perspective of the population being studied (the emic perspective), as well as observe those partaking in the activity in question as they partake (the etic perspective). Practically, for this research, that meant that I went with the teams on the medical missions to different areas of the country. After meeting and interviewing the coordinator, I would negotiate the cost of my participation in the trip, sometimes just with the coordinator, sometimes after submitting a proposal to a research committee or director, depending on the size of the organization. A total of 228 VMT staff and medical volunteers consented to participant observation and direct observation.

The amount that I spent to participate with teams varied wildly. At the least, some teams were glad to have someone who wanted to participate in research with them and did not charge me a cent, though I was provided lunch and travel. The teams that worked in more remote areas or had strict policies for volunteer participation and payment would charge me to go with them. It made sense to me—traveling from Antigua to Guatemala City each day costs much less than a seven-day trip up to Alta Verapaz or out to Santa Rosa in the south. Most often, teams asked between $50-100 to cover group meals and gas in order to get to mission sites. One team charged around $300 for the hotel stay and meals for a week in Totonicapán, while the most I paid was $695 to go to Santa Rosa (94 km from Antigua Guatemala)—this covered travel to Santa Rosa, seven days of inter-department travel, and all meals. When I was responsible to get to mission sites for daily trips (not staying with the group), I paid for buses (the cheapest option, usually between $5-10 per day, tourist shuttles (closer to $12 per way), or Uber to get to Guatemala City (around $20 per way).

While in my Institutional Review Board protocol, I stated that I would not be paying participants directly for participating in the study, in a way, paying to go with the team was paying for access to the group. However, I never paid participants directly. Due to the logistics of getting to different research sites (where sometimes, there was only one hotel in which to stay!), my own safety, and the desire to not just study teams that worked in the corridor from Chimaltenango to Guatemala City, I conceded to wade into that research gray area.

As often as possible, I tried to travel with the medical mission teams to the locations in which they were to provide care. This meant hours in shuttles together, not always discussing medicine or the patients—but often, as I have traveled for many years to Guatemala and at the start of my research, had been living there for three-and-a-half months, I turned into a tour guide for several hours at a time. With the first few teams going to Nahualá, the Verapaces, and to Tecpan, I felt uncomfortable and burdensome on the inside, while trying to not to appear so on the outside. Eventually, I was cured of any remaining shyness and self-doubt and embraced this identity as the “researcher” and “anthropologist,” titles that scared me because of the assumed knowledge and cultural expertise that came with them--knowledge and cultural expertise that I have finally accepted I have.

The providers always wanted to know all of the places I had visited within the country, what it was like, and what I thought about the people there. They do want to know about the different languages that people speak, how the health care system works, the history of the area the team is going to—some of them would even ask how to say good morning to someone in K'iche' or other Maya languages because they wanted to try and greet the patients that way. The problem is that they wanted to know this while driving to the area and it is unclear whether or not such timing allows for the digestion of information and implementation of it into bettering the relationships they have with patients. Unfortunately, due to the size of teams, I was often unable to get a picture each provider or volunteer's prior knowledge and greater participation of the CCSAQ would have afforded me that information.

By the time I was working the last two teams recruited in my research in the summer of 2019, I had many stories about visiting small towns in Alta Verapaz, the *casas de remesa*[18] I saw creeping across the Pan-American highway in Nahualá, and the deserted feel of the area around Ixcan, where I passed thousands of African palm trees, *Elaeis guineensis,* cultivated for palm oil--but very few people—and I arrived into town and see expensive vehicles owned by the plantation owners or, as one coordinator told me, the narcotraffickers that also operate through the corridor extending through northern Quiché. Knowing the wide variety of socioeconomic and cultural contexts that patients

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[18] A *casa de remesa* is a home built through the funds (*remesas*) sent back to Guatemala from family members working in the U.S., Canada, or other nations that Guatemalans commonly emigrate to for work.

came from and what they might be experiencing aided in my ability to understand the descriptions of their work, their illnesses, and their family situations that they would later describe in consultations I observed. Even if the providers did not always seek these details, I wanted to understand these contexts.

I often stayed in lodging with the providers and volunteers, especially if the medical mission was located beyond daily travel for me. I also got to know some of the providers, especially those I roomed with, far beyond what I could know simply interviewing them. Obviously, that impacted some of the perspectives I was exposed to as a researcher—a great opportunity to understand the nuances of a physician's health philosophies or attitudes towards patients after building rapport with them. But many times, I got additional stories about someone's trips to other countries, their medical school experience, or was shown many pictures of their grandchildren. One of the advantages of participant observation, when a researcher is alongside their subject, is that the researcher can more fully view the humanity and individuality of their participants (Jorgensen, 2015).

With all missions in which I acted as participant observer, the coordinators first gave me access to the group, acting as gatekeepers (O'Reilly, 2009). However, according to the IRB protocol, I also needed the agreement of those in charge of the facilities in which medical care would take place; this meant speaking to COCODES leaders, school directors, NGO directors, hospital directors, hospital committees, among others in supervisory roles. I was not always made privy to the deciding factors or processes of whether or not to let me conduct research with the team, but I do know that in some cases team leaders were consulted prior to making the decision. The IRB protocol, which required several levels of consent, did stipulate that individual written consent had to be provided by all participants in order to participant observe—which mitigated the influence of arriving with some level of access already granted to me by the coordinators.

Because there is usually some degree of travel and group lodging, I normally chose the first night together as a group to introduce my study and pass out consent forms. Often, the group would have a nightly meeting to first explain policies and procedures (which I needed to attend anyway) and what the next day was going to look like. Then the team leader or coordinator would give me the floor to explain my study, explain that participation was voluntary, and hand out consent forms. Sometimes team members would ask me questions in front of everyone about my study; other times, there was total silence and signatures and not a single question was asked.

There was universal consent to participant observation, which allowed me to simply be present with the team in all their activities. But some team members declined to be recorded or observed in direct observations (of the clinical encounters) with patients—of the 228 total volunteers (adult non-medical and medical volunteers) that consented to take part in the study, three declined to be recorded. Those that declined were older providers; I did not ask them to explain why they did not want to be recorded, as I thought it might appear to not be accepting their decision. I just responded, “that’s totally fine.”

One American NGO director, who had previously approved the research through the in-country coordinator, arrived on the final day of a rural mission and angrily confronted me as I was consenting him to include him in participant observation and direct observation that day, as he was going to assist with interpretation. I assured him, “this research is confidential, and the name of your organization is never going to appear in any publications, and I guard the names of my collaborators because I take this research, and your reputation, seriously.” He asked me to write out, in my own handwriting, “I will not publish the name of this organization” on the consent form and sign it, in what seemed to be a fit of paranoia—especially since this was something already clearly explained in the consent form.

At one point, I was questioned about certain aspects of my study in front of around thirty team members—specifically, if I was going to publish information about the importation of medications, which is a contentious topic for every group. She said to me, “I don’t want to give you information that will make the government any harder on medical missions than they already are or make us stop doing what we’re doing.” After that, the coordinator came up to me and apologized for her team member being ‘difficult,” but I tried to assure her that I wanted people to ask questions if they have doubts. I would either collect the consent forms the night of the first meeting or the next morning at breakfast if people wanted time to read the form in greater detail, Google me to verify who I was, or just think about participating in more depth. If a provider agreed to participate but declined to be recorded, I honored their wishes as best as I could. If there were minors volunteering in the mission, I avoided observing interactions between them and the patients as much as I could in order to exclude them from the study. There were minors in four of the thirteen teams who allowed me to conduct direct observation and patient observation, who were mostly relegated to clean-up and entertaining-the-children duties. In one case, a sixteen-year old administered fluoride to children.

Participant observation first and foremost showed me how hard the volunteers do work. The efficiency of organization and coordination and the quality of it are separate, valid points of interest when observing medical missions. Both a poorly planned medical mission and a medical mission team full of providers trying to do right by their patients can, and often does, coexist. The effort that the providers and non-medical volunteers put into the work they do—sometimes twelve-hour days with insufficient lunch, infrequent water breaks, and often hot clinical environments—is noticeable. Many coordinators periodically reminded their volunteers to not push themselves too hard or they would not be able to fully attend to patients. In addition to the team members, I was also tired after standing for twelve hours, not getting enough for lunch, or dealing with unbearable heat. Or in one case, overstimulated and with a headache after observing several hours of the medical mission and consultations next to the oral surgeon extracting teeth from screaming children while listening to Led Zeppelin on the Bluetooth speaker he brought with him.

Direct Observations

The final research method I utilized to conduct my research was direct observation. This helped me understand the dynamic between the providers and the patients, and most importantly, the interpreters. In contrast to participant observation, direct observation limits the engagement of the observer to their presence and nothing more; I tried my best to be a ghost in the room, with my recorder close enough to record what was going on, but far enough away to not be in the way of the clinicians and patients nor allow my presence to become part of the interaction. In practice, this was mostly how the direct observations proceeded, but occasionally the patients would speak to me or look at me. In a few cases, patients were nervous and looked at me—I did not say anything, but I smiled.

Patients were recruited prior to their triage. Written consent was required of patients per the IRB, but this often consisted of reading the consent form to them and receiving a thumbprint and written name to the side of the thumbprint if they chose to participate. In retrospect, this requirement likely blurred patient understanding of the study rather than clarify it, as the literacy of potential participants was not known to me unless they specifically stated, “I can’t read this, do you mind reading it to me?” or they declined participation altogether when I handed them the form, saying, “No, I can’t read, sorry.” Monolingual patients were consented through bilingual Spanish-Maya language interpreters. This likely introduced bias into the direct observations; in some cases, there was not someone there to help me properly consent patients, so I consented only those with which I could communicate effectively—what I thought was the most prudent thing to do. However, a representative sample of direct observations was not achievable in the first place, since the number, linguistic, ethnic, and gender makeup of medical missions is only mildly intuitable due to the ‘first come, first served’ mode of patient recruitment.

When discussing their participation, I specified that they would receive neither positive nor negative benefits from their participation, though they might have felt obligated to consent, since they likely identified me as similarly white, educated, and/or a member of the VMT. Per the consultation and protocol of the IRB, patients were not paid for their participation likely due to the ‘undue influence’ that payment would cause (Klitzman, 2013). While I obviously did want patients to participate, I was often content to receive rejections (which happened in every mission), as that told me the patients felt comfortable enough to say no if they did not want to participate.

Prior to conducting my research, the interpreters were not at the forefront of my mind; I was much more interested in what I thought the attitudes of the providers towards the patients would be. In practice, the interpreters are *the most important facilitators* of the interaction between providers and patients; the approaches towards interpretation varied wildly across languages and interpreters. That is to say, a few interpreters attempted to directly interpret word-by-word and as “invisible” third parties—these were mostly people who were professional medical English-Spanish interpreters in the United States (Angelelli, 2004). Most of the interpreters, however, were not trained in medical interpretation specifically or were volunteers that spoke two or more of the languages fluently (English, Spanish, and sometimes a Maya language) and took on the role of the advocate, someone who understood the cultural differences and tried to mitigate them for the benefit of the patient (Dysart-Gale, 2005). At times, the interventions of the interpreters were the most biased and problematic aspect of the medical care provided.

One of the coordinators who had agreed for me to join his team for a week of rural mission work contacted me the day before we left from Antigua to go up the Verapaces—he asked me to be an interpreter because they were one interpreter short. He assured me that I would still have plenty of time to make observations and asked me how I would prefer to work. I was angry—I felt that this was going to compromise the way that patients would view me; that I would be associated too closely as a medical provider and thus compromise the patients’ ability to distinguish me as a researcher.

However, interpreting was one of the most important aspects of participant observation that was not initially part of my research plan and influenced my understanding of the interpreter's role in the medical mission teams and how I analyzed the direct observations. In the above example, I chose to interpret for the team the second half of each day I was asked. In that way, the patients in the morning would at least meet me as a researcher first—and if they chatted with other patients about who I was, that would be their first description of me. I hoped to avoid being identified first as an interpreter, since that was not my primary purpose for being there. During that mission, each day the medical mission provided care in a different location (often hours from each other), so I was able to start "fresh" each morning. When I spent several hours interpreting for a provider, they often thanked me for helping them; this most certainly influenced their perception of me as part of the team, rather than simply an observer.

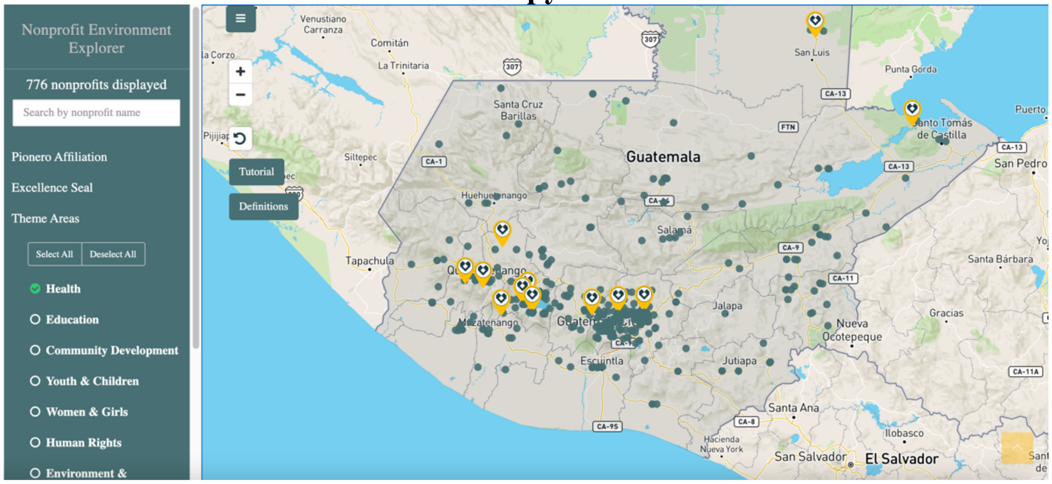
Even as a fluent English-Spanish speaker and someone who learned Spanish primarily in Guatemala, it was incredibly difficult to work in the medical mission environment. It is loud, there are usually many other people in the room with the interpreter besides the provider and the patient, and sometimes there is a Maya language-speaking family member or interpreter that is trying to communicate the technical language just communicated to them into languages that do not always subscribe to Western biomedical linguistic terminology when talking about the body and illness. Thus, listening to the recordings of those encounters a second time engendered more questions and doubts, but sympathy for the interpreters as well.

I also explored other aspects of direct observation beyond interpretation. Body language in such a context is critical, in fact more critical than within a context where everyone speaks the same language and is coming from a similar cultural context. I noted the way that providers engaged with patients—whether they looked at them directly in the eye when speaking (or at the interpreter), when they touched them, and in the case of more sensitive exams such as men's exams for hernias or women's pelvic exams, to what extent the providers acknowledged the potential sensitivity of patients. Finally, I noted the length of the consult; however, I did include a variety of types of medical mission within my research (e.g., some medical missions that were consulting with patients for surgery, some that consulted with patients over aches and pains, etc.). Direct observations were written at the time of observation. My direct observation notes were interspersed within the participant observation notes, but designed with "DO #001, #002…" so that I could easily remove the direct observation notes and put them into their own Word document at the time of transcription.

GPS Locations

One Guatemalan non-profit organization dedicated to fostering philanthropic connections, Pionero Philanthropy, launched an interactive non-profit map of Guatemala in 2021, showing a total of 8,850 non-profit organizations in Guatemala, 776 of which are health-related. The focus of the map is less driven by the motivation to demonstrate coverage (as the map includes all types of non-profits, among them 'health'-categorized non-profits) than driven by a desire to help prospective donors to find suitable organizations with whom to connect (Pionero Philanthropy, 2021). As shown in the photo below, most organizations are concentrated in the corridor between Guatemala City and Lake Atitlán.

Figure 3.1 Health-Related Non-profit Organizations in Guatemala, per Pionero Philanthropy's Website



The organization classifies organizations on the map according to their affiliation status with Pionero based on parameters of the organization—marking those organizations that are eligible[19], not eligible, or partner status[20]—interestingly identifying their parameters and their organization as an arbitrator of non-profit/NGO quality in administration and merit of investment, but not of the quality or necessity of the services being provided.

Because medical missions have no central monitoring or guidance with regard to the locations to which they travel to provide services, other than the authorization for the facility they will be working within, there is no record of their distribution within the

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[19] To be eligible for partnership a nonprofit must: Be registered in Guatemala and/or the United States… have a constitution or bylaws providing legal statutes for operation.. meet Pionero Philanthropy's definition of a nonprofit… meet the nano-large size categorization… have a public presence online with recent activity within a 1 year period of time.. [and] have no proven evidence of illegal, fraudulent, corrupt or unethical activity" (Pionero Philanthropy, 2021)

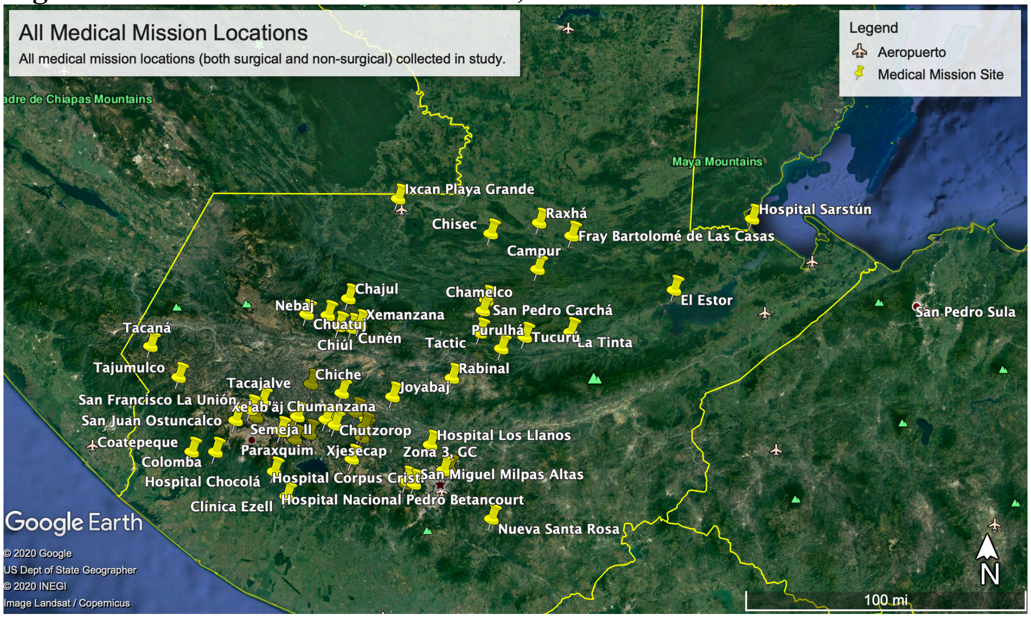
[20] To form and maintain a partnership an eligible nonprofit must: maintain all eligibility requirements… complete all preliminary forms, evaluations, and site visits… provide all requested documents… annually update all information with Pionero Philanthropy.. have values that align with Pionero Philanthropy… maintain good communication with Pionero Philanthropy (ie. timely, honest and respectful)… maintain a positive status and reputation within the community… [and] have less than 3 fundraising staff abroad" (Pionero Philanthropy, 2021)

country. Additionally, concerns have been raised about the duplication of services within medical missions—e.g., that teams may visit the same location within a certain period of time, utilizing human and material resources in the same community twice that might have otherwise helped a different community (Burt, 2017). While I could not collect data for all mission teams and organizations, due to my limitations as a single researcher on the project and the occasional resistance towards sharing such information, I decided to collect this data to make a preliminary 'coverage' map of the locations visited by medical mission teams.

I collected the GPS coordinates of communities visited by medical missions offering different types of services (basic care, surgical consults, and surgeries) among the organizations I worked with. This included GPS locations of places I went while accompanying the teams as well as their master lists (if they have them) of the towns visited yearly. I did not include identifying information about the teams or NGOs themselves—the IRB protocol for this project prohibits sharing that information. In some cases, a STMM's presence, or that of its partner organization, is singular to the area, so in some cases, a local resident of the area would be able to identify which STMM sends teams there. Figure 3.2 shows the distribution of locations where both surgical and basic services missions recruited in the dissertation research provide medical care.

One strategy that surgical medical mission NGOs utilize is visiting smaller communities in isolated areas to find surgical candidates for future surgical teams to operate on in urban centers or operate 'feeder missions.' Five medical mission organizations known in Guatemala utilized this strategy.

Figure 3.2 Medical Mission Locations, 2018-2019 Dissertation Research



Two declined to participate; one specifically due to seeking to not share this information, while the other was unresponsive. Mission F runs around four rural missions per year to recruit surgical candidates from remote areas (GPS locations taken) and conducts primarily general surgeries in Guatemala City and Obras Sociales Santo Hermano Pedro, as well as offering cleft palate surgeries. Mission L recruits orthopedic patients from one feeder mission once a year, then operates on them in Hospital Nacional Pedro de Bethancourt later that year, but the location of the feeder mission changes frequently and the data was not taken.

IV. Positionality as a Researcher

A clear understanding my own positionality within the medical mission teams is something that I never completely achieved—it depended on the week, with which team, and even sometimes what I was asked to wear. While I appreciated that some coordinators truly wished to make me "part of the team" (which is in fact the point of participant observation), there was also no doubt that I looked, spoke, and was dressed exactly like a medical provider from the United States when asked to wear scrubs. To coordinators, this seems like such an innocent practice and does serve a practical purpose when the environment is a large space with up to thirty volunteers and sometimes hundreds of patients—it is easier to find fellow volunteers if they are wearing brightly colored scrubs, or the same t-shirt. And the volunteers take their jobs seriously—if they run into the pharmacy to grab a medication they believe the patient needs, they are trying to do so efficiently as to not waste their time or the patient's time. However, the insidious side of the practice of dressing all volunteers the same is that patients likely interpret everyone to be a provider.

What is the harm in this? The harm is that while I know the symptoms of gastritis in and out after hearing them repeated several dozen times, and I know the side of the body that should be in pain if someone has gallstones, I am no physician. And neither is the non-medical professional who was trained to draw blood on the job (a 'lab technician' in the mission) and never informed patients that she was not actually a medical provider in the United States. No one questioned her, likely because she was wearing the uniform that identified her as a medical provider. Thankfully most volunteers did not wish to do take on positions within their teams far beyond their skill level or outside of their professional duties. However, as I will discuss in subsequent chapters of this dissertation, I did observe instances of this behavior.

The volunteers would frequently grab me and ask me, "Translate something for me real quick?" as I was, apart from hired interpreters, one of the few people that was a bilingual English-Spanish speaker, and critically, *was one of them.* I share the volunteer's whiteness, their high level of education, and especially if they come from the Southern United States as I do, their shared position of privilege that is so deeply engrained in their social interactions with people of color that it feels natural to always ask someone to understand *you in your terms*—rather than trying too hard to understand them in theirs.

Many volunteers also come from religious communities, where missions, broadly, are par for the course in a young person's social development. Like many of them, I grew up in a religious community; in Central Texas, where I grew up, most people's social lives revolved around church on Sundays and Wednesdays and religious proselytizing openly occurred at my public high school during school hours. I learned to smile, be nice, and have good manners. But as an adult, I had to consciously unlearn the prejudices and assumptions I carried as a young woman. I stopped listening to the conversation-killer "In God's eyes all are equal," and started paying attention to the ways people in power used the Gospel to explain away structural racism and justify their concern for Black and Latinx babies that begins in the womb and ends at birth.

This is not something that someone can unlearn, even if they want to, in a week spent in a poor community of a Central American country. And while this wasn't a specific aspect of my research questions, I do think that combining the humility necessary to understand someone from another culture and the hierarchical, knowledge-is-power paradigm of Western medicine results in frustration and the perpetuation of stereotypes that American providers often have about patients of color in the United States or abroad.

Witnessing Suffering

A few people, mostly my family, asked me at times, “How did you deal with seeing so much suffering?” At times, the answer was, “not well.” Specifically, seeing very ill children was always difficult—sometimes to the point that I removed myself to cry or to calm myself down. It was interesting as someone who often was very critical of medical missions, especially the way that missions can objectify and dehumanize patients—taking photos without consent, talking about them in English in front of them when they cannot contribute to the narrative being spoken about them, having their photos shared to strangers on the internet, among other problematic behaviors.

While all of these behaviors do take place, there is also a sense of collective relief when someone has the weight of a health problem lifted off them. I distinctly remember an obstetric surgeon excitedly telling the team about the 27-year-old patient he treated. Initially, she thought she was 8 months pregnant—but the baby never came. The surgeon found a non-cancerous cyst in her uterus that was filled with 4 liters of brown liquid, which he removed. The patient was obviously very happy to no longer be carrying around such weight and with the knowledge that she did not have cancer. It is also perhaps not fair to only focus on the problems associated with medical missions and not recognize that for some, access to low-cost medical care (especially surgeries) is perceived as a blessing. One of the conclusions I made after conducting my research is that the characterization of medical missions as ‘good’ or ‘bad,’ is about the most useless thought process people studying this phenomenon can exercise; I think that the path of accountability and mitigating harm is the most realistic and beneficial path to take.

I developed a bond with one of the pediatricians on a trip to Santa Rosa. She is in her 70s, has attended to children in many countries, and is the type of person who has collected and maintains her own data on malnutrition in the community her team works in for twenty years—not for publication, but because she's invested in seeing how the community changes over time. She meticulously sets up her clinic space for the week that the team goes to Santa Rosa twice a year, putting up both homemade and purchased posters—my favorite homemade one says, "*No deja a sus niños tomar el café*!" ("Don't let your children drink coffee!") She explained to me, "It's because they don't absorb calcium and Vitamin D as well, and it rots their teeth."

We exchange emails a few times a year. I value her perspective because of her lifelong experience, but also the comforting sternness with which she attended to patients—always kind, but also sitting parents down to ask them about the sugar intake of the children or if they've been feeding them vegetables. She treated everyone that way, included the other volunteers. So one day I emailed her, after seeing a child in the waiting area of the hospital I worked at who had a particularly horrific case of malnutrition and a woman who was sent home with morphine after a Stage IV cervical cancer diagnosis. I told her that I felt angry that my pity could accomplish nothing. I was reminded that providers who participate in medical missions can be some of the most questionable examples of their field, but also some of the best. She said to me:

> So, what you did was to be present and take in the pain of those patients. You recognized their humanity in a way that perhaps they had not felt before. By being touched by their pain, you let them know that they were not alone, they mattered. So many people who suffer from physical or social or emotional pain have their

> pain exacerbated by the feeling that they are somehow invisible, that no one recognizes them as actual people. You did that. You felt their shared humanity, and your shock at their condition meant that they had meaning to you as another human being. Even if you cannot do anything else, that very recognition has value.

That recognition still does not feel valuable enough to me.

While the most favorable outcome of witnessing suffering is of course, to take action and alleviate it, I am not a medical provider, nor can I perform miracles. I also do not want to veer into the territory of "witnessing" as detailed in the medical humanitarianism literature; that is, objectifying and exemplifying the suffering of patients in order to prove their worth as recipients of humanitarian aid (Fassin, 2007). But what this pediatrician touched on is to interact with patients in such a way as to recognize their humanity and their right to health. Medical mission providers still must operate within the confines of the Guatemalan health care context, which can be dehumanizing, frustrating, and discriminatory for many patients (Chary et al., 2016). They work in the absence of creating structural change, hyper focused on the individual.

In the case of the cancer patient, her illness was not the failure of an individual, but the failure of a system. A system that had several potential points of diagnosis and intervention that were not realized. However, the physician who diagnosed her did his due diligence, getting assistance to call contacts with information about INCAN (Guatemala's National Cancer Institute), the cost of private cancer treatments, and explaining the options to the patient, as she ultimately chose to return home with medication to alleviate her pain.

When I think about my work—understanding a phenomenon that is clunky, inconsistent, obtuse, and also high-stakes—I try to stay positive and continue believing that with understanding comes mastery. That with eventually understanding medical missions, they can be regulated and assure a quality care option within the vast sea of providers in Guatemala, as realistically medical missions do not seem likely to disappear. I do not want to make a saccharine statement about seeing people suffering and using it as motivation. Personally, I see the suffering. I would like to see less of it in the future.

V. Data Cleaning and Analysis

The data collected in this study was composed of audio recordings, documents sent from coordinators to me, online research, GPS coordinates, and field notes. Two types of audio recordings were collected. I collected recordings of the sixty clinical observations I sat in on—those were not transcribed because of the audio quality; the consultations with patients often involved at least four people—the patient, the provider, at least one interpreter, and myself (though I was silent). Combined with the proximity of patients to one another, and the recordings ended up rather chaotic, but listenable. These were used in data analysis to compare the speaking time of patients, interpreters, and providers and to recall information written in the field notes.

