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Stephanie Saladen
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**RESHAPING HEALTHCARE INITIATIVES IN THE DEVELOPING
WORLD**

**A thesis submitted to
Regis College
The Honors Program
In partial fulfillment of the requirements
For Graduation with Honors**

by

Stephanie Saladen

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Thesis Written By

Stephanie Saladen

Approved by

Thesis Advisor

Thesis Reader or Co-Advisor

Accepted by

Director, University Honors Program

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I. Introduction and Context:

Too often we confuse short-term medical work with development. We fail to recognize that temporary aid and charity cannot provide the lasting solutions that development works to achieve. As a result of this, we utilize our time and resources to create healthcare initiatives whose solutions are fleeting and unsustainable. This is particularly endemic among health practitioners, who are trained to fix and medicate in the short-term but not to engage in processes of continuing collaboration in the long-term.

There is therefore a need to examine misguided attempts at medical development and how they can be remedied. True progress requires methods of self-interrogation, relationship building, and ultimately a willingness to reshape the traditional techniques of practicing global health. There is great potential if we begin thinking of development as a steady process of mindfulness, proactivity, and flexibility. There is no one-size-fits-all solution to healthcare in the developing world. Perhaps the best place to begin is with my personal narrative—the story of how I came to confront these challenging, but ever-important, issues of development.

My Narrative

At least once in the course of a lifetime, every individual will experience an unexpected turning point or life altering realization. If we are fortunate, these opportunities provide a moment of clarity—one that allows us to reconsider or reimagine our rightful role. For me, this moment came after embarking on a medical trip to Nicaragua. Though my experience in the field of development is limited, it has been an extremely influential aspect of my life. As a result my ideas, aspirations and ultimately my understanding of the world have been challenged in a way that would have been impossible otherwise.

My story begins with the desire to practice medicine. From the time I was young, I imagined myself as a doctor. As I grew older, I carried this dream to Regis University where I chose to study biochemistry in hopes of one day going to medical school. Here, I realized that my dream of being a doctor was about more than simply practicing medicine. Fundamentally, it was about helping others. This truth, small and cliché as it appeared was my reality. This realization was ultimately what encouraged me to volunteer with Global Brigades.

Global Brigades is an organization that describes itself as “the largest movement for global health and holistic development” (<https://www.globalbrigades.org/>). This organization offers one to three week trips to a variety of developing countries, and strongly encourages sustainable projects. They offer an assortment of brigades, some of which include business, engineering, environmental, and medical. Immediately, I was

drawn to the medical brigade and signed up for the trip to Nicaragua the following summer. And so, in August of 2015, a small group of Regis students and several others embarked on the weeklong brigade.

After arriving late in the night, we traveled by bus to what would be our home for the next week. I remember that in the darkness, I could see towering barbed wire fences and tall stadium lights that surrounded our camp. This place was generally used as a camp for children, but during our stay it would be turned into a makeshift hotel with constant security protection. I also clearly remember driving up and seeing the large pile of water jugs that we would use as drinking water for the next week. Naturally, I felt a sense of relief that I was safe and well protected. Yet I also remember the overwhelming feeling of separation.

The next day would consist of packing medicine and preparing for the clinic. On the third day, we woke early in the morning to leave for our first day in the field. The drive was several hours long. As I looked out of my window, I recall the beautiful green terrain and winding roads up into the mountains. This place was beautiful but it was also clear that it had been marked by great hardship. My first indication of this was in the animals. The cows and horses that lined the road were plentiful, but were weakly and had skeletal appearances.

I also remember the conversations that occurred between volunteers on the long bus ride up into the mountains. The question “Why did you decide to volunteer?” was one that came up quite often. Of course, some of the more common responses included “I want to serve,” and “I feel called to help others.” I was more surprised by others, such as,

“I want to go to medical school. Hopefully this will set me apart from other candidates,” or, “I really wanted to travel this part of the world!” I found myself somewhat bothered by these statements. Yet I was also unable to deny the fact that I had thought about these things as well. It was at this point that I found myself questioning the importance of intent. Did it matter what our individual intentions were? Or were we just bodies coming to help with something that was much larger than ourselves?

When we arrived at the clinic, the line of people already reached several hundred. For almost an hour, we set up the clinic while the locals continued to wait outside in the heat until finally we were able to begin. The process of filtering people through began with the triage station, where individuals were asked of their symptoms and had their blood pressure, height, and weight taken. Next, they were sent onto the doctors (all of whom were locals) and given a written prescription for their necessary medications. It was then decided whether or not they would need to see the dentist, physical therapist, or receive a pap smear. Their visit ultimately ended at the pharmacy, where they were given their prescribed medications, most of which were for ibuprofen and parasite medication. Children then had the option of attending the Charla—the only educational portion of our clinic—either before or after they had gone through the entirety of the clinic. Here, they were given a small bag that included a toothbrush and toothpaste, and they were taught proper brushing technique. In the three days and two villages where we set up clinics, over 1,500 people received care.

I left Nicaragua feeling extremely positive about the services that we provided, and felt as though Global Brigades had given me a wonderful opportunity to help those in

need. However, only a few short weeks after our return, I began to reflect further on our work. I suddenly began to question whether or not we actually provided any service at all. I began to think about the sustainability that Global Brigades proudly touted on their website. When I really thought about it, our final objective had been to provide ibuprofen and parasite medication. But what would happen once that supply ran out? Certainly the parasites would return since the drinking water remained the same. Ibuprofen offered a mere temporary release from pain, and was something that the locals may not have access to in the near future. Perhaps one positive aspect of our work was that of the physical therapist, who was able to teach daily exercises to relieve muscle and joint pains. Yet very few people in the clinic actually had the opportunity to learn these exercises.

