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Perceptions of a short-term medical programme in the Dominican Republic: Voices of care recipients

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Abstract

Participation in short-term global health programmes for low-income countries is increasing amongst practising clinicians and trainees from high-income countries. However, few studies explicitly examine the perceptions of programme recipients. In July 2012, we conducted semi-structured interviews with a purposive sample of 47 adults receiving care from Medical Ministry International (MMI), an international nongovernmental organisation providing short-term medical programmes in the Dominican Republic. Thirty interviews met criteria for inclusion. Transcripts were independently coded using a descriptive approach. After thematic saturation, 20 interviews were included in the final analysis. Nine major themes were identified: misidentification, access, identified needs, social determinants, faith, language, student involvement, areas for improvement, and respect. Recipients were reluctant to discuss programme improvement directly and frequently misidentified the researcher as a caregiver, suggesting a need to separate clearly programme evaluation from care provision. They viewed student involvement positively in a setting where supervision is emphasised, suggesting a potential to develop measures of supervision's adequacy. Finally, recipients' perceptions of respect as an important but intangible programme element encourages broadening the ethical discourse around short-term programmes beyond only tangible goods and services. Our findings support the usefulness of qualitative methods for short-term programme evaluation and generate important hypotheses for future research.

Keywords

global health; short-term medical outreach; medical missions; qualitative study; ethics

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Potential Conflicts of Interest

All authors declare that they have no conflicts of interest related to the content of this manuscript.

Introduction

Interest continues to rise in global health as an area of research, scholarship, and practise aimed at improving health across the world (Maki, Qualls, White, Kleeffeld, & Crone, 2008). Short-term medical programmes abroad are a commonly recognised yet ill-defined part of global health practise, alternately referred to as ‘short-term global health service’, ‘outreach’, ‘volunteerism’, or ‘missions’, among other terms. These programmes encompass trips of varied durations that provide diverse medical, surgical, and educational services to underserved communities. In academic settings, there is extensive interest and participation in short-term global health programmes abroad amongst Canadian (Anderson et al., 2012) and US medical students (Association of American Medical Colleges, 2010), as well as postgraduate medical trainees (Anspacher et al., 2011). Many trainees and practising clinicians participate in short-term programmes through non-governmental organisations (NGOs), including charities and faith-based organisations, although the activities of such organisations are less frequently described in the academic literature.

Short-term programmes can generate controversy, sometimes reflected in descriptions of ‘voluntourism’ or ‘fly-by medical care’ (Snyder, Dharamsi, & Crooks, 2011), as well as ‘duffle bag medicine’ (Roberts, 2006). Such epithets reflect concern about short-term programmes’ potential to be self-serving (Parminder et al., 2007), to lack sustainability (Montgomery, 2007), to provide inadequate follow-up (Langowski, 2011), or to be culturally insensitive. This concern is more than practical; it reflects concern about the ethics of short-term programmes, be they service (Crump & Sugarman, 2008; DeCamp, 2011; Lahey, 2012; Reisch, 2011; Shah & Wu, 2008; White & Evert, 2012; Wilson, Merry, & Franz, 2012) or research programmes (Hunt & Godard, 2013; Provenzano et al., 2010). Recently an international, multi-stakeholder group developed best-practise guidelines for global health training abroad (Crump, Sugarman, & Working Group on Ethics Guidelines for Global Health Training [WEIGHT], 2010). While geared toward training programmes, the guidelines’ principles arguably apply broadly to institutions and sponsors of short-term research and service programmes. For example, sustained communication and responsiveness to local priorities are critically important to all short-term programmes abroad.

Accomplishing sustained communication and responsiveness to local priorities requires understanding the perspectives of the individuals and communities who receive care. Yet despite attention to the perceptions of individuals who provide care abroad (Chiu et al., 2012), including medical students (Abedini, Gruppen, Kolars, & Kumagai, 2012); postgraduate trainees (Brook, Robertson, Makuwaza, & Hodges, 2010); and faculty (Eneriz-Wiemer, Nelson, Bruce, & Chamberlain, 2012), the perceptions of individuals who receive this care remain relatively unexplored. One study included a single group interview with seven parents whose children had received care within a short-term programme in Guatemala (T. Green, Green, Scandlyn, & Kestler, 2009). Another involved care recipients in the design and piloting of an impact assessment tool (Maki et al., 2008). Related studies have focused on humanitarian aid during crises, for example, following the tsunami in Sri Lanka (Lee, 2008) or regarding the humanitarian work of Médecins Sans Frontières (Abu-Sada, 2012). To our knowledge, there have been few systematic investigations of the

perceptions of individuals receiving care from short-term medical programmes operating regularly outside acute humanitarian crises. In this paper we present the findings from a study of semi-structured interviews exploring these perceptions within a United States-based short-term medical outreach programme in the Dominican Republic (DR).

