BEST PRACTICES FOR SHORT-TERM HEALTHCARE MISSIONS	
Question: How should we best engage in successful partnerships?	
Participants in discussion	Background (perspective)
Michael Soderling MD Initiator and primary author	
Phil Butler	
Peter Yorgin, MD	Reviewer
Why is this important? The purpose of this position paper is to discuss the vital importance of using the concepts of networking and partnership to create a synergistic effect in the arena of Christian healthcare ministry, especially healthcare ministries that minister to the poor. This paper is written for anyone who is actively involved or plans to become actively involved in short term healthcare missions work.	

Biblical concepts involved

Effective Networking and Partnerships for Short Term Health Care Missions

The use of providing health care to further the “mission” of the church dates back to at least the sixteenth and seventeenth centuries when Jesuit and Franciscan physicians and pharmacists were involved in missions abroad, though they did not carry the title “medical missionary,” they were involved in practicing the arts of medicine, surgery, and pharmacy[1]. The first reference made to “missionary doctor” appears in a correspondence between the missionaries of the Danishch-Halle Mission working in

Tranquebar, Southeast India and their home board in 1733. It was not until 1838 that the concept of using medical missions as a means of establishing contact with peoples and cultures otherwise closed to missionary work was explicitly formulated[1]. Medical missions took on many forms during the initial phases of medical missions and the number of health care professionals involved in this endeavor reached its peak of 2164 non-indigenous workers in 1925[1]. The greatest concentration of this work took place in China and involved the use of dispensaries, polyclinics, and hospitals.

More recently there has been a decreasing interest in building and supporting large health care projects such as clinics and hospitals and indeed hundreds of Christian hospitals have been closed in India alone for lack of adequate funding due in large part to donor fatigue and mismanagement, as well as a continued lack of local resources.

The lack of resources involves not only monetary and material factors but also a human factor. A survey conducted by George Barna that showed that for every 100 Christian medical students who believe they are being called into medical missions work only one or two actually end up in the field of foreign healthcare missions. The reasons for this dismal statistic vary with the two most common reasons cited being having a large school debt to pay off and having small children. The fact remains that there is a severe shortage of healthcare workers in developing nations while at the same time there are perhaps thousands of Christian healthcare workers in the West who have been called to foreign medical mission work but who now believe they can fulfill that calling by being involved in short term medical mission trips, where there exists a cornucopia of choices with regards to where to work.

The short term medical missions (STMM"s) phenomenon has become, over the past 20 years, a tsunami with no indication that this will change any time soon. In 1979 an estimated 22,000 Americans were involved in short term missions (not necessarily medical) while in the year 2007 it is estimated that number will have exploded to around 1.6 million! There are an estimated 600 short term teams visiting Guatemala each year, again not all medical, but of those that do healthcare related work, an estimated

$14,000,000 of healthcare service is being provided. And this is likely a conservative estimate.

The Challenge

The Alma Ata declaration of “Health Care for All by the year 2000” has clearly not been achieved and in some parts of the world the availability of health care has actually diminished. In the WHO 2006 annual report it was estimated that there were 59.2 million full-time healthcare workers for the world’s population of 6.5 billion. This translates to 0.11 per 1000 population. In the US the ratio is 10/1000 and it is believed that a minimum of 2.5/1000 is needed to meet the most basic needs of the world’s population. There are 57 countries with a critical shortage of healthcare workers which is the equivalent of a global deficit of 2.4 million doctors, nurses, and midwives.

The maternal mortality rate is as high as 2000/100,000 in Sierra Leone (SL) while in the US it is 14/100,000. (Not the lowest rate in the world) The neonatal mortality rate in SL is 56/1000 and the infant mortality rate is 165/1000, while in the US the rates are 4 and 7, respectively. It is clear that more can be done to change the overwhelmingly dire situation that exists with regards to healthcare for the poor of the world.