Global Brigades had ensured us that another group of volunteers would eventually take our place in those villages, and then another, and then another. But was a string of weeklong visits by strangers really enough? Was this what sustainability really meant? Though I knew that the locals were extremely grateful and that all of the volunteers left feeling as though the trip was a success, the truth seemed to be that this trip had not succeeded in much at all.

At this point, I found myself questioning not only Global Brigades but also service work as a whole. My life seemed built on the belief that I could make a difference, and that I would be able to do so without much effort. One week in a developing community and surely I could impact the lives of hundreds. This idea now seemed ludicrous. Even with the support of a substantial organization such as Global Brigades, I had not been able to achieve this feat. Ultimately, this single experience was

enough to make me recognize that I wanted to learn more about how this extreme naivety in service could be remedied. How could the good intentions of overly confident volunteers be put to a better use? Could it? It was this desire that ultimately led me to enroll in Regis University's Master of Development Practice (MDP) program.

The MDP program has not only provided me with a plethora of resources on this very subject but has also allowed me to begin to address all of the frustrations that I had built up after my trip to Nicaragua. Through this program, I have been able to begin replacing these frustrations with positive alternatives, and begin building a new outlook on development practice as a whole.

In order to begin *truly* sustainable and holistic work, there are so many important questions to consider and topics to address. First and foremost, how can we escape this seemingly broken method of service and find true success in development practice? And what exactly should this look like for the medical field? By examining these questions, I will simultaneously explore the importance of intent, methodology, relationships, and much more. I fully believe that these are questions that must be addressed and topics that must be explored if we are to hope for a better future. Ultimately, it seems to come down to a question of how we can best serve the world, and more importantly the people within it.

II. An Examination of Intent

My experience with Global Brigades sparked a much deeper consideration of the notion of intent. This is true not only on an individual scale, but on an organizational scale as well. Global Brigades describes their work as the “largest movement for global health and holistic development,” and states that they are able to “sustainably transition communities” (Global Brigades USA). In reality, it seems that these notions of *sustainability* and *holism* have become buzzwords—lacking any serious interrogation of their meaning. Again and again, we hear the bold claims of development practitioners. Organizational and government plans continue to declare a war on poverty. But the reality is that we have yet to experience the miraculous transformations that are so often promised. Perhaps it is time that we step aside and consider how exactly we define development practice. What is our intent in development? How and why has this been successful? How and why has it failed?

Examining the Notion of Success

Before engaging and implementing a development plan, it is crucial that we begin looking critically at our notions of success. We must ask a seemingly simple yet incredibly important question: What is the success that stakeholders of development seek?

Our understanding of success is often defined by fleeting and unsustainable solutions. The initial distinction that must be made is the difference between development and charity/aid. Charity works seek to provide immediate care for immediate needs. This

can be extremely critical in times of natural disasters or epidemics—money is donated, resources are provided, and the immediate needs of a people are met. Development on the other hand, seems to imply a more longstanding investment into the wellbeing of a community. This difference has been likened to the infamous words of Mark Twain, which state, “The difference between the almost right word and the right word is a really large matter—‘tis the difference between the lightening bug and the lightening” (Yeoman 2012). Certainly, charity plays an important role in alleviating the pains of the world; however, problems begin to arise when charity works are mistaken as means of development. It must be made clear that charity does *not* have the power to change the much deeper and longstanding problems of the developing world. Where efforts of achieving large-scale change are concerned, charity is the wrong word, and therefore the wrong approach. This misidentification of charity as lasting success runs deeply within the medical field.

In developed countries, individuals can generally rely on medications, vaccinations, and surgical procedures to maintain a healthy state of wellbeing. For the most part, our medical concerns are temporary and able to be resolved. Even more dire health conditions—cancer for example—coincide with a prescribed treatment plan. This reality has largely shaped our plans for helping the developing world, and has often directed us towards more charity-based approaches. Talk of access, quality, and cultural norms of healthcare are often left out of these discussions, and because of this, we find development initiatives to be lacking.

The World Health Organization (WHO) defines health as the “complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.” This statement works to direct our attention away from the purely medicinal and clinically based approaches that we have become so accustomed to. These useful but temporary solutions are not true acts of development, in that they do not reach at the deeper roots of health. So what exactly does it mean to find health that is not simply the “absence of disease or infirmity?” I would argue that this means we must look beyond the boundaries of physical wellbeing, and also begin to pursue a wellness that allows us to flourish and prosper in other ways as well. Individuals should not only be *physically* healthy enough to pursue a successful life, they should also feel *able* and *empowered* to do so. If this is the goal or success that we seek, we will need to look beyond purely medicinal solutions.

In truth, medicine alone cannot carry a people out of the harsh reality that they face. This is something that health-based development initiatives must come to terms with. How can we rethink our own understanding and experience of healthcare, and transition to a methodology that is capable of wholly transforming the livelihood of a people? For these reasons, acts of clinical charity and aid cannot be the final success that we seek. There is a need to stop aiming for the eradication of disease and instead work towards creating a healthy people. How then can we redirect ourselves in this way?