Methods

Study design

We chose a qualitative approach to capture recipients' personal experiences and contextual circumstances (Taylor, Hull, & Kass, 2010). This method allows for the emergence of unexpected thematic content. Using one-on-one, semi-structured interviews enabled us to conduct interviews in private and to explore participants' experiences in greater detail as compared, for example, to surveys. The study was designed collaboratively with individuals from Johns Hopkins University and Medical Ministry International (MMI), the NGO operating in the DR, with input from Dr Teo Beato and Dr Frida Luna in the DR.

Setting

This study took place in the DR. The DR has a population of approximately 10 million people. Average annual per capita health spending is US\$529, compared to US\$8608 in the United States (World Health Organization, 2011). The leading causes of death among Dominicans are ischaemic heart and cerebral vascular diseases. Maternal mortality is high, with 150 deaths per 100,000 live births in 2010, compared to 21 per 100,000 live births in the US (World Health Organization, 2011). For children, diarrhoeal diseases are prevalent (14.7%), as is chronic malnutrition (Centro de Estudios Sociales y Demograficos, 2007). Significant health disparities exist between urban areas and rural or poorer ones.

The DR's health system includes the private and public sector. The private sector includes private practitioners and non-governmental health organisations, but most individuals receive services through the tax-funded public sector. Despite a 2008 law establishing a national health insurance system, approximately 55 to 65% of the population does not have adequate health care coverage, and most people pay out-of-pocket for health services (Rathe & Moline, 2011).

Within the DR, our study took place at one hospital (Batey Verde, a small hospital affiliated with Hospital Dr. Elias Santana) and four mobile clinics (Altagracia, San Pedro, Batey Nuevo, and Majagual). Hospital Dr. Elias Santana is a private, mission-based hospital founded in 1984 with an explicit focus on providing care for the poor. It serves thousands of patients each year, predominantly with major and minor surgeries or ophthalmologic procedures (e.g., for cataracts and glaucoma). Elias Santana was the first private hospital to accept the national insurance, and 75% of its services are covered by this programme. The other 25% are covered by out-of-pocket contributions or donations.

The four mobile clinics were located in remote areas near Sabana Grande de Boyá, a municipality in the Monte Plata province. Here the population uniquely includes Haitian immigrants and native Dominicans who work in the sugarcane fields. The dominant language is Spanish, though Haitian Creole is also spoken. Access to the public system is

poor in these areas. Haitians and their children who are born in the DR lack access to the national health insurance.

MMI has worked in the DR for over 40 years and in Sabana Grande de Boyá for over three decades. It has long-standing relationships with local community members and the government. MMI collaborates with each of the five sites studied and visits these sites yearly to offer education and medical care. On average, MMI teams are present in Batey Verde for two weeks per year and one day per year at the other four sites, which are significantly more remote. When MMI is not present, locals must travel long distances by public transport to reach a clinical facility without the certainty of being seen. The communities around Sabana Grande de Boyá lack a year-round local physician.

MMI is a faith-based Christian organisation. Its mission is to provide health care and compassion in a world of need (<http://mmint.org>). MMI focuses on treatments for physical and mental ailments as well as support for spiritual growth. As part of its Christian worldview, MMI volunteers work closely with local pastors and community church members, offer prayer, and in some cases share their faith with care recipients; however, professions of faith by recipients are never required for them to receive care. MMI targets underserved populations and does not discriminate based on race, background, or religion. MMI charges a nominal fee for services to preserve recipients' dignity and recognise their partnership in their health. Clinicians within MMI's programmes are typically volunteer members from US- or Canadian-based church congregations or Dominican volunteer clinicians. Students frequently connect to MMI through their local churches or university student groups. Students assist based on their skills and experience; for example, university students are involved as general helpers, medical students and nursing students can serve as health educators, and students with language fluency can serve as translators. Students always operate under the direct oversight of a licensed clinician or appropriate supervisor.