Is it too optimistic to believe that the thousands of Christian health care workers that do short term healthcare outreaches can have an effect on these disheartening statistics? Granted, the purpose of conducting healthcare outreaches in the name of Christ should be to make His name known to those who may otherwise not have an opportunity to hear the good news. And this author believes every effort should be made to strengthen the local church when doing short term healthcare outreaches. But how much honor are we bringing to His name if we make no effort to improve the health of the people we leave behind when our week or two is up?

A disturbing fact related to the increased interest in short term medical missions is that there is no indication that these short term medical teams have been able to have any effect on the overall health of the people they serve. At least there are no statistics

being compiled that this author is aware of. In fact there is circumstantial evidence that some of what is being done in the name of Christ in the area of medical missions is reflecting very poorly on His name.

This author assisted a surgical team that came to Guatemala to work in a remote town where a small missionary hospital was located. Near the beginning of the week the General Surgeon on the team removed of a diseased gallbladder from a young woman who had been suffering with much abdominal pain. She went home at the end of the week, seemingly fine. One year later we returned for another week of surgical work and this young lady and her husband were first in line. They were clutching all the receipts that had accumulated from the follow-up surgeries she had to undergo to correct a post-op complication. Our team from the previous year did not have any local healthcare workers involved during the week and so there was no one to accept responsibility for this mistake. Last year a team from the US doing a week of surgery completed a hysterectomy on a woman at the beginning of the week and on Friday this woman died from an unknown cause. Who can the family hold responsible for this clinical disaster? And what does this type of work do to improve the overall health of the people?

This lack of long term impact on the part of Western attempts to help the poor is highlighted in William Easterly's recent book, "The White Man's Burden. Why the West's Efforts to Aid the Rest Have Done So Much Ill and So Little Good[2]." In his book Easterly asks the question how is it possible that the West has spent 2.3 trillion dollars over the past 60 years on fighting poverty with so little to show for their investment? Part of his conclusion is that the "planners," in other words those with the money, are acting irrationally when they set goals for fighting poverty and design programs to meet those goals that are based on their ideas on what will work. While at the same time, on the other side of the world, "searchers," those on the ground level working with the poor and who are often native to the area, are asking what foreign aid can do for the poor people. But these two groups of people rarely are brought together to more effectively design and implement projects that will truly benefit those who are most needy.

An equally unsettling question that I believe must be addressed is whether or not the millions of dollars spent on short term medical work are actually having a beneficial effect on reaching people groups that have never heard the gospel of Jesus Christ?

This author believes that a significant impact on these very serious problems can be made through the use of effective networks and carefully crafted and maintained partnerships. I will use the following definition for network as found in Phill Butler's book, "Well Connected"[3].

A **network** is: "*Any group of individuals or organizations sharing a common interest, who regularly communicate with each other to enhance their individual purposes*."

And a **partnership** is: "*Any group of individuals or organizations, sharing a common interest, who regularly communicate, plan, and work together to achieve a common vision beyond the capacity of any one of the individual's partners.*

These definitions are not to be confused with the situation that exists with the majority of partnerships that are talked about in Christian circles at the present time. What is referred to so often as a partnership is most commonly a type of sponsorship where the North American "partners" are simply giving money or other material resources to a receiver in a developing country without much planning, organizing, or accountability built in to the arrangement. This will most often simply lead to poor use of God's resources and will contribute to creating dependency that so often plagues developing nations[4].

The Solution: Making effective networking and partnering happen.

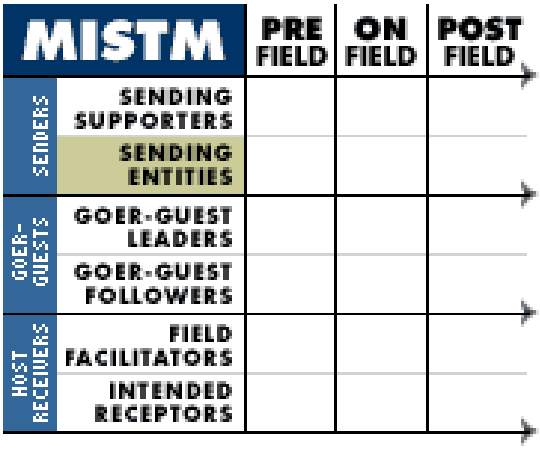
As we begin exploring the ideas that make for effective networking and true partnerships (NP) it may help to refer to Peterson's MISTM grid. **MISTM Theory** — Maximum Impact Short-Term Mission — was developed and published in a 288-page book in 2003 by STEM Founder/CEO Roger Peterson and Wayne Sneed, a colleague

from Memphis[5]. **MISTM Theory** states that all short-term mission endeavors exist through these three phases:

- Pre-Field
- On-Field
- Post-Field

MISTM Theory further claims that short-term mission "participants" are not just the short-termers, who go, but also those who send, and those who receive. MISTM Theory states that these three groups of participants are equal participants, and that one is not more important than the other:

MISTM Theory is visually organized into the MISTM-Grid.

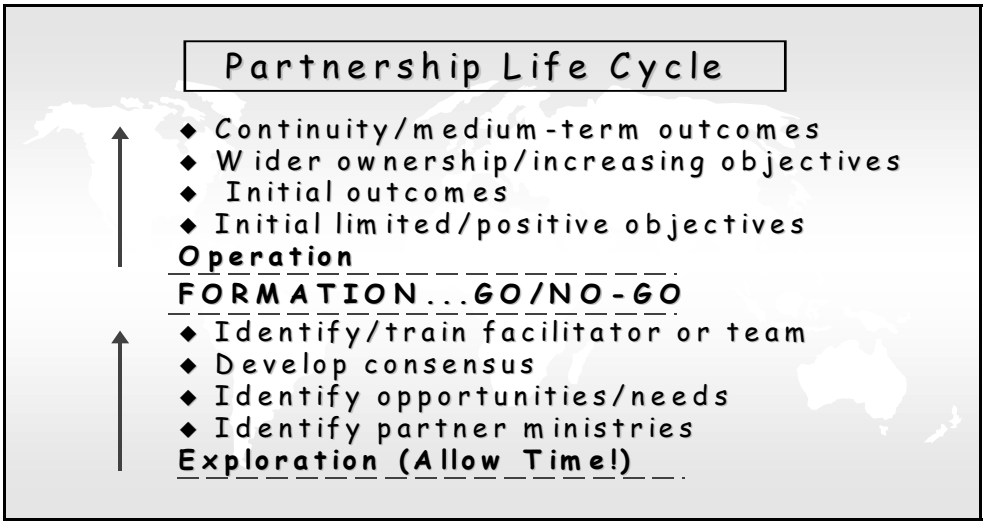


- **Senders**: those who send short-term missionaries; specifically includes two subsets: all of the Sending Supporters and the Sending Entity(s).
- **Goer-Guests**: those who go to the field to serve; specifically includes two subsets: all of the Goer-Guest Leaders and all of the Goer-Guest Followers (i.e., all of the individuals or team members who are being sent)
- **Host Receivers:** the on-field persons who receive short-term missionaries; specifically includes two subsets: Field Facilitators and Intended Receptors (i.e., everyone at the on-field location: full-time missionaries, other expatriates,

national pastors and local leaders, local nationals and any local organizations which they represent such as churches, civic organizations, NGOs, etc.)

MISTM Theory concludes that all organizers of any short-term mission outreach must consider and take into account all those who Send, all those who Go, and all those who Receive during the Pre-Field, On-Field, and Post-Field phases concerning every plan or idea being made, and every decision or action being taken.