The interviews I conducted were of much higher quality and were transcribed. The audio recordings were first processed through the transcription service HappyScribe, which worked well in both Spanish and English. I reviewed them by listening to and correcting the transcriptions thoroughly. Once cleaned, the data were put into MaxQDA for organization and thematic analysis.

The documents received by organizations included items such as welcome packets, packing lists, treatment manuals, book recommendations, prayer sheets, among others. There truly was a lot of variety in what coordinators included as preparation materials for their teams. I also reviewed the websites of the medical missions for 'pre-trip' materials, if available. I classified the information according to the common types presented: welcome packets (often the most basic information), manuals (more in-depth and clinically focused), and reading guides. The preparation materials for volunteers often contained very little information about the structure of the medical mission.

The online research conducted was primarily for the purpose of writing Chapter 5, wherein significant legal research (reviewing the online versions of the Guatemalan Constitution, health code, and other relevant health laws) was needed to understand the legal requirements of volunteers, the consequences (mostly hypothetical) for not following the law, and the legal rights of patients. This was incredibly helpful in establishing an understanding of where many organizations go wrong in the assumptions they make about their duty to patients and the false sense of security about the decision to not register their providers.

I collected the GPS locations of the medical missions most often while I was with the teams, but additionally from coordinators that have a set schedule of communities they visit and/or taking down the coordinates themselves as they visit them. The number of communities visited by different STMM organizations ranged from a single community to over 16. These were put into Excel spreadsheets (if possible, during the dates of the year visited) and then GoogleEarth, where they were visually inspected in relation to data such as poverty rates.

Finally, the field notes were transposed into Microsoft Word and then uploaded to MaxQDA in order to easily recognize themes within my observations. I separated my direct observations and field notes while conducting my field work—noting the date and time and number of the direct observations. So, those were separated into different document sets so the two distinct contexts (e.g., the whole clinical environment vs. individual clinical encounters) were easily organizable during analysis.

When beginning to analyze the data, I first sought to understand the structure of medical missions, creating mind maps of the processes I observed combined with the common necessary steps repeated within all the interviews with STMM coordinators and participant observation notes. While there of course was some variation in the execution of the medical missions, analyzing the essential steps taken by VMTs allowed me to truly understand the structure and preparation of the missions.

One of the early themes I identified within the "preparation" process was the lack of cohesion between accounts of the coordinators regarding the legal requirements of teams and the claim that the process was difficult and convoluted. While this topic had always been of interest to me, it became obvious that I needed to write a chapter that 1) laid out what, according to the Guatemalan laws and policies, is in fact required and 2) added the patient vulnerability and common STMM policy contexts as a lens with which to examine potential impacts on patients.

Some themes had already emerged when conducting participant observation, due to their frequency and ubiquity within the STMM context, such as the overwhelming cultures of individualism and neoliberalism latent in the structure of STMMs, as well as the perception of government facilities (and how this positions STMMs or non-government care as automatically superior); these thus became a priori themes when later working with the data in MaxQDA and an important feature in the comprehensive analysis of STMMs for this dissertation. Finally, one of the principal themes that emerged through thematic analysis was the juxtaposition of contradictory ideas about patients; the language used by providers and coordinators articulated patients as helpless, poor, and needy, while the frustrations in the execution of the STMMs expressed incredulity at how patients could know so little, care for themselves so poorly, etc. This theme is discussed further in Chapter 6.

VI. Limitations of the Research

Studying medical missions is both an exciting and intimidating subject to study. Logistically, collaborating with beyond one single medical mission organization, as most studies seem to do, is a nightmare. When conducting qualitative research with several VMTs in a single medical mission organization (that charges standard pricing and forms a similar composition of teams) or working in a single location that hosts multiple teams (such as several studies have done at Obras Sociales Santo Hermano Pedro), it is easier to make predictions about sample size or make comparisons of like preparation and coordination processes. However, working with diverse organizations providing care in many different locations allowed me to further explore the known ways of coordinating care along with the preparation, coordination, and execution of missions that *did not* appear in prior literature.

It was nearly impossible to get a ‘representative’ sample of medical volunteers because of the varying sizes of different volunteer medical teams, as seen in Figure 3.1.

Furthermore, a lack of transparency in the data from Guatemala's College of Physicians and Surgeons makes it difficult to understand the scale of STMM activities to try to produce a ballpark figure for a sample. When a larger sample of volunteer medical providers was taken successfully, it was taken separated from the missions themselves and done on an individual, survey format (Caldron, Impens, Pavlova, & Groot, 2016). While such research is useful for understanding the potential biases providers might bring to the STMM context, critical study of structural factors, organization, and coordination of STMMs through face-to-face research leads to a more holistic understanding of STMMs.

As with most nonprofit organizations, permanent staff that work within medical mission organizations often seem stressed and overextended—I had to email many organizations several times in order to get a response. Larger and more well-known organizations get more requests for research collaboration. One coordinator, in declining to allow me to conduct participant observation with one of her teams, said, "The deal is that we get requests similar to yours multiple times a year. I actually had another one come in two days after I responded to you, from a student at Harvard University. It's one of those things where if we were helping everybody we'd be creating a lot more work for ourselves." (Am_Coordinator_3, Pos. 55). I was glad to receive approval to work with larger organizations, but smaller organizations were often the most friendly and excited to participate in research.

The study of medical missions lends itself well to qualitative research because of the richness of observing the clinical environment and taking advantage of the social rationale for volunteers to go on missions. Many volunteers expressed their joy at the teamwork aspect of missions and creating memories with their fellow volunteers and patients. The storytelling strategy that many organizations utilize to exemplify their work, including highlighting patients with extreme health issues (especially in surgical missions) or sympathetic stories of misfortune or heartbreak also allow researchers to explore characterizations of patients. In particular, participant observation and direct observation was useful because I could compare and contrast the 'live' actions of coordinators, interpreters, and patients to the more generalized, aggregated information often described by coordinators in interviews.

While I was not able to conduct participant observation and direct observation with every team, recruiting 11 teams for that research allowed me to see a wider diversity of medical mission contexts than is portrayed in the literature. While the primary dichotomy of surgical/non-surgical missions remains a useful distinguisher, especially regarding important issues such as the legal requirements and follow-up care, such categorization does not represent the creativity, richness, and variation that I observed in STMM care delivery. Through my recruitment strategy, I observed medical missions that often adapted to the communities they work in following similar templates, which are discussed in the following chapter.

CHAPTER 4

MODELS OF ORGANIZATION, VARIATION, AND PREPARATION IN MEDICAL MISSIONS

Seeing the setup of a week-long medical mission is impressive. I met up with the volunteer medical team (VMT)[21] at the Guatemala City airport, spotting the mass of at least twenty people in matching t-shirts and luggage almost immediately. We traveled from the airport across Guatemala City on the Pan-American Highway, passing several shopping centers and the famous evangelical megachurch Casa de Dios, until we descended into the department of Santa Rosa, our final destination. We put our luggage in the hotel, then held a meeting upstairs to properly introduce everyone and for me to explain my study and pass out consent forms.

The next morning, we traveled from our hotel in Cuilapa to Nueva Santa Rosa, where the VMT has visited the population twice a year for over twenty years. We arrived to find a five-bedroom house, as the Catholic church the group had worked in for many years was unavailable for them to use and the municipality scrambled to find a location large enough for the endeavor. The house would quickly resemble a pressure cooker, with so many bodies inside, so much humidity, and so much heat, as there was no protection from the massive mountains offering relief elsewhere in Guatemala. In the course of the week, over a thousand people would pass through that house—a concentration of people that seems unbelievable now, given the way that Covid-19 has impacted health care around the world in the last two years.

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[21] A volunteer medical team (VMT) is the group of medical providers and volunteers that provides health care within a short-term medical mission (STMM). The VMT is the people, while the STMM is the practice or method of health care delivery.

In only one day, the entire clinic was set up. In the front, volunteers from SOSEP (the Secretary of Social Work of the President's Wife) set up an outdoor waiting area under tents, while police officers mulled around discussing where to locate the lines of people who would arrive the next day. A single corridor ran from the front door towards the back of the house. At the front, chairs were set out to serve as a waiting area, while the first room was allotted to the dental hygienist. The main living area became a registration area, triage, and was set up with dental chairs so fluoride could be administered to children.

The first bedroom became women's health—where two gynecologists conducted pelvic exams, performed ultrasounds, prescribed birth control, and only women were allowed to enter. Across the hallway was the general clinic, where four providers were set up to consult with patients, perform exams such as urinalysis, and check patients' vital signs. The furthest room to the back on the right was the pediatric room, covered wall to wall with informative pictures of babies growing in different stages, nutritional information for parents, and decorations to make children at ease. In the back left room was the pharmacy—filled to the brim with medications. In the back of the house was the kitchen and garden, where those seeking reprieve went to drink some water, eat peanut butter and jelly sandwiches, or take a break.

That same day, a woman came in wrapped in bandages. She was one of the medical missions' long-term patients—someone who, over ten years ago, they had diagnosed with Epidermolysis bullosa, an inherited skin condition that causes painful chronic blistering and peeling. Every six months, they bring her a supply of gauze so that she can wrap her arms and legs. Often, she is not strong enough to make it to the clinic, but this time, she felt well enough to come and visit the team. Because of her delicate condition and the likelihood of infection, they invited her to the clinic on the setup day to avoid contact with too many other patients. When she walked in, slowly and painfully, the veterans in the group, many of whom had known her for 5-10 years, excitedly rushed to the entrance of the home to see her and evaluate her state of health. Another volunteer ran to the back to retrieve the supply of gauze to supply to her and her caregiver.

The pharmacy team handed bottles and labels to almost everyone, urging us to start labeling so that it would not have to be done later in the week. Diabetes and hypertension medication took up most of the space in the pharmacy—a dining room that was about ten feet by fifteen feet, with a small pathway from the hallway to the kitchen created between the 6-foot-tall plastic shelves that took up practically the whole room.

The team leaders prepared a few hundred “recall” cards, as they were called. The recall cards were given to patients diagnosed with chronic illness or health care needs, so that they could more easily navigate the health care system in the team’s absence and allow the patient to come back without waiting so long in line the next year to pick up their medication. Patients with recall cards were given priority to enter the medical mission and did not have to stand in line and wait as long to be seen.

For example, patients newly diagnosed with diabetes were given a recall card with the diagnosis listed, their blood glucose level at the time of the consult, and six months of Metformin, with the dosage written on the card; they would then come back in six months for a blood glucose checkup and to receive more Metformin. If the patient lost their medication, they could go to the health center to receive more of the correct dosage.

In another case, a woman hoping to use condoms as birth control might have a recall card, entering the mission to quickly receive a supply of condoms and then exit.

Each year, the cards were printed on paper of a different color—one, so that it would be difficult to replicate them and sell them (which had apparently happened when the cards were only printed on white paper), and two, so that the team would have a visual cue to know how long the patient had lived with their illness. As the team leaders stamped each card with the stamp of the medical mission, it dawned on me how sincere an effort the team was showing to do what the government health care system often cannot: see patients regularly, develop a relationship with them, supply them with sufficient medication, and give them a record of their chronic illness so that they can inform an alternate health care provider of their condition. It seemed that the team was not only trying to implement a twice-yearly medical mission, but also an entire health care system.

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I. Introduction

This chapter compares medical missions to understand their commonalities and their key differences. The results in this chapter are based upon thirty semi-structured interviews with representatives of seventeen different medical missions and organizations[22], as well as participant observation and direct observations with thirteen mission teams over the period of one year.

As I aimed to study the preparation of VMTs, I analyzed the documents distributed to teams prior to departure by the coordinators that prepare them to provide

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[22] One of these thirty interviews was conducted with a consultant who lives permanently in Guatemala and floats among several mission teams for twenty weeks a year assisting in managing surgical teams

medical care abroad as well as the content of their pre-departure meetings, based on interviews. The documents included virtual and paper pamphlets, PDFs, group emails, and manuals. Cultural competence failed to appear as a principal element of short-term medical mission planning. Few organizations truly grappled with the concept of ‘culture’ or provided pre-trip planning materials that helped guide volunteers navigate the process of engaging with someone from a different culture, providing them medical care, and avoiding the generation of biases that have been widely acknowledged to exist in health care (FitzGerald & Hurst, 2017). In fact, the absence of engagement with indigenous Guatemalans in the planning process, beyond naming the cultural markers foreigners identify them by, is a meaningful indicator in the positionality of providers to patients.

This chapter also addresses a core element of my first research question: what kind of variation is there in the organization of medical mission teams? Finding similarities and patterns between the organizational strategies was helpful in determining the essential elements and structure. But, just as gene mutations create changes in DNA that can deeply alter the life of whatever organism has been altered, the differences in organization and strategy among STMMs is what can generate problematic situations--or new and innovative ways of bringing medical care to their target populations.

Though the teams demonstrated creativity in their planning and diversity among their organizational structures, these innovations primarily served to ease the process for the VMTs, relying heavily on Guatemalan staff that live locally. Patients often experienced some of the same logistical burdens as they experienced when seeking health care from government entities, with the exception of a few teams that implemented structural changes that made seeking health care easier for patients. Most surgical teams still followed a model that relied on patients to arrive to the hospital setting in which surgeries would take place—no matter how far they had to travel. Basic teams largely followed a model that relies on the good will and effort of individual communities or Guatemala-based NGOs to set up the facility in which the medical mission takes place. The expectation that patients prove their worthiness by their effort to access health care where it is being offered remains consistent.

II. Research Process

While I outlined the entire research in Chapter 3, this section explains in more depth the methods used to study the team preparation and organizational strategies. To study the organization and variation within medical mission teams in Guatemala, I chose to utilize semi-structured interviews and participant observation. As I contacted medical mission teams or organization to conduct interviews, I sought after teams that worked in different geographic areas or provided different types of care. I conducted research with 14 total teams: large teams, small teams, teams associated with organizations, independent teams, religious teams, non-religious teams, teams that collaborated with the government, teams that rejected any government collaboration, among other variables.

This research design provided me with exposure to a wide spectrum of processes and behaviors that both prove that more research needs to be conducted in this area and implies the possibility that these methods might one day be compared to constitute 'best practice.' However, snowball sampling possibly introduced bias: I did not have access to two large organizations that coordinate surgical missions, as well as many other smaller missions who may not have an interest in collaborating or opening up their work to the observation of outsiders. While we certainly know what theoretically constitutes best practice in the STMM context, marrying that knowledge with what is currently being practiced without much surveillance or guidance by way of clinical observation and participant observation will surely lead to new conclusions.

First and foremost, the semi-structured interviews allowed me to ask coordinators to walk me through the process of preparing for the medical mission team to arrive from the United States and execute medical care. Because of the tendency for laws to change in Guatemala (with frequency!) and inconsistency in the bureaucratic system itself, there was inconsistency in the responses I received. However, I was able to break down the process into its essential elements to examine them further because of the interviews.

The semi-structured interviews also allowed me insight into the division of labor between U.S. and Guatemalan volunteers and staff, Guatemalan paid employees and Guatemalan volunteers, and to understand how additional (e.g., health center, hospital staff, municipal employees, and COCODES[23] members) actors contributed to the execution of missions and what was the logic behind such collaborations, expanding upon some of the work conducted in Guatemala (Berry, 2014; Roche and Hall-Clifford, 2015). Because of this, I was able to develop models of organization for basic care missions and surgical missions that fit the data.

Participant observation gave me access to observe the way that medical missions were physically and logistically laid out, as I drew pictures of the layout of every day of every mission, accounting for the teams that traveled to a new location each day. I was

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[23] COCODE stands for "Consejos Comunitarios de Desarrollo Urbano y Rural" or Community Council for Urban and Rural Development. These councils, made up of and directed by community members, are civil society organizations that work to promote community programming and betterment (CEPAL, 2021).

able to walk around, observe where the pharmacy was located, see how the individual ‘rooms’ were designated for each provider, and observe what the flow of patients looked like.

The labor to set up the spaces was most often carried out by volunteers from the communities receiving health services or paid staff in hospitals or Health centers. It would be inaccurate to divest this labor and effort from the overall process of executing a medical mission and demonstrates how provider-centered medical missions tend to be represented (Berry, 2014), which, while thoughtfully discussed by scholars in this research area, ought to be re-examined from the standpoint of evaluating the process itself and not only the intentions or ethical basis for STMMs.

Finally, I analyzed pre-trip documents shared with volunteers, as appear in information packets, online, or in emails shared with group members for themes. This information is critical for the VMTs, especially those going on their first medical mission to Guatemala, as it creates expectations for their safety, what illnesses or diseases they might encounter, and the behavior of patients in this care context.

III. Team Preparation

A key question of my research was how medical mission coordinators prepare teams to go abroad to provide medical care. Firstly, it was impossible to not note the issue of representation within both U.S.-side coordinators and team leaders; for the purpose of this quick demographic analysis, the ‘U.S.-side” of both coordinators and team leaders were combined because of the similar roles these individuals play, discussed below. As a note, not all teams had coordinators both in the U.S. and Guatemala.

The distinguishing factor between a U.S.-based coordinator and a team leader is primarily the permanence of the role of coordinator and that the role is often, but not always, paid. Team leaders are responsible for the same preparations (e.g., booking flights, organizing medication, gathering pre-departure releases, medical licensure, and other documents, preparing team members, among others) but may only be responsible for a single trip. I encountered paid U.S. coordinators, volunteer coordinators, and unpaid team leaders. Some teams did not utilize a Guatemala-based coordinator and took care of the setup from the United States. I was not able to gather demographic information for a few of the teams who only agreed to an interview but declined participant observation—it was during the process of coordinating participant observation and direct observation that I was able to meet the team leaders and coordinators of the VMTs.

As can be seen in Table 4.1, the U.S.-side of coordination was overwhelmingly white, confirming prior studies of STMM demographics that show largely white American participation in STMMs (Caldron, Impens, Pavlova, & Groot, 2016). Of the 17 Guatemala-based coordinators, nine (52%) are *ladino*, the most historically privileged ethnic group. The next largest group are white/non-Latinx (29%). Only two coordinators self-identified as indigenous or with indigenous heritage.

This information highlights an important aspect of STMMs that is under-studied. While there are certainly cultural similarities between *ladino* and indigenous Guatemalans regarding national identity, there are also many differences, interplaying with the rural/urban divide, traditional religious practices, average educational attainment, privileges, and experiences of discrimination.

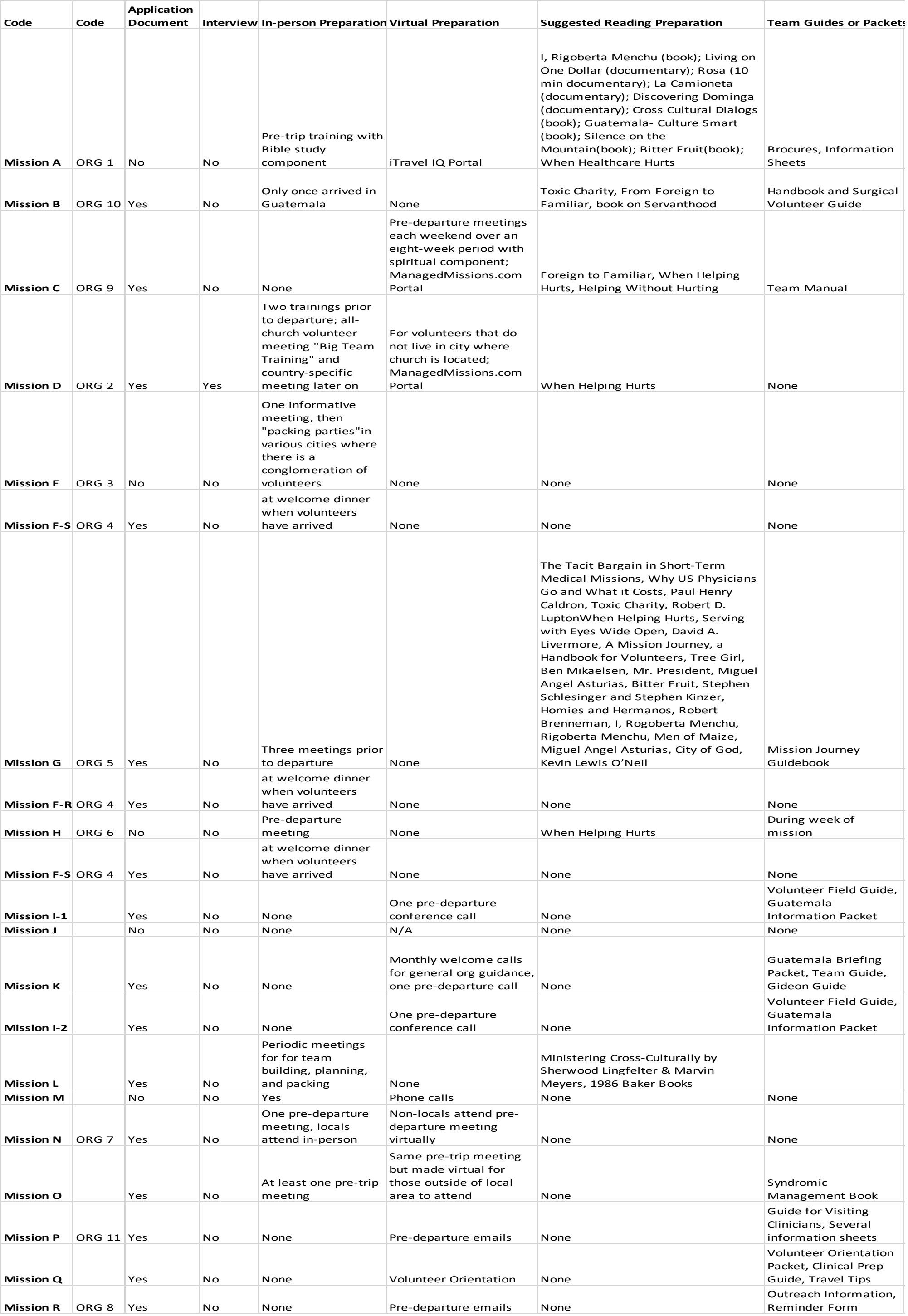
Table 4.1 Coordinator and Team Leader Demographics

	⬛	Only interview, no participant observation with team	🟩	Confirmed, no Guatemala-side coordinator					
	U.S.-side	**U.S.-side**	**U.S.-side**	**U.S.-side**	**U.S.-side**	**Guatemala-side**	**Guatemala-side**		
Code	**US-side Coord 1, 'Team Leader'**	**Coord. 1 location of work**	**Coord. 1 gender**	**Race/ethnicity**	**also provider?**	**Guatemala-side Coord. 2 nationality**	**Coord. 2 location of work**	**Coord. 3 gender**	**Race/ethnicity**
Mission A	American	USA	Female	White/Non-Latinx	No	⬛	⬛	⬛	⬛
Mission B	⬛	⬛	⬛	⬛	⬛	American	Guatemala	Female	White/Non-Latin
Mission C	American	USA	Male	White/Non-Latinx	No	⬛	⬛	⬛	⬛
Mission D	American	USA	Female	White/Non-Latinx	No	American	Guatemala	Male & Fe	White/Non-Latin
Mission E	American	USA	Male	White/Non-Latinx	No	Guatemalan	Guatemala	Female	Ladina
Mission F-Surg1	American	USA	Male	White/Non-Latinx	Yes	Guatemalan	Guatemala	Male	Ladino
Mission G*	American	USA	Male	White/Non-Latinx	Yes	Guatemalan American*	Guatemala USA*	Male Female*	Maya K'iche White/Non-Latinx*
Mission F-Rura	American	USA	Male	White/Non-Latinx	Yes	Guatemalan	Guatemala	Male	Ladino
Mission H	American	USA	Female	White/Non-Latinx	Yes	Guatemalan	Guatemala	Male	Mestizo
Mission F-Surg	American	USA	Male	White/Non-Latinx	Yes	Guatemalan	Guatemala	Male	Ladino
Mission I-1	American	USA	Male	White/Non-Latinx	Yes	🟩	🟩	🟩	🟩
Mission J	⬛	⬛	⬛	⬛	⬛	Guatemalan	Guatemala	Female	Ladina
Mission K	American	USA	Female	White/Non-Latinx	No	🟩	🟩	🟩	🟩
Mission I-2	American	USA	Male	White/Non-Latinx	Yes	🟩	🟩	🟩	🟩
Mission L	American	USA	Male	White/Non-Latinx	No	Guatemalan	Guatemala	Male	Ladino
Mission M	American	USA	Female	White/Non-Latinx	Yes	Guatemalan	Guatemala	Male	Ladino
Mission N	American	USA	Female	White/Non-Latinx	No	Dutch	Guatemala	Female	White/Non-Latin
Mission O	American	USA	Female	White/Latina	No	Guatemalan	Guatemala	Male	Ladino
Mission P	American	USA	Female		Yes	American	Guatemala	Female	White/Non-Latin
Mission Q	⬛	⬛	⬛	⬛	⬛	Guatemalan	Guatemala	Female	Ladina
Mission R	American	USA	Female	White/Non-Latinx	No	American	Guatemala	Female	White/Non-Latin
	Data compiled from semi-structured interviews and participant observation								
	**In Mission G, there is a second Guatemala-based coordinator								

The *ladino* Guatemala-based coordinators work diligently to bring teams to Guatemala, often to primarily indigenous patient populations—however, they still must contend with the normalized racism directed towards indigenous Guatemalans that permeates through arguably all aspects of society. This is an avenue of research that deserves to be investigated further.

Below, Table 4.2 shows the different preparation activities undertaken by teams. There are a wide variety of approaches, most of which include a pre-departure phone call or meeting and a reading element, often suggested but not required. The most popular title was the book *When Helping Hurts: Alleviating Poverty Without Hurting the Poor. . . and Yourself* by Steve Corbett and Brian Fikkert (2009), which appeared on several reading lists and were also verbally communicated to me as a book instructed to their volunteers to read.

Table 4.2 Preparation Activities of VMTs



Code	Code	Application Document	Interview	In-person Preparation	Virtual Preparation	Suggested Reading Preparation	Team Guides or Packet
Mission A	ORG 1	No	No	Pre-trip training with Bible study component	iTravel IQ Portal	I, Rigoberta Menchu (book); Living on One Dollar (documentary); Rosa (10 min documentary); La Camioneta (documentary); Discovering Dominga (documentary); Cross Cultural Dialogs (book); Guatemala- Culture Smart (book); Silence on the Mountain(book); Bitter Fruit(book); When Healthcare Hurts	Brocures, Information Sheets
Mission B	ORG 10	Yes	No	Only once arrived in Guatemala	None	Toxic Charity, From Foreign to Familiar, book on Servanthood	Handbook and Surgical Volunteer Guide
Mission C	ORG 9	Yes	No	None	Pre-departure meetings each weekend over an eight-week period with spiritual component; ManagedMissions.com Portal	Foreign to Familiar, When Helping Hurts, Helping Without Hurting	Team Manual
Mission D	ORG 2	Yes	Yes	Two trainings prior to departure; all-church volunteer meeting "Big Team Training" and country-specific meeting later on	For volunteers that do not live in city where church is located; ManagedMissions.com Portal	When Helping Hurts	None
Mission E	ORG 3	No	No	One informative meeting, then "packing parties"in various cities where there is a conglomeration of volunteers	None	None	None
Mission F-S	ORG 4	Yes	No	at welcome dinner when volunteers have arrived	None	None	None
Mission G	ORG 5	Yes	No	Three meetings prior to departure	None	The Tacit Bargain in Short-Term Medical Missions, Why US Physicians Go and What it Costs, Paul Henry Caldron, Toxic Charity, Robert D. LuptonWhen Helping Hurts, Serving with Eyes Wide Open, David A. Livermore, A Mission Journey, a Handbook for Volunteers, Tree Girl, Ben Mikaelsen, Mr. President, Miguel Angel Asturias, Bitter Fruit, Stephen Schlesinger and Stephen Kinzer, Homies and Hermanos, Robert Brenneman, I, Rogoberta Menchu, Rigoberta Menchu, Men of Maize, Miguel Angel Asturias, City of God, Kevin Lewis O’Neil	Mission Journey Guidebook
Mission F-R	ORG 4	Yes	No	at welcome dinner when volunteers have arrived	None	None	None
Mission H	ORG 6	No	No	Pre-departure meeting	None	When Helping Hurts	During week of mission
Mission F-S	ORG 4	Yes	No	at welcome dinner when volunteers have arrived	None	None	None
Mission I-1		Yes	No	None	One pre-departure conference call	None	Volunteer Field Guide, Guatemala Information Packet
Mission J		No	No	None	N/A	None	None
Mission K		Yes	No	None	Monthly welcome calls for general org guidance, one pre-departure call	None	Guatemala Briefing Packet, Team Guide, Gideon Guide
Mission I-2		Yes	No	None	One pre-departure conference call	None	Volunteer Field Guide, Guatemala Information Packet
Mission L		Yes	No	Periodic meetings for for team building, planning, and packing	None	Ministering Cross-Culturally by Sherwood Lingfelter & Marvin Meyers, 1986 Baker Books	
Mission M		No	No	Yes	Phone calls	None	None
Mission N	ORG 7	Yes	No	One pre-departure meeting, locals attend in-person	Non-locals attend pre-departure meeting virtually	None	None
Mission O		Yes	No	At least one pre-trip meeting	Same pre-trip meeting but made virtual for those outside of local area to attend	None	Syndromic Management Book
Mission P	ORG 11	Yes	No	None	Pre-departure emails	None	Guide for Visiting Clinicians, Several information sheets
Mission Q		Yes	No	None	Volunteer Orientation	None	Volunteer Orientation Packet, Clinical Prep Guide, Travel Tips
Mission R	ORG 8	Yes	No	None	Pre-departure emails	None	Outreach Information, Reminder Form

When Helping Hurts explains poverty from a Christian perspective, denouncing the focus on material aid to poor communities and encouraging Christian volunteers to value the non-material needs of communities—such a self-esteem and holistic wellness. is ultimately detrimental to them, demonstrating the heavily intertwined web of modern Christian belief and late-stage capitalism in addition to a poor understanding of the history and context of many poor communities in which Christian volunteers work. The book itself does not offer a critique of capitalism and the neoliberal policies that have worsened inequality in many low-income countries and former colonies that receive volunteers, focusing instead, as always, on individual impact.