Study sampling and participants

We used purposive sampling to identify and recruit study participants, focusing on obtaining equal numbers of men and women from a range of ages. Potential participants were identified after having received MMI services. Exclusion criteria included being less than 18 years old and being unable to speak Spanish. MMI staff initiated contact with potential participants and referred interested participants to the interviewer. The study was reviewed in full, approved, and declared exempt from further review by the Johns Hopkins Medicine Institutional Review Board and the research ethics committee at the Hospital Dr. Elias Santana (DR). Oral consent was obtained from all participants.

Data collection

From 14 July to 28 July 2012, one investigator (SE, an American not affiliated with MMI for whom Spanish is a second language) conducted digitally recorded, semi-structured, face-to-face interviews. Each interview began with introductory questions, such as 'Who is here providing medical services'? and proceeded to include questions about community needs, MMI's relationships with local health care workers, and areas where MMI could improve. The interviewer used reflective questions and responses to clarify and probe further into

participants' experiences and emotions. No protected health information was collected. The interview guide is in the Supplemental Online Material.

Interviews were conducted in Spanish, transcribed, and translated into English by the interviewer. Difficult quotations were reviewed and translated or verified by a native Spanish speaker. To protect participants' privacy and confidentiality, interview transcripts were not shared with MMI, except in a de-identified form. Due to our inability to contact participants again, they were not provided with transcripts for correction.

Data analysis

We analysed the translated transcripts using an 'editing' style (Crabtree & Miller, 1999) of qualitative descriptions (Sandelowski, 2000). Two investigators (MD and SE) independently analysed the first six transcripts to develop a preliminary coding scheme. Subthemes were identified by concepts and ideas expressed by the participants; we then grouped related subthemes into major themes. As the review proceeded, MD and SE revised and updated the coding scheme when new subthemes arose or it became necessary to revise major themes. Areas of disagreement were resolved by consensus. The final scheme is in Table 1. TAMS Analyzer (Version 4.45) was used to manage and to organise the data. Consistent with our analytic approach, a duplicate review was discontinued after thematic saturation was reached (Creswell, 1998). This occurred after coding 14 interviews and was confirmed by coding 6 additional interviews. The use of 20 interviews is consistent with other qualitative studies using similar methods (Wright et al., 2013). One investigator (SE) reviewed the remaining 10 interviews to verify that no additional novel themes were present, and the second (MD) reviewed these notes to confirm this.

Characteristics of participants and interviews

A total of 47 interviews were conducted and digitally recorded. Of these, five recordings were of insufficient quality (e.g., due to background noise). One interview was incomplete; the participant left the interview early to catch transportation. In 11 interviews, we discovered difficulties in comprehension and use of Spanish by native Haitian Creole speakers that prevented us from conducting a reliable analysis; these were excluded. Therefore, 30 complete interviews were included in our study; as described above, 20 were reviewed in duplicate and included in our final analysis. Characteristics of these participants and interviews are displayed in Table 2.

Findings

In the sections that follow, we summarise and interpret the most salient findings from each major theme. Where relevant, we suggest potential areas of future qualitative and quantitative research. Themes did not vary significantly between sites, with the exception of an emphasis on access to surgical services at the hospital site (where surgical procedures are performed). In qualitative studies, theme frequency does not necessarily correlate with importance; for illustrative purposes, in some cases below we indicate the number of times a theme appeared.

Misidentification

Ensuring that participants understand ‘who’ is providing care during a short-term programme seems prerequisite to truly collaborative and informed engagement between the programme and local individuals and communities. Therefore we explicitly asked participants whether they could identify the group providing services. In 10 of the 20 interviews, the participant did not know the name of the group. Two interviewees referred to the group as ‘the Americans’:

‘The group that is working here? I always say the Americans. The American group comes to help us, and give us medicines’.

‘The group of medical volunteers? I do not know [who they are]. I have not met them [before] but I know the Americans are coming’!

This finding was unexpected because of MMI’s long-standing relationships in this community. Interviews did not reveal why this was the case. One reason might be that individuals learn of the medical team’s presence predominantly through word of mouth. Another hypothesis is that access to care could be so poor that recipients focus on ‘what’ more than ‘who’.