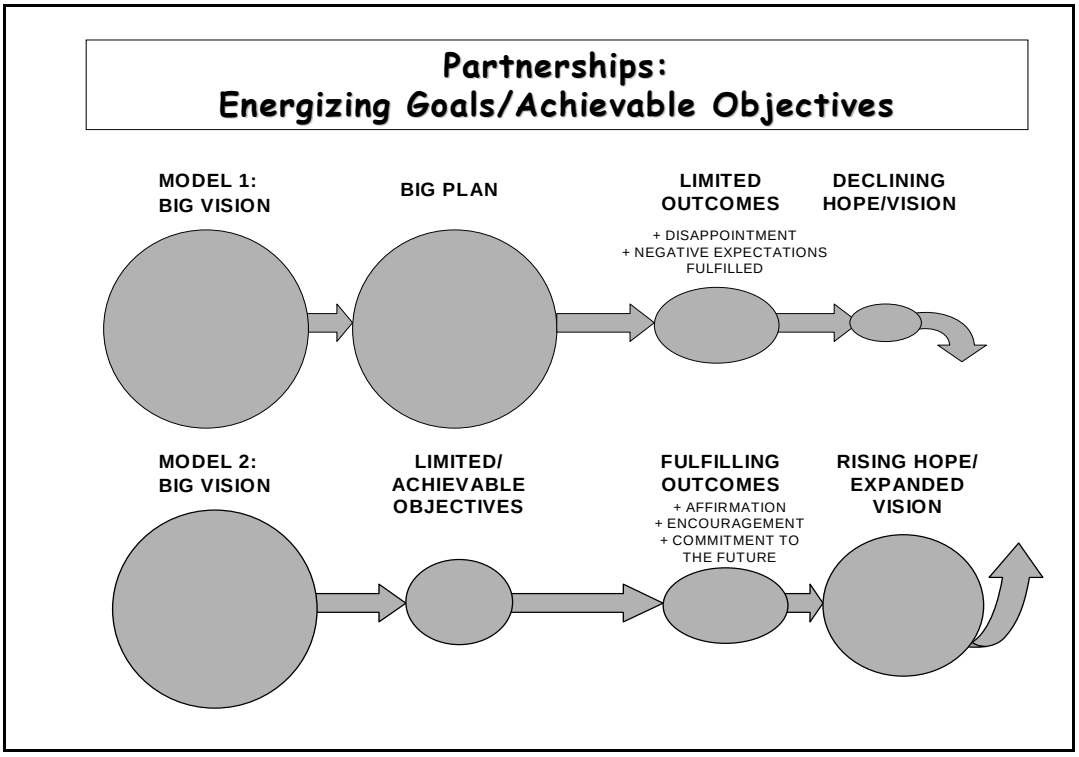
In order to form effective networks and especially to build true partnership it is important that all of the above interested parties be involved in the process at some point in time. The first steps in effective NP may begin with healthcare projects or ministries that are already functioning in some part of the world and being carried out by well established ministries of a church or para-church organization. It could range from an organization the size of World Vision all the way down to an organization run by just a few volunteers. But in all cases the various parts that make up the MISTM grid can be identified.



(Used by permission from Bulters book, "***Well Connected***."[3])

True partnership formation is not something that happens overnight. The above illustration provides a basic outline for the steps necessary for building a true partnership. The reader is referred to Butler's book for more details on the partnership life cycle. Once the involved parties are identified the most important step is to identify the shared vision that brings you all together. This could be identifying an unreached people group and making it your partnership mission to get a foot in the door of that people group by carrying out medical outreaches which are coordinated with another ministry whose strength is evangelism and church planting. Or the vision could be to reduce the infant mortality rate in a specific region of a country into which the Lord has led you to work. It could be to build a comprehensive healthcare system in a part of the world where there previously was none. It may be what Collins and Porras refer to in their book," ***Built to Last: Successful Habits of Visionary Companies****,"* as a BHAG (Big Hairy Audacious Goal) or it may much more simple and basic[6]. Be that as it may, it is this shared vision that makes things happen. As Butler points out, "Vision is the driving force! Without it, no lasting, effective partnership is born, much less sustained." Daniel Rickett, in his book, "Making Your Partnership Work" states, "Shared vision is to partnership what the North Pole is to the compass[7]. It exerts a certain gravity that tends to align everyone's actions with the partnership's avowed purpose and values." Shared vision is essential and developing this vision should include all parties represented on the MISTM grid. And most effectively this vision will come primarily from the Receiver/Host group or the group that would correspond to Williams' description of a "Searcher."