Some teams created handbooks or sets of documents sent to volunteers prior to their departure which, according to the coordinators that compiled the information, largely were the result of both learning what volunteers needed to know and missteps of years past. "Culture' as a concept in these handbooks was presented as a static set of lists describing cultural characteristics such as dress, language, and mannerisms or behavior, resembling the 'cultural assimilators' and 'lists of traits' approaches to cultural competence mentioned in Chapter 2.

The characterizations of the 'expected patients' highlighted the differences between patient and provider, emphasizing the patients' role as receivers and the providers as givers. Several pre-mission guidelines forbid distributing money to patients, citing that as a catalyst for poor behavior of future patient—for example, expecting future donations from providers and attending the medical mission not for medical care, but to hopefully receive money from a volunteer. There was no further inquiry into why such an attitude would exist, both from the perspective of the VMT's outward-facing identity as well as the extent of poverty and attempting to empathize with the patients who would be in such a vulnerable financial state.

Before starting my research, I thought that addressing culture would feature more prominently in the preparation materials. Only one handbook described how an encounter with patients might look. It emphasized patient passivity and that patients might not ask many questions, bringing up the categorization of Guatemalan patients as poor health consumers, discussed further in Chapter 6. Some of the teams suggested readings such as I, Rigoberta Menchú, which at least is a K'iche' woman's perspective. But overall, Maya culture was presented as unequivocally tied to poverty and homogenous, especially considering Maya women.

In Guatemala today, there are Maya women who identify as Maya but do not wear *traje*[24]; there are women who wear their *traje* when at work or social functions but wear sweats at home, or when they go to the gym; there are Maya women who are the breadwinners of their homes and who went to get degrees at university. There are Maya women who call themselves Maya, and there are some that do not identify themselves that way and prefer to identify themselves by the name of their ethnic group. In sum, there exists a diversity that gets overshadowed by the expectations of identity placed on Maya women by foreigners (Nelson, 2001).

What struck me the most was the absence of Guatemalan culture in the pages of handbooks, reading lists, and preparation materials—but the absolute dominance of Maya people on organizations' websites. While the reality of indigenous people includes

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[24] *Traje* is the traditional Maya woman's clothing, consisting of a *huipil* (top), *faja* (woven cloth belt), and *corte* (long woven skirt). This outfit is often an outward marker of Maya cultural identity.

cultural vitality and prosperity, as well as poverty and lack of access to social services and health care, many of these organizations' websites only show indigenous people's passive suffering. Every organization with a functioning website included photos and/or videos of indigenous Guatemalans receiving health care from the organizations' volunteer medical teams. It seems that indigenous Guatemalans can be part of the product of the medical mission but are erased from the planning process and implementation of STMM care.

IV. Typologies and Models of Short-Term Medical Missions

These models originated as a result of investigating the "medical mission" as a cohesive process that, I postulated, must contain a discrete set of elements in order to be executed, meaning that certain elements are both legally and logistically necessary in theory for the medical mission to occur. These typologies serve to show the diversity of organizational structures that STMMs utilize and dispel the notion that all VMTs in Guatemala work in the same way. The diversity in structures is where social scientists and policy makers (including those within STMM organizations creating internal policies) will make progress defining certain issues, such as quality of care, follow-up, and legal compliance. Some organizations or medical mission teams certainly missed specific elements (often the legal requirements, as discussed in the following chapter), which implies certain risks for patients. However, most teams did comply with the legal requirements or hold someone responsible for carrying them out.

The medical mission literature tends to divide medical missions conceptually into two groups—surgical missions and basic care missions. Coughran and colleagues developed a typology of three primary types of surgical STMMs (hospital-based STMMs, mobile STMs/VMTs, and locally-driven missions) which will be expanded upon in this chapter (2021). Hospital-based STMMs, according to their classification, work primarily with a single hospital, repeatedly. Mobile STMs/VMTs are constituted of foreign surgeons that go to small towns or rural areas to provide surgeries (it was not noted what type of facilities these are performed in), and locally-driven STMMs are facilitated primarily by Guatemalan surgeons (Ibid.). While this typology is a useful starting point, it will be developed further in this chapter.

Some of these differences were evident in the surgical teams with whom I conducted my research and informed how the organizational models were developed, but within the literature, non-surgical teams have not been analyzed or assigned any kind of typology. Essentially, surgical teams require more legal approval, more coordination with local providers, and a level of facilities management that basic care providers do not. However, surgical missions, because of their focus on the surgical aspect of care, do not act, or present themselves to act, as primary care providers, as is the case in some medical mission teams observed.

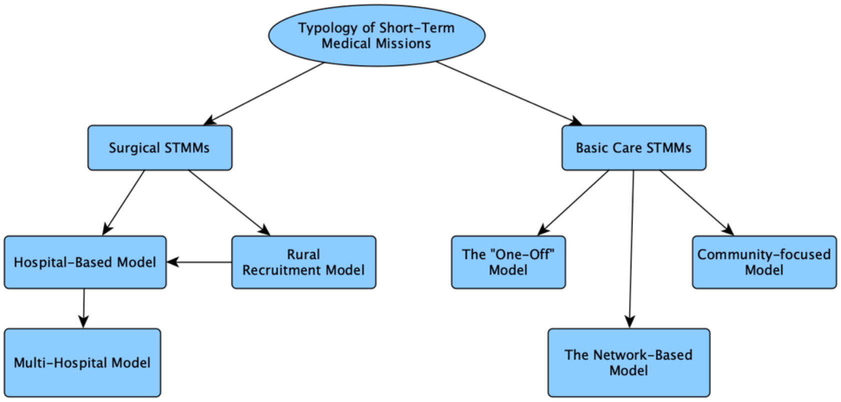
“Basic care” is the nomenclature I have decided upon to describe the type of teams that compose the non-surgical classification. While many teams promote the “primary care” that they provide and utilize that nomenclature, it is inaccurate to use such terminology. The definition of primary care by the Institute of Medicine is as follows, “the provision of *integrated, accessible health care services* by clinicians who are *accountable* for addressing a large *majority of personal health care needs*, developing a *sustained partnership* with *patients*, and practicing in the *context of family and* *community* (emphasis placed by authors)*"* (Donaldsonm, Yordy, Lohr, & Vanselow, 1996).

While the argument can be made for some teams as to the 'sustained partnership' aspect, most groups visiting a community once per year is not considered a 'sustained partnership' or capable of meeting the 'majority of personal health care needs.' Furthermore, many teams fail to reach any degree of integration into the existing health care system—integration that would likely be mutually beneficial, provided a high quality of care delivered by the STMM. Furthermore, some teams struggle to identify their own approach to health care or, at the least, demonstrate a poorly articulated approach. One basic care team coordinator, when asked the type of care provided by her organization (whose revenue is over $64 million USD per year), said, "acute primary care," delivered to areas in Sacatepéquez and Chimaltenango—two departments with the greatest concentration of health facilities and access behind the Guatemala department.

So, in the context of short-term medical missions, basic care missions are categorized first by their lack of surgical intervention (with the exception of dental extractions performed under local anesthesia), and second by the types of services offered—primarily consultations, drug prescription, and referrals. Basic care missions are likely the profile that comes to mind when thinking about medical missions—a team of Americans under tents, in a church, or set up in a school with a long line of patients outside waiting to get in. It is important to note, however, that the requirements for site approval and medical provider registration are the same for both types of missions.

In seeking to further develop the typology of both surgical and basic care STMMs, I was able to classify organizations and teams that collaborated in research with me into six organizational typologies, through an inductive process of studying the factors that would group organizations and VMTs together. These typologies are based on several factors: 1) site of care, and how it is chosen 2) utilization of intermediary organizations (or not) 3) patient recruitment, 4) volume of patients, and 5) frequency of missions. These typologies are not, however, fixed and frozen in time. As a result of the Covid-19 pandemic, as of May 2021, none of the basic care STMMs were sending VMTs to Guatemala, and only one surgical STMM had begun to send surgical teams to its normal network of hospitals. Figure 4.1 below shows the six types of STMMs, followed by more detailed explanations of their classification and an exemplar of each type.

Figure 4.1 Typology of STMMs.



Typology of Surgical STMM Models

"*Hospital-Based Model*:" This model, like that detailed by Coughran and colleagues (2021), demonstrates a long-term collaboration between individual volunteer medical teams and a hospital, public or private. That is, there is not necessarily a Guatemala-based organization facilitating communication between the VMTs and the hospital.

Some of the advantages of this model include better patient safety (contrasted against surgeries performed in less-equipped clinics), a regular supply of qualified surgeons visiting the hospital, a method in which private hospitals can augment their earnings (charging a base fee for hosting VMTs), and at times, a permanent place in which VMTs can store supplies. Disadvantages include disruption to normal hospital activities, and if located in urban areas, the same difficulty for rural patients to access care and find affordable lodging while accompanying familiar members there for surgery.

One exemplar of this model is an orthopedic mission (Mission L) that works in the National Hospital Pedro Bethancourt in San Felipe, Antigua Guatemala. Patients are selected in October of each year in a mission dedicated to orthopedic consultations. Representatives from a prosthesis company accompany the mission team in October, take the relevant measurements from the 35 patients selected for (most commonly) knee and hip replacements. The team leader explained to me that they visited several hospitals before deciding upon the National Hospital in San Felipe, explaining that the location close to Antigua, their sanitation schedule (changing the cleaning antiseptic every month, rotating between 8 different chemicals—to reduce bacteria such as drug-resistant staphylococcus), and being within a regional hospital[25] were the advantages most attractive to their team.

In exchange for working within the National Hospital, the team agreed to 1) not charge patients for their surgeries, per the norms of the national hospital system, where for the surgery itself, patient do not pay, 2) pay the National Hospital $5,000 per day to use the facility, include recuperation areas and operating rooms, and 3) take on one surgical patient each day at the discretion of the national hospital. While I was there

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[25] The Area de Salud normally requires that surgeries be conducted within a certain vicinity of regional hospitals within the MSPAS system.

observing the team, the entire left wing of the fourth floor was taken over by the mission patients. The recuperation room for the patients had twenty beds, all occupied and watched over by both U.S. and Guatemalan nurses. In one hallway, non-STMM patients were recuperating with the lights off—one of the ways the National Hospital tries to cut costs.

Looking through the window of an isolation room, the team leader showed me one of the trauma patients they were to operate on, who had been in a car accident and had a fractured femur, waiting in the hospital for the past four months for a surgery and strong enough antibiotics to heal the festering drug-resistant wound. There was a pending negotiation between the VMT, the National Hospital, and a group of nuns that had been providing financial assistance to the patient to decide upon the donation of antibiotics and follow-up care for the patient after the team left.

This example of hospital-based model shows how a long-standing relationship between a STMM organization and the National Hospital benefits both actors—providing an acceptable location for the STMM close to Antigua and resolution for patients with traumatic injuries who are costly for the National Hospital to operate on or maintain. Among the STMMs recruited for this research, only two national hospitals, those in San Felipe, Antigua Guatemala and San Benito in the Petén, were used to receive foreign VMTs at the time, though at least two other national hospitals (those in Retalhuleu and Huehuetenango) were mentioned as other hosting hospitals in prior experience. Other teams also made similar agreements or relationships with private hospitals as well.

"*Multi-Hospital Model*:" This model, in contrast to the hospital-based model, is characterized by the size of the medical mission organization. In this model, the organization brings numerous VMTs to a limited network of hospitals (public and private) with which the organization has a long-term relationship. Patient recruitment for surgery (through consultations) is performed on-site and based on the patients' knowledge of the STMM schedule and access to information. Recruitment methods can involve radio announcement, flyers handed out to patients with the schedule of VMTs for the near future, referrals, and word-of-mouth.

While this model understandably provides many of the same advantages of the hospital-based model, such as patient safety and the supply of surgeons to these hospitals, STMM organizations that work in multiple hospitals benefit from reaching a more geographically diverse patient population. Patients still might have to travel long distances, but a few of the private hospitals I observed were located in areas without a strong national hospital presence. If the STMM organization wishes to charge patients for their surgery, they may do so in private hospitals. Some of the hospitals that work within a model such as this are Obras Sociales Santo Hermano Pedro, Hospital Corpus Cristi in Patzún, Hospital Llano de la Virgen in San Raymundo, and Clinica Ezell in Suchitepequez, among others.

Mission P utilizes the multi-hospital model to run around 13 missions per year, rotating between different private and public hospitals in different departments of the country, due to the size of the STMM organization and the number of volunteers they receive each year. This model works well for them because of the variety of hospitals in which they work. One hospital, fully equipped with volunteer quarters, is located a few hours from Guatemala City—volunteers travel directly to the hospital from the airport. Another surgical facility is located in a remote area of Izabal, close to the border with Belize and only navigable by boat. Both facilities do not conduct any type of prior consultations or referrals for the surgeries to be performed the week of the mission; they rely on word-of-mouth, their continued presence and reliable yearly schedule, and radio announcements.

The coordinator, when explaining these sites to me, said that having different surgical facilities works in the favor of the organization: volunteers hoping for more creature comforts tend to go to the more developed hospital-volunteer facility, while more adventurous volunteers enjoy the remoteness of the other. However, she said they have to be more judicious in the remote environment regarding the risk of surgeries and generally prefer to not attend to births there.

The patients arrive with the necessary imaging and may be scheduled for surgery with 24 hours' notice—a stark contrast to the timeline in which patients are constrained by the national system. In my observations in a week in one of these hospitals with a VMT, the providers conducted all of the necessary tests on patients before operating—primarily blood pressure and blood glucose, as well as a general examination to make sure the patient was healthy enough for surgery. However, the quick turnaround period meant that some diabetic patients spent several days attempting to reduce their blood glucose levels in order to receive their surgery before the team left. While the prudent and safe choice was to turn away patients that were not ready for surgery (which happened several times), this observation pointed to the limitations of medical missions; if a patient was a candidate for surgery but did not have their blood pressure or glucose controlled, they had to show up during the next week-long period in which a different mission came to the hospital, hoping their laboratory tests would show low enough levels for them to have their surgery.

"*Rural Recruitment Model:"* Specifically, these medical mission organizations utilize outreach trips to rural communities (either conducted by U.S. VMTs or Guatemalan teams) to conduct preliminary consultations with patients to select surgical candidates to arrive in hospitals or surgical centers at a later date. More patients come to be evaluated for surgery than leave with a surgery scheduled, but the teams treat the patients, regardless of whether their case is selected for surgery.

Teams advertise through radio announcements, posters, and community meetings, which include the instructions for all patients arriving to the mission that they need to bring any prior imaging with them—e.g., ultrasounds, cat scans, or other laboratory tests. The "Rural Recruitment Model" is utilized by some of the larger organizations working in Guatemala that bring many teams down each year and thus need a larger roster of patients. This model similarly utilizes multiple hospital locations, but the key difference between this model and the multi-hospital model is the recruitment of patients primarily through separate missions to rural areas.

I was fortunately able to observe both a recruitment mission and two surgical missions for this STMM organization—Mission F. The primary advantage of this model is the reduced burden on low-income, rural patients to travel to urban areas for surgical consultations—especially since surgical referrals are not always given to patients in national facilities and become a cost burden for low-income patients if the patients go to a private provider.

While other medical mission organizations confirmed that they use this model for patient recruitment, they declined to allow me to conduct participation observation and ask more detailed questions about the process. For Mission F specifically, the STMM uses paid health promotors/interpreters from primarily indigenous areas (Q'eqchi', Achi', Poqomchi', and Ixil) from which they recruit patients to accompany patients in vans from their communities to Guatemala City or Antigua to receive their surgery. Because the health promotors live in these communities, there is a chain of contact for patients to utilize in the case of post-surgical complications.

Mission F runs four rural surgical consultation missions per year, spaced 2-3 months apart, which all take place in health centers and are free of charge to patients. Prior to the day of the mission, the health promotors are instructed to hand out numbers to 75-100 prospective patients—those with complex health issues or possible surgical needs. Because the team works between 8am-5pm, they do completely disrupt the normal operations of the health center each day. In between those week-long missions, the organization runs surgical missions in private urban facilities.

Typology of Basic Care STMM Models

"*One-Off Model*:" A basic care VMT visits a single community once per year or less frequently. While I anticipated this model to be the most common model, there was only one VMT that fit within this model. Mission H was, in fact, facilitated by an in-country organization (ORG 6)—however, there was no plan in place to visit the same community again in the next year. The 'one-off' model is the type of medical mission most highly criticized in the literature for its lack of positive impact and follow-up (Snyder, Dharamsi, & Crooks, 2011). From the research standpoint, these types of medical missions are the most difficult to collaborate with because of the lack of rootedness in Guatemala-based providers or organizations.

Mission H held a one-week mission consisting of five clinic days in Totonicapán, in a mixed agricultural/small-scale clothing manufacture community. The mission was highly religious, openly evangelical, and delivered services through the home of a local evangelical committee member—a committee made up of six elderly K'iche' women. While this mission was religiously oriented, religiosity should not be considered characteristic of this model of STMM; I was simply not able to observe more than one mission of this type within my sample.

Referrals for complex care or surgeries depended upon one male Guatemalan physician, who, ironically, was the only medical provider whom I observed fervently evangelizing patients within the clinical context. Public health facilities, when receiving patients for surgery or other advanced care, require referrals to be signed off by Guatemalan physicians (even if another signature is present). While the physician was able to provide the referral, he was rather disconnected from other physicians in public facilities to give patients recommendations for follow-up care or direct them to specialists.

One of the disadvantages of not coordinating with a Guatemala-based organization, which often happens within this model, is the lack of human resources, such as Guatemalan physicians, or more importantly, the "somebody that knows somebody" to help facilitate follow-up care or more complex care. In one case in Mission H, one provider diagnosed a female patient with depression, hoping to give her access to anti-depressant medication. She expressed frustration at not knowing whether or not the patient would be able to experience the positive effects of a consistent, months-long SSRI (selective serotonin reuptake inhibitor)[26] regimen. She prescribed the SSRI to the patient and informed her that she needed to keep taking the medication consistently, but otherwise could only hope the patient understood and would keep taking them long-term.

"*Community-focused Model*:" In this model, a single community or defined set of communities receive STMM care at least two times per year. This model is defined by the continued relationship between the VMT and the community receiving the team, a contrast to the following model, which is facilitated by a Guatemalan partner organization. In the community-focused model, a leader within the VMT (whether it be a team leader, medical director, or coordinator—the nomenclature often varies) is in direct contact with a representative of the community. This was by far the most common STMM model for basic services that I encountered in my research—five STMM organizations fit into this model.

One commonality of STMMs operating under this model was their assertion that they were providing 'primary care' to these communities. Mission I, for example, went to the same four communities three times in 2019—in February, June, and October. The medical director told me, "The idea of our mission is true primary care. We encourage

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[26] SSRIs are a type of antidepressant drug that inhibits the reabsorption of serotonin by neurons, so increasing the availability of serotonin as a neurotransmitter.

patients to come in for wellness checks every four months, even if they're not sick, so that they learn to not just go to the doctor when something is wrong." While this demonstrates a sincere effort to introduce the concept of preventative care to a community, the team still was out of the country 49 weeks of the year and the communities relied upon the health centers for the rest of their needs.

The key exemplar of this organizational model is Mission O. This mission was started twenty years ago and has only ever worked in the same community in the department of Santa Rosa, southwest of Guatemala City. When I asked them if they'd ever considered working in a different municipality, they said "no"—the reasons for not working elsewhere were a sense of obligation to the municipality they worked in, and not wanting to cultivate new relationships with a different mayor, director of SOSEP[27], and the health center. The municipality helps the team find a place in which to work, provides police to operate the entrance, and provides water for the team for the week.

Many of the senior volunteers in the VMT have volunteered for most of those twenty years; occasionally, adult patients came in with their children, who were treated as children themselves in the early 2000s. The medical mission prescribes and gives a medical supply for six months of all medications—often for diabetes, high blood pressure, and even a supply of condoms for patients that use that contraceptive method. They tried to import birth control pill packs one year using a Catholic customs liaison organization—their shipment was stuck in customs for months and the organization obligated them to re-order the shipment without including birth control.

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[27] SOSEP is the "*Secretaría de Obras Sociales de la Esposa del Presidente de la República de Guatemala*," or Secretary of Social Work of the Wife of the President of the Republic of Guatemala; it is an entity run by the current president's wife focused on social welfare projects.

Observing this quasi-parallel health care system at work was fascinating; there seemed to be equal investment from both the local government and the medical mission. Patients that go to the medical mission (which number in the thousands—at least two hundred people were seen each day) are given ID cards with the medical mission's logo, their name, their age, the illnesses they are usually treated for (e.g., hypertension, diabetes), and the drugs and dosage they are normally prescribed. Patients that already have ID cards are given priority to enter the building each day, sometimes just entering to get a check-up and six-month supply of medications.

Because of the long tenure of the organization in this community and positive relationship with the health center, in theory, patients could go to the health center with their ID cards for medication or to inform the physician there of their chronic illnesses. Additionally, the last day of the mission, Friday, is dedicated to first responder and healthcare worker training by members of the team. I attended the "Helping Babies Breathe" seminar that one of the volunteers gave to a group of midwives, the purpose of which was to introduce updated information (e.g., the concept of skin-to-skin contact, waiting 1-3 minutes before tying the umbilical cord rather than immediately cutting it, using an Ambu bag) and donate Ambu bags for them to use.

"*Network-based Model:"* A defined network of communities receives STMMs in a regular cycle (often every six months), though the community might not receive the same VMT each cycle. The network of communities is decided upon by a Guatemala-based STMM organization. While communities receive teams consistently, they do not always receive the same set of providers or same VMT, limiting the ability to develop continuity of care or lasting relationships between patients and providers.

Two of the organizations I collaborated with enacted this model, both executing missions in populous areas of the country—towns in the Panchoy valley (Antigua Guatemala, San Antonio Aguascalientes, Jocotenango, Pastores, among others) and towns along the Pan-American highway in Sololá and Southern Quiché. I was able to observe Mission G, which came to work in a small sample of predominantly K'iche' towns in Nahualá, facilitated by an organization (ORG 5) with a long-term presence in the area. One of the coordinators shared with me the Excel sheet of the communities they work in and the schedule, showing the communities to be visited and the corresponding team. The facilitating organization coordinates with community leaders to set up facilities (community centers and schools) for the health care to take place.

Levels of Organization and Categorizing STMMs

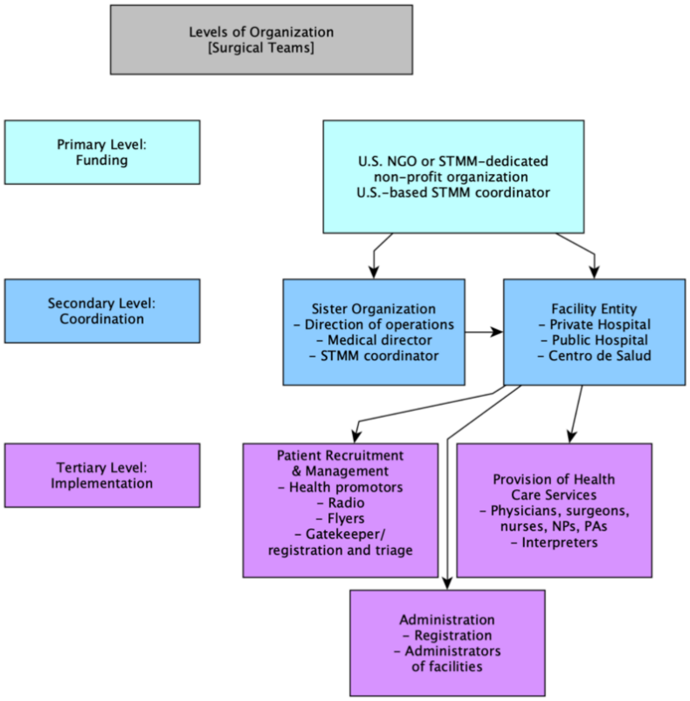
In seeking to model the levels of organization of medical mission teams, I chose to focus on the commonalities and essential elements among all the teams, as varied as they were. While this may seem like general information, it allows for further examination at different levels of a team or organization taking into consideration important issues such as funding, facilities usage, cooperation and coordination with other providers, and local political considerations.

Categorizing and Describing Surgical Teams

Figure 4.2 below shows the levels of organization among surgical STMMs. At the primary level, funding tends to come from U.S.-based nonprofit organizations or medical mission-focused organizations, and very occasionally Guatemalan donors. Because of the costs and risks associated with surgical care, more capital is needed to fund the medical mission activities than for a basic care team. For example, the orthopedic mission (Mission L) that provides primarily knee and hip replacements reported bringing in equipment valued at over $1 million USD in order to properly fit patients with the correct artificial joints, perform the surgeries, and rehabilitate patients to the level at which they could leave the hospital.

At the second level are the sister organization and the facility entity. The majority of surgical VMTs (four of the seven) who participated in my research were affiliated with a sister organization (sometimes as simple as the same organization name, but in Spanish and run by a primarily Guatemalan staff) and some sort of facility entity, including private and public hospitals or health centers. The two surgical missions that followed the hospital-based model directly communicated with the hospital facilities in which they worked. These actors serve as intermediate facilitators of health care and perform much of the labor required in order to get the mission approved, set up the surgical care facility, and, as will be explained in the following chapter, bear the brunt of the legal responsibility for the health care providers. At this level are the medical mission coordinators, specifically those located in Guatemala.

Figure 4.2 Levels of Organization in Surgical Teams



Surgical medical missions require more coordination to meet the facility requirements outlined by law, which is why this step of coordination is almost always left to someone working within Guatemala. Some of those requirements include 24-hour nursing staff to monitor surgical patients and a location within a reasonable vicinity to a national hospital in case of an emergency the local hospital staff cannot handle, among other factors. Some groups work directly within an MOH facility, which allows them much more support in case of a failed surgery or emergency. Other coordinators and teams (such as Mission N) prefer to work in private facilities—whether because they are generally nicer and better equipped or because of negative perceptions of government health care facilities, which are not completely unfounded.

Finally, at the tertiary level are the actors that locate, treat, and refer patients, including the health care providers. This level includes a wide variety of staff and medical personnel and necessitates the most collaboration between U.S. team members and Guatemala volunteers and staff. What is most interesting about these different levels is the ability of U.S. volunteers to be highly removed from the processes associated with the primary and secondary levels. When referring patients for further treatment, a surgery not able to be performed by the surgical mission (often cancer ends up in this category), and/or rehabilitation services, none of the surgeons or physicians I observed knew specifically how to begin this process—it was completely dependent on a Guatemala-based staff member or coordinator.

This is one of the major disadvantages of medical missions for the patients. For a given patient with a complicated diagnosis or need for outside referral, at least two to three other actors must be involved in order to complete the patients' consultation or treatment process in the context of the medical mission. For example, I observed a medical mission (Mission P) that included a women's health component. Practically speaking, this meant many hysterectomies due to prolapsed uteruses, but there were also cyst removals and removal of ovaries. One woman in her 70s came into the mission complaining of pain and was examined by the gynecologist, who determined that she likely had Stage IV uterine cancer and had likely less than a year of life left. Because this was shocking and traumatic news to deliver to the patient, the gynecologist sought information regarding cancer treatment, its cost, and where it might take place.