An important starting place is with the examination of intent, as intentions are rooted in how we view and seek successes. When entering into a developing community, personal agendas, plans, and technologies may overshadow self-interrogation and understanding of intent. In this way, we begin to build plans and projects that are ignorant

to the realities faced. We subsequently lean more towards those charity-based planning or gird ourselves with western solutions. Our intent becomes personal in that it is grounded in our own experience of the world. In order for development to be truly successful, we must step away from this very limited approach and pursue a more authentic development. But what exactly does this look like?

One of the greatest problems that arises with this misguided intent is that which embodies a savior complex. This type of understanding is grounded in the belief that those in developing countries are helpless and require a hero—one who knows what is right and that has the necessary knowledge, resources, and plans to save them. There are two fundamental reasons why this is an approach that will never work.

First, it must be said that development is about much more than the implementation of a master plan, the provision of monetary funds, material goods or medications. In fact, such plans have the potential to restrict and ultimately harm development efforts. These types of models often lack the self-interrogation that is fundamentally important to development. By this I mean that they fail to slow down and examine the effects of their work, and the possibility that their methods are ineffective or harmful. Yet the lacking plans and insights of development workers are not necessarily the sole root of the problem; rather, it is the unwillingness to allow for flexibility and adaptability in their efforts. John Paul Lederach, a specialist in international conflict resolution addresses these ideas in *The Moral Imagination*. His words help us to see beyond the reliance on rigid structures and plans, specifically in his discussion of serendipity. He defines serendipity as, “the wisdom of recognizing and then moving with

the energetic flow of the unexpected” (115). Although training and schooling on development work or medicinal practice is important, this sometimes has the ability to limit us. We must be able to move with the reality of the developing community, rather than remain rigid in our own perception of someone else’s reality. Lederach describes this as “smart flexibility,” which brings us to the second fault of the savior complex.

Smart flexibility often requires that we relinquish control altogether and instead let others take charge of finding their own meaningful solutions. In the case of development, this means allowing local people to take on leadership roles, and allowing them to find solutions to their own reality. In this way, we must learn to adapt to *their* needs, not the other way around. This locally driven development is a theme that in many cases is a fundamental key to success. Rather than focusing on outside money, technologies, or resources, this calls us to work within the given environment, and through the work of local leaders. For example, what medical solutions are readily available to a people without having to bring in antibiotics or pain medications? Perhaps the greatest lesson we can learn before entering into development work is the importance of self-interrogation in the planning and implementation of development processes, and moreover, a willingness and openness to constructive transformation of these processes. What is it that *we* can learn from the environment within a developing community *before* we bring in our outside knowledge and resources? What tools of change are *already* readily available? The potential for success often sits directly in front of us.

A definition of development and its overarching goals and intentions is a difficult concept to conceive. For now, I will use this working definition: Development is a

process that aims to cultivate the freedoms, aspirations, and *overall* wellbeing of a people. It does so in a way that heeds all voices and perspectives, allowing people to define their own assets, needs, and desires. Development is *not* the strict implementation of a plan. It is not a place for “I know best.” Development is ultimately the process of allowing others to seek and achieve their *own* successes and flourish in this way.

Whose Reality Counts?

Thus far, we have established that outside perspectives and ideals alone cannot make up successful plans and processes within the field of development. Because of this, the following question must be put forward: Whose reality counts? Who and what should be the driver of development and the success we seek? Amartya Sen’s work, *Development as Freedom*, explores this problem of how exactly we should approach development. Sen—a Bangladeshi economist who was awarded the 1998 Nobel Prize in Economic Sciences for his contributions to welfare economics and for his interest in the problems of the world’s poorest members—begins the conversation by presenting the parable of Annapurna’s garden.

The story begins as Annapurna is in the process of finding someone to tend her garden, and has narrowed her search down to three contenders: Dinu is the poorest of the three, and Annapurna feels inclined to hire him for this reason. Bishanno on the other hand, has only recently become impoverished, but as a result is the most depressed of the three. Annapurna also feels pressure to hire him as well, as he is suffering the most emotionally. Lastly, Rogini is debilitated from chronic ailment and requires the income to

seek treatment of the disease. Annapurna only has the ability to hire one of the three, as she believes the work is indivisible and therefore cannot be distributed amongst the three. In a sense, Annapurna's parable reflects the multiple approaches and arguments of differing development theories, many of which are very segregated from one another. A medical practitioner, for example, would feel most inclined to help Rogini and take the route that addresses the burden of medical impairments and disease. This story exemplifies the truth that while some development practitioners might place higher importance on the economic well being of a people, others focus on the physical health, and so on. This begs the question of what information must be taken into account as we begin planning and implementing development processes. What approaches must we take on and how do we decide this? Whose voices must we choose to focus on?

For Sen, the answer lies in a more *integrated* approach that encourages discourse across the different development theories. His understanding of integration specifically requires that five systems are always in place: security, transparency, political participation, secondary education, and economic opportunity. He argues that when one of these components is missing, the others are not only weakened, but also unable to be brought to their fullest potential. We see here that he directly challenges Annapurna's insistence upon a single choice. When we choose a single isolated path of development in this way, too many individuals are left behind and because of this our work will never reach genuine success.