It cannot be emphasized enough that any big compelling vision must be accompanied by limited, high-value, achievable objectives throughout the life of the partnership – providing 'signposts' for evaluation, progress reports, communication among partners, celebration, and assessment of progress toward the BHAG. Typically, the specific goals established within the BHAG are so large so that when accomplishment and vision do not align, disillusionment and disappointment set in with bad implications for the partnership. The following diagram, again from Butlers book, spells this out.



In order to come up with such a clear, concise, and motivating vision it will require some time spent in the field prior to the actual short term medical outreach. This is essential for building the relationships necessary to achieve long term kingdom goals. Developing partnerships takes time. “Instant partnership, long-term failure,” as Butler so succinctly puts it. This phase will determine the compatibility of all parties involved and requires much time asking questions and listening. It is at this point in the process that the partnership facilitator or champion, is identified. And actually two partnership facilitators who have a strong bond of trust are the single most important ingredient for a successful partnership[3,7]. This will most commonly involve one person from the Sending/Goer group and one from the Receiving/Host side of the equation.

Once the exploration phase has been completed and the facilitators selected it’s time to begin the formation phase. This happens when the potential ministry partners can say, “We agree, the only way we can accomplish this vision is by working together,”

As both Butler and Rickett point out, building up trust is of the utmost importance. There are two core principles that partners must have trust in. There must be trust in the people involved and in the process. And for trust to develop there must be these six elements:

1. Common vision as we have already stated in this paper.
2. Common values which determine how we will realize our vision.
3. Holding each others best interest at heart. This is indeed one of the most difficult to accomplish in the mission field where there is such a sense of needing to protect ones ministry territory.
4. Competence in being able to do what you say you are going to do.
5. Reliability. The willingness to carry out what you say you will.
6. Faithfulness. Do you have the staying power to continue what you start? Will you continue to follow through on your promises? Or when things get difficult will you stop being involved?

These things take time to develop and involve much relationship building amongst all who have been identified in the MISTM grid. Of course some will be more intimately involved than others but at all levels there must be an adequate level of trust for the vision to be achieved. And due to the nature of what goes into building trust it is also the most fragile element of a network or partnership. Our tendency is to trust only after someone has proven their trustworthiness. And if that trust is broken, which is nearly always the case, almost nothing can be done to repair the damage that has taken place. We must develop a mentality that we will not allow ourselves to be easily offended and we must put on an attitude of forgiveness which allows for true reconciliation. In a personal communication, Dr Dan Fountain has expressed to this author the need to trust people first and then allow them to either reinforce that trust with appropriate actions or to lose that trust via inappropriate conduct. We cannot go into a relationship with others who share our vision with an attitude of distrust that can only be changed over much time with what we feel is appropriate conduct.

At this point the common vision has been identified and an adequate level of trust has developed. You will have become knowledgeable about the context of the problem

and the current situation and you will have identified the primary roadblocks or challenges. You have also outlined what you believe are the primary roadblocks and challenges you may face. And you will have identified what you believe are the high priority action points. There must now be a further definition of who does what in the partnership. Both Butler and Rickett cover this topic in detail and the reader is encouraged to explore both resources further with regards to the details of the structure of the network or partnership. There is more detail involved in this process than can be included in this paper.

This is the time where those involved in the partnership begin to identify what it is each has to contribute to the achievement of the shared vision. Very often, perhaps too often, it will be assumed that those who fit in the senders and goers (SG) category will have the material resources that the host/receivers (HR) feel they so desperately need. This need not always be the case. More often than not what is needed is information and training that will enable the HR to use local resources to meet the needs of those they seek to minister to. This is a very important point in the process that when properly pieced together will go a long way towards avoiding creating problems of dependency[4].