A second subtheme was discovered indirectly, i.e., not through direct questioning: misidentification of the interviewer. Our consent process involved informing potential participants that the interviewer was not affiliated with the care team and that receiving care did not require interview participation. It also required participants to restate this before proceeding. Nonetheless, seven participants subsequently associated the interviewer with the MMI care team. In most cases this was by referring to the interviewer in the second person; in others it was more direct. On one occasion the participant misidentified the interviewer and expressed uncertainty about the care team’s identity:

‘I would say that an institution like *yours* [MMI] should build a hospital here. It is called MMI right’? (*emphasis added*)

Misidentification of the interviewer suggests that separating the role of the researcher from that of a care provider could be difficult in short-term programmes, particularly in settings like ours where by necessity the research and care occurred simultaneously. Our interviewer was recognised in other social contexts within the DR as a foreigner; as such, interviewees might have naturally associated him with MMI. This contextual factor might have been reinforced by conducting interviews within the clinic or hospital setting. It raises a concern that participants might not have felt free to express themselves or to criticise MMI, perhaps due to worry that their care could be jeopardised, despite our consent process.

Access to care

Participants identified diverse elements of care provided by MMI that were universally perceived as high in quality. Important dimensions of access to care identified included lower-cost care (‘It costs less, and is faster’), greater availability of health care workers (‘Without MMI, there are no doctors ... not close to here’), and access to medicines provided by MMI. For example, one participant reported:

‘If there were a local pharmacy, perhaps I would be able to buy it here. But we lack a place to buy it’.

Not surprisingly, in the 10 hospital-based interviews, access to surgical services was emphasised. However, across all interviews, concern with lack of transportation (and identifying MMI as overcoming this access barrier) was commonly described and mentioned nearly twice as frequently as access to medicines. The following sentiment was representative:

‘[MMI] is an advantage because one does not have to take public transport to get to clinic or medications because they are here [with MMI]. Look, I live over there [several miles away], and I came here on foot’.

The emphasis on transportation appeared to occur because participants sense that health care goods and services are available—for example, through the national health insurance and public clinics—but are inaccessible due to transportation barriers. The quoted participant, for example, lives in a remote area of the DR with virtually no access to medical services. Similarly situated individuals might see MMI as ensuring service delivery extends all the way to its final destination (i.e., the patient) and thus might be less concerned with exactly which services are provided. They also might see transportation as one efficient and sustainable means to access. Whether the emphasis on transportation (compared to the specifics of medical goods and services) would remain if transport were not the main barrier could not be determined from our interviews.

Identified needs

The need to be responsive to community-identified needs is an obligation of short-term global health programmes (Crump, Sugarman, & WEIGHT, 2010). We asked participants specifically about unmet health needs. Their responses were seemingly in concordance with health statistics in the DR. For example, reflecting the local disease burden (e.g., high maternal mortality and high incidence of diarrhoeal disease), two participants specifically mentioned obstetrics and gynaecology and one noted the need for a paediatrician. Two others also explicitly identified vision services, not just for their own sake, but also by relating them to particular community circumstances. One participant said:

‘What services does it need? It needs services for vision for older people. A service for vision because many of the old people are living alone. They are alone and suffering from vision loss’.

In addition, four individuals reported the absence of accessible health education. One participant, when asked whether opportunities exist for health education, responded directly:

‘No. Here we have a place but there aren’t any [health talks]. Here there was a centre. They used to give talks about AIDS for the community. It existed before but now it does not’.

By identifying needs, participants provided feedback that can be implemented and evaluated in future MMI programming and confirmed the utility of asking individuals about their community’s needs.

Social determinants of health

Our semi-structured interviews did not ask about social determinants of health (i.e., the social, environmental, political, and economical contexts in which people live, and how they influence health). Nonetheless, in nine interviews, participants referenced these factors, particularly poverty and environmental issues. As one participant said:

‘One of the things that most affects this country is poverty. The small amount of development. There are no jobs for the poor. ... That is what most affects us’.

Another participant identified a particular medical problem due to social/environmental conditions:

‘Currently, there is a lot of fever. It is very damaging because there are a lot of mosquitoes that can give people dengue fever or fever to a lot of people’.

In follow-up, the participant was asked whether MMI was addressing this need:

‘Yes. Are you asking me if they are able to fight it and [if] they are able to help us? Yes, of course’.