He first needed to speak to the coordinator in order to explain to her what the diagnosis was and what he wanted to know. The coordinator, speaking good but not totally fluent Spanish, then needed to speak to one of the interpreters so that she could call INCAN (the national cancer institute in Guatemala) for information on treatment costs and what would be needed for an official referral. They were then able to present two options to the patient—pay for treatment in Guatemala City (around two hours away, around Q4,000 per session) or go home with pain medication to administer to herself, understood as entering hospice. She chose to go home and not seek treatment, so as to not put a financial burden on her family. While it was certainly the kind and responsible approach to research the patients' options for her, the process of diagnosis, gathering the information, and delivering the information took close to 90 minutes and three people to complete. This was occurring at the same time as consults in four other clinic rooms, many consults of which needed additional information or referrals such as this case.

It seems odd that this medical teams delivers medical care that is thought to be highly specialized--"American" or "foreign" in nature--as every other aspect of the medical mission besides the face-to-face interaction between provider and patient is wholly Guatemalan, for better or for worse. When entering the hospital buildings, the patients were first greeted by hospital employees or guard staff at the door. The patients would go to 'triage', the STMM vernacular used to describe the process wherein patients approach the desk often run by Guatemalan nurses (and occasionally STMM volunteers) to describe their chief complaints and be directed to the proper line in which to wait—a far cry from the original use of the word 'triage,' used to describe the process of deciding the priority of patients based on the severity of their case or injury, often in a war context (Nakao, Ukai, & Kotani, 2017). In all of the surgical missions I observed, patient registration was performed by Guatemalan hospital staff. The surgical consults and surgeries were performed by the U.S. medical providers. Finally, the process of putting down contact information for follow-up was performed by Guatemalan staff.

While much of the STMM literature focuses on the experiences of volunteer medical providers, with the exception of a few studies that juxtapose Guatemalan physicians and foreign providers to understand that dynamic (Green, Green, Scandlyn, & Kestler, 2014; Coughran and colleagues, 2021), there is relatively little attention paid to the Guatemalans working within and alongside medical missions—and how their participation changes the STMM environment. The spaces I observed were multi-ethnic, multi-national, multilingual, and spanned across many different class lines—class lines that in Guatemala are characterized by a different structure than in the United States and to many Guatemalans, are more obviously apparent.

These levels of organization and aspects of surgical mission preparation first and foremost show that the concept of a context-free, culture-free, and purely biomedical medical mission is completely false, that missions can somehow "pop in" from the United States and make up the bulk of the effort. No medical mission operates without the labor of Guatemalan volunteers and staff, nor can the realities of the Guatemalan health care landscape ever be taken out of the clinical environment and provider considerations for care.

Categorizing Basic Care Teams

Basic care teams require much of the same funding and team formation resources located in the United States as surgical teams do. However, one of the key differences is that I observed some teams opting out of coordinating with a Guatemalan-based sister organization and communicating and collaborating directly with other actors on the secondary level—a completely separate NGO, COCODEs, municipalities, or faith-based organizations. While this opens up the U.S.-based organizations for more opportunities to collaborate with other organizations or work in new locations, this also creates more work for the coordinators and volunteers to complete themselves, rather than rely upon a Guatemalan-based team to do so.

While the origin stories of the basic care VMTs in this research differed and their rationale for starting to work in various communities varied, the majority of basic care teams (5) follow the community-focused model, working directly with COCODES (1), the local municipality (2), or with a community institution—an orphanage (1), and an NGO working to serve a specific community, the children and families of Guatemala City dwellers that search the garbage dump for valuable items to be re-sold (1). The key element to this coordination is the dedication of the VMT to the single community.

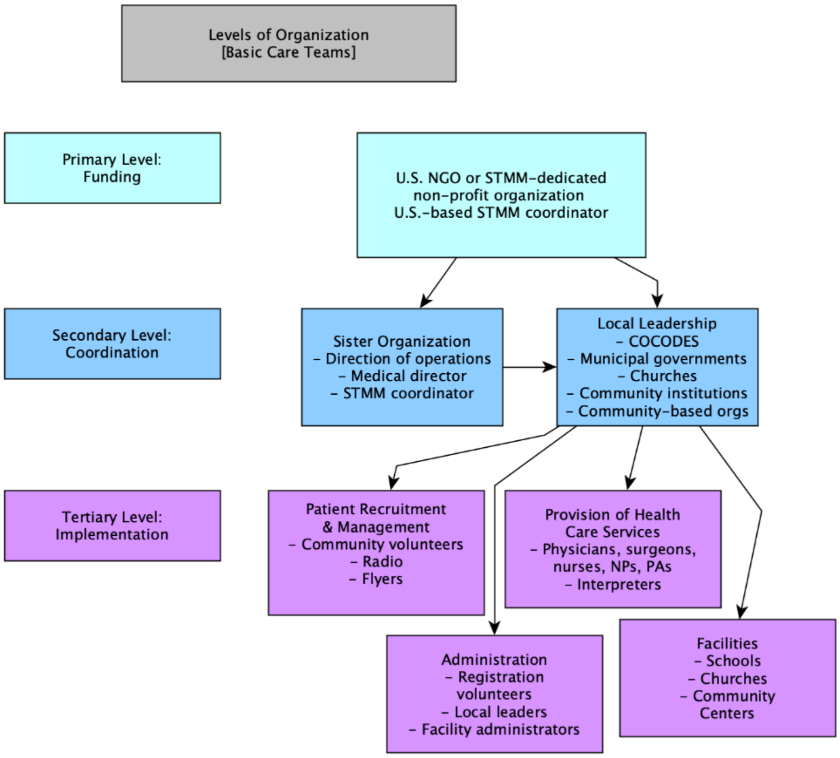
For example, one team working in the Altiplano area, primarily inhabited by rural and semi-urban Kaqchikel, chose the communities to work in based on prior collaboration of those communities with a permanent Guatemala-based NGO. However, the work in order to decide upon specific dates to go into communities, get permissions, process COLMEDEGUA paperwork, form the team, bring them to Guatemala, store supplies and equipment, etc. was up to volunteers working and living in the United States. Thus, much faith was placed in the drivers, interpreters, community leaders, and hotel owners contracted by the team leaders to realize the logistical aspects of the mission—which caused the team coordinator significant stress.

In the process of researching the organization of STMMs, it became clear that the cardinal rule of running a medical mission is to remain adaptable, often adapting without considerable forethought as to how it might impact patients. This is not to say that all the ways in which team coordinators molded their schedules and structures to their particular contexts were done poorly or unethically, but that the adaptations were often made on the fly and due to necessity.

For example, one team visited the same community for 18 years. For most of that time, they conducted their consultations and medical care within a Catholic church, where they had ample space and a longstanding relationship with the local priest. However, the church became unavailable the week that I was to go with the team and observe their mission. Because they work closely with the municipality, the municipality found them a four-bedroom home to rent for the week they provided services. While that ultimately allowed the team to execute their mission, it was also extremely hot, did not allow for easy flow of patients to different rooms, and caused extreme crowding in the consultations.

Basic care team coordination involves more input and collaboration with the communities they work in. Firstly, because they tend to work more within communities of varying sizes rather than in hospital settings that tend to be centralized to larger urban or semi-urban areas. Entrance into communities is somewhat guarded by different entities—in the urban basic care mission I observed, this was due to security issues. The poorest communities in Guatemala City are often, unfortunately the most violent. So, the urban mission I observed was delivered through the supervision of a local NGO in the area that provided armed security guards to accompany volunteers between facilities and ensure safe transportation between the zone it was located in and Antigua Guatemala where the volunteers stayed.

Figure 4.3. Levels of Organization of Basic Care Teams



Guatemala's rural communities, especially those heavily impacted by the years of the armed conflict, can be reluctant to engage with foreigners. The basic care teams I observed that worked in such areas (6 of the 7 basic care teams) always engaged with the municipality, an NGO with an established relationship in the area, or the COCODES. This observation runs counter to one of the generalizations often made about medical missions—that they drop into communities with no prior notice or permission. The municipality, NGOs, and/or COCODES also often aided significantly in the setup needed to physically run the mission, including the facility itself (as I observed in some cases, community centers), providing tables and chairs, and setting up divided areas with ropes and cloth to distinguish "clinic" rooms from each other.

Figure 4.3 above shows how the tertiary level of organization includes facilities. While technically facilities still must be approved DRACES and the Area de Salud, those medical missions not involving surgical care delivery seem to be monitored with little to no supervision or are approved "remotely," as one coordinator explained to me. Healthcare, as I observed, occurred in community centers, schools emptied of their students for the day, homes procured by the municipality, or churches. Only one basic care team delivered services in a clinical environment, which was the team delivering services in Guatemala City.

V. Conclusion

In this chapter, I showed the structure and organizational strategies of the STMMs and their associated organizations who took part in the dissertation research. Guatemala's health care landscape is already chaotic and confusing for patients. The STMM context is no different, as there are many ways to execute a medical mission, involving myriad non-governmental and governmental entities in the process. Additionally, inconsistencies in the availability of STMMs and their patient recruitment practices likely means that STMMs do not always access the target populations (often referred to as "the poorest" people) they desire to reach.

The process by which patients access medical care from STMMs exposes both the weakness of short-term medical missions as a health care provision strategy and how they are an extension of the same neoliberal model as other health care providers in the country. Patients must have the geographical proximity, access to technology resources, and transportation at their disposal to become aware of the STMM, plan to go, and arrive at the medical mission site.

While many of the coordinators perceive their work as bringing health care to the patients and improving accessibility, patients must exert an often-tremendous effort to arrive where the care is taking place, especially in the case of surgical missions. This is due to the (understandable) limitations of where surgeries take place—that the locations are supposed to be approved by the Ministry of Health—and the insufficient planning of VMTs to conduct needs assessments or other methods of discerning existing health care access for their target populations. Putting the burden on patients to arrive to health care facilities mirrors the same burden placed upon them by local health care providers.

STMMs require a much planning and labor from the Guatemalan side, a fact often ignored in the popular understanding of STMMs, perpetuating the idea of simply transferring the personnel (medical volunteers) from one place to another, regardless of all aspects of the context—medical facilities, interpreters, auxiliary medical staff, nurses, etc. Such a misrepresentation continues to be perpetuated because of the invisible pre-mission labor of Guatemalan staff, the ignorance of U.S. providers regarding the necessary steps to prepare a STMM, and the speed at which providers are in and out of the country.

STMM coordinators prepare their volunteers to go abroad and provide medical services in a few limited ways. Notably, the absence of indigenous coordinators and leadership centers U.S. volunteers, their experience, and their expectations of patients rather than centering the experience of patients. Additionally, the strong emphasis on cultural traits as being wholly representative of Maya culture excuses further consideration of variation among individuals and contributes to the objectification of patients, discussed in Ch. 6. That is, the memorization of cultural traits as a method to prepare for the mission halts the engagement and critical thinking that would allow STMM volunteers to develop nuanced characterizations of STMM patients.

While much of the prior literature has only distinguished between surgical VMTs and non-surgical VMTs, this chapter contributes a degree of nuance to the existing information on medical care delivery through STMMs, demonstrating the wide variety of ways in which STMMs utilize their volunteers, reach their desired patient population, and coordinate with local medical institutions. Furthermore, this opens the conversation to compare models and conduct further research on the efficiency of different types of STMM coordination and the effect on patients. Indeed, if STMM volunteers want to reach the ‘poorest’ or ‘most in need,’ coordinators and leadership within those organizations need to think critically about how to deliver care in a way that does not simply repeat the issues of access present within the existing health care landscape.

Surgical STMMs and basic care STMMs come with both strengths and limitations. Surgical STMMs will likely always be limited in their geographic distribution, especially if they aim to follow government guidelines regarding approved surgical facilities. However, if they develop a sophisticated and community-based recruitment model, they can reach patients without access to surgeries and, assuming a plan for follow-up care, deliver targeted impact to vulnerable populations. Basic care services, while more limited in the set of health care services they can deliver, have the potential to supplement existing health care services in rural areas and, depending on the composition of the team and knowledge of local health context, provide valuable specialized care and referrals for patients. While basic care missions will never provide what constitutes “primary care,” VMTs that develop lasting relationships with communities can provide a more lasting impact and relationship with their patient population.

These models also show the pluralistic, if not chaotic, nature of STMM preparation, organization, and collaboration with the local health sector. While STMMs are minimally required to interact with the government through the process of registration and approval by government entities, many organizations, as evidenced above, choose different routes to engage or disengage entirely with the government for the actual delivery of health care. The disengagement shows the sense of mistrust characteristic of the neoliberal orientation of STMMs; the governments of countries classified as “poor” or “underdeveloped” cannot be trusted and certainly are not thought of as reliable health care providers—at least during the week that the VMTs are in Guatemala.

The diversity of structures and strategies does not distribute risks and benefits to patients in even ways, as will be demonstrated in the following chapter. As an approach to health care delivery, STMM organizations really do experience blind spots—decision-making, or lack thereof, that can seriously jeopardize patient rights, safety, quality of care, and autonomy. While many coordinators defend their methods of preparation and organization as the result of years of experience, there is still much progress to be made regarding responsible and ethical STMM planning.

CHAPTER 5

THE BEST OF INTENTIONS: HOW THE GUATEMALAN LEGAL SYSTEM AND STMM ORGANIZATIONAL POLICIES LIMIT PATIENT RIGHTS AND SELF-ADVOCACY

"Boy, did I have a bad week last week."

My research collaborator and friend, a Guatemalan short-term medical mission (STMM) coordinator, sat down across from me at the pub. Every few months after I initially conducted research with his team, we would have lunch and a few beers, catching up about our respective projects and always circling back to how frustrating and impossible health care is in Guatemala. He coordinated surgical teams for twenty-three weeks a year, in between making trips to areas of the country where the organization's health promotors work to visit them, scope out lodging for volunteers to stay, and look for new local activities for the teams to do on the rest day they take in the middle of the volunteers' week.

"What kind of bad week?"

"The kind of bad week where someone threatened to kill me."

"No, you're kidding. What happened?"

One of the organizations' health promotors called him from Baja Verapaz the week prior, completely frantic. The organization monitors infant candidates for cleft palate surgeries for two to three months before their surgery, providing nutritional supplements and baby formula so they will be strong enough to endure their surgeries. The health promotor arrived at someone's home to find a very ill baby. She called the coordinator and told him that the parents said the baby showed signs of a respiratory infection and distress for a few days, but this was the first time she had seen the baby herself. The parents believed the nutritional supplement provided by the STMM organization had caused their baby's illness—and they were livid. The health promotor pleaded with him to come help her since she felt unsafe in the situation but also unable to leave because of the condition of the baby.

He drove as quickly as he could from Guatemala City to the town in Baja Verapaz, arriving in about four hours. He arrived to find chaos: the mother, weeping while watching her baby turn blue; the father, shouting at the health promotor in Q'eqchi'; the health promotor, sobbing and beyond overwhelmed. The baby would not survive the hour-long trip to the nearest hospital and he had to communicate that to the family. "Even if we leave for the hospital now, I don't think your baby will survive the trip." Within a few minutes, the baby slowly faded, until his laborious breathing stopped.

The father turned to him and snarled: "This is your fault. This is your organization's and whatever-you-put-into-my-baby's fault. We will burn you alive."

This was not an empty threat. In many communities in the Verapaces, Petén, and Quiché, lynching, setting someone on fire, or burning them alive is considered a just punishment for a horrific crime—such as murdering someone's infant. The government, who once sent armies of men to 'suppress' subversive activity and was responsible for the brutal rape and murder of indigenous people for being even tangentially associated with communism, now claims to deliver justice and enforce the rule of law to the same towns its armies previously terrorized. So, many communities are not convinced that justice can be delivered by the government. But Maya law is governed by its own logic, logic that makes sense for the community context in which it is applied; it is also respected at the national level as one of the three recognized legal traditions in Guatemala, though how the law is and should be interpreted and applied in relation to Guatemalan law is still debated (Schwank Durán, 2005); Sieder, 2013).

Panicking, the STMM coordinator called his boss. She suggested that he offer to pay for the funeral and try to explain to the family that the formula and nutritional supplements would not cause a respiratory infection. That the organization was so sorry—but it was not at fault. He hung up the phone and asked to speak to the father. The father accepted his offer, but he had to go get the casket, immediately. He called the number of a local carpenter suggested to him by a bystander.

"I was so furious. I was furious that this poor baby died. I was furious at the parents, for not acting sooner. I was furious that someone had threatened my life. I know they were just angry and wanted justice, but I shouldn't be their target. Don't they get it?"

He paused.

"But then, I arrived at the carpenter and saw the size of the casket… it was so small. It was the size of my own son. And I thought, 'if that were my little boy…'"

❦

I. Introduction

Short-term medical missions are attractive to both volunteers and patients because they provide a way for volunteers to make an individual difference in the life of someone that they see suffering. As seen in Chapter 4, the ways that STMMs go about addressing that suffering vary significantly, according to the type of health care provided, the location and facility in which the health care will be delivered, and the connections that exist between the STMM organization or volunteer medical team (VMT) and local actors, among other factors.

This chapter explores the paradox that, while STMM volunteers and coordinators seek to empower patients through better health, break the cycle of poverty, and many ideas that follow the "traditional wisdom" regarding the purported contributions of medical humanitarianism to the health of people in low-income communities, structural deficits within short-term medical mission planning and organization can result in the same problematic treatment of patients and violation of patient rights. These deficits include non-compliance with local laws, poor sharing of information about the providers with patients, geographic considerations, and deficits in language services made available to patients who do not speak Spanish as their primary language.

STMM organizations often present their work as contrary to both public and private systems within the country that do not adequately serve the Guatemalan patient population, but they in fact must operate within the same framework as other providers. Acting *outside* of the that same bureaucratic framework, including the myriad legal, customs, and health facility requirements is not an ethical option either. While many STMMs succumb to the temptation of non-compliance, as there are often little to no consequences for the providers, some simply are unaware of the regulations surrounding the delivery of health care by foreign medical providers. Regardless, non-compliance results in the reproduction of the existing paradigm in which patients, especially those who are low-income or indigenous, are left with few avenues to resolve problems with respect to the quality of care they receive.

The Guatemalan legal system is difficult to navigate. The patients, especially in rural areas, do not necessarily speak Spanish—and if they do, they may not have the reading literacy or health literacy to fully engage with medical providers from the United States or self-advocate. Additionally, the cost to pursue legal action is prohibitively expensive for most Guatemalans. Many do not have the financial means to make a civil *demanda* or a criminal *denuncia*[28] in court to sue for damages if a treatment or surgery goes awry. Many more do not have the social or financial capital to push for an investigation in the Public Ministry, that while free to pursue, often necessitates participation in the corruption that in Guatemala pushes matters forward. Furthermore, institutions such as the College of Physicians and Surgeons seek to suppress patient rights and sustain an opaque policy for disciplining unethical or unprofessional behavior in medical providers—both Guatemalan and foreign.

While Chapters 1 and 2 reviewed the factors that lead to the poor health outcomes and explained the health care landscape in the country and Chapter 4 established the organizational structure of STMMs, here I focus more specifically on the "perfect storm" of Guatemalan government policies, lack of international regulation or U.S.-based policies, structural vulnerabilities of patients, and the organizational practices of many medical mission teams that intend to provide a means of empowerment and forward progress in the lives of their patients but in fact, place them in situations where legal recourse becomes untenable. Because of ignorance, the difficulty of completing the legal requirements for medical mission care, and deficiencies in medical mission structure,

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[28] A *demanda civil* is the equivalent of a civil claim and will be described as such in this chapter. A *denuncia* is a criminal complaint and will be referred to that way in this chapter.

many organizations or individual teams do not complete the steps necessary to provide a pathway for patients to advocate for themselves and seek recourse for improper care or failed surgeries.

Besides the issues related to legal services, medical mission planning and organization affects the individual experiences of patients and can exacerbate or ameliorate the vulnerabilities patients already face. I connect the structural and institutional factors related to STMM planning and show how they can affect patient vulnerability at the level of social groups (e.g., women, indigenous Guatemalans, illiterate populations) and individually, based on my participant observation with the teams and the opportunity to observe a wide variety of patients in their clinical encounters with U.S. medical providers.

II. U.S. or International Regulatory Body Positions on Medical Missions

While no cohesive, universal statement exists on the practice of medical missions, some regulatory bodies have released statements on their regulation, ethics, and conduct. Guatemalan laws will be the focus of this chapter, but the international positions will be briefly reviewed as context for what international volunteers are exposed to in their home countries.

Rowthorn, Loh, Evert, Chung, & Lasker, J. explain that according to their research, most countries do in fact have strict requirements for registering and approving foreign doctors to practice—even resource-poor countries that are often advertised as ideal places for such an exchange because of the ability to curtail restrictions that exist in the U.S. (2019). Other academic articles have outlined some of the best practices or recommendations for following local guidelines for practitioner registration (Lasker et al., 2018) and recommendations for ethical ways of managing unintentional harm (Zeintek & Bonnell, 2019). Medical malpractice is an additional topic touched upon in the literature. While the U.S. is often criticized for its overly zealous pursuit of malpractice cases, as the authors note, it is often a means of assuring quality care and care practiced by licensed practitioners (Rowthorn, Loh, Evert, Chung, & Lasker, 2019). Linked to the American Association of Medical Colleges, the Stanford University Center for Global Health and Johns Hopkins Berman Institute of Bioethics published a training program for learning ethical practices in global health. The University of Minnesota also has a page for the GAPS online workshop, emphasizing patient safety in global contexts. The AAMC has its own guidelines, but they are only three pages long. What is conspicuously missing is any sort of legal or governing structure that monitors medical mission activity abroad or ensures that U.S. providers follow local laws.

III. Guatemalan Laws and Health Care Regulations that Impact Medical Missions

The primary barrier for medical mission organizations (who do not have a Guatemalan attorney on staff) to understand the laws that apply to their operations is, of course, language. There are no easily accessible translated versions of several key documents that explain the legal context that medical providers operate within—whether foreign providers or Guatemalan providers. The key documents that affect providers are 1) the *Ley Orgánica del Ministerio Público*, which outlines the hierarchy of the legal system in which all citizens exist 2) the *Código Penal,* which illustrates what are considered serious crimes (*delitos*) regarding health within Chapter IV ("Crimes Against Public Health") 3) the *Código de Salud*, or Health Code, which provides guidelines for relevant topics in public health for the country, and 4) the instructions from the College of Physicians and Surgeons for bringing foreign providers into the country to provide medical services and registering with the Department of Regulation, Accreditation, and Control of Health Establishments (DRACES).

Organization of the Legal System in Guatemala

Guatemala's legal system is divided into civil law (private) and penal or criminal law (public). Civil disputes are resolved through the cases being brought before a judge as a civil claim, wherein both parties (the plaintiff and the defendant) present their sides with the aid of attorneys. The judge decides to dismiss the case, decides on damages and the amount awarded to the plaintiff, etc. For example, this is where a worker who was injured on the job might sue the employer—the judge could decide that the employer must pay the employee or declare the employee "unable to work," thus getting them into a system of government benefits. In this case, no crime is acknowledged to have been committed. The cost can vary between Q20,000-Q500,000 (between $2,700-67,000 USD) to take someone to court for a civil claim, and many trials take at least three years to be fully realized.

Penal law is administered through the Ministerio Público and the *fiscales*, who are public attorneys with varying degrees of legal experience and power within the hierarchical structure. The *Fiscal General*, who is at the very top, is in a position similar to the Attorney General in the United States and gets appointed by the President of

Guatemala. Regional and local attorneys get appointed and are responsible for carrying out the law in their jurisdictions, including forming investigative teams of experts if necessary to investigate crimes (Ministerio Público, 1994). The police do not have a role in the investigation beyond their general role to protect humans and property; they participate in the apprehension of a suspected person, only when an arrest warrant has been authorized by a judge.

If a crime is thought to have taken place, the victim can go to file a criminal complaint in their local Public Ministry. The burden is on the patient (or the plaintiff) to file a criminal complaint. *Auxiliares fiscales*, the lowest-ranking of the public attorneys, must hear the complaint and determine if there is enough evidence to believe that a crime was possibly committed and the Ministerio Público should investigate (Ibid.). The investigative team uses a period of 90 days to investigate the crime, collect evidence, and establish motive. If a crime is believed to have occurred, the public attorneys will take the case to court, proceeding with a formal accusation. If within the 90 days, the team does not find sufficient evidence or decides that the case does not have standing, the case gets more-or-less abandoned and it is up to the plaintiff to continue persuading the MP to investigate.

The Penal Code and Health Code

The Penal Code includes surprisingly few actions that are considered serious crimes and are thus clearly punishable through the process of criminal complaints. However, there are several punishable actions that, in the past or presently, have been commonly executed by medical missions. Administering drugs that are past their expiration date is a punishable offense--usually a fine between Q200-Q3,000 (Congreso de la República de Guatemala, Decreto 17-73, Codigo Penal, 1973, Articulo 304). Bringing medications into the country without authorization can result in 3-5 years in prison and a fine ranging between Q500-Q5,000. Under the same article and resulting in the same punishment is administering medications without authorization (Congreso de la República de Guatemala, Decreto 17-73, Codigo Penal, 1973, Artículo 304).

Article 308 states that any of the punishments illustrated in Article 304 can be increased if the crimes are proven to be committed in educational, public, or private health centers, or if the crime was committed by "doctors, chemists, biologists, pharmacists, odontologists, laboratory employees, nurses, obstetricians, midwives, educators… or those responsible for the direction or conduct of groups," denoting that bringing in or administering unauthorized medications is considered to be taking advantage of their position (Congreso de la República de Guatemala, 1973, Artículo 308). The increase in punishment is up to the range of Q5,000 to Q100,000 (Ibid.).

The penal code clearly outlines the consequences for entering the country with expired medication and for administering that medication. This is a relatively common practice of medical missions going through *aduanas*, or customs. If medications are presented to patients in plastic baggies or otherwise outside of their original containers, patients do not know the expiration date of their medication. This also often goes unnoticed by patients who, at the most basic level, often are neither aware of the laws nor able to read the labels on the bags of medication they receive.

There is also the issue of how medications are brought in. Medications brought within checked baggage through La Aurora airport in Guatemala City sometimes get evaluated by customs—the airport has the right to look through all of the bags and/or discard medications. But most of the time, bags are randomly chosen to be examined rather than systematically or consistently chosen. Entering visitors push a button that lights up as green or red—red bags get further inspected and green bags move on.

Medications brought through customs officially (either in shipping containers or through an agency) go through a more rigorous review process by customs—the medications come with a manifest that must match the products being introduced to the country and include the expiration dates.[29] Ironically, many NGOs try to avoid the import tax as much as possible, while also bemoaning the low tax base and lack of government resources available to the general population.

Some of the topics broached by the Health Code (Decreto No. 90-97) include the organization of the Ministry of Health and its responsibilities, how health promotion and disease prevention are supposed to be carried out (including curbing infectious disease), regulations for water and solid waste sanitation, the disposal of dead bodies, food and medication regulations, disposal of hazardous waste, among other topics. The fines for infractions of these rules are also outlined (Congreso de le República de Guatemala, Decreto 90-97, Codigo de Salud, 1997).

Specifically, the Health Code again addresses pharmaceuticals that are donated. Donated medications should adhere to "quality norms" (Article 186), should be appropriate for the disease and illness they are being used for and approved for such use in the country of origin (Article 187), and should adhere to international norms for use—e.g., medications should be used for the intended purpose and a patient with "X" disease

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[29] The specific rules for this are outlined in Article 232 of the Health Code.

should not be prescribed an “off-label” treatment (Article 188) (Congreso de la República de Guatemala, 1997). Chapter 5 also states that “only to practice in the professions related to health are those with corresponding degree(s), incorporation into The University of San Carlos of Guatemala, or those who are actively professionally associated, in the case of university careers from private universities. The Ministry of Health will carry out a registry of said professionals” (Ibid., Artículo 193).

In Article 228, “Special Cases,” the Health Code states that it is an infraction to provide private health care services (which is how the majority of medical mission services would be characterized) without the approval of the Ministry of Health. Additionally, it is not permitted to operate pharmaceutical establishments without MOH approval (Ibid.).

For any of the infractions listed in the Health Code that are proven to have been committed, the involved parties are supposed to meet with a judge within five days of being notified of the infraction and resulting punishment (Ibid., Art. 238). Article 219 of the Health Code explains the punishment for breaking the health code depending on the infraction, as a first offense. If the entity is fined, it must be paid within five days and the entity must prove that it has remedied the issue that was identified as an infraction and the payment made and notarized. The Ministry of Health can also choose to close the establishment or cease the operations of the entity, if it chooses—this would also be decided in court within five days (Ibid., Art. 239).