For healthcare practitioners, avenues towards holistic development are often difficult to recognize. Instead, it becomes easier to remain rooted in those purely

medicinal approaches. A good example of this can be found within the story of Hôpital Albert Schweitzer. This story begins in October of 1947. At this time, *LIFE* magazine published an article on the medical missionary Albert Schweitzer and his honorable work in Africa. This article then influenced another man, Larry Mellon—the heir of the Mellon banking and industrial fortune. The article inspired him to return to school in the pursuit of a medical degree, and ultimately make a move to Haiti, where he and his wife opened up Hôpital Albert Schweitzer. Larry and his wife were devoted to helping the Haitian people. Finding an abandoned banana plantation, entering into a 100-year lease with the government, and converting it into a hospital were only the beginning of what would become a lifetime of service. The Mellons were spending approximately one million dollars each year on this endeavor and had made it their life goal to see successes in their work. However, after ten years, Larry made a startling discovery—the hospital was never going to be enough.

At this point, the Mellons decided to begin a public health outreach program. Not only would this enable education systems to be put in place but it also allowed for a more integrated approach to healthcare. Medicine did not hold the answer. The local people did. This was their reality. Without them, healthcare in Haiti could never be truly transformed. Today, the mission of the hospital is to “*collaborate* with the people of the Artibonite Valley as *they* strive to improve their health and quality of life” (Hôpital Albert Schweitzer Haiti). The term collaboration in and of itself implies that development cannot be derived from a single voice or a single understanding of the world. Rather, it is a dialogue and exchange of ideas.

Again, we are reminded to allow for openness and flexibility in the development process. We can then learn to engage alternative approaches and most importantly sustain self-interrogation throughout. From here we can integrate and engage not only different development techniques, but also learn openness and become proactive listeners of others. How shall we carefully hear and examine what others say—specifically the locals of developing communities? The truth of the matter is that it is *their* reality that we are considering and *their* voice matters most of all. In this way, there is a need to encourage and empower the voices of locals in the planning and implementation processes.

The Entry Points of Development

With the vast array of backgrounds, training, experiences and beliefs that each individual in this world cultivates, the following question must be asked: “What is it that each of us can offer to the field of development?” On a basic level, the answer to this question lies within our various entry points. For some, an entry point can be that of a particular profession—an individual may come from experience in the medical field, engineering, business, and so on. In other cases, an entry point can be grounded in religious beliefs that encourage missionary work. Yet our entry points run much deeper than this. They are also rooted in our socioeconomic and cultural roots and our overall worldviews. An individual’s entry point includes all of this baggage—both good and bad—which causes them to enter into the field of development.

Just as the story of Annapurna describes, we often observe separation and underlying conflict between the various paths of development work. This separation

commonly reaches back to various entry points. When deciding to enter into this field of work, we generally align our goals with personal experience. For this reason, entry points often remain segregated. When aiming to tackle the vast problems of developing countries, we seem to fall into a mindset that our own methodology is best. For example, if we simply provide adequate medical care to a people, they will be able to be more proactive members of their community, have more time for education and work, and then be able to become a more successful society as a whole. We seem to migrate towards the notion that one path can lead to the success that we desire. This is yet another fault that has become commonplace in development work. Perhaps a better approach is to begin seeking ways that we can integrate the ideas and methodologies found within various entry points.

Demonstrating the importance of cross-disciplinary work in development, Richard Skolnik describes the following situation in his text, *Global Health 101*:

“Rashmi lived in the eastern part of Nepal in a modest home. She often had difficulty breathing. This was linked to the way Rashmi cooked, with an unvented household stove that was fueled by cow dung or wood. She cooked two meals a day on the stove, and she often held her new baby on her back as she did so. She heard about the different stoves and about using kerosene or gas fuel. However, she lacked the money to buy a new stove or to use kerosene or gas for cooking” (Skolnik 171).

The story of Rashmi provides an example of the necessity to integrate various entry points. If we simply look at the health repercussions of Rashmi’s unvented stove, we would fail to address architectural, environmental, and economic issues that are equally important to this discussion. To be narrow-minded in the field of development is to continue a cycle of false progress. We cannot continue to advocate for *holistic* work

when we seem to have lost sight of what exactly that means. Beginning to integrate various entry-points has the potential to guide us back in the proper direction—one that not only has various specialties working on development projects, but has them working together in a truly integrated way. Moreover, there is a need to recognize that Rashmi too provides an extremely important voice. Her entry point—unlike the outside voices of development workers—comes from within the reality itself. Failure to include her perspective is to once again fail at a genuinely holistic goal. To discredit individuals like Rashmi, is to lose the most important component of truly successful development work.

The Dangerous Effects of Our Intentions

As previously discussed, there is great danger when we begin to view acts of charity as means of development. Not only are these types of solutions unsustainable, they also encourage an unhealthy level of dependency upon development practitioners and the services they provide. An important voice to this discussion comes from Jessica Alexander and the following passage in her autobiography, *Chasing Chaos: My Decade In and Out of Humanitarian Aid*:

“Aid agencies need to collaborate to provide people with material relief—and ideally, help them preserve a sense of human dignity... A single organization doesn’t have the resources or expertise to do it all. If one organization builds a school, another must deliver water and a place for kids to go to the bathroom. If another organization doesn’t provide a meal in school, children will typically go hungry and be too exhausted to study. And if yet another organization doesn’t come in to assist parents in finding and maintaining their livelihoods, they might not be able to afford to send their kids to school, or pull them out to work instead. If there isn’t a clinic nearby where a child can get treated if he gets sick—well, then he wasn’t going to be coming to school anyway. People didn’t need just one kind of intervention. They needed a package of services, and agencies had to come together to provide comprehensive support. It’s like building a house: you

need a contractor to pour the foundation and erect the walls, an electrical to install the lights and outlets, a plumber to put in the sinks and toilets.” (Alexander 105).