Interestingly, MMI was not working directly on mosquito control. The participant appeared to be referencing MMI’s work in the clinic treating conditions caused by mosquitoes or in educating the community, e.g., about mosquito nets. However, because the government does have vector-control programmes, this response raises the possibility that the participant is misperceiving MMI’s work in the area or does not expect a short-term programme like MMI to address this social determinant directly. Meeting participants’ expectations or correcting their misperceptions on this aspect of programming could be a way to foster deeper community and governmental collaboration. For programmes it is also ethically important to clarify this division of responsibility.

Faith

Although not asked directly, faith in God emerged as a particular theme of importance in 13 interviews, including three distinct subthemes: the role of personal spiritual growth, MMI as part of God’s plan, and more general statements of a spiritual nature. General statements of a spiritual nature ranged from ‘Thanks be to God’ to describing MMI’s work as a ‘miracle of God’. When expressing MMI’s role as part of God’s plan, two participants suggested explicitly that ‘God sends them’ or ‘It is through Him [God] that they get the medicines to cure us’. This latter participant went on to suggest the importance of MMI for personal spiritual growth:

‘Also, they are reading the word of God in order to cleanse our hearts, and they make us feel good’.

Another said:

‘They talk about the word of God, and that is good because no one travels alone’.

Whether statements within this theme reflect the community’s own spiritual capital, the faith basis of the NGO, or both, could not be determined from the interviews. That participants expressed the importance of faith in our study suggests that recipients view MMI as more

than a purely medical organisation. However, this finding must be interpreted cautiously. Because we did not specifically ask all participants about the role of faith, and because MMI is a faith-based organisation, views opposed to faith could be underrepresented.

Language

We asked all participants whether they had difficulties communicating with the medical team due to language differences. In only two interviews, individuals responded that they had difficulties with communication, suggesting that miscommunication was not commonplace. Although participants did not reference the Dominican or Haitian translators that assist English speakers, their presence might be a reason why.

One participant provided an illuminating comment:

‘Everything that they [MMI] offers us is [metaphorical] bread that will last us a long time. ... It will not cause things to get worse. And this is good for us and the community because we are a poor community. In reality, I cannot read. Only a few people can read and write. Most do not understand what they [MMI] are saying. But, the service is phenomenal’.

The nature of our methodology prevents us from determining whether this participant is correct that ‘most’ participants do not understand what MMI volunteers are saying. The participant might also be referencing when MMI volunteers talk to each other. However, for this individual, there is significant trust in MMI—or perhaps such poor access to services otherwise—that miscommunication seemed relatively less significant. Even so, accurate communication is fundamentally important, and our findings suggest that programmes might be unable to rely wholly on recipients to report miscommunication.

Student involvement

Because students play a role in MMI’s work, we asked general questions about how participants perceived their involvement. Although student involvement could be seen as inefficient (because students are less knowledgeable and need more support) or even risky (because they might exceed their level of training or be misperceived as fully trained practitioners), no participant expressed a negative view regarding students. Participants described student involvement in three ways: as beneficial to the student’s professional development, as beneficial to the communities because of the care delivered (e.g., ‘they take your blood pressure’), and as part of future non-specific benefits to the community:

‘[I feel] very good because when you [mistaking the interviewer for an MMI volunteer] are practising on me you are studying. You need to practise because medicine is 50% theory and 50% practise’.

‘They [students] give us competent and intelligent services, and we are very pleased with them because it is a great service’.

‘It [student involvement] is good because now they know ... they help the campaign [referencing this participant’s previously expressed view of the political campaign to increase access to health care in the community]’.

The positive assessment of student involvement cannot be separated from MMI's commitment to adequate supervision. As one participant reported:

'When a student does not understand something, he is able to ask another doctor in order to do the right thing. For that reason, I feel good'.

This suggests, therefore, that care recipients perceive student involvement as good under particular circumstances; perceptions might not be as positive without this supervision.

Ways to improve MMI

One goal of our study was to examine explicit ways MMI could improve its services. We asked about this directly, but few participants offered suggestions. Seven of 20 responded simply that MMI should come more often; one asked if MMI could stay longer, echoing concerns about the sustainability of short-term programmes. In the most substantive comment, one individual asked MMI to

'... try to recruit more volunteers ... from the community that know the community, that know the problems of the community'.