While these laws and regulations establish that Guatemala indeed has standards of operation for all health providers—including foreign health providers—the executability and enforceability of these laws is questionable. For a medical team that does not associate itself with a brick-and-mortar institution in Guatemala and only spends up to five days providing medical care (of any kind, even surgical), these laws are practically inexecutable. Furthermore, if the team has not registered with the College of Physicians and Surgeons (in the process described below), naming the providers or the American organization that committed an infraction makes the legal process of fining the team or ceasing their operations near impossible.

Process for Registering Jornadas Médicas and Foreign Health Care Providers

Registering medical providers who come from other countries to provide health care (named as consulting physicians, surgeons, and epidemiologists) is the responsibility of the Guatemalan government entity known as the *Colegio de Médicos y Cirujanos* (COLMEDEGUA), or the College of Physicians and Surgeons. In Guatemala, a physician who has graduated from medical school must become *colegiado*, or professionally associated as a member of this entity, in order to practice medicine. The building is located in the complex in Zona 15 in Guatemala City along with several other Professional Colleges serving to professionally associate college graduates in their respective disciplines.

The process of registering a medical mission is outlined in an online PDF in Spanish available on the website—there is no English copy available. It acknowledges the different government entities that must be notified or paid in order to register and conduct a medical mission, including the *Departamento de Regulación, Acreditación y Control de Establecimientos de Salud* (DRACES)—the Department of Regulation, Accreditation, and Control of Health Establishments and the Dirección of the Area de

Salud—Director of the Area of Health. COLMEDEGUA is responsible for authorizing the medical teams that come, while the *Area de Salud* is responsible for the actual supervision of the teams after they enter.

The online instructions specifically state that professionally associated Guatemalan physicians act as supervisors to foreign medical providers that come into the country. The Guatemalan physicians backing the medical team are supposed to be identified clearly to be "institutionally responsible" for the foreign providers (COLMEDEGUA, 2014, p. 2). This means that should anything occur to a patient in the care of the foreign medical team, the Guatemalan physician is legally responsible.

The instructions state that foreign medical teams need to take into account complications or high-risk cases and be prudent when deciding to operate or not; COLMEDEGUA suggests avoiding complicated surgeries. The medical teams providing surgeries are supposed to agree upon a follow-up care or emergency plan for patients ahead of the surgery. They suggest agreements or "letters of understanding" between the teams and the hospitals in which they are providing surgeries or medical care to account for these situations (Ibid.).

The process of registering a mission goes as follows, all taken from the same document:

1) Foreign providers notarize copies of their medical degrees and board certification in the U.S.
2) Foreign providers notarize copies of their medical licensure in the U.S.

3) These photocopies are presented along with the form requesting information about all members of the team that will be providing medical care to COLMEDEGUA at least fifteen days in advance of the mission.
4) A letter from the health institution, hospital or organization backing the team's presence in the country, signed and stamped by the professionally associated Guatemalan physicians backing the team, confirming that they are backing the medical team—and assuring that they will be responsible for the legal and technical follow-up for these providers.
5) Payment of Q500.00 (around $67 USD) paid to COLMEDEGUA, with a photocopy of the receipt of payment.
6) Proceeding to DRACES, all of these documents (including the processed, approved documents from COLMEDEGUA) in a folder with a paperclip turned into the DRACES office. DRACES will give the person turning in the documents a password so that they can return in five days to pick up the processed paperwork. Along with this paperwork, the medical team must turn in a request form to DRACES, which shows the location, days, and times of the medical care to be provided. They must provide a copy of the same letter from the institution, hospital, or organization and Guatemalan physicians backing the medical team. And finally, a photocopy of the current sanitary license of the hospital or clinic in which the care is to be provided. (COLMEDEGUA, 2014).

Medical Malpractice in Guatemala

The above legal requirements and processes provide a murky environment for foreign medical provider accountability in Guatemala. There is the geographical limitation for providers who do wish to follow the rules—much of the paperwork must be turned in in-person to the proper institutions, which in practice means navigating Guatemala City weeks prior to the medical mission. This is something that foreign providers might be unwilling (as some have stated) or unable (due to travel or language limitations) to execute.

Beyond the first issue of registration and there being a record of the medical providers' presence in the country, there is the issue of medical practice itself and the quality of care. What happens if a provider makes a fatal or debilitating mistake within the medical mission? The structural vulnerabilities that many patients face have already been outlined, but there are also barriers to patient self-advocacy and compensation inherent in the medical-legal structure. Notably absent from the penal code and health code of Guatemala are regulations outlining the procedures that patients can take to self-advocate (with the support of the law) or more detailed legal responsibilities on the part of medical providers towards their patients—and the consequences for not treating patients properly, whether on purpose or on accident.

Legally, malpractice is introduced within criminal complaints as "damages"—(in this case, bodily damage) or homicide. According to Plaza Pública, in the ten years between 2002 and 2012, there were 76 cases of damages and homicide combined reported (Reynolds, 2013). Although there is a hotline for patients to call and report criminal complaints through the public health service (MSPAS), no complaints have denounced medical malpractice. There is also no easily accessible way for patients to report medical malpractice when going to private health centers, hospitals, or providers' offices (Ibid.). Interestingly, the popular opinion of the health care system is poor—so, while people are disinclined to make complaints in towards the health care system, many journalistic articles in the *Prensa Libre*, one of Guatemala's national newspapers, have been dedicated to exposing hospital management and physicians.

The College of Physicians and Surgeons has an entity called the Honor Tribunal that receives criminal complaints and petitions for review of physicians and surgeons that are reported to have engaged in malpractice. They argue that they are not subject to the Law of Public Access to Information (Reynolds, 2013); patients thus are not able to review past investigations of malpractice or impropriety for themselves and make decisions about the providers from which they seek health care. Additionally, there is no way to know whether medical mission visiting physicians have been investigated by this entity. This is especially troubling given the fact that this entity is responsible for ensuring that the providers, who face more limitations than Guatemalan physicians do (e.g., language barrier, often unfamiliar endemic health problems, lack of knowledge of local culture) provide ethical, professional care.

The College of Physicians and Surgeons was especially vocal in opposing Law 4282 after its proposal in 2010—the "Law of Patient Rights and Creation of the Defense of the Patient." The opposition was reported to oppose the law because it did not address of systemic problems, promoted an individualistic attitude towards health (rather than collective societal health), included too extreme of sanctions, and that it would damage the image of doctors (Reynolds, 2013). In practice, the failure to push forward the Law

4282 in 2012 by the Guatemalan Congress shut down any progress towards improving patient rights at the national level and laid bare the prioritization of physicians' careers rather than concern for patients by COLMEDEGUA. The discourse of collectivism undercuts individual claims for responsibility among physicians and surgeons, despite the clear need for better protection for patients at the systemic level.

The form itself to turn into the Honor Tribunal is complicated and likely would need to be completed by an attorney. The author of the criminal complaint must 1) include their personal information 2) provide the full account of the incident and legal basis of the criminal complaint (e.g., what law/regulation was violated) 3) the identifying information and location of the provider responsible 4) proof, and additional copies of proof, that the incident occurred (Junta Directiva del Colegio de Médicos y Cirujanos de Guatemala, n.d.). This is far beyond the legal capabilities of the average Guatemalan. In the case of an issue within a medical mission, most patients do not leave their procedure or consultation with such information about the physician. For medical missions that rotate locations by day (e.g., one day in one pueblo, one day in the next), the location component of that information might be difficult to acquire or explain in such a petition for review.

IV. Perceptions of STMM Regulations by Coordinators and Volunteers

Coordinators and volunteers who participated in the research displayed a wide variation of knowledge and awareness about the regulations surrounding STMMs in Guatemala. During the interviews, most coordinators independently mentioned complying with the registration requirement for foreign medical providers when asked what they do to prepare to take volunteer medical teams to Guatemala. However, beyond acquiring the information from the providers and sending it to a contact in Guatemala (a Guatemala-based coordinator, facility contact, or local volunteer associated with the STMM organization), most coordinators did not understand the process itself or name the entity to which the paperwork is sent.

One coordinator, previously mentioned in the same anecdote, who works in a STMM organization that runs over twenty STMMs per year, realized mid-conversation that her team was not complying with the requirement to register foreign health care providers. As an American coordinator based in Guatemala, she trusted the contact at the hospital where surgeries take place to do what was necessary with the information she collected from the volunteer medical providers. In this case, she believed that she merely needed to collect the information and have it on hand, rather than go to the College of Physicians and Surgeons in Guatemala City and let them process and approve the volunteers' practice as volunteer medical providers.

I had the chance to ask the contact in the hospital about the process and his decision not to submit any of the provider registrations to the College of Physicians and Surgeons. This contact is an attorney who conducts the legal preparation, retrieves the medical supplies sent to Guatemala through customs, and acts as a liaison between the STMM organization and the executive board of the hospital, made up of local community members with a connection to the Christian church who built the hospital. While I suspected that he might not want to discuss the lack of registration with me, I was surprised when he agreed to talk about it with me, just asking if I would turn my audio recorder off. In retrospect, I understand that as a sign of culpability—that he knew that not registering the medical providers was wrong.

His justification for not registering the providers reflects the same discrimination and lack of respect towards the patient population already existing in the government health care system. He said,

> "In all of the years we've been operating, we haven't had a single compliant about the quality of the care received by the patients. So I trust the medical providers, and so does the hospital director. We see no need to register the physicians if they always provide excellent care to patients. It's also a huge hassle to go to the city."

Coupled with the obvious power dynamic in favor of the STMM coordinators and volunteers, providing no mechanism or space for patients to voice their concerns about the quality of care, of course, results in no complaints of the quality of care. Furthermore, it perhaps suits the self-interest of the hospital director to not register the teams because the registration requires him to sponsor the whole team and risk his licensure, career, and credibility. Those two Guatemalans, perhaps due to their own conscious or unconscious prejudices and privilege, do not value the patients coming to the hospital to receive low-cost care as people equal to themselves. The patients, in this case, are perceived as passive receivers of superior "American care," who are not presumed a right to the quality of care they receive.

In a separate case, one hospital director in a different hospital in the Western Highlands took great pains to register all the foreign medical providers who arrived to conduct cleft lip and palate surgeries. In fact, the day that I met the director, she arrived thirty minutes late to our meeting because of her travel to Guatemala City earlier that morning—a three-hour trip, at minimum. She came in, exasperated, and we naturally began to talk about the registration requirements.

While she stated that she hated the requirements to register the medical providers, she understood why the requirements were in place. She even stated that she did not want to coordinate any more than the ten medical missions that take place in the hospital each year because of the labor involved to register the foreign medical providers. Interestingly, when I spoke of the registration requirements to one of the team leaders in the very same hospital a few hours later, she was ignorant of the process, beyond submitting the paperwork to the hospital director.

Another STMM organization director running a different STMM in that hospital, who has organized cleft lip and palate repair missions for over fifteen years, admitted that she sees a lack of oversight by COLMEDEGUA and STMMS taking advantage of it:

> "I do think also that the Colegio de Medicos is not really checking on who is coming into the country. So there are a lot of residents, practicing going on. There needs to be a voice to protect those kids who are that sick because I work in medical mission and I stopped another mission team still because I did not agree with their, you know, ways of thinking. (Guate_Coord_10).

This echoes prior research condemning the practice of 'training' residents or students on foreign, brown bodies (Langowski & Iltis, 2011; Rowthorn et al., 2019). The coordinator continued, indicating that for her, the standard is very high for the caliber of plastic surgeons she hopes to form her team, especially considering the vulnerability of the children and their families, who often come from rural, indigenous areas.

> "You know they don't check them first. Ah you know if I think a plastic surgeon is, wants to come I need a couple months before and after picture, I want to know if they do that in their practice back home and think that of course people here don't do that right. They maybe trust them too much. Because when we are back in the states and you know you are going to have surgery, you know your surgeon." (Guate_Coord_10)

Thus, compliance to Guatemalan laws regarding the registration of VMTs is inconsistent and rendered more complex by the relationships between the STMM organization and the local contact who registers the team. Both shoulder the responsibility the complete the process—while some of the contacts actively choose not to register VMTs, the STMM organizations themselves bear the responsibility to know the regulations and follow through with local contacts to ensure compliance. While realistically there are little consequences for VMTs who do not complete their registration, patients can experience the consequences and meet a dead end when trying to file a legal complaint. Finally, low levels of government resources for oversight and regulating STMMs appropriately stymies patients' access to legal resources and the government's ability to follow through when documented cases of malpractice do occur.

V. **Patient Vulnerabilities**

One of the key elements of health care delivered in the short-term medical mission context is the power dynamic between patients and providers. While there exists a power dynamic within any patient-provider interaction—in the United States, too—the chasm between the patient and provider in the short-term medical mission context is even wider. Guatemalan patients in the STMM context, due to increased levels of poverty, more intensely experienced poverty, and high rates of malnutrition, are more vulnerable patients than a patient engaged in a patient-provider interaction in the United States.

In fact, part of the attraction and very open aim of medical mission organizations in Guatemala voiced by volunteers and coordinators alike is the opportunity to treat the most vulnerable patients. While vulnerabilities such as poverty, low levels of education, gender inequality, and ethnicity/discrimination are all well-known factors contributing to poor health outcomes in Guatemala, some vulnerabilities more specifically apply to the medical mission context. And when the medical mission context is poorly organized or improperly planned, patient vulnerability is exacerbated even further.

One of the repeated truisms of short-term medical care is “any care is better than no care,” a concept artfully addressed by authors such as Nicole Berry (2014). While the standard of care in Guatemala is low, especially for indigenous, rural, and low-income Guatemalans, that does not absolve foreign medical providers of the responsibility to provide high-quality care—or at least a quality of care on par with what is provided in their home country. As prior scholarship has noted, the standards of who may provide medical care to whom, under what conditions, and using what methods are strict in the United States, but are often loosened while volunteers are abroad, creating a risk for patients (Lasker, 2019). If there is already a poor health care structure in place, and thus the perceived need for STMMs, why, for example, operate on a high-risk patient, knowing that the health context the person must navigate is insufficient, difficult, and discriminatory?

Low-income patients often arrive to STMMs in a vulnerable state. They face a lack of access to health care, language barriers within both public and private health care, low rates of literacy (including the legal literacy needed to know and exercise their rights), and gender vulnerabilities for the majority female population that seeks care in STMMs. These vulnerabilities affect patients in multiple ways—they affect the power dynamic between patient and provider, a patients' ability to understand their health care provider, and they affect the ability of patients to self-advocate.

For example, one woman from Totonicapán arrived at one of the medical missions looking haggard. She came into the providers' room divided by curtains wearing the *traje* typical of the area in Totonicapán where the team provided care. The provider began the intake process, asking the patient if she had experienced any sudden life changes. She signed and said that she had recently returned from the Arizona—that she reached the border with Mexico but had been deported. She was diagnosed with anxiety and gastrointestinal illness, which she had suffered from since making the trip from Guatemala to Arizona. I could only imagine what she experienced on the journey, possessing the intersecting identities of being female, indigenous, and undocumented.

Geographical disparity and access to primary care

Those who are familiar with Guatemala know where to find the poorest patients. The Western and Northern departments are where the bulk of the statistical evidence shows poor health outcomes, gender inequality, geographical distance from health services (and subsequent lack of resources), and income inequality that plague the country.

Most medical mission teams do not seem to make it to the poorest and least accessible areas of the country, despite many claims of doing so publicized on websites and Facebook pages. The poorest regions of the country are the Northwest region (78% of the population in poverty, 39% in extreme poverty), made up of the departments of Huehuetenango and Quiché and the North region (77% of the population in poverty, 42% in extreme poverty), made up of the departments of Alta and Baja Verapaz (Instituto Nacional de Estadística, 2014). Among the organizations I conducted research with, only two of fourteen medical mission organization ever sent teams to Huehuetenango, Alta, and Baja Verapaz. Only two organizations total sent teams into the department of Quiché. Of the organizations that I was not able to work with, two send teams to those areas.

To compare, the two most affluent regions of the country are the Metropolitan region, made up of the department of Guatemala (32% of the population in poverty, 0.6% of the population in extreme poverty) and the Central region, which includes the departments of Sacatepéquez, Chimaltenango, and Escuintla (51% of the population in poverty, 13% in extreme poverty) (INE, 2014). Not including travel or free days—so, the provision of services in the form of consultations, prescribing medications, and performing surgeries, at least eight of the organizations included in the study worked in those two regions.

While there were certainly many teams not included or who declined to participate in the study, there were a notable number of teams that did not venture outside of the two most affluent regions of the country. This perfectly mirrors the existing issue of access to care that plagues rural Guatemalans, both regarding the availability of quality surgical services, providers, and facilities, and consistent, basic services. While there are several regional hospitals across the country, they are mainly situated in population centers—more urban environments, as discussed in the first chapter.

Part of the issue, as stated in the above section of the chapter, is the requirement for surgical facilities to maintain a certain geographic proximity to Ministry of Health facilities. However, when organizations grow sufficiently to consider building their own facilities, few appear in the departments of San Marcos, Huehuetenango, or Northern Quiché—rather, Sololá, Chimaltenango, Sacatepéquez, and Guatemala are peppered with private surgical facilities. As shown in Chapter 4, some organizations do in fact build and run facilities in remote areas, such as the facility on the border between Guatemala and Belize; others devise creative strategies to limit the burden placed upon patients to travel to urban areas to receive medical care, such as providing transportation for patients from their communities to the site of care operated by the VMT.

Language and Injustice

With over twenty-four languages spoken in Guatemala besides Spanish (22 Maya languages, Xinka, and Garifuna), the country is linguistically diverse. In theory, public services such as legal services and health services should allow anyone who speaks an indigenous language to be attended to in their local language (e.g., at the department or municipality-level), but the government frequently fails to provide this right. These services are justified by the Peace Accords of 1996. This document provides *symbolic* guidelines for better access to services for indigenous Guatemalans—the document was never officially ratified, though it was signed by both the URNG and the military (Spence and Vickers, 1998). Considerable debate has followed language justice in the years after the armed conflict, generally resulting in a heavy incumbrance placed on indigenous Guatemalans to self-advocate within systems that continuously disrespect them.

Some STMM coordinators argue that the number of monolingual indigenous language speakers is declining and that there is less need for translation services than in the past, but there are still many isolated communities in which indigenous languages are primarily spoken, and many people of older generations that had limited education in Spanish or limited exposure. This is also a reflection of the pressures for indigenous Guatemalans to learn Spanish and/or prioritize English learning over Maya language learning to participate in the formal economy and civic life (Choi, 2013).

One prior study conducted in Guatemala of Spanish-English translation in the medical context demonstrated the many ways in which communication can affected by a language barrier (e.g., misinformation, informed consent understanding, hesitancy towards asking questions, etc.). While they found significant barriers to effective translation, their study did not address issue of multi-layered translation and the patient population was not identified as indigenous or multicultural (Sceats et al., 2018), which adds significant complexity to the delivery of care.

The lack of language services in indigenous languages in Guatemala is a systematic governmental problem and not just a problem under the purview of medical mission health care. In other words, the lack of proper language representation in medical mission health care mirrors the lack of language representation at the national level-- in the Ministerio Público and in the national hospitals and health care centers that are part of the Ministerio de Salud. However, if STMMs seek to differentiate themselves from existing providers, supporting language justice within the medical mission context is an overwhelmingly critical way to do so.

This lack of language representation cannot be explained simply in terms of ignorance (e.g., that medical mission coordinators and/or team leaders do not know how many languages there are, do not understand or speak the languages themselves), though that seemed to be true in certain cases. Additionally, it seems to be due to the participation and leadership of mostly non-indigenous Guatemalans in the organizations in which research was conducted and that the systematic de-valuation and negligence to provide proper language services reflects already existing national policy and attitudes. Many coordinators were satisfied with indigenous language services being provided by family members of patients, signposting the idea that non-Spanish speaking Guatemalans do not conform to the dominant language of the country and need to in order to access services.

Facets of literacy

The ability to read and write allows people to receive an education, but also to exercise one’s rights. The national rate of literacy for reading and writing is 78% for women and 85% for men (Censo, 2019)—though this number is much lower if investigated by department (especially excluding the Department of Guatemala). Illiteracy hinders someone’s ability to participate in civic life and to advocate for themselves legally. This includes filing complaints, true informed consent when signing documents, and seeking out information about their rights or opportunities.

In the medical mission context, the disadvantages for illiterate patients start early. Volunteer medical teams, when consenting patients, often do so with Spanish-language consent forms. Post-operative forms, if given, are written in the Spanish language. In many cases, illiterate patients lack (among the financial or social factors) the ability to properly consent to treatment, clearly follow post-operative care (in the case of surgical STMMs), file their own criminal complaint at the Ministerio Público or understand their rights as patients and citizens.

One of the other factors that renders medical mission patient populations vulnerable is the lack of health literacy. Ratzan, Parker, Selden, and Zorn define health literacy as, “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions” (2000). Furthermore, “an individual's health literacy capacity is mediated by education, and its adequacy is affected by culture, language, and the characteristics of health-related settings” (Kindig, Pander, & Nielsen-Bohlman, 2004). Considering the common patient characteristics (low education, low socioeconomic status, Spanish as a second language) and the health care landscape discussed in Chapters 1 & 2, it is unsurprising to hear complaints of low patient health literacy and that it impacted care.

There have been only two studies attempting to measure health literacy in Guatemala. In their studies of youth in Guatemala City, Hoffman, Marsiglia, Nevarez, and Porta found that less than one third of the study participants had adequate health literacy (2017) after the establishment of the New Vital Sign as an appropriate measure of health literacy (Hoffman, Marsiglia, Lambert, and Porta, 2015). A lack of health literacy specifically hinders the ability of a patient to fully take advantage of an encounter with a health professional, whether it is a Guatemalan or a foreign volunteer, or to adhere properly to treatment.

In the interviews conducted with coordinators, many emphasized the lack of this basic capacity of patients to both understand what was going on inside their own bodies (granted, from a biomedical perspective) and to make health decisions. Many Guatemalans, especially those living in rural areas, do not have the ability to read the labels on the prescriptions they receive, read and sign consent forms for procedures, read and digest signage in health centers informing them about infectious disease and preventative care (unless adapted specifically for indigenous language speakers and illiterate populations), differentiate medications from one another, or, most importantly, understand the bureaucratic health care system and how to navigate it in order to receive necessary treatment.

While this issue of patient health literacy was often recognized by VMTs, there were not many teams that addressed health literacy as a cohesive issue—one originating in the structural barriers that reproduce poverty in primarily indigenous populations, such as lack of access to education, health education, and positive, empowering experiences in the health care system where patients are primed to learn how to navigate it (like many middle or upper class *ladinos* do experience, especially in private health care settings). This issue was primarily observed in basic services missions, where chronic illness diagnosis and management were more salient and prevalent.

Issues of health literacy often were addressed as discrete ‘fixes,’ such as using memorization techniques with patients to remember their treatment regimen or symbols on pill bags to designate times to take medication, as mentioned previously. Discussed in the following chapter, I will examine further the intricacies of provider expectations for patients; while the ‘volunteer experience’ many VMTs specifically aim for includes treating low-income populations, many volunteers simultaneously are frustrated by patients’ lack of health literacy.

Gendered Vulnerabilities

Although male patients surely face many of the same barriers as female patients, certain aspects of life for low-income and/or rural Guatemalan women disproportionately affect women regarding health. First and foremost, indigenous Guatemalan women in every department of the country exhibit rates of illiteracy lower than their male peers (INE, 2019), a result of the complex economic and social factors that have historically affected women’s access to education, such as gender roles, *machismo*, child marriage and early unions, and poverty (Remedi-Brown, 2013). This likely contributes to lower health literacy in women than men, though there have been no studies so far that specifically study health literacy and gender among rural, indigenous Guatemalans.

Interestingly, while several STMMs offer medical missions that specifically target common medical problems found in women—cervical cancer screening, access to surgical contraceptive options, uterine prolapse surgeries, STI testing and treatment, among others—the intersection of identities that make indigenous Guatemalan women the most vulnerable population in the country is inadequately addressed.

In this research, exact ratios of male to female use of medical mission services were not measured, but there was an observed skew of higher female participation in medical missions than male—across the different types and organizational structures of medical missions in the country. This is most likely due to traditional gender roles that are more rigid and apparent in rural communities; men often are working in the fields or outside of the home, while women still often work inside the home and those who are mothers attend to numerous children. Thus, women have the ability (and in many cases, the responsibility) to take themselves and their children to medical missions, which tend to operate from 8am-6pm. Cultural expectations and norms of masculinity also discourage men from seeking health care (Barker, Ricardo, Nascimento, Olukoya, and Santos, 2010).

The national data on inpatient and outpatient care in national facilities shows the most typical illnesses and diseases treated. In all departments in 2018, overall use of health facilities was 38.7% male, 61.2% female (INE, 2018). Four of the top ten issues treated in public health facilities were specific to women—Cesarean sections, spontaneous births, miscarriage, and uterine leiomyomas. The others include renal disease, gastroenteritis, cholecystitis (inflammation of gall bladder), pneumonia, urinary tract issues, acute appendicitis, cataracts, and lymphoid leukemia (Ibid.). A healthy literature exists on women's experience in health care, including the high incidence of cervical cancer in Guatemala. Specifically, the difficulty of achieving testing and diagnosis (Austad et al., 2018), seeking quality treatment with the national health care system (Chary, 2015), and the social limitations that women face (Chary, Dasgupta, Messmer, & Rohloff, 2011).

Long-term pelvic inflammatory infections and human papillomavirus are contributors to cervical cancer, whose symptoms tend to appear in the more advanced stages of the disease, and later in life. While the topic merits a longer discussion, it is important to note that many women in medical missions that offered women's services did in fact find out that they had PID or sexually transmitted infections, which are risk factors for cervical cancer (Skapinyecz et al., 2003). This was not uncommon, according to the providers.

Differential expectations of fidelity between men and women also contribute to such infections—men who migrate to other areas of Guatemala or to the United States to work come home and infect their female partners or wives (Tasnim et al., 2020). In fact, in one mission, the providers diagnosed a female patient with a sexually transmitted infection, explaining to her that her husband would need treatment as well. The patient, who likely had suspicions of infidelity on the part of her husband, called her husband to explain to him that he would need medication and that he had infected her. The husband, defensive and livid, berated the volunteer medical provider (who spoke Spanish) through the phone. This is only one example of the way in which gender norms can lead to male behavior that produces negative and long-lasting health outcomes for women.

VI. Exacerbating Patient Vulnerabilities Through Common Organizational Policies

While there were distinctions among the different organizations with respect to the details of implementing their organizational policies, among the organizations and missions observed, there were common policies or practices exhibited by most, if not all the teams with whom I collaborated in participant observation. Each practice will be described below, as well as how it can negatively impact patients. This is often either through reproduction of the same systematic discrimination indigenous patients receive through government or private health care or through the unique position medical missions are situated in which they appear able to absolve themselves of the responsibilities to which other permanent organizations or health providers are subject.

Record-Keeping and Documentation of Procedures

While all of the medical teams that participated in this study collect patient records—often several copies—those records are all kept for use by the NGO or the individual medical mission team and not distributed back to the patients. Basic services teams tended to keep paper records[30], while surgical teams were mixed in keeping paper or electronic medical records. Only one team in the study gave patients a document that included basic health statistics and the medications prescribed to the patients. There are several rationales stated by coordinators and volunteer medical providers to justify not providing patients with documentation of their own medical history or care: the documents might seem meaningless to the patients, the environmental impact of producing more paper products that could contribute to pollution, and the cost to print everything and transport it.

However, the assumption that patients will not need or want documentation of their procedures limits the patients in their own self-advocacy in later consultations or health care visits. Almost every time, when patients came into the clinics to be seen by physicians, one of the first questions the providers asked them in triage was if they were

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[30] One basic services team was, however, in the process of migrating their medical record management to an electronic system, Redcap.

currently taking any medications. A few patients would bring in their bags containing every single medication they were taking, with the labels.

But many patients had vague responses, such as "una inyección" (an injection), which could mean something as simple as Neurobión (a Vitamin-B shot commonly administered in small communities at the pharmacy), a strong antibiotic, or a sedative—any of which might have an impact on subsequent medications prescribed to the patients. While part of this might be due to patient lack of knowledge of medications and/or failing to remember the names of the medications they are taking, the practice of medical mission teams labeling medications in English or in difficult-to-read handwriting limits their ability to reproduce this information when asked later on, either in a public health facility or another medical mission (see Hall-Clifford et al., 2017 for further discussion of medical record keeping). Furthermore, providers treating ex-STMM patients for follow-up care must conduct guesswork in order to treat their patient, if the patient was not provided with information about their medication, diagnosis, or medical procedure.