This passage provides insight into the vicious cycle of dependency that can form when we choose to build development work in this way. The locals begin to build their entire lives around the help that they receive from outsiders. Though this *does* encourage interdisciplinary development work it does *not* engage the locals in an empowering way. This ultimately seems to leave out a very important aspect of the question “Whose reality counts?” Though it may seem as though the individuals within the community are able to improve their lives through these means, the results are unsustainable and do not stem from the capabilities of the people themselves. At the end of the day this work is exactly what Alexander describes, that is, “material relief.” Relief may allow for a sense of release in times of great hardship, but this is far different from the aims of development. Development digs much deeper at the heart of the world’s problems, and dares to face them in a way that allows for long-lasting solutions. In this field, we must aim to step away from this cycle of dependency, and focus our intentions upon solutions that enable a people to stand on their own. This is where true successes will begin to arise.

Still, we must continue to recognize the dangerous impact that our intentions can have if not executed in a mindful and educated manner. Perhaps a final consideration of intent can be found in Ivan Illich’s address, “To Hell With Good Intentions.” In his speech, he speaks to all development practitioners. He speaks specifically to those who travel to Mexico in an aim to solve the many problems. He states,

“I am here to tell you, if possible to convince you, and hopefully, to stop you, from pretentiously imposing yourselves on Mexicans... All you will do in a Mexican village is create disorder... I am here to entreat you to use

your money, your status, and your education to travel in Latin America. Come to look, come to climb our mountains, to enjoy our flowers. Come to study. But do not come to help” (Illich 1968).

This too, is a truth we should consider. As a whole, have we as aspiring or current development practitioners, come to implement more harm than good? When our pursuit of success becomes clouded by an unwillingness to integrate different perspectives, or when we remain rigid in the implementation process, not only do we run the risk of failure, but also the risk of causing harm to a people. Creating dependency on outside aid, internalizing notions of inferiority, or leaving communities with unfinishable projects are merely some of the potential threats that we can pose. These faults certainly hold true for the healthcare field, where foreign medical “specialists” flock to developing communities to provide their western solutions and medications. Though good work has certainly been done in the past, I maintain that this cannot be the mindset that we uphold for development work in the future.

This savior complex, which claims to use superior knowledge and resources to help the supposedly “helpless,” cannot be at the heart of our intentions, missions, or work in the developing world. In contrast to Illich’s statements, I believe that there *is* potential within our human capacity to help one another and to work *together* towards success. But with this must come the following question: “Who does not belong in this process? That is, who should go home?” Rather than allowing Illich’s word to discourage development work as a whole, it provides an opportunity for reflection and self-interrogation. How can we reform our intentions to fit the needs of a people? Are we willing to do so? If not, Illich’s words begin to hold a greater and unavoidable truth. In

the end, our successes will never come from a mindset of “fixing” or “saving” a people. They must be rooted in the desire to work collaboratively and constructively with a variety of people, voices, and perspectives. If it is success that we seek, then these successes can no longer be one-sided. Change does not come from a single direction; rather, it must flood in from all around us. Ultimately, we must learn to direct our vastly differing strengths, specialties, and experiences towards helping one another to build a greater reality for all. This is the success that we must seek.

III. The Importance of Relationships and Culture

If our intentions are to be molded by various peoples and perspectives then there is a need for deeper consideration of what exactly positive relationships and collaborations look like. How can we begin to interact with one another in a way that is grounded in notions of respect—one that listens carefully and utilizes the strengths and views of all constituents? In order to truly gain an insightful answer to this question, we can first evaluate the mistakes that we have made in the past and how we can replace these methods of communication and partnership in the future.

Fostering Relationships of Equality and Collaboration

At this point, it seems self-evident that local people should have the opportunity to voice their opinions and even lead their own development projects. If we are to be successful in development, there is a need to begin looking at the importance of fostering positive and collaborative relationships. And moreover, we must look to foster relationships of equality. But what exactly does this look like? A good place to begin is with a discussion of Rachel Naomi's article, "Helping, Fixing, or Serving?"

In this work, Naomi explores the differences between *helping* and *serving* a people and how this difference can make an impact for all individuals involved. Naomi describes, "Fixing and helping create a distance between people, but we cannot serve at a distance. We can only serve that to which we are profoundly connected." This statement suggests that there is an innate difference between the more disconnected or sterile approach of helping/fixing and a more integrative approach of serving. Naomi's article

largely associates this disconnect with the sense of superiority that volunteer workers tend to embody. When volunteers see the drastic differences in lifestyle such as those seen in developing communities, it often becomes difficult not to separate oneself from the people who experience these conditions every day. We become stricken with the notion that these are a helpless, hopeless, and altogether foreign people who we must fix. Yet, to isolate oneself from these individuals is perhaps one of the greatest misfortunes that has become commonplace in service work. Again, Naomi iterates the difference between helping and serving, stating,

“Serving is different than helping. Helping is not a relationship between equals. A helper may see others as weaker than they are, and people often feel this inequality. The danger in helping is that we may inadvertently take away from people more than we could ever give them.”

This sense of division and superiority ultimately causes a dilution to development work, and in many cases, may be entirely detrimental. What volunteers must be reminded is that the individuals within the communities being served have much to offer us as well. The relationship between a volunteer and the individuals they serve is unique in that it provides the potential for all to be active shapers of a more positive future in development.