Another asked MMI to target its services to those areas most in need. These two comments support intentional programming aimed at health equity and cooperation with local human resources. However, understanding the general reluctance among interviewees to provide suggestions for improvement requires reflection on several of our major themes. Were participants reluctant because they 'misidentified' the interviewer as part of MMI and did not feel free to share? Is 'access' to services so poor in some areas that participants feared losing MMI's services if they appeared critical? Importantly, when closely examined, the 'access' and 'identified needs' themes suggest that participants are willing to discuss improvement strategies—but not when asked about these directly. For example, the participant-described need for gynaecology, while not highlighted as a specific suggestion for MMI, could nevertheless inform future MMI programming.

Respect

A final major and unanticipated theme emerged in all but two interviews. We denoted 'respect' to cover participants' expressions of trust, solidarity, and being listened to or attended to closely. The ubiquity of intangible 'respect' in response to questions about the benefits of MMI suggests that this concept was significant:

'[The service is excellent] because they talk to each one of us, they treat each one of us well'.

'What is MMI doing here? They attend to us well. They are very friendly. They attend to each person very well. They help with everything. I like how they work. They are very kind. They give a lot of attention to each person'.

'[MMI is helpful] because you are friends. You are treating me. All of this time, I am with you'.

Access to tangible goods or services and the concept of respect were sometimes linked. For example, after discussing the benefits of the programme in providing medicines and education, one participant stated:

‘I feel very good because I know that they are giving us help [i.e., medicines], and they are in solidarity with us’.

It is critical to emphasise that participants expressed this notion of respect when asked about MMI generally. That they did not immediately discuss goods or services suggested that these tangibles were not the only benefits of the programme, and might not be the most important ones. Our interviewers did not ask whether participants directly weighed these different domains, or whether the nominal fee charged for MMI services contributed to this sense of respect. Both could be areas of future research.

Discussion

Our data provide preliminary support for some of the concerns motivating our work while also expanding our knowledge about them. For example, we documented instances of language-based miscommunication, which reinforces the need to deliver culturally appropriate services (Roberts, 2006). Fortunately, this was rare; however, that this miscommunication was discounted by the participant and revealed only through our qualitative methodology suggests a need for further research exploring and measuring effective communication in short-term programmes. Our findings also revealed that some participants desired the group to work more closely with locals, emphasising the importance of local collaboration (Crump, Sugarman, & WEIGHT, 2010) even though MMI had long-standing relationships in the area studied. Finally, sustainability as a concern for short-term programmes was underscored by not only this emphasis on local collaboration but also participants’ calls for MMI to come more frequently, even though no participants described ‘sustainability’ directly or reported harm due to its absence.

In other cases our findings counter some criticisms of short-term programmes, at least in our study’s context. Participants expressed a variety of universally positive views of student involvement, despite concerns in the literature about students or trainees abroad (Al-Samarri, 2012). Our results suggest that, in specific circumstances (e.g., with adequate supervision), recipients appreciate students’ involvement. This may be reassuring for some educational programmes while reinforcing the importance of providing adequate supervision.

In still other cases, our findings—particularly about ‘respect’—support broadening of the ethical discourse around short-term programmes to include concepts of mutual solidarity and mutual caring (Benatar, Daar, & Singer, 2003). Participants did not describe nor evaluate the programme as a mere purveyor of goods or services. This sentiment has been documented in recent studies of aid recipients outside health care (Anderson, Brown, and Isabella, 2012). Further exploration of the importance of respect and solidarity with MMI, and in particular determining how to measure and to weigh it against other programme objectives (e.g., access to medicines or services) is necessary.

It is worth emphasising the implications of our findings for nascent efforts at evaluating short-term global health programmes (Maki et al., 2008). First, our results support the importance and usefulness of qualitative methods. Evidence of miscommunication arose during the course of the interview, not in response to closed-ended questions about communication. This suggests a need for programmes not only to ask about miscommunication, but also to develop ways to monitor for it proactively. Similarly, the topic of significant areas for quality improvement arose indirectly, and not when interviewees were directly asked about improvement. Qualitative interviews are a specific tool for programmes to use in evaluating health needs and designing programmes to meet these needs. Our findings are thus consonant with recent related efforts at documenting recipients' perceptions of international assistance (Anderson, Brown, & Isabella, 2012).