All but one surgical mission provided follow-up care, though the methods for providing follow-up care differed depending on the approach of the mission. For example, the STMM organization that utilized health promoters in different rural communities was able to provide more localized follow-up with patients because the employees of the organization live in the same communities or nearby to the surgical patients. Other STMM organizations, especially those that worked in private hospitals, came to an agreement with the hospital to continue post-operative appointments with patients once the STMM left. One team did not provide follow-up care and instead depended on the memory of the volunteer medical providers, who came regularly.

Apart from the implications for patient-initiated follow-up—that is, the ability of the patient to contact the medical mission team in the event of, for example, an adverse effect of medication or an infected surgery site—there are legal implications for a lack of medical records. If a patient does not have the name of neither the organization that organized the medical mission[31] nor the name of the surgeon or provider who saw them, the patient cannot seek legal recourse for any bodily damage done to themselves or loved ones.

The short-term nature of the care provided by medical teams also ensures that the doctor or surgeon cannot be easily relocated. The lack of documentation and contact information for medical mission patients may be overlooked because of the amount of malpractice insurance required to practice in the United States and the built-in mechanisms providers have for their accountability to patients. Practitioners in the U.S. context are heavily embedded within a medical-legal framework supported by robust laws to protect patients, electronic records, and strict licensing requirements. While the Guatemalan medical-legal framework is inconsistent at best, leaving patients without information is an oversight that needs to be corrected to be truly accountable to them.

Insufficient translators

The strategies that teams utilized for finding translators both for Spanish-English translation and Spanish-Maya language translation varied widely across organizations

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[31] This can become complicated. Many medical missions involve the participation of at least one Guatemalan health providing organization (an NGO or private or public health facility) and a U.S.-based nonprofit—this can range anywhere from a single non-profit that only seeks to send a mission team once or twice a year to a church to a large organization with many employees.

and teams. Many teams had no specific strategy for contracting interpreters at all—bringing along Spanish-speaking volunteers when possible, overexerting bilingual members of the Guatemalan staff, and filling in with last-minute interpreters if needed. While looking at whether teams paid translators or not, around half of teams paid their translators, but this is basic information and does not capture some of the more specific issues in how teams do hire translators or utilize volunteer resources for translation.

Spanish-English translators who were not volunteers or staff in a Guatemala-based organization affiliated with the mission were paid for their work (the one exception being a team who utilized University of San Carlos undergraduate students in linguistics—the students got credit for practice in a medical environment and the team got fluent translators). Seldom did Maya translators get compensated for their work. Only two of the medical missions paid their indigenous interpreters/health promoters, while five paid for Spanish-English interpreters—the others relying on volunteers or their own paid staff who serve other roles. Some indigenous translators did become incorporated into the operational model of organizations bringing medical missions from the U.S.

In particular, one organization utilizes what they call “health promoters” from Achi, Q’eqchi’, Ixil, and Poqomchi’ communities in their paid staff. These health promoters serve three primary purposes. They remain living in their communities in Alta Verapaz, Baja Verapaz, and Quiché and while there, help administer nutritional supplements to the candidates for cleft lip and palate surgeries—often babies under two years of age. When the time comes for the children (or adult patients with different surgeries scheduled) to receive their surgeries in Guatemala City or Antigua, the health promoters travel with the patients to help them get to the hospitals safely and to translate for them with the many Spanish-speaking health providers they encounter in those facilities.

However, most organizations in the study largely rely on family members of patients to translate between Spanish and their indigenous language. While this is widely seen as culturally acceptable because of the close bonds many people have with their families, it can become a privacy issue for the patient receiving care. A Spanish-speaking parent is commonly utilized as an interpreter within surgical missions, especially those dedicated to cleft palate where the surgeries are performed on infants or toddlers. In one community populated by two to three extended families, the organizers of the facility, COCODES (community development committee), and Kaqchikel translators were all from the same family. Because of the perceived difficulty of finding Kaqchikel to English interpreters for the older patients, the STMM utilized community members as interpreters. Which, when considering patient privacy, impedes the comfort level the community members can have in their honesty with the providers, especially when asked the typical intake questions such as: "Do you drink? Do you smoke? Do you use drugs? Are you sexually active?"

While community members are arguably the experts in their own language, without training or instruction to adhere to professional medical norms (e.g., never discussing a patient's health issue with anyone other than the patient and health provider), the level of privacy a patient receives cannot be guaranteed. As the organizers and executors of the health care being provided, it is the responsibility of the STMMs to plan to include impartial and trained Maya language interpreters, of which there are plenty candidates in the region. This is reminiscent of the same attitude found in government facilities, where lack of Spanish proficiency is seen as a patient’s personal issue to resolve rather than the responsibility of the health care institution to mitigate (Chary et al., 2016).

Occasionally, an organization or team had volunteers with indigenous language capabilities that they could call upon to show up on the appointed days and times to help, most often bilingual indigenous professionals or indigenous people who have lived outside of their community for a period of time thus necessitating Spanish acquisition. In one case, there were K’iche speakers in Guatemala visiting from Phoenix, AZ where they lived—they were able to translate directly from K’iche to English, which the medical volunteers evaluated as increasing the efficiency of those interactions with K’iche’ patients. However, the number of trilingual interpreters available to work in medical missions is low and the exception to the rule, despite the efficiency they bring to the medical mission.

The issue of multi-layered translation, from English to Spanish, Spanish to a Maya language, and vice-versa was most evident through reviewing the direct observations between patients, interpreters, and providers. While I am not fluent in all the indigenous languages spoken in Guatemala, I could note a difference in the time dedicated to what was said by a Maya language-speaking patient, the interpretation of that by the bilingual Spanish-Maya speaking interpreter, and what information was delivered to the English-speaking medical volunteer. What I frequently observed was a ‘trimming’ of the story told by the Maya language-speaking patient into a summarized version for the provider.

I recorded 65 direct observations in the clinical context, taking notes for each encounter and noting both the demeanor of the providers, patients, and interpreters as well the basic clinical information of the patients pertinent to the clinical consultation. Twenty-two percent of the consultations required Maya-language interpretation. The average time per consultation for all patients was 14:40 (median 10:27), and for monolingual Maya patients who needed multi-layered translation, the average time per consult was 16:56 (median 15:42). This included all types of consultations, including the pre-examinations for surgery, basic care, and consultations to determine whether patients were candidates for surgery.

Due to issues of background noise and interference in the audio, only 28 direct observations from the study could be analyzed further to study the content and timing of the interactions between providers, interpreters, and patients. Significantly, only 32% of patients, ever asked a question to the provider, such as to request clarification for taking medication, ask about where to go to receive follow-up care, or the long-term implications of their illness. Only two Maya language-speaking patients asked questions in their consults.

The total average time spent speaking by patients was 0:43, while interpreters spoke an average of 1:13, and finally providers spoke for 2:13 per consult; in theory, the interpreters should speak the most, as they represent the communication made by both providers and patients. It is important to note that many consultations involved checking blood pressure or heart rate, leaving "blank" space in the total consultation time where the providers or patients were executing an action and not speaking. Though a small sample, this data confirms the interactions I observed, where interpreters often cut down the content of the little time patients did spend speaking, summarizing rather than engaging in word-by-word interpretation.

The lack of professional Maya interpreters in the STMM context points to a wider systemic problem in Guatemala (language injustice) and shows that even within the medical mission context, the same issues repeat and reflect the perhaps-unconscious biases of non-indigenous Guatemalan coordinators and volunteers. They make little effort to put the STMM organizations' financial resources towards hiring professional Maya language interpreters and seeking professional Spanish interpreters who are trained to work in a clinical setting.

Language injustice replicated in the STMM context is important to remedy not only out of respect for patients, but also for their safety—it is critical for patients to be able to express the details of their illness as well as faithfully communicating the information back to the patients from the providers. While the medical volunteers' reaction to Maya language-speaking patients in the clinical setting will be discussed at greater length in Chapter 6, it is important to note here that U.S. expectations of patient brevity certainly had an impact on medical providers' perceptions about their Maya language-speaking patients.

Inconsistent strategies to assist patients in recalling their treatment regimen and/or medication regimen

Patient adherence to medical treatment is an issue salient to medical providers worldwide and is the subject of plenty of research in the United States. Metanalyses show that patient adherence to treatment programs via their providers do positively impact health outcomes (DiMatteo, Giordani, Lepper, and Croghan, 2002) and "patients with higher levels of health literacy are more adherent to treatment" (Miller, 2016). As established earlier, patients in Guatemala have less access to education, and at least as measured among youth, very low health literacy. Thus, all medical providers, those within medical institutions and in STMMs, are faced with the task of optimizing patient adherence given the low health literacy and the difficulties that this presents.

During the interviews and observations, medical providers showed different strategies for improving patient adherence. In interviews, two coordinators specifically mentioned the issue of literacy and sought to utilize pictures on the plastic bags containing the medications for patients in order for the patients to understand the timing for their medication dosage—e.g., a moon for the medication to be taken at night, a sun for the medication to be taken during the day.

Interestingly, one of the provider-driven strategies noted during the direct observations was to ask the patient to repeat back several times the treatment regimen to the physician before the patient was permitted to leave—a strategy that certainly takes time to execute (rare given the generally "rushed" ambiance of medical missions) but allows the provider to ensure that the patient has properly digested the information given them, also observed as a strategy in prior studies (Sceats et al., 2018). However, there was often variation between teams and within them regarding the strategies utilized to improve patient adherence. The providers who seemed to consider the patients' literacy and health literacy tended to work in environments in the United States where they were exposed to patients with lower health literacy.

Unclear referral path

Some of the patient referral observed in the research conducted highlighted the brokenness of the health care system and the powerlessness that many coordinators feel trying to navigate it on behalf of their patients. One of the most memorable anecdotes was the process by which a coordinator attempted to transfer an eight-year old child who weighed 25 pounds to the National Hospital in Antigua for a blood transfusion and follow-up care. While I did not have the opportunity to sit in on the consultation with the mother, the provider later told me that the mother brought in her son because he was exhibiting pica—eating earth—which indicates malnutrition and lack of nutritional absorption. The physician's assistant strongly suspected anemia, a chronic intestinal infection, and potential damage due to the child's colon due to the parasites. She had seen the child six months prior on a previous mission trip and noted that the child had lost weight—he now appeared the same size as his three-year-old sister. She urged the coordinator of the medical mission to send the child immediately to a national hospital to get the child a blood transfusion and to perform the fecal exams to determine the parasite or organism in the child's digestive system.

I stood with the coordinator as she consulted with the staff of the private hospital in the area we were in; a call to the Hospital Nacional Pedro de Betancourt in Antigua yielded no results. Instead, the physician's assistant (a non-native Spanish speaker) wrote a handwritten letter describing the child's symptoms, what tests she believed the child needed, and her prognosis of the boy over the past six months. The child, his sister, and his mother were sent in a taxi with some sandwiches made by the hospital kitchen to Antigua. A sense of nervousness was felt by everyone; the child's poor physical state was obvious but sending the trio to the hospital in Antigua felt like sending them into oblivion.

The coordinator of this medical mission organization lives in Antigua and planned to visit the child in the hospital with the physician's assistant who tended to him in a few days after the team went back to Antigua for their free days. Beyond that, there was no plan for how to proceed with the child. The only guarantee was that the medical mission team that saw this child relatively consistently planned to go back to the same private hospital in six months and the family lived in the same community as the private hospital.

VII. Conclusion

There is a strong legal basis for foreign medical practitioners in Guatemala to follow the laws and regulations regarding registration of medical providers and approval of health care facilities, in stark contrast to the assumptions made by STMM coordinators and volunteers about the country's lack of a regulatory framework for STMMs and other foreign medical providers. It is true that the implementation of these regulations and how they are supervised is uneven, especially for teams engaged in the provision of basic services who can fly under the radar without experiencing consequences. But the implication for the patients is more extreme in the case of surgical missions, where the lack of registration also means zero recourse for patients.

The factors that place STMM patients in Guatemala into such a vulnerable position are inter-connected and reinforcing. Patients are already incredibly vulnerable if they are within the target population of medical mission teams—often indigenous, poor, uneducated, and female. Structural forces that have been at play for centuries marginalizing Guatemalan's low-income, rural, and indigenous population (further exacerbated when examining the cross-section of indigenous women) characterize patients who, through no fault of their own, can be unfamiliar with biomedicine, marginalized by the health care system itself, and thus without the experience and knowledge that promotes health literacy.

Furthermore, through a lack of education and a justice system that historically has seldom served this population as social and political equals as well as actively lobbying against patient rights, many patients do not know their rights or know how to exercise them. Combined with STMM organizational policies that disregard or directly inhibit the access to information that would make legal recourse possible, patients are left with little to no ability to advocate for themselves. The point is not, in fact, to provide medical services of such a high quality that they are unreproachable; the point is to provide patients with the tools and information they need to seek recourse for the inevitable errors that occur in any mode of health care delivery.

While this chapter primarily addressed clear examples of laws, structural vulnerabilities, and STMM policies that inhibit patients' ability for self-advocacy, it is important to briefly mention the common thread that runs between government policies and STMM organizational policies, which greatly resembles the analysis of the health care delivery mentioned previously. While citizens' rights under a government are often purposely less malleable than programs within social services, such as health care, and thus less subject to policy initiatives such as austerity measures, there is an organizational culture within the sphere of patient rights that mimics neoliberal ideals in Guatemala—specifically, the ideal of consumer responsibility.

That is, the burden is placed upon the patient yet again to know and collect the right information, advocate with the VMT to gain it (e.g., ask for documentation of their procedure), and put forth the economic investment and labor necessary to advocate for themselves legally should an issue with quality of care or malpractice occur. The laws and structure in place first and foremost protect providers and institutions, not patients. This burden seems impossible for someone from a low-income, indigenous, and/or rural background to bear, which is reflected in the relative silence surrounding patient rights in Guatemala. It is imperative that VMTs examine their organizational practices to ensure that not only are patients given the best opportunity to advocate for themselves in the STMM context, but that teams lift the invisible burdens they place on patients.

The Guatemalan Ministry of Health is already dramatically overburdened and underfunded, with lower-level civil servants, nurses, and doctors quickly burning out while not receiving pay. High-level officials attempt to distribute money for the MOH's various programs—half of which has likely already been stolen through widely recognized corruption. At the institutional level, regulating STMMs through the avenues of the Área de Salud and the Colegio de Médicos y Cirujanos does not appear to result in consistent good faith efforts by STMMs to register and stay accountable to their patients. The Área de Salud does not have the resources to properly register STMMs or regulate them by sending representatives to monitor the delivery of health care services. COLMEDEGUA operates as a professional association for health care providers, not an institution committed to protecting the rights and wellbeing of patients.

Thus, at both the individual and institutional levels, short-term medical missions, armed with the upper hand of biomedical knowledge, technology, and the incontrovertibility of good intentions, enter Guatemala to provide medical care that places invisible burdens on both the institutions they interact with as well as the patients. While these burdens are often placed inadvertently, they demonstrate the extent to which neoliberal ideals and views about social responsibility have permeated U.S. medical culture, and culture at large. In Chapter 6, I will further explore the layered contradictions of provider expectations in the STMM context and how these expectations reflect neoliberal health ideology.

CHAPTER 6

COGNITIVE DISSONANCE IN THE CLINIC: COMPETING PARADIGMS OF THE GUATEMALAN PATIENT

The sun was setting, and we were all finally cooling off after a late-in-the-day basketball game. The providers were impressed that the K'iche' and Kaqchikel female employees of the coordinating medical mission organization joined in on the game, running for the ball in their *traje*. Even though the school the medical mission used that day backed up to a mountain, the sun still shone hot on us throughout the nine hours we were there that day—9am to 6pm. We were deep into Nahualá. Even though the mountain seemed devoid of roads, the patients walked from small communities in the mountains and beyond to come see the mission. This time, there were dentists, a big attraction for many folks in this rural area.

We packed up the bus, many pounds lighter from the last of the medication administered that day. Spirits were high on the bus ride back, with volunteers cheering and clinking bottles of Gallo[32] against each other, bumping along the road at a speedy pace. I felt a sense of camaraderie with them—I, too, was glad for the week to be over, to return to my rented room in Antigua, and mostly, to eat something other than a peanut butter sandwich for lunch. I reflected on the week I spent with the team, thinking: *Well, they were a bunch of conservative white people from Texas, but all the offensive things I saw and heard were the kinds of things I expected to see and hear.*

That is, until the objects started flying out the windows of the bus. It was close to the turn-off from the Pan-American highway onto the road to Sololá that the team started

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[32] Guatemala's most well-known beer brand

to throw things out the window. A few volunteers at the front of the bus, noticing the leftover box of small toys and toothbrushes in the front seat, giddy with satisfaction at having completed hundreds of consultations and tooth extractions, started throwing the objects out the window towards people stationed on the side of the road, waiting for their own buses or for family members to arrive home. Soon the whole volunteer medical team was tossing toys out of the right-side windows.

I had forgotten what the feeling of second-hand embarrassment felt like. I imagine my facial expression: eyes wide, face white, mouth open. I quickly looked to the volunteer coordinator, a trilingual, endlessly patient K'iche' man, whose facial expression mirrored mine, expressing, "I don't know what to say, and even if I did, I don't think I would say it." I sank deep into my bus bench, trying to make sure that neither the Guatemalans receiving missile-launched objects, nor the volunteers, could see my obvious shock and disgust.

I knew that many of the volunteers thought that *all Guatemalans* were *so poor* they could not afford to feed their children, buy toothbrushes, or provide a U.S.-approved quantity of toys for their children. But to assume that every random person on the side of the road from Xajaxac to Sololá would want their fluffy keychains, toothbrushes, and tiny plastic junk, and then proceed to smile and excitedly thank them for it was a level of hubris I thought to be merely hyperbole, not something I would see in the flesh.

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I. Introduction

Short-term medical missions are arenas in which different health ideologies, emotions, and expectations constantly compete with one another for dominance. Much of the global literature on short-term medical missions (STMMs) does not examine the connection between neoliberal health ideology and the interactions between providers and their patients. Health care providers come to Guatemala with expectations for patients that are often contrasted with U.S. patients—Guatemalan patients, especially those from rural environments, are expected to be passive, humble, grateful, and obviously and deeply materially lacking. While several authors have examined these expectations for humility and gratefulness (Berry, 2014; Roche et al., 2018) or the burden placed upon patients from the health care sector at large in Guatemala (Chary & Rohloff, 2015), this analysis explores the above expectations from the lens of neoliberalism in the STMM context. Patients are perceived to be responsible for their health care and making rational decisions in the 'market' to which they are exposed, despite the barriers to health care that volunteers may or may not see.

Secondly, this analysis expands upon the concept of cultural health capital—that "certain socially transmitted skills and resources are critical to the ability to effectively engage and communicate with providers" and, summarizing the original work of Bourdieu, "contributes to the accumulation and exercise of power and the maintenance of inequality" (Shim, 2010, p. 2). Paradoxically, in the context of the medical mission, patients must both meet the idealistic expectations of passivity, humility, and material deficiency while also demonstrating that they can be "good" patients—able to understand and abide by the authority of the medical providers, know what information to provide, and communicate effectively—and above all else, subscribe completely to Western biomedical principles. These expectations are set despite the inadequacies of the education and health systems here that often do not allow them to develop the skills and resources required to achieve cultural health capital.

Volunteer medical teams do not just bring their expertise and supplies with them to conduct a short-term medical mission. They also bring together two seemingly contradictory orientations towards health—the neoliberal health paradigm and humanitarianism. However, the neoliberal health paradigm and the humanitarian approach to health in the STMM context are complementary based upon both approaches' wholehearted embrace of individualism: while neoliberalism focuses on the individual's navigation of a world that is supposedly fair, the humanitarian recognizes that the world is unfair, but seeks to show that individual interventions can fix it. This chapter will explore these assumptions and the paradoxical expectations of STMM patients through the thematic analysis of interviews, participant observation, and direct observation data.

II. Neoliberal Health Ideology in the Volunteer Health Providers' U.S. Context

While neoliberalism in health care in Latin America was discussed in-depth in Chapter 1 and abides by many of the same principles in the U.S. context, it is important to distinguish the ways in which a neoliberal health ideology has manifested in the U.S. context from which STMM volunteers originate. Neoliberalism is conceived as having been born in the U.S. by right-leaning theorists and applied to the Latin American context via international loans, followed by structural adjustment measures that allowed wealthier nations to promote advantageous agendas in those countries—though other interpretations of neoliberalism exist as well (Connell and Dados, 2014). This is the health care context of U.S. volunteer health care providers during the 50-or-so weeks of the year in which they are not volunteering in Guatemala or another country.

Keynesian economic policy, enacted in the post-WWII period, focused on government regulation, “progressive taxation, new social protection programmes and sharp declines in income inequalities” (Labonté & Stuckler, 2015, p.312). During this thirty-year period, population health in the United States improved with widespread vaccination campaigns, increased public spending on health, the advent of birth control for public use (Szreter, 2003), and social change that contributed to the improvement of the health of populations of color. The Civil Rights movement, when considering its effect on health care, most importantly ended the segregation of health care facilities, but it also empowered black Americans, including efforts to promote community health by organizations such as the Black Panthers (Hoffman, 2002; Brown, 2016).

Once segregation was over (including the segregation of schools, health services, and other social services), public investment into social services meant public investment into black Americans, something that many wealthy and poor white Americans opposed, especially in the American South. Austerity measures meant divestment of social services that benefitted blacks and framed them as a white burden, including health care; privatization allowed for wealthy whites to segregate themselves in a way that did not outwardly appear racist (Hohle, 2015; Borst, 2021). Furthermore, the de-emphasis of citizen entitlement to state social services and the promotion of philanthropic or charity delivery of services allowed the owners of material wealth in many communities to choose beneficiaries determined to be deserving of aid.

In the 1970s, the U.S. faced an economic downturn, which included economic stagnation and inflation (referred to as ‘stagflation’), for which the ‘poor,’ often coded as ‘people of color,’ were to blame (Crawford, 1977). While neoliberalism is often presented as an ideology that stems primarily from an economic perspective (as ‘the science of money’), it in fact is just as deeply rooted in political and social beliefs. ‘Social entitlements’ to the poor and working class in the welfare state and progressive tax reform were the easy targets of blame, representing a complex set of factors that led to economic stagnation and lowered profitability during that time (Connell & Dados, 2014).

The primary points of current neoliberal health ideology are based in market capitalism—that consumers (in this case, patients) will benefit from a less-regulated market by exposure to the best quality options, which naturally occurs when the market is allowed to flourish with unfettered competition (Maskovsky, 2000). Patients, in theory, all enjoy the same access to information and ability to interpret it. Within this framework, intervention by the state is perceived as inefficient and infringing upon the freedom of the vendors (an emphasis on private health care providers) in the market (McGregor, 2001).

Brown points to the “economization” of society following the period of the 1980s-2000s, when all aspects of society were reduced to their value as viewed through the lens of economic efficiency and prosperity (2016). She states, “When democracy undergoes the economization of state, society and subject specific to contemporary neoliberal rationality, these terms and practices are transmogrified. They lose their political valence and gain an economic one: freedom is reduced to the right to entrepreneurial ruthlessness and equality gives way to ubiquitously competitive worlds of winners and losers” (Brown, 2016, p.1).

Social services, including state-funded health services, are thus framed as charity acts provided to the fraction of the population who have not achieved economic prosperity—failures of the system who, in popular mythology, are often thought to be people of color or immigrants, though national participation in government assistance programs demonstrates a contingent of low-income white beneficiaries, too (Thomas, 1998; Hao, 2007; Foster & Rojas, 2018). Austerity measures and federal funding cuts to health care, de-regulation, and the decentralization of services (a shift to state responsibility) show a turn towards healthcare as individual responsibility rather than a human right and mutual responsibility (McGregor, 2001).

The turn towards neoliberalism in the U.S. context has altered the cultural meaning of health: it is used a cultural marker to communicate a person's worth (Defossez, 2016). The ideal health citizen is "an individual who is able to engage in self-discipline and ethical self-examination and reflection. In doing so, she or he achieves the objectives that the state envisages for developing and maximizing the potential of its population" (Lupton, 1999, p. 289). This emphasis on personal responsibility towards health conceptualizes the body as a tool to achieve neoliberal ideals: live longer, produce more, and consume more.

The logic of neoliberalism applies to the STMM context and has been observed in some studies of U.S. medical missions, often referred to as mobile clinics. Recipients of local medical mission services are often framed as failed consumers and, due to their lack of economic prosperity, are demoted to passive receivers of care without the right to question the quality of care (Rivkin-Fish, 2011). So et al., acknowledge that clinicians working in environments with low-income patients in the United States need guided experience and training with these populations in order to develop empathy for patients and improve treatment outcomes in the mobile clinical context (2020).

III. The 21st Century Patient: Informed, Empowered, and Compliant

Doctors have long been praised for their contributions to health, steadily earning a position of privilege in most societies—one where they are respected as knowledgeable, noble, and working for the public good. During the period of the 1700s-1900s, doctors rose in status and claimed a role of privilege in accordance with the standardization of medical education, better technology, and transformation of hospitals to centralized places of care (Starr, 2017). Later on, aside from claims of "quackery" at various points, the medical establishment remained impervious to serious critique of its power and privilege for much of the 20th century (Widder & Anderson, 2015). In the Post-War period, health altered from what was once an individual concern to a public concern, with the dramatic expansion of the federal government and public health beginning in the 1940s (Ristic, Zaharjivec, & Milicic, 2021; Manchikanti, Benyamin, & Hirsch, 2017). Surgeons have gained a particularly high perceived prestige among the hierarchy of medical subspecialities (Norredam & Album, 2007).

Michel Foucault, in his analysis of medicine-at-large, *The Birth of the Clinic: An Archaeology of Medical Perception,* formed one of the central and still-pertinent critiques of medicine. While the professionalization and scientification of medicine augmented the status of physicians as 'sages' and special interpreters of the language of the human body, it simultaneously subordinated patients and separated their physical bodies from their personal identities; this subsequently produced the field of power where such interactions take place, known as the ‘medical gaze’ (1963).

Ristic, Zaharijevic, and Milicic offer further logic to explain this divorce of body from patient: the widespread reliance on autopsies and cadavers for establishing knowledge about medicine. While understanding the geography of the body is paramount to our modern understanding of disease, it is interesting that the act of the physician dissecting a person’s body after death was often seen as a more reliable account than the patient’s. The focus of the interaction was not the patient, the person inhabiting the body, but the disease—a silent, common enemy (2021). Good & Good found contradictions in the medical education of physicians, where they were both expected to develop empathy and ‘caring’ for patients while simultaneously examining the patients through the ‘medical gaze,’ focusing principally on their ‘objective’ physiological state (1989).

The medical gaze fits neatly into the current health care paradigm of neoliberalism, forming a symbiosis of the power of medical authority and the burden placed on patients, who must make the ‘right’ health choices irrespective of their socioeconomic status, access to education, or an ethnic identity that makes them demonstrably more vulnerable to discrimination in health care (Robertson, 2019). Patients are reduced to being simply occupants of their physical bodies, erasing the above aspects of their identities and obliging them to conform to medical authority regardless of their uniqueness or the circumstances that affect them (Hsu & Lincoln, 2007). Medical authority becomes reinforced as patients without access to resources “fail” repeatedly, are labeled “difficult,” and become further marginalized (Spencer, 2018).

Patient compliance was first introduced as a concept in the 1970s; after so many new live-saving drugs had been developed, practitioners began to observe that their patients did not always follow the treatment regimens laid out for them (Blackwell, 1973). Thus, the concept of patient compliance to understand why patients were not following the directives given to them began to appear in the medical literature, coinciding with the neoliberal turn in healthcare (Eraker, Kirscht, and Becker, 1984).

The patient, in the contexts described in early patient compliance literature, is always subordinate to the medical practitioner and at the end of a unidirectional interaction (Defossez, 2016), and is personally responsible for their own outcome. "The fundamental conceptualization of compliance" is "deviant patient behavior" that can be remedied by unquestioning adherence to directives made by physicians (Spencer, 2018, p. 172). Other authors have connected the concept of patient compliance to larger conversations around biomedical hegemony and the portrayal of patients who do not comply with biomedical norms as 'undisciplined' (Brown & Baker, 2012; Keshet & Popper-Giveon, 2018).

'Cultural health capital' becomes the currency by which patients distinguish themselves as worthy to medical providers and allows them to leverage themselves and engage effectively with them (Shim, 2010). Cultural health capital includes "linguistic facility, a proactive attitude toward accumulating knowledge, the ability to understand and use biomedical information, and an instrumental approach to disease management" (Ibid, p. 2) which aligns with neoliberal paradigm of individual responsibility and self-maximization to achieve health. While health literacy and self-efficacy are aspects of cultural health capital, the term also acknowledges "how such skills and resources offer direct, indirect, symbolic, and instrumental resources in healthcare interactions" (Madden, 2015).