In order to consider this notion of positive and collaborative relationships further, another distinction must be made—that of pity and compassion. Though this distinction seems quite clear, it becomes more difficult to process and distinguish these emotions when in the field. Certainly, it would be unreasonable to suggest that we must ignore the differences between development practitioners and the people within developing communities. These are differences that cannot and should not be erased or forgotten.

Instead, we should learn to process these differences in a more insightful manner. Rather than allowing a sense of pity to become the driver of our relationships with the developing world, we can instead nurture a thoughtful sense of compassion—one that is mindful of the struggles of a people, but does not lose sight of their equal abilities or strengths. In order to understand this concept, we can look to the words of two important teachers.

The first of which, is Gregory Boyle, and his work *Tattoos on the Heart: The Power of Boundless Compassion*. Here, Boyle—a priest—discusses his personal experiences running Homeboy Industries, a gang-prevention program located in Los Angeles, the gang capital of the world. This represents an extremely important example of two vastly different peoples coming together to achieve positive change. Boyle's words are specifically useful in his reflection upon what exactly it means to be a compassionate individual in service of others. He states, "Compassion isn't just about feeling the pain of others; it's about bringing them in toward yourself... in compassion, margins get erased. 'Be compassionate as God is compassionate' means the dismantling of barriers that exclude" (Boyle 75). This type of kinship between individuals fosters a more genuine and rewarding experience for all. Regardless of the fact that people experience entirely different lifestyles, development work provides the opportunity to erase margins as Boyle suggests. Moreover, it allows us to get past the ignorant notion of pity, hierarchy, or "I know best." Instead, these ideas are replaced by the potential for positive collaborative work amongst equals.

A reading of *Tattoos on the Heart*, might also lead one to consider yet another integral work that deals with this discussion of compassion: *The Places that Scare You: A Guide to Fearlessness in Difficult Times*, by Pema Chödrön. Chödrön is an ordained Buddhist nun that is a leading exponent of Tibetan Buddhist teachings and the implementation of these teachings in everyday life. She states, “Compassion is not a relationship between the healer and the wounded. It is a relationship between equals.” This statement in itself seems to directly echo the ideals of both Naomi and Boyle in that it expresses the need to see past segregating views. The notion of hierarchy that often attaches itself to development is a topic that should certainly be addressed. In order for a mission to be truly successful, this is something we must work to alleviate and progress instead towards a different perspective.

With this notion of mindful compassion comes the need for volunteers to enter all situations with a sense of respect. Again, we are presented with a seemingly simple statement, but in truth, this is something we often neglect when in the field. Glenn Schwartz presents this idea in his article, “How Short-term Missions can go wrong.” Schwartz’s work too, addresses this reoccurring sense of hierarchy that establishes itself in service trips. His first example describes a group of Americans who visited Zimbabwe to volunteer for a six-week building project, but were asked to leave early. When asked why this was, the local builder in charge responded, “What the Americans didn’t know is that we here in Africa also know how to build buildings... we built buildings before they came and we will build buildings after they leave. Unfortunately, while they were here they thought they were the only ones who knew how to build buildings... we had to ask

them to leave.” This example presents the dangers that arise when we obtain what is often described as the “great white outsider” syndrome. Similar to the savior complex, this mentality takes on the idea of “I know best,” even when it is clearly untrue. To make a positive impact, there is a need to fully respect the individuals within a community being served, and, once again, a need to expunge this hierarchical way of thinking.

The Power of Images and Parables

When envisioning the developing world, images of starving children, debilitating disease, and slums are the first images that come to mind. We look out and see a people that appear destitute and helpless, and reply, “I am going to help fix this.” Yet too often, our understanding of the developing world is limited to these images. We fixate on the visions that have been branded into our minds—perhaps one of a starving African orphan with flies in its eyes—and allow these images to define the work that we do. It would be foolish to deny the fact that these individuals experience a very different reality than our own, but to assume that this is their defining factor is a dangerous assumption to make in the field of development. Unfortunately, this is a presumption that has become commonplace in service work, and one that has had a lasting effect on development work as a whole.

We now know that too often development practitioners enter into a community with the intent of personally solving the problems at hand. This was certainly true for my own experience with Global Brigades. What is specifically concerning though, is when volunteers aim to “fix” or “civilize” the individuals who reside there. When we allow images of supposed hopelessness to distort our vision, we begin to understand all aspects

of a developing community, as a failure. This includes the people themselves, and because of this there is often an extreme lack of reverence and respect for the cultural identity and customs that define the locals. We forget that a Westernized view of wellbeing and success is not the only way of living a good life. Development workers have made a habit of trying to convert native people to align with their own ideals. This outlook was a trademark of colonialism around the world. Chinua Achebe lends a particularly powerful voice to the impact that this had in his parable *Things Fall Apart*.

This parable tells the story of Okonkwo, a commanding leader and hero of a small village who returns home to Umuofia after seven years in exile. Upon his return he comes to find Christian missionaries among his people. The outsiders not only preach new religion but also implement new laws and carry out retaliation for those who do not abide. Okonkwo is deeply disturbed by the outsiders and is persistent in maintaining his traditional way of life. Ultimately though, he is unable to reconcile the two realities and commits suicide by hanging—a grave sin within his culture.