Second, the reluctance of participants to discuss ways to improve MMI programmes and their misidentification of the researcher-interviewer as a provider further inform programme-evaluation efforts. Understanding why participants misidentified the organisation (or whether this matters to them), for example, is a critical future research need that could be pursued in parallel with interventions to better inform participants of MMI's identity. Separating evaluation from provision of services may also require explicit attention. This was underscored by participants' overall positive assessment of services, which can be difficult to interpret in a setting where few other accessible services exist. A mixed methods approach, where qualitative studies are followed by anonymous surveys, is worth considering. Another option to explore is administration of an evaluation outside the clinic setting (such as in a community health centre) by local community health workers who are explicitly not part of the short-term programme. Where possible, it would be important to include community health workers, translators, community leaders, and other important stakeholders in the analysis, both to confirm the findings and to potentially reveal additional themes. Third, the themes we identified generate hypotheses for developing novel and specific outcome measures to evaluate short-term global health programmes. For example, further research could more thoroughly describe adequate supervision and then develop relevant metrics for it from the perspective of students, supervisors, and recipients. In addition, from our findings about access (or by conducting similar studies at their sites), programmes could develop specific metrics regarding access to medicines, services, and education interventions to monitor programme improvement over time.

Our study has limitations. First, given the particular characteristics of service delivery in this project and the design of this initial project, we are unable to explore the themes we identified in greater depth. Nonetheless, our findings provide valuable information that can inform both additional descriptive studies and programme-evaluation efforts within this particular setting and in others. Indeed MMI plans to use the findings for exactly this purpose. Second, as a qualitative study, our findings do not necessarily generalise to other populations. We used purposive sampling to identify a range of ages and to attempt to achieve gender equality. Our sample did not represent the population served but instead sought a range of perspectives. Future research should seek to determine the population served and to obtain representative samples. Third, certain themes may be unique to our setting. The importance of faith, for example, must be interpreted cautiously. We cannot determine the relative importance of this spiritual dimension as compared to the more

tangible education and medical services provided by MMI; this requires further study. In addition, we did not interview individuals who did not receive or who might not have sought care; this limits our ability to capture alternative views of the programme or faith. Might faith-based organisations, even when they do not expressly discriminate based on faith, unintentionally attract only those of a shared faith? Fourth, our study excluded individuals who did not speak Spanish. This included 11 individuals whose Spanish proved difficult to interpret during the interview and analysis because their primary language was Haitian Creole. Individuals in these communities who speak little Spanish or only Haitian Creole may be particularly vulnerable to inadequate access to health care. Future efforts should include them.

Conclusion

We have completed one of the first systematic qualitative studies to begin to understand the perceptions of recipients of care within short-term medical programmes abroad. Our findings demonstrate not only some of the challenges but also the feasibility and utility of qualitative methods to evaluate short-term programmes. Additional research will be necessary to ensure recipients' voices continue to be heard; to explore these themes in greater depth; and to ensure that short-term programmes contribute to, and do not detract from, the pursuit of global health and global health equity.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1

Major themes and subthemes.

MAJOR THEME	SUBTHEMES
Misidentification	Of the interviewer
	Of MMI
Access to care	Less costly
	Health care workers
	Medicines
	Transport
	Surgical services
Identified needs	Specialty services (paediatrics, gynaecology)
	Education
	Vision
Social determinants of health	Poverty
	Environmental concerns
Faith	Personal spiritual growth
	MMI as 'God's plan'
	General spiritual statement
Language	No miscommunication
	Occasional miscommunication
Student involvement	Benefits community
	Benefits student
	Future non-specific benefits
Improving the organisation	Stay longer
	Come more frequently
	Work more with locals
	Target communities
	No improvement suggestions
Respect	(No subthemes)

Table 2

Characteristics of study participants and interviews (N=20).

Participant characteristics	
Gender	
Male	7 (35%)
Female	13 (65%)
Average age, years (SD)	
	38 (15)
Age range, years	
	18–63
Interview characteristics	
Site	
Hospital Batey Verde	10 (50%)
Mobile clinics:	
<i>Altagracia</i>	4 (20%)
<i>Batey Nuevo</i>	1 (5%)
<i>Majagual</i>	3 (15%)
<i>San Pedro</i>	2 (10%)
Average interview length (range)	
	13:21 (9:22–23:53)