This term is especially applicable when studying differential health care treatment among marginalized populations, such as ethnic minorities and immigrants (Næss, 2019; Madden, 2015; Sudhinaraset, Treleaven, Melo, Singh, & Diamond-Smith, 2016), prisoners (Novisky, 2018), and substance users (Chang, Dubbin, & Shim, 2018). When seeking healthcare, patients from marginalized communities must contend with stereotypes about their identit(ies), lack of access to healthcare due to geographic location, cultural and linguistic barriers, and low socioeconomic status—all of which can both affect the way the medical provider treats them and their ability to follow the treatment regimen outlined by their provider (Madden, 2015).

While health care providers are not a monolith in their adoption or rejection of neoliberalism and its offshoots, this is the healthcare context in which they work—and one that still battles with systemic discrimination, made especially evident in the United States during the Covid-19 pandemic (Devakumar, Shannon, Bhopal, & Abubakar, 2020). Neoliberal values permeate health care institutions, influencing the way providers orient themselves to their patients and conceptualize the roles played by patient and provider. The same health care providers then travel to other countries like Guatemala with drastically different cultures, economies, levels of social and income inequality, and health care systems. Complex expectations of patient gratitude in Guatemala govern the established giver-receiver relationship between provider and patient, showing that the preferred patient is a silent patient—at least when it comes to criticisms of STMMs' work (Roche et al., 2018).

The same attributes that make the low-income patient population of Guatemala the target receivers of short-term medical mission care also make them least likely to exhibit cultural health capital in the Guatemalan biomedical context, though patients may learn to exhibit it in order to receive care. Prior research has touched upon the evident discrimination within the public and private health sphere in Guatemala affecting the indigenous population (see Berry, 2008; Burton, 2012; Ceron et al., 2016; Chary et al., 2016; Samuel, Flores, and Frisancho, 2020). As established in Chapter 5, patients often do not have high health literacy, and some monolingual Maya language speakers struggle in a Spanish-dominant bureaucracy and health context. Finally, Maya traditional medicine is a common form of complementary and alternative medicine, especially in rural contexts (Hoyler et al., 2018).

I argue that the setting of expectations of patients, the lived experience of running the medical mission, and the subsequent ‘failing’ of patients to exhibit the desired cultural health capital of providers is a necessary element of the continued justification of short-term medical missions to Guatemala. Short-term medical missions prime volunteer medical providers to value individual engagement and problem-solving on behalf of patients, embodying neoliberal beliefs about the power and agency of the individual while simultaneously reifying the “Guatemalan patient” as a stereotypical disempowered object. When Guatemalan patients demonstrate their lack of cultural health capital, which generates frustration and disapproval, volunteers feel further called to action, justified by their experience with patients. STMMS are the perfect stage for the neoliberal health paradigm to flourish: individuals with privilege have the opportunity to demonstrate the impact they can make, while individuals experiencing every structural vulnerability constantly prove their unworthiness as users of biomedical care and justify external intervention within the context of limited national health resources.

Initially, I sought to understand characterizations of patients from the vantage point of cultural competence; that is, to tease out the information that U.S.-based coordinators do know about the Guatemalan patient population, and among Guatemala-based coordinators, to understand their position as cultural intermediaries, privileged enough to have access to education, English classes, and interactions with foreigners, but who are distinct from U.S. coordinators, with whom they do not share nationality and culture.

However, many of the coordinators, team leaders, and providers in the medical mission context are often still trying to figure out who the patients are, and the objectification of patients that often comes part and parcel with engaging in medical missions discourages providers from engaging in any real reckoning with their own biases or assumptions about the patients. As echoed in prior literature, the act of charity, intrinsic to the popular understanding of the medical mission context, can shut down the challenges that patients who wield more power in the physician-patient relationship in the U.S. context can offer (Berry, 2014).

U.S. medical providers know enough about the patients to pity them, but by becoming objects of pity, their individuality is erased and they occupy the role of passive receivers of care—easy to be idealized in the abstract. But in the conscious interactions with the providers, they notice the flaws of patients and, because of a medical culture that values cultural health capital in patients, then characterize them negatively.

The Guatemalan health landscape embodies neoliberal values, characterized by its perhaps extreme emphasis on patient responsibility and individual burden, with little space to consider cultural competence due to the structural limitations and discrimination at play. In Guatemala, the middle and upper class primarily use private health care services, while the low-income population uses national health care services marked by few resources (and thus, side costs for patients that drive up the expense for low-income patients even within the public health care setting). NGOs provide free services but must be sought out by patients and cannot always offer continuous primary care.

The medical mission is presented as a single healthcare opportunity—whether the team visits one a year, twice per year, or more. As discussed in the prior chapter, the mechanism by which patients can hold providers accountable is severely limited. Thus, the framing of medical missions as 'something to be taken advantage of while it lasts' rather than a concrete, reliable source of health care, combined with the lack of accountability, makes this a space where concerns of patient experience are considered through the lens of charity rather than a systematic means of controlling the quality of care in the market.

While conducting the research, I noticed few intentional efforts to deliver cultural competence training, but I did notice wildly different characterizations of patients in the abstract compared to characterizations of them in the context of care. I chose to analyze this data using a framework that assumes two truths can co-exist. The participants in power within this medical mission space—coordinators, team leaders, and providers—exhibit dissonant concepts of the patient: a concept of the patient as worthy and justified to receive free medical care, *and* the view of a patient who is undeserving and fails to meet expectations.

IV. Characterizations of Guatemalan Patients Prior to Clinical Care

During semi-structured interviews with coordinators and pre-clinic participant observation time with providers (e.g., the first night the team is in Guatemala, but has not yet started clinical consultations or surgeries), I asked participants (both based in the United States and Guatemala) some iteration of the question, “What are Guatemalan patients like? How would you characterize them?” Many of the answers, as I soon found out, both reiterated findings from previous scholarship and furthermore clearly indicated an idealization of the patient that, while expressed in a positive way, bore no resemblance to humans that actually exist.

This data was analyzed thematically, falling into a few primary dimensions: passivity, obvious poverty or marginalization, and otherness—that patients were exotic and different compared to coordinators and providers, who, aside from one Guatemalan STMM coordinator, were all non-indigenous. Patients, in the popular mythology of these short-term medical missions, were universally, humble, grateful, materially lacking, and suffering in easily identifiable ways, making them the ideal objects onto which volunteers could project expectations—at least until the coordinators and providers interacted with them in real time.

While no mission I observed treated a patient population composed of entirely indigenous patients or entirely *mestizo* or *ladino* patients, the expectation of STMM coordinators and providers was to interact with indigenous patients. Some coordinators and providers who had prior experience with Guatemala knew about Maya traditional medicine, characterizing it as exotic or superstitious, rather than its own health paradigm that serves an emotional, spiritual, and practical purpose.

Humility and gratitude

Prior to delivering care, patients were unanimously painted as grateful, confirming prior scholarship (Roche et al., 2018). Medical mission volunteers acknowledged the limitations of their work, especially those in basic care missions, expressing some variation of the quote below:

> “So I think the biggest thing that we talk about is just how humble the people of Guatemala are, how even if you're not a doctor, they'll call you "doctor" in the missions and how it's like if there is something that we're not able to help them with, they'll still be so thankful for our time, for our services” (Am_Coord_6)

However, I noticed that this characterization was often accompanied by negative characterizations of U.S. patients. Providers, when I asked them in unstructured time such as on bus rides or at breakfast what it is like to practice in Guatemala, characterized U.S. patients as “impatient” and “ungrateful,” in contrast to Guatemalan patients who were “humble” and “grateful.”

One ER physician described the difference, in his opinion, between Guatemalan and U.S. patients. He described it as difficult to return home after mission trips because he perceives patients in the U.S. to be impatient and ungrateful, but patients in Guatemala are grateful and will “wait in line all day without complaining.” A team leader from a different group differentiated between Guatemalan patients and U.S. patients in terms of sincerity—he said that U.S. patients exhibit “fake gratitude” after receiving health care services, while Guatemalans show “genuine gratitude.”

“Poor”—but in a desirable way

STMM coordinators and medical providers all expressed the desire to help the poor via medical missions, though the understanding of poverty in Guatemala and its context was highly variable. The “poor but happy” characterization was echoed across several missions, with many U.S. volunteers praising Guatemalans for having happy families despite being poor. One volunteer offered an idyllic interpretation of poverty, praising them for being “happy to work” and that “they don’t know what they don’t know”—referring to the blissful ignorance she imagines the rural poor to demonstrate regarding worldly possessions.

Many expressed a desire to help the ‘right’ kind of people—noticeably without material wealth or possessions.

> “That makes them [the volunteers] feel good that they know that they're helping the right people. It's not like you're coming to Guatemala City and you set up a mission and you know that you see people coming in with Beemers or you see people with their iPhones or you know these are people that they can afford going to a private hospital where they can get the care that they need. We focus on the people that are making a dollar a day.” (Guate_Coord_4)

One of the team leaders for an orthopedic team performing knee and hip replacements lamented past instances of receiving IGSS (Social Security) patients for surgeries or patients who reportedly bribed hospital staff to be put on the list to receive surgeries. The organization at the time was considering methods of verifying the income level of patients as to only perform surgeries on indigent patients. Upon discovering a patient is not poor, he said, “If Dr. *X* finds out, he reschedules or cancels.” While describing this internal guideline, the team leader never explained exactly what makes a patient sufficiently or insufficiently poor to receive a surgery, but rather offered anecdotes as exclusionary criteria. One example he offered was a patient screened for surgery saying they had no money, who at the time of discharge was picked up from the hospital in a Mercedes, to the irritation of the volunteers helping the patient exit.

While the desire to offer medical care and surgeries to patients who do not have financial resources is understandable, the route to verify income can be problematic. Firstly, while many U.S.-based coordinators and providers know that many people in Guatemala are ‘poor,’ they simply do not know enough about the complex web of poverty, inequality, migration, debt, employment, and how some of those factors interact with health care to make judgments about the worthiness of patients to receive care. One coordinator exemplified this by explaining her disdain at poor people’s spending:

> “In our little village there's a swinging bridge that we can walk to and you walk through a long path where there's just house after house and you can see people living with their chickens and their pigs and their kids and um, cell phones and satellite tv. Dirt floor and satellite TV, doesn't make much sense.”

For example, 70% of the Guatemalan labor force works in the informal sector, meaning that they are ineligible to receive social security through the Guatemalan Social Security Institute (Banguat, 2019). This also means that those working in the informal sector do not have contracts, job security, or any guarantees to their income if they lose their jobs. While someone may appear to be economically secure, many Guatemalans work informally and experience economic precarity or depend on inconsistent remittances from family members or spouses in the United States. Additionally, 20% of the population was estimated to experience food insecurity in 2021 (SICA, 2021).

Secondly, the concept of being "poor enough" pressures Guatemalans to perform poverty in a socially desirable way. For example, one STMM participant explained to me how reluctant one of the teams was to operate on a teenaged boy injured in a gang fight in Chimaltenango, the subtext being the boy's implicit gang membership—membership to a gang that was likely founded within one of the prisons in the U.S. system of mass incarceration of Black and Latinx people (Rodgers & Muggah, 2009; Wolf, 2010). This distinction detached the boy from his context, ignoring the violence that often accompanies poverty in Guatemala (Lesniewski, Kang, Qin, & Helmuth, 2021).

Demanding desirability from patients strips them of their humanity and removes them from their own context, hearkening back to the idea of "culture-free care" within the medical mission—a myth. Poverty motivates people to do what they need to survive, but they do not become less human or less deserving of social and health services than those in the middle or upper class, who have the luxury of broader decision-making.

Marginalization as identity

The characterization of Maya patients was complex. When I interviewed coordinators and team leaders, they spoke both complimentarily of Maya patients while also considering them to be uniformly poor, disempowered, uneducated, and fertile. While many indigenous communities do experience poverty, disempowerment, lack of educational opportunities, and high fertility, I observed the merging of indigenous identity with poverty. STMM coordinators and team leaders likely do not do this consciously, but conflating indigeneity with poverty reinforces negative stereotypes about indigenous Guatemalans and overshadows the efforts of indigenous activists and leaders to fight discrimination and achieve better socioeconomic representation.

One *ladino* Guatemalan coordinator summed up his perception of the indigenous experience in Guatemala:

> "To anyone who is indigenous, the whole world is going to discriminate against them. Well, the majority, not the whole world. But the majority of people will discriminate against them. Because they feel superior, because "those ones are Indians." And that the Indian is ignorant, is dirty, is poor, is ugly, is short. So, "we're better than that" and that gives them [non-indigenous Guatemalans] the right and I hear of so many people working who are discriminated against because they're "Indians." (Guate_Coord_7)

The coordinator was clearly trying to express acknowledgement of discrimination and the historical inequality that indigenous Guatemalans have experienced. But here, the indigenous identity is integrated with suffering and discrimination—conceptualizing suffering and discrimination as a defining characteristic of being indigenous.

One team leader, when we spoke about Guatemalan patients, offered an iteration of the "poor but happy" trope (Crossley, 2012). She is complimentary of what is her perception of Maya culture: she says they respect elders more in Guatemalan than people do in the United States and they are "happy to work." And when it comes to poverty, "they don't know what they don't know"—in other words, they are unaware of how much they do not have. If anyone is acutely attuned to the difficulty of providing for oneself and their family, it is probably an agriculturalist living in rural Nahualá.

With one team, morning meetings while eating breakfast served as the appropriate time to pray together, share stories of successes, and review important reminders for the day. During the first morning session with the team before accepting patients, one of the translators, a *ladina* Guatemalan who had spent time living in the United States, got up to explain what it meant to be an indigenous woman. She described a patient from four years ago, who had needed a hernia repair and was operated on by the team. She characterized Maya women as becoming "baby-making machines,' often losing out on educational opportunities or career advancement because they are indigenous.

A different team leader, a white woman from the U.S., also chose that language when I interviewed her prior to accompanying her team on a basic care mission:

> "This is what I call my "baby-making village" because everyone--I was the only woman in that room who did not have a child on her back and one on her breast." (Am_Coord_7)

This is troubling for two primary reasons. First, that indigenous women are portrayed as drivers of fertility independent from men—neglecting the complex gender expectations placed upon women, lack of access to contraception, and sexual assault that occurs both within and outside of formal unions (Sieder, 2013). Second, the particular word 'baby-making' connotates sexual activity—and differentiating Maya women as any more sexually active than any other group of women in the world contributes to the exoticization of them.

Non-biomedical health ideologies

One of the commonly mentioned characterizations of Guatemalans, especially indigenous Guatemalans, was the adoption of non-biomedical disease etiologies and interventions and their inferiority to Western biomedicine as the dominant health paradigm. These etiologies and interventions are framed as quirky and not threatening to the ‘correct’ health paradigm, Western biomedicine. Often, cultural constructs of distress (CCDs) or other aspects of traditional medicine were referred to as a ‘superstition’:

> “But I don't know what the midwives know. It would be interesting to know what they know. I know that there is among Mayans, there's a lot of superstition too.” (Am_Coordinator_9)

In this quote, the coordinator connected midwifery to the Maya, and the Maya to superstition, as well as orienting the knowledge of Maya midwives as otherworldly or secretive. Midwifery practices among the indigenous population of Guatemala have served the Maya for much longer than government services—for hundreds of years. Midwifery practices were put on the radar of national health services and thus, examined under the spotlight of government bureaucracy during the last 50 years (Maupin, 2008). The following excerpt is of an American coordinator based in Guatemala who describes some of the culture-bound syndromes that affect Guatemalans:

> “You have to be very sensitive to many of the superstitions and some of the Mayan traditions that they may have and even ask what sort of remedies they've already tried, and if those have helped or not. You hear some crazy things sometimes about what they've tried to get rid of the frog they've swallowed… We would talk about things like evil eye, where parents believe that their baby might

> get looked at the wrong way, and that could be the cause of their illness. Or the fact that someone is trying to steal their soul, that kind of thing. We talk about the superstitions and how those are part of even the faith of the Mayan people."
>
> (Am_Coordinator_3)

While cultural constructs of distress such as evil eye are relevant for those within the culture, to many coordinators and providers, these afflictions are superseded by the 'correct' Western biomedical care provided by VMTs. This coordinator, while well-versed in what some of these traditions might be, culturally gaslights[33] the traditions, calling them 'crazy' or 'superstitious.' While most Guatemalans do have access to biomedical care, at varying degrees of quality, the emphasis by VMTs on traditional medical practices serves as one of the justifications of their work with an exotic population. That is, if there is believed to be no acceptable health care, or erroneous beliefs on the part of the patient population, STMMs offer a crucial and correcting set of basic services or surgeries.

When juxtaposed, biomedical etiologies and interventions won out against acknowledging CCDs. One patient came into a STMM in Totonicapán complaining of symptoms of *susto,* translated directly as "fright," but in this context referring to the experience of a traumatic event. The young man, who was eighteen, had been robbed at gunpoint in Xela while on his way to work on a Friday six months prior. He complained

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[33] *Racial gaslighting* is "the political, social, economic and cultural process that perpetuates and normalizes a white supremacist reality through pathologizing those who resist" (Davis & Ernst, 2019). A similar term, *cultural gaslighting*, was created by feminist Latinx scholar Elena Ruíz, applying similar criteria to the treatment of indigenous peoples in North America: cultural gaslighting is "the social and historical infrastructural support mechanisms that disproportionately produce abusive mental ambients in settler colonial cultures in order to further the ends of cultural genocide and dispossession." (Ruíz, 2020).

of headaches, pain in his throat, trouble sleeping, and a sense of extreme fear each Friday that he had to go to work. While the provider was attentive to the patient, she ended the consultation by prescribing him Benadryl as an off-label antidote to the sleep problem. She did not disparage the young man for describing his condition as *susto*, but rather than investigate further, or ask the Guatemalan provider in the group for assistance, she treated the symptoms of the condition with a biomedical solution.

V. Provider Characterizations of Guatemalan Patients During and After Care

While the pre-clinical characterization of patients tended to be idealized and positive from the perspective of coordinators and volunteers, the actual experience of providing medical care to the patients resulted in more objectification, frustration, and negative characterizations. Additionally, as a foil to the humble, passive, and grateful patient, many coordinators and providers, once surgeries commenced or basic services were provided, began to share more characterizations of patients as difficult, greedy, or committing the cardinal sin of neoliberal humanitarian natural law: becoming overly reliant on the 'charity' provided in medical missions.

Patients divorced from their socioeconomic context

Sometimes, in the clinical context, providers divorced the patients from their socioeconomic contexts, treating the body rather than the person. For example, in an urban mission in Guatemala City, a female patient walked into a chaotic clinic space composed of three providers, their interpreters, and me, within a squared space of about 20 feet by 10 feet. She sat down, and the provider began asking her basic questions, one of which was, “Has anything eventful happened to you recently?” She lifted up her shirt to show a scar.

“Here is where I was shot a few years ago.”

She turned her head to the side, lifting her bangs. “And here is where I was hurt last week. A few men attacked me while I was walking home.” She did not cry and described her wounds matter-of-factly. The provider expressed her concern, then continued asking her questions about her health. She stated that she felt numbness and tingling in her fingers and toes. The provider told her she need to take a test to measure her level of blood glucose. The provider pricked her finger, then told her to wait outside the room while she took the test to the laboratory space.

She got the results, and looked to me saying, “Poor thing, she’s already been through so much. She has diabetes.” She ushered the patient back into the room to deliver the news. While this woman had bravely maintained her composure while showing the provider her gunshot wound and evidence of her recent assault, the diabetes diagnosis was too much. She began to softly sob.

“So, we’re going to start you on a medication called Metformin, which will help you regulate your blood sugar. But you really need to try and get as much exercise as you can. Do you like to walk outside? That’s a great low-impact activity.” I tried to contain my shock. Was she not listening? Did she not understand that this woman likely fears for her personal safety as soon as she walks out the door? And she suggested *walking outside in her neighborhood?* The patient’s expression melted into defeat.

While the provider surely meant well, dispensing the same advice she had dispensed with hundreds of primary care patients in the U.S. before, it was more than just a misjudgment of context. It was the same expectation that repeats through similar interactions all the time: the patient must mold their life, demonstrate their will, and dedicate themselves to the treatment regimen assigned by the provider, not the other way around. There was no room for the provider to adjust her expectations for the person in front of her, and the universally accepted behaviors and treatment regimens for the patient did not coincide with the local reality she faced living in a dangerous area of Guatemala City (Yates-Doerr, 2015).

One provider in a basic care mission, with over fifteen years of experience volunteering in the country, instructed the nursing students working under her in the pediatric area to not give out many vitamins. She stated that with young children and their parents, it is better to provide education—that is, explain the basics of pediatric nutrition, emphasizing a better diet and limiting sugar. She said, “I’m tired of handing out vitamins to people who won’t eat correctly.” Both malnourishment and over nourishment are relevant nutritional issues in Guatemala, both of which are deeply intertwined with poverty (Yates-Doerr, 2015).

While the provider offered suggestions of vitamin-rich foods that are also cheap, malnutrition in children was explained as the failure of the parents to provide and cook nutritious foods, a framing that could further stigmatize parents and neglects the complex factors that lead to childhood malnourishment (see Sellen, 1999). Even a provider with that much experience in the country could not rectify her beliefs about the patients as agentive actors in their health care landscape and the realities of their socioeconomic context.

Patients as difficult

The pre-clinical phase of the trips, often 1-2 days, was often full of positivity and energy, but by the middle of the week, I observed produced more negative characterizations of patients. While it may be tempting to justify some of these characterizations as the product of tiredness and stress, my position is that the care environment at mid-week most resembled the volunteers' normal work experience—providing medical care to low-income patients in hot, crowded settings without the glimmer of pre-trip idealization. Thus, providers expressed views that closely mirror the perceptions of low-income patients by those in the medical community in the United States throughout the last forty years (Price, Desmond, Snyder, & Kimmel, 1988; Larson, Colangelo, & Goods, 1998; Chirayath, 2007; Moskowtiz, et al., 2011). They use the narratives that they are familiar with—patients are difficult, greedy, abusers of the system, and abusers of the 'system.'

For basic services teams, listening to patient stories often becomes repetitive—something I validated through my direct observations with providers and patients. Gastritis, chronic headaches and backaches, urinary tract infections, and hernias were abundant. I observed one of the nurses working in triage in a medical mission in Nahualá, who sternly asked patients to describe their primary motive for arriving at the medical mission. The services provided in this mission were medical consultations and medication, dental hygiene and extractions, and basic eye examinations.

The patient, a monolingual K'iche' speaker looking to be in her late forties or early fifties, explained her symptoms as a complete story to the K'iche-Spanish interpreter—the beginning of her symptoms, feeling sick with diarrhea, and explaining why she arrived that day. The interpreter summarized the explanation, saying, “She came because she has diarrhea.” The nurse turned to me and commented snarkily, “it took her that long to explain that she has diarrhea?” This method of storytelling in the medical setting is widespread and characteristic of many Maya ethnolinguistic groups (Harvey, 2013), but to the provider, the patient had not lived up to the expectation of being efficient.

One U.S. coordinator showed contempt towards patients who expressed doubt about patients who have removed their gallstones during the surgical mission she ran in a rural community in Chimaltenango. She explains the practice of delivering to patients their gallstones after their surgeries:

> Although these people, like we give them their gall stones. Okay, because they're miserable afterwards. They feel worse after the surgery than they do before the surgery, and they're convinced, "you didn't help me." So you have proof here. Here's your gall stones. This is what we did. (Am_Coordinator_9)

Rather than acknowledge the patients’ pain and doubts about their surgery, this volunteer medical team opts for transactionality—giving the patient gallstones as proof of their surgery rather than address the valid emotions of the patients, who likely expected to feel better after their surgery rather than experience heightened pain.

In another mission, which offered both basic services through consultations and surgeries for female patients, one of the nurse practitioners described becoming frustrated with a patient. She described how, in the past year, the patient had first come in October first, and her blood pressure was too high to perform the general surgery. In February, her blood pressure was still too high. In May, when I conducted research with the team, it was still too high. She said, “We have to figure out how to get through to them,” conjecturing that the patient’s blood pressure was too high because of either an unwillingness to take blood pressure medicine or not understanding.

While it is impossible to know exactly why this patient was not able to lower her blood pressure, the assumption of the nurse practitioner was echoed many times by providers in different medical missions trying to help patients manage chronic illness or help them achieve laboratory results indicating the feasibility and safety of their pending surgeries. Dentists shook their heads and expressed disappointment that patients consumed so much Coca Cola. Other doctors lamented the existence of Coca Cola and why their diabetic patients continued to drink it. Interestingly, there was clear and uniform acknowledgement by participants in the study that the patient population treated by the VMTs was poor and had little access to education. Why then, was there surprise when patients did not demonstrate health literacy, efficiency, or other aspects of cultural health capital?

Patients as greedy

One provider, who has volunteered with many missions and many different organizations over the last fifteen years, explained to me his position on the delivery of free care and serves as an exemplar for the jadedness I observed in a few of the long-term volunteer providers. In addition to explaining his position, he perhaps unintentionally exposed himself as incredibly resentful of low-income patients, characterizing them as greedy or exploitative. He began by recalling a physician’s strategy to reduce the number of patients waiting in line to receive care:

> One of the [organization] doctors you know, I loved it... He said, "I did around 100 consults this morning" and he said, "It was easy--I walked outside, said 'Who has a legitimate problem and who's here only for vitamins?" Well, you know 80 hands went up like this for vitamins: "OK you come over here" and they got their vitamins, they were gone because they don't come in and go, "Well I got a headache I got this... now can I get vitamins too?" …But [organization] does it for no charge for anybody. (Am_Coordinator_13)

The patients in this context, who very likely could not afford vitamins, had learned that in order to receive them, they needed to provide a justification through their consultation.

While this provider was criticizing the medical mission for offering vitamins towards people taking advantage of the medical mission (juxtaposed with ‘legitimate’ patients), the tone of this comment was equally derisive of patients for wanting free vitamins. He continued, criticizing the chain reaction of patients coming to the medical mission, having heard that free medication and consultations were being offered, and expected to be attended to:

> “Because [mimicking patient] ‘What, you got something for free? They got something for free. I need it for free too, it's my right.’ … OK… whose fault is this then? It's the fault of organizations that come and do everything for free. (Am_Coordinator_13)

Towards the end of the conversation, he became oppositional and suspicious of patients, claiming that they pretend to be poor in order to access free surgeries:

> “You know because I've also been in places where people have financial, they could afford to go and have the surgery in, let's say Miami, trying to make use of

> it by pretending. Well. You know, … people milk the system either way wherever you are. You know, trying to get something for nothing. (Am_Coordinator_13)

It was fascinating to listen to this person who has dedicated so much of their time to serving low-income Guatemalans and who works within a framework that generally agrees upon health care and surgeries in Guatemala being widely financially inaccessible, to position himself so oppositionally to those patients.

Patients as abusers of the system

Finally, in a similar vein as the section above, patients were characterized as free-loaders, abusing the "system" of medical missions. Often, coordinators and medical providers demonstrated these attitudes as they sought to justify the use of user fees or absolve themselves of a formal commitment to be permanent providers of care. One coordinator heeded the advice of one of the books in the Christian missionary canon:

> "Toxic Charity, for instance, talks about how you can destroy the dignity of a person by doing too much for them, by giving things away for free, they sort of feel like they're entitled to something for free, instead of feeling like they have the responsibility for caring for their own well-being"(Am_Coordinator_3)

The logic is thus: people in Guatemala are poor and do not have access to health care services, so STMMs should intervene by offering low-cost and free health care services; however, they should not become accustomed to low-cost and free health care services, because that means they are taking advantage of the 'system.' In such a Catch-22, providers set a capricious and unclear expectation of wanting to help patients, but only to a certain point. However, many patients never reach the point of having sufficient economic stability, mastery of navigating the health care system, health literacy, and patient cultural capital to be able to use the public health care system to their advantage, achieve employment that comes with social security benefits, or become successful consumers of the private health care market.

One Guatemalan medical mission coordinator working in a private hospital in a Kaqchikel area, expressed frustration at what she believes to be a ‘culture’ of expecting surgeries to be free.

“So we also have to help as little economically as possible so that the person can contribute, too. We ask everyone for a contribution independently. Why? Because we have to show our people a culture of gratitude and that not everything is free in life. Because “I give to you, I give to you,” and we keep accustoming our people to [think] that everything in life is free.” (Guate_Coord_8)

In fact, prior studies of health expenditures show that Guatemalan households in fact do spend a significant amount of money on their health care, with Guatemalans showing the highest percentage of catastrophic health expenditures in Latin America (Knaul, et al., 2011) and unequitable burden of household spending on out-of-pocket healthcare (Bowser & Mahal, 2011). While many STMM patients do spend on private care, other areas of their lives (income, discrimination, health literacy) remain unchanged, and because of their poor health status, they are continuously labeled as failed consumers.