Achebe's portrayal of Okonkwo speaks to the deep cultural divide that often presents itself between "outsiders" and locals. Okonkwo's fate can in some ways be seen as a metaphorical death of the traditional African culture that once thrived. This is largely because the missionaries were unable to see the value of a strange and foreign existence. Instead, they saw a people who needed to be saved, a people who needed to be led away from a seemingly barbaric way of life. Achebe seems to be suggesting that one of the fundamental problems with missionary work is the failure to recognize the value of those traditional cultures. Additionally, it is important to note that as a whole the people of

Umuofia were not an uncivilized people. They had a justice system, an economic system, and a hierarchy that served the community well. Outsiders are often blind to this truth, instead focusing on how they can remedy the clearly broken lifestyle. And so, locals are often left with two options: conform, or accept failure.

In many cases, it seems as though the ultimate goal is conquest rather than service. This can lead to more destruction than good, a truth that is clearly illustrated by Okonkwo's fate. If this is not the case though, and we genuinely seek a way to serve those in need, how can we shift towards a better understanding of the local people, their needs, and better comprehension of what development should look like? The answer seems to be that we must learn to see beyond the wrongful stereotype of a helpless, savage people, and instead see our equals. Ultimately this example speaks to the extreme importance of parables within development work. A parable—such as the one Achebe presents—forces the reader to take on the perspective of each character, and therefore incites a sense of self-interrogation that would otherwise be lacking. Stories such as this trigger reflection that is essential to development work and our relationships with local peoples.

Another example that speaks to the power of images and its often destructive impact is presented by the Taylor family in their work *Empowerment on an Unstable Planet*. For four generations, the Taylor family has worked towards collaborative efforts in the developing world. Their work has been done through the incorporation of missionary work, science, nonprofit work, and even through the lens of poetry. Their voice is therefore particularly relevant to this discussion. Together the Taylors present the

story of Arunachal Pradesh, a state in northeastern India that is isolated from the outside world by dangerous terrain, hostile tribes, and endemic malaria. Because of this isolation, Arunachal has remained a largely independent state, having minimal interaction with India's government. The locals therefore adapted to their environment by utilizing one of the few resources available to them—bamboo. The Arunachal people were able to use bamboo for almost everything, including food, shelter, weapons, clothing, and even the bridges across the deep gorges of the surrounding terrain. They were a very resourceful and therefore successful people. Eventually though, social entrepreneurs and development practitioners became interested. These outsiders saw an isolated and hopeless people in need of help. This help then came in the form of gifts, projects and the innovative ideas of outside professionals. Yet with this, also followed a growing dependence on outside aid and eventually the people forgot how to be resourceful in their own environment. This became particularly severe during monsoon season when the locals were cut off from this assistance. They began to starve—an event that never would have occurred prior to outside intervention and the subsequent dependency that formulated. Essentially, they “lost the sense of their own capabilities” (Taylor et. al 14). The outside world saw them as helpless, and so they became helpless.

What both Achebe and the Taylors' examples illustrate is the dire importance of how development practitioners interact with the communities they visit and work in. We seem to filter out the strengths and the many admirable qualities of developing communities, and strip their existence down to something that is broken. Though it is true that there are many communities in dire need of help, this service must not come at the

cost of their many positive qualities, and certainly should not leave them worse off. How then, can we find a positive way to introduce new ideas and technologies and encourage locals to innovate without subsequently encouraging dependence? Furthermore, how can we also take into account the importance of maintaining and respecting the culture and traditions of a people throughout a process that often requires change?

When considering such questions, it is not only important to take into account the mindset of the service provider but of the local people as well. One of the fundamental reasons why dependency has become such a large issue has to do with the fact that the locals have also come to believe in the stereotypical images of their homes and countries, and have allowed these images to define them. They too, have come to identify their lives with a sense of hopelessness, and because of this the process of development becomes even more complex. Perhaps development practitioners should begin asking how a new sense of empowerment can be achieved for these individuals. What would this empowerment look like? Furthermore, how can an outsider come to understand the value of the locals and their ideals, and also aim to provide aid without detracting from this sense of empowerment? In the end, if neither party sees true value or capability in a people, their traditions, and opinions, then how can anyone hope to cultivate positive and lasting growth?

A final example can be found in the healthcare systems of Haiti. After the 2010 earthquake that caused devastating damage, international attention began to focus on the failing health systems within the country. Again, images of mass destruction and a hopeless people swarmed media outlets around the world. Outside aid and development

practitioners were quick to join in on restorative efforts. This was certainly true for foreign doctors that were eager to confront the mental health issues in Haiti.

Majority of Haitian citizens practice the Vodou faith, an aspect of their culture that is central to their understanding and interpretations of mental health. Paul Farmer states, “Etiologic beliefs may lead mentally ill away from doctors and toward those better able to ‘manipulate the spirit’” (Farmer 267) This became a particularly troubling problem for outside medical practitioners who aimed to address these issues of mental health in a more scientific way. A large contributor to this phenomenon was the lack of access to biomedical solutions, but even when people were given a choice, they often favored spiritual healing options. Moreover, in the instances that locals *did* choose medical solutions, “the treatment offered was not contextualized within a spiritual cosmology that [they] understood or believed” (Khoury et. al 15). Here we see that medical practitioners were unable or unwilling to communicate with their patients in a way that was conducive to their cultural or religious understanding of the world, and because of this, problems of mental health often remained unresolved.

What these doctors failed to recognize, was that Vodou and biomedical solutions did not have to remain in opposition to one another. In reality, “the incorporation of local perspectives and existing resources related to mental health among Haitians would be integral to creating sustainable solutions” (Khourey et. al 1). Unless outside doctors would contextualize their solutions, biomedical practices would remain largely unutilized. It was found that many Vodou priests and priestesses were actually active in referring individuals with mental illnesses to medical facilities. The foreign doctors,

unlike the Vodou leaders, had simply neglected to consider the notion of working *together*. To quickly assume Vodou practices as ridiculous and foolish was to miss the point of development. That is, our work is not about imposing beliefs or understandings of the world on a people. It is about adapting to local environments, cultures and peoples in a way that will allow for collaboration and true progress. It is about looking beyond the overly domineering failures of a people, and seeing their many amazing qualities and values. We must not let images of something that appears hopeless or different define a peoples' ability to work towards a solution. These false images will only hinder our pursuit of positive change.

A Further Consideration of Cultural Differences

To form meaningful and constructive relationships in development often requires us to *address* these drastic differences in understanding and culture. The convergence of differing worldviews and traditions has the potential to form tremendous rifts between individuals, and in many cases stops relationships from forming altogether. But, if we are willing to work through these differences there is greatly unrecognized potential in our collaboration. One of the greatest examples of this was seen during the 2014 outbreak of Ebola in West Africa.

The Ebola virus is transmitted through direct contact with infected blood or bodily fluids. As the death of an infected individual approaches, the virus levels peak. Those who come into contact with someone who is about to die or has recently deceased are at

high risk of contracting the virus themselves. This reality would become particularly troubling for the relationships between medical practitioners and local peoples.

National Geographic tells the story of a pregnant Guinean woman who died after contracting the Ebola virus. As outside medical workers moved quickly to bury the infected body, they were soon stopped by local community members. Their Kissi culture strictly dictated that a pregnant woman must have her fetus removed prior to burial. If this task was not completed, her soul would be unable to reach the village of the dead. Moreover, her fetus would disturb the natural cycles of all surrounding humans, animals and plants. For these reasons they refused the burial to be performed. To medical practitioners it was clear that the procedure of removing the fetus could not be done, as it was far too dangerous to risk further spread of the disease. And so there was a direct clash between the parties, with both groups refusing to waver in their beliefs. The two parties each believed that the very livelihood and wellbeing of the people was at stake, and it must be stated that each was justified in their own right. So where would the solution lie?

In this case, the district medical officer called in an anthropologist by the name of Julienne Anoko to help find a solution. Anoko, who was originally from Cameroon and had decades of experience in West Africa, would become an integral component of the resolution process. Her background and experience led her to believe that there must be a way to make reparations to the spirits if a traditional burial could not be completed. In the end, she found help in an old man familiar with the reparation rituals, and discovered that the solution would require twelve yards of white tissue, salt, oil, and rice. Once the

materials were acquired, the locals were presented with the idea and accepted (Maxmen 2015).

For much of the Ebola crisis, such cultural and traditional considerations would not have been made. Rather than taking into consideration the views of the locals, the visiting medical workers would be more likely to proceed with their own agenda. In the face of such a devastating disease, it becomes difficult to entertain the idea of alternative processes or take a moment to consider issues of cultural conflict. For an outsider, it appears painless to neglect such foreign burial practices, or any such tradition that they are unfamiliar with. In this way, detachment from the local peoples is easily accomplished. But what we fail to realize is that doing so has the potential to be extremely detrimental. To neglect relationships in this way can cause deep distrust and even conflict. Taking the time to account for and address these differences is invaluable to forming positive and collaborative relationships.

Another important example of cultural differences in development work is that of female genital mutilation (FGM). This has marked a significant collision between international and local norms. The World Health Organization defines FGM as procedures that involve partial or complete removal of external female genitalia, or other injury to the female genital organs for non-medical reasons. This is a particularly common practice in African and some Asian countries. The fact that there are no health benefits, and that it has been found to cause extensive bleeding, infections, complications during pregnancy, and even infertility, have led it to be largely recognized as a human rights violation. For many working against the continued practice of FGM, the image of

a young girl being held down and harmed against her will is the first notion that comes to mind. What is often forgotten is that many women are eager to take part in the ritual. Even with the negative side effects in mind, they are willing participants of this long-standing tradition. Certainly, this is not commonly the case, but what is to be done for these individuals who see FGM as an integral part of their culture?

When unnecessary harm is caused, and atrocious consequences arise, it becomes difficult to consider the notion of compromise or understanding. It is not to say that the practice of FGM should continue, but there is a need to be mindful of the differences that lie between groups and individuals. It must be understood that there are aspects of culture and tradition that will never be fully understood or accepted. To immediately write off the differences of others as nonsensical or irrational is to disrespect the individuals themselves, and is not the path to finding meaningful or lasting solutions.

The cultural differences presented through the Ebola and FGM crises in no way suggest that disagreements or varying backgrounds should be thought of solely as barriers to positive relationships. Cross-cultural interaction has the potential to build more meaningful understanding between us, and can allow us to grow together in remarkable ways. But in order for this to occur, we must be willing to confront our social differences in a more constructive and open way. If this is done on a personal and individual level, we can hope that it will also carry through to greater scale and allow groups of people to work together towards positive change.

Education Among Equals

At this point, it has been firmly established that development work implies a need to create relationships of compassion, equality, and true collaboration. How then, can we maintain this sense of equality when we take on the role of an educator? How do we avoid the seemingly *unavoidable* notion of “I know best?” And how do we encourage education that incites mutual processes of self-interrogation? This