Historically this process has often involved what has been called a “needs assessment,” whereby the SG group meets with the HR people to come to a better understanding of what is lacking in the host country. A completely different environment can be achieved if one takes the attitude of doing an “asset” assessment instead. Rather than focusing solely on what the HR’s lack and what the SG’s can give them you make it a higher priority to discover what it is the HR’s already have that can contribute to achieving the vision. It is too often assumed that money and other materials are not available in the host country in sufficient amounts to make a significant contribution to the cause. But this is a very paternalistic opinion that short circuits how the Holy Spirit may be working in the lives of wealthy believers in the host country. There may also be a significant body of healthcare professionals in the host country who are willing to be a part of a significant healthcare initiative that is well run and managed.

So far we have talked about how the Senders, Goers, and Hosts must identify a common vision which they all share. Be it reaching an unreached people group by

carrying out healthcare initiatives, or attacking a disease process that plagues a certain part of the world, or be it helping build a healthcare system where there was none before. There must be a shared vision that inspires those who are involved. We have talked about the formation phase which will identify the work that needs to be done and who will do what to achieve the vision. The overall vision, our BHAG, will be reached by succeeding at achieving a series of smaller though no less significant short term goals. These are important for the group to be able to see progress and to not become discouraged. The last and most often neglected part involves the follow-up and follow-through. This is where the difficult topic of accountability must be discussed and the methods to carry it out established.

This process can be aided by the use of a roadmap which is developed jointly with all interested parties. A PERT (Program Evaluation/Review Technique) chart can be helpful in this regard. (www.netmba.com/operations/project/**pert**/) This detailed a chart may not be necessary but a more basic method will usually suit your needs. Proper use of these tools will help us assess whether or not we are meeting our objectives. Are we seeing meaningful results? Rickett offers five criteria for assessing whether a partnership is producing meaningful results.

1. Meaningful results are measured.
2. Meaningful results are strategic: they confirm the vision and values of the partnership.
3. Meaningful results are balanced in that they benefit the partners in proportion to what each contributes.
4. Meaningful results are synergistic
5. Meaningful results are co-created.

Rickett goes on to state that measuring outcomes, or progress, has several advantages. First it provides evidence that the set goals are being achieved. If one is measuring results it is not easy to hide the fact that some aspect of the partnership is not being conducted as planned. The second advantage is that measurements give feedback. Does it make sense to continue to approach the problem with a method that is not working? It puts into your hands the information necessary to make a change in course

if necessary. Measuring outcomes also enhances motivation. As the smaller short term goals are accomplished that will lead to achieving the overall vision it provides a motivation to those who may be getting worn down by the demands of the work. The fourth advantage Rickett sites is that measuring results can lead to renewal. “The process of measuring results leads naturally to discussions about the vision, the relationship, and what constitutes meaningful results.” And lastly measurements give rise to celebration.

Both Butler’s and Rickett’s books have excellent resources for such things as partner assessment and selection, how to do working agreements, and evaluation tools to measure outcomes.

Some final points. Accountability is a very delicate subject in many underdeveloped countries. And it is a concept that is often seen as being a “western” mindset that cannot be applied universally. But it is indeed a biblical concept and we must be careful to explain its importance to all involved because it is a concept that God finds very valuable to our spiritual growth. If the tools are provided to accomplish some portion of the overall vision then everyone involved should expect that chore to be accomplished, barring any unforeseen circumstances. I believe the lack of good follow through is often related to the fact that not enough resources were provided to accomplish the task in question. Those who contribute the material resources for accomplishing the vision have every right to expect that those materials will be used in the way they were intended. This is an excellent opportunity for teaching some valuable basic biblical principles.

Also, the importance of good communication cannot be overstressed. All interested parties should be included in frequent and open communications. It is the life blood of the partnership. Without this vital factor suspicions set in and questions begin to form about what is being done on the ground level. With an almost universal availability of internet access there is no longer an excuse for not being in frequent communication with all interested parties.

Finally the value of prayer cannot be overstated. This is an oft overlooked factor in long term ministries. It is of vital importance for everyone involved to be actively praying for the success of the partnership and its vision. Frequent communications can be a good reminder of the need to continue praying for all those involved at all levels of the ministry.

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