I asked participants about the future of STMMs towards the end of my time conducting participant observation. The director of a surgical organization stated, “I think we should get to a moment that… doesn't depend anymore on medical teams.” Another team leader, whose organization paid the hospital facility for a patient’s antibiotics and future gallbladder removal surgery, performed by a future team, expressed anxiety about 'dependency' on STMMs:

> So if we take that obstacle out and we're not giving away, we're not trying to create a dependency or anything like that. But this woman needs help. And so if we can create a path where she doesn't have any obstacles to get there, you know, we will help her get there. She's going to have to heal twice. It's the least we can do for her, you know? (Am_Coordinator_9)

The fear, then, was setting expectations for patients that in the future, they would be cared for. A mindset informed by the extreme brand of individualism characteristic of U.S. capitalist ideology considers reliable, inexpensive access to a necessary surgery as a privilege, rather than a right. This fear of dependency also echoes criticisms of non-government provision of services—that NGOs ease the pressure off the state to provide health care to its citizens (Chary & Rohloff, 2015).

Many VMT coordinators and team leaders echoed the phrase, "we hope to one day become irrelevant," but they did not suggest operational changes to their activities that would create, for example, a lasting surgical care structure that favors low-income rural patients or meaningful relationships with primary care providers in the areas visited by basic care missions. One might argue that such lofty goals are not the responsibility of STMMs. But if neither dependency, nor long-term responsibility, nor meaningful structural change are not the goals—well, what is the goal?

VI. Discussion and Conclusion

These competing paradigms of patients show that, while engaging in an activity that falls under medical humanitarianism, providers cannot escape the neoliberal health care context in which they primarily work—a context that values patients as health care consumers, and those who cannot be ‘good’ patients demonstrating their cultural health capital are justified in being treated as failed consumers. Just as there is no ‘culture-free’ care, medical providers cannot simply code-switch to a state of mind that fully comprehends the limitations of their patients and engenders empathy.

I do not argue that the coordinators and medical providers are conclusively empathetic and understanding of patients nor that deep down, they are conclusively judgmental and cruel towards them. It is much more complicated than that. Instead, I think it is more useful to view STMM volunteers as attempting to reconcile conflicting narratives about patients—narratives that expose just how unwelcoming a health care atmosphere can be, despite the values of altruism and generosity it might claim to uphold.

One of the critical limitations of this research is the effect that these competing attitudes have on the patients themselves. Aside from body language and tone of voice, it is unclear how much of these attitudes were communicated to the patients and how that made them feel. While this chapter shows some uncomfortable examples about attitudes towards patients, the first step to move forward is to examine underlying assumptions about patients in pre-departure settings and radically dismantle the expectation that patients perform—in any way.

Though VMTs often seek to differentiate themselves from Guatemalan providers, negatively characterizing low-income patients can contribute to the very same stereotypes that perpetuate discrimination. Providers often volunteer in medical mission settings out of a sense of altruism and wanting to “do good,” but the expectations of providers to treat the ideal, humble patient is often too entangled with the self-idealization that participating in altruistic or humanitarian activities can create to allow space for meaningful reflection and improvement (Berry, 2014).

While it may seem counterintuitive to state that negative characterizations of patients and their failure to live up to the idealized pre-clinical expectations result in the perpetuity of medical missions, this disappointment is a necessary element of the proliferation of STMMs. In fact, if patients did not exhibit their lack of cultural health capital, demonstrated compliance in multi-year basic services settings, and conformed to the provider expectations vis-à-vis the U.S. neoliberal health care context, medical missions likely would not continue.

CONCLUSION: THE FUTURE OF STMMS IN THE GUATEMALAN HEALTH LANDSCAPE

The four of us walked home, contemplative. Three members of a volunteer medical team (VMT) and I had just attended a dinner with a locally known physician who had begun his medical career in his home country in the Caribbean, moved to New York City to practice gynecology in a low-income neighborhood, and dedicated his later years to advocacy work in Guatemala, where he had met his wife decades prior.

The VMT, which is based entirely in the United States and comes four times a year to provide basic care services in several areas of the Western Highlands, invited me to a dinner with the physician. I got along well with the leadership of this team, and they were eager to receive post-research feedback. In fact, they implemented my suggestion to hire a Kaqchikel-Spanish interpreter on their next trip, rather than rely on community leadership and family members to interpret for their patients. I did not understand exactly why I had been invited, but I relished the opportunity to make new contacts and spend more time with each team. In retrospect, I think it was a combination of genuinely valuing the contribution I could make to the conversation and the intimidation felt in the presence of the guest of honor, the board member of a local organization. While it was true that this man had a commanding presence, I discovered in later conversations with him that he was simply a markedly no-nonsense person rather than gruff or unkind.

At this dinner, the conversation immediately turned to short-term medical mission (STMMs) with the team members: a young Guatemalan-American physician who often volunteered with the team, a registered nurse who had been working for over a year to digitize the team’s health records for their Guatemalan patients, and the medical director, an internal medicine specialist from Texas. During the discussion, I watched them completely deflate. The elderly physician tore apart STMMs, questioning the team about their long-term impact and whether their efforts would simply amount to a band-aid over a gaping wound[34]. While no one was fighting—rather, the VMT volunteers were humbled and meekly answering his pointed questions—there was a marked tension during this conversation. I wondered how many times the leaders of volunteer medical teams (VMTs) actually hear such critical feedback; I imagined that they mostly received unquivering praise for their altruistic intentions from other Americans positioned to see all volunteer work as impactful and good.

The group asked for the check, and we parted ways with the physician. On the walk home, we all shuffled along slowly, talking about the dinner. The medical director of the STMM, who had already disclosed to me his doubts about being able to continue his role as medical director due to the model of STMM work and his work obligations, said to me, "Well, this makes my decision for me. I don't want to keep going in this position until I know Guatemala better, I speak better Spanish, and I have a clearer idea of what the hell we're doing here."

We continued to walk as I listened to him explain his doubts. He told me he felt overwhelmed by the work in the STMM. And that, while he agreed with the model this STMM utilized, he was unsure that any meaningful change was taking place. He was doubtful of the relationship that the STMM could forge with the health centers, as they

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[34] The elderly physician's criticisms were valid, though he did not disparage the actions of the team, but rather the practice of STMMs in general. I asked him for a meeting because I sensed his perspective would be helpful to me. While we lost touch after the Covid-19 pandemic, I appreciated the times we met for coffee and talked about the progress of my dissertation, his experience observing the changes in Guatemala in the last thirty years, and the many problems to be found in the health care system.

were always changing leadership—in this case, the health center was now being led by a non-indigenous recent medical school graduate in the area the VMT worked, which is 93% Maya Kaqchikel. He was worried about acceptance by the local community, mentioning the free medications they give as potentially competing with the few pharmacies in the area and wondering if that would harm the local economy or generate resentment.

This conversation saddened me, precisely because many STMMs begin with the good intentions of people like these volunteers, but only along the way do the teams realize the complexity of the work they are trying to do or the extent of goals they try to achieve. They do make mistakes in planning, mistakes that could harm someone or simply lead to the no impact of the STMM at all. After spending time with so many teams, I can only conclude that there is a wide variety of motivations for starting something like a medical mission with so little contextual knowledge, community support, or institutional permissions. STMM organizations often rise out of a reaction to seeing that many Guatemalans need more and better health care services—but many make the mistaken assumption that there is simply "nothing there" for them to begin with.

Some of the volunteers and leadership do have white savior mentalities and look upon their patients with condescension and criticism. Some hold a respect and appreciation for the population they serve but are unaware of how neoliberalism has permeated global health institutions, even down the model they follow to deliver health care, and how such a neoliberal model might hold the STMM back from creating the desired impact. Very few utilize a model that looks at all different from existing health care institutions in Guatemala or have the mechanisms to only bring providers with the experience and skills necessary to bring anti-racist, non-judgmental health care to the patients.

While no STMM I observed was without need for improvement, some organizations made it closer to these goals. Organizations fared far better with a fluent Spanish speaking, full-time, in-country coordinator who was able to navigate governmental bureaucracy and ensure compliance with local laws. Those who developed a consistent base of Maya language interpreters—either through a system of health promoters who live and work primarily in their communities of origin, or the hiring of professional indigenous interpreters—were able to attend to indigenous patients without compromising patient privacy and could offer a quality of care higher than that of many government institutions. STMMs that invested in a record-keeping system to both benefit the organizations' administration and the personal health knowledge of patients contribute to better year-round health care for patients, leaving their next provider with critical health information. Surgical missions that cultivate positive relationships with distal hospital facilities, especially in pockets without accessibility to surgeries, are positioned to provide a greater impact to rural, indigenous patients who most often struggle in national hospital facilities in urban contexts.

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I. Main Findings

Global neoliberalism dramatically influenced the trajectories of health care systems, especially in former colonies and lower-to-middle income countries, many of which experienced revolutions or social unrest during the latter half of the 20th century.

Neoliberal health care policies influenced Guatemala through the implementation of austerity measures, including the systemic divestment of government funds into population health, deregulation of markets, and a push towards the privatization of health care services. This opened a space for a chaotic landscape of poorly funded public health care providers, private health care providers unregulated in what they may charge patients, non-government organizations, and short-term medical missions to take hold. Above all else, patients are expected to navigate this landscape, advocate for themselves in health settings, pay for the hidden costs of health care and surgeries, and take personal responsibility for their health—despite the rampant inequality and discrimination that characterizes the experience of over 50% of the population.

STMMs Reproduce a Similar Care Context to That of Other Health Care Providers

STMMs, often seeking to distance and differentiate themselves from such local health care providers, fit neatly within the neoliberal health care paradigm, despite their aims to target marginalized populations in Guatemala and improve the health of Guatemala's poor. STMMs undoubtedly contribute to health care in Guatemala, especially when they ease the pressure of government health institutions to provide surgeries. However, this impact is negated by the inadequate design of many STMMs, including structures that mimic the health care system as is (primary focus on one easily accessible region of the country, burdening patients with issues of transport and cost), a lack of legal accountability, and confusing and often-contradictory expectations of patients by volunteers who fail to see their biases or question the neoliberal orientation of care in their normal work context.

The preparation of the fourteen volunteer medical teams in this study focused on the experience of providers and reduces Maya culture to generalizations; while some teams did provide more detailed documents to volunteers aimed to help them provide better care, most were focused on the experience or comfort of the volunteers. Similarly, only two STMM organizations sent teams to areas outside of the Guatemala City-Lake Atitlan corridor, mostly ignoring the geographic areas of the country with the most demonstrable need for access to health care and especially, surgeries. Surgical care teams and basic care teams each fit into three primary models of organization, respectively. While rigorously evaluating these models is a needed line of future research, my observations showed more possibilities for development and improvement among basic care missions that developed strong, multi-year relationships with communities, and surgical teams that integrated local representation of the organization into their model, providing reliable Maya language interpretation services to patients and a local contact for follow-up.

Common Organizational Practices Limit Patient's Ability for Self Advocacy

While many VMTs ignore or underestimate the laws surrounding foreign medical providers in Guatemala, the research shows that Guatemala does provide a strong legal basis and professional organization to monitor and regulate STMMs—its only problem is the execution of these laws and regulations. However, my analysis also shows that ignoring or bypassing the laws and regulations pertaining to foreign medical providers only serves to create further vulnerability for patients that often already lack legal literacy, health literacy, Spanish mastery, and the economic means to pursue legal action in the case of medical malpractice or post-operative complications. The reasons that some STMM coordinators gave for not complying to the laws—that they did not know about them, did not think them necessary because of the quality of health services they believe the teams provide, and the unwillingness to complete the bureaucratic steps required—all point to a concept of patients who do not have the right to complain. The practice of ignoring laws and regulations plunges patients more deeply into a position where their ability to self-advocate in the STMM context and after receiving care is reduced and burdens them with the effort and financial commitment to do so.

Providers and Coordinators Have Complex and Contradictory Characterizations of Patients

The view of patients by coordinators and volunteer medical providers is complex and contradictory. Interestingly, while the concept of the 'medical gaze' was clearly at play in this medical care context and the individuality of patients was erased in favor of their symbolic role as receivers, as bodies to treat, STMM providers and coordinators also emphasized their desire to treat the individual and shied away from recognizing the systemic role they might play, often defending their itinerant health care role and not wanting to be depended upon too much. Such attitudes are deeply rooted in the neoliberal concept of the individual responsible for their own health—a concept that denies the economic reality that many Guatemalans face.

Prior to the STMM trip or providing care, coordinators and providers were positive and idealistic when forming their concept of the patient—characterizing patients as humble, grateful, and performing poverty in a desirable way that positions the volunteer medical providers as givers and the patients as deserving receivers. While many of these characterizations were positive, seeing the patients as symbolic of what poverty should look like, or how poor people should act (e.g., being humble), robs patients of their right to experience their lives and express themselves authentically, even if the reality is more grim than the trope of the "poor but happy" person.

After engaging with patients in the clinical context, the characterizations of patients changed, and the providers emphasized the frustrations they encountered and the ways in which the Guatemalan patients understandably did not live up to the ideal. Providers and coordinators characterized patients as greedy or taking advantage of the free care (thus, doubting their status as ideal impoverished people) and were frustrated at the inability of patients to live up to expectations. For example, patients demonstrated a lack of health literacy and cultural health capital by spending "too much time" explaining their illnesses. Additionally, medical providers sometimes dispensed medical advice that did not mirror the context of the patient, showing the ways that the biomedical health care model demands that people's bodies conform to established treatment regimens, rather than the need to mold treatment regimens to what the patient can realistically manage.

The volunteer medical providers appeared to exhibit a cognitive dissonance when it came to the characterization of patients. They were characterized as grateful, but also greedy. The providers recognized the marginality and poverty that many patients faced, but also remained suspicious that patents were taking advantage of the 'system' that was set up to benefit them. Finally, providers recognized that the patients lacked health literacy, lacked an education and financial resources that allowed them to make informed decisions surrounding health, but also were expected to abide by the same treatment regimens and behavior change prescribed to middle-income American patients.

Analysis and Conclusion of Data

The neoliberal health ideologies that guide structural adjustment and austerity measures, that drove down government investment into healthcare in Guatemala, are the same neoliberal ideologies that drive the dynamics seen in short-term medical missions. The same patterns of organization and coordination that burden patients within the government health care system also burden patients within STMMs to "take responsibility" for their health in the absence of the structural and economic resources to do so.

It is, of course, difficult for STMM patients to ever achieve the "ideal patient" modes of communication, consumer identity, and health behaviors due to structural limitations. This is confusing for medical providers and at first glance, there appears to be oppositional forces at play: neoliberal health ideologies and medical humanitarianism. However, neoliberalism and medical humanitarianism go hand in hand because of the shared emphasis on individual interventions (e.g., the act of a volunteer medical providers giving their time) for individual people who become stripped of their context in the clinical care environment. This emphasis on the individual distracts from the possibility of systemic improvements, and, in the case of STMMs, ways that STMMs can organize and run their missions to make greater collective impact, reduce the vulnerability of patients, and respect the right of patients to institutional accountability.

Recommendations and Impact

While many prior studies and literature written about STMMs has focused on categorizing them as positive or negative, this study offers much-needed nuance to the current discourse surrounding STMMs. Because the context in which STMMs provide care can vary—including by the type of care, the ethnolinguistic makeup of the population, the local health care needs, and local politics, qualitative and context-specific research is critical to better understanding the preparation, coordination and organization, and execution of STMMs. As a practice, STMMs must be demystified, especially regarding the rules and regulations that define the limitations of what they can achieve. Rather than operate outside the confines of the law and avoid integration into health care provision, and thus be laid aside the narrative of health care providers in Guatemala, STMMs, and the people who study them, can find ways to improve the quality of care, maximize the impact that STMMs can have on the population, and increase the accountability STMMs have towards their patients.

While no one faults volunteer medical team members for wanting to make an impact, there is a way to move forward while improving STMM organization and planning. STMMs should seek to create robust working relationships with local providers to ensure they deliver an impact worthy of the time and money they dedicate to delivering medical care in Guatemala. While in practice it may look different for each team depending on the area in which they work and the type of care provided, it is paramount to pay indigenous interpreters to work in STMMs, not only to provide professional interpretation to patients, but also to show respect and value for the very indigenous communities many STMMs purposefully seek out to recruit patients.

In both countries, STMM coordinators must research and become well-versed in the legal obligations of their teams when they enter the country to provide care, and plan for the footwork required to submit all necessary paperwork. Providing summaries of the procedure or surgery completed and who provided the surgery to each patient in Spanish would ensure accountability for the providers and continuity for patients who seek follow-up care at other health institutions after the team has left. In essence, STMMs coordinators and team leaders need to shift the mindset from working in Guatemala as a way to deliver health care without all the rules, to prioritizing patient rights and their own accountability with the due respect and knowledge of the social, economic, and health vulnerability of their patients.

II. Guatemala During Covid-19

With this research, I wanted to address the future of STMMs in Guatemala—what I foresaw, the kind of change realistically possible within the structure of Guatemalan health care at all levels, and how STMMs could utilize aspects of the models I have presented to inform their own design and decision-making. After the Covid-19 pandemic, it is difficult to predict how this model of health care delivery will change, and how the context in which STMMs operate has changed—or stayed frustratingly the same. I spent a significant period of time doubting the value of my work; I felt like Guatemala, my experiences, and the version of myself from before Covid-19 were no longer real, maybe a dream I once had. How would any of the information I had still apply? It is clear that VMTs will continue to provide health care in Guatemala, but new research will need to address the way that Covid-19 has changed STMMs or what opportunities there might be to reposition for the better.

Besides a few select epidemiologists and policy makers, no one saw the Covid-19 pandemic coming, nor could have imagined the worldwide toll of the virus. In March 2020, I had flown to the U.S. to visit my family and give a lecture at the university where they live. I flew back into Guatemala the day before the country closed its borders—my data was in Guatemala, my life and my routines were there, as well as all my belongings. I thought that the panic would last a few weeks at most.

Swiftly after the government closed the border, it introduced a state of emergency ("*estado de calamidad*") that suspended travel to and from the country, imposed curfews, and introduced a mask mandate that, as of February 2022, has still not been lifted—one of the government's clear triumphs. During that time, I lost one of the privileges that I had always taken for granted: the ability to leave. From April to July of 2020, there were no flights available out of the country. Between July and October, aside from chartering a private flight to the United States, there were no affordable commercial flights.

While I still had many of the same socioeconomic advantages as before the pandemic, such as my work, which was already online, and thus my financial stability, I experienced something new in the pandemic that added depth to my understanding of my research: I became subject to the public health care system in Guatemala. Most tourists, expatriates, and wealthy Guatemalans, prior to Covid-19, were able to meet all their health care needs and still totally avoid the public health care system. While private access to Covid-19-related health care needs quickly became exclusive and prohibitively expensive, for the first six months of the pandemic, Covid-19 was the responsibility of the government and briefly became an equalizer of sorts.

I learned to patiently wait in line at the health center in Antigua for hours to receive a Covid test, as there were no privately available tests until about six months into the pandemic. I stayed at home, crippled with anxiety and scared to even go buy groceries, knowing that the same hospital described in Chapter 1 would be my destination if I were to develop a severe case of Covid-19, since the government at the time was managing all Covid cases. I watched from my second story window as a Ministry of Health van pulled up to my elderly neighbor's house and a team of workers in hazmat suits went into her home and came out with a body bag on a gurney. Guatemalans waited months longer than many other countries to receive the vaccine because of a disastrous rollout plan, poor decision-making, and corruption. Even though I had the privilege of returning to the United States in June 2021 to get my vaccine, upon my return to Guatemala, most of my loved ones in Guatemala were still waiting for theirs.

The Covid-19 pandemic laid bare the weaknesses of both the wider Guatemala government and its health care institutions. The neoliberal health model had never been subject to the stress test of a global pandemic and based upon the many times the news in Guatemala showed the headline, "Health care system under threat of collapse," I would say the neoliberal model of health care is a failure in Guatemala. Who trusts the market now to determine a fair personal cost for health care? Who believes that concern for one's health and one's health alone will keep them alive?

Encouraging Guatemalans to take individual responsibility for themselves and their families, despite decades of divestment from health education and did not slow the spread of the virus. Free testing that required people to take a half-day off work due to the wait discouraged the population from testing and self-isolating; private testing options quickly made wealthier Guatemalans safer and less likely to spread the virus. Forcing lower-to-middle income countries (LMICs) to navigate a global vaccine market and compete with COVAX slowed Guatemala's vaccine rollout. While radical change in public health in Guatemala is still far away, the pandemic exposed the errors in the logic of neoliberalism and its heavy emphasis on the individual, especially regarding population health.

Many people prior to the pandemic had been able to ignore and bypass health care services provided by the government and the structural limitations that came along with it. After March 2020, everyone experienced the anxiety that there would not be enough supply of Covid-19 tests or hospital beds, everyone faced health care providers that were doing their absolute best but still lacked a deep knowledge of how to treat Covid, and everyone looked longingly towards the day when the vaccine would arrive in Guatemala. Inequality stared even wealthy Guatemalans in the face, who suddenly needed to be concerned with the health and living conditions of their care providers, nannies, maids, and gardeners.

By the end of 2020, health care returned to its previously unequal state. Those with jobs in the service sector faced going to work with zero social protections to provide for their families. Those with better-paying jobs, including those in technology, call centers, and administration could work from home—provided they had a home internet connection, something many Guatemalans still cannot afford. Public school, which already suffered a lack of human, economic, and technological resources, was suspended and has yet to fully reopen (as of February 2022), while private schools remained open, went online, and the children enrolled within them continued to enjoy the advantages of belonging to the middle and upper class. Many rural, indigenous, low-income children left their education in 2020 and likely will not return.

The hospitals created specifically for Covid-19 cases, one called Hospital Temporal Parque la Industria, located in Guatemala City, and two other hospitals in Quetzaltenango and Zacapa, were widely criticized as an administrative failure by President Giammatei. Guatemala experienced the highest fatality rate for Covid-19 in Central America, at 3.8%--perhaps a reflection of the poor response (Enríquez & Saenz, 2021). Guatemala introduced the fewest measures to expand public health in comparison to other Central American countries that introduced widely available free Covid testing, expanded health care access, and/or extensive hospital facilities adapted for treating Covid patients (Enríquez & Saenz,, 2021).

The promotion of an individual Covid-19 response rather than systemic responses, such as the idea of "*Quédate en casa*" or "Stay at home" which only worked for people wealthy enough to forgo whatever income they would earn leaving the home to work, reflect the neoliberal over-emphasis on the power of the individual to protect themselves and care for their health. Guatemala began a mask mandate in April 2020, and still has not lifted it—one of the government's few policy triumphs, yet still completely dependent on individual willingness to comply. Curfews[35] mandated that all Guatemalans stay at home after a certain hour each day, under the threat of arrest or fines by the police—orienting the Guatemalan population as aggressors towards community health

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[35] Referred to in Guatemala as "*toque de queda*"

and needing to be controlled. Congresspeople and government officials were often exempt from these curfews (Juarez, 2020).

Few controls were placed on the economic sector, and prices rose for basic services such as propane gas, with which most families cook their food (Ibid.). The price of gas rose 30% between the beginning of the pandemic and November 2021, when it last increased (LaHora.gt, 2021). Wages did not increase, and many Guatemalans' employment status became more vulnerable (Enríquez & Saenz, 2021).

Once vaccines became widely available in the United States, Guatemalans with the financial means and U.S. visas flew *en masse* to places like Florida, Texas, California, and New York to receive the vaccine due to the slow vaccine rollout in Guatemala (Ozaeta, 2021), characterized by a strategy of vaccinating one age group at a time (starting with the oldest), with about one month between each age group. Others traveled to the border of Guatemala and Mexico to towns such as Tapachula, as Mexico's vaccine rollout happened faster and was open to non-citizens (García, 2021).

Even so, Guatemala faced powerful social forces that discouraged vaccination and mask-wearing, such as evangelical churches, which are enormously popular throughout Guatemala among both *ladino* and indigenous populations and influenced by U.S. evangelical church ties (López, 2021). Some communities completely refused the vaccine, such as one in Alta Verapaz that attacked health workers who tried to administer the vaccine to the population and destroyed the vials they brought with them (Domínguez, Pérez, & España, 2021). It is unclear how Covid-19 vaccine hesitancy will change, or how it will affect the vaccination rates for other diseases, as Guatemala's system of Puestos and Centros de Salud has historically delivered robust vaccination campaigns for diseases such as poliomyelitis, measles, whooping cough, and diphtheria (MSPAS, 2020).

III. The Future of STMMs in the New Reality

Short-term medical missions completely halted their operations during the state of emergency in Guatemala. After the state of emergency was over, I followed up with one coordinator, who turned towards Guatemalan health care providers in the months after, organizing medical missions composed of Guatemalan volunteer nurses, physicians, and surgeons. He said that the scale of operations and number of missions was much lower, but that he was impressed by the effort of Guatemalans (often from Guatemala City) to provide surgeries free of charge for low-income populations. Thousands of people who needed surgeries during the pandemic likely held them off or succumbed to their illnesses while waiting for national hospitals to return to their pre-Covid capacity to provide surgeries.

Once volunteers could be fully vaccinated, many began to travel again with larger STMM organizations that were able to weather the economic insecurity of the pandemic. However, new limitations on travel, from both the sending countries and Guatemala, posed new challenges for the teams. One organization that frequently received Canadian volunteers (as about 1/3 of their VMTs) shifted towards U.S. providers because of the two-week quarantine enforced by the Canadian government upon their return: providers who already took time off work could not or did not want to spend two more weeks in quarantine upon their return.

One of the basic services teams reached out to me twice: once in March 2021 and once in August of that year, to ask for assistance in creating a needs assessment for the community they had worked in for twenty years. They admitted they were afraid to know what they would find—longtime patients passed away, connections with local leadership embittered or severed, and more severe childhood malnutrition than before. Regardless, they hoped to take a pragmatic approach to meet the needs of the community in its new reality, whatever that might look like. After two years without a trip to the community, many of the members from that VMT experienced a heightened awareness of their influence on that community's health—and the effects of their total absence.

I sometimes wonder what it would be like to conduct my research in the current state of Guatemala: providers, already limited by language and cultural barriers, now with the barrier of masks and face shields, even further restricted in their communication; patients, weary after two long years of economic instability and the loss of family and friends; coordinators, making heavier decisions about where to go, who to treat, and what risk is acceptable for both patients and providers in the operating room. Not only was there a pause in STMMs to Guatemala during the pandemic—many other providers, such as non-government organizations (NGOs), had to completely pause health care delivery, leaving a vacuum of many patients who could not seek health care anywhere besides government facilities.

While the Covid-19 pandemic demonstrated the necessity for a robust health care system and clear public health policy in Guatemala, meaningful structural change is unlikely. The oversight of short-term medical missions is especially critical now, given the vulnerability of patients in all forms. However, the pandemic slowed many bureaucratic processes, and the country faces a shortage of physicians. This likely means less oversight by the College of Physicians and Surgeons as they contend with the internal struggles of the medical establishment.

A population of travelers from another country can easily transmit new variants of the virus. Those with chronic health problems (especially diabetics and hypertensives) have battled their risk for two years, and it is even more critical to make wise choices to operate or not. Economic insecurity means fewer potential resources for patients to safely coalesce at home. Widespread malnutrition as a result of the pandemic will affect the young population of cleft palate surgery candidates and other child patients. Even fewer patients have the financial means to denounce malpractice or speak up about post-operative problems.

Unfortunately, the same factors that contributed to the country's insufficient and inconsistent response, such as corruption at the administrative level, are not easily solvable and weaken the role of the Ministry of Health plays in public health and oversight. If public health administration is in such disarray that doctors working in Covid-19 hospitals must strike in order to receive their pay during a pandemic, other administrative and supervisory roles within public health, such as the oversight of VMTs, are likely similarly weakened.

Future studies of short-term medical missions will encounter a context distinct from the context in which I conducted my research, but many of the themes will persist. Neoliberal health policies restructured health care in Guatemala, characterized by insufficient resources, heavy burdens born by a population limited in its health and legal literacy to make decision about their health, and a poorly regulated inter-institutional, inter-organizational strategy to improve population health and ensure patient safety. Despite these challenges, there is still hope that the STMM organizations that weathered the pandemic will be motivated to rethink and redesign their approaches, knowing that the stakes are even higher for patients than they were before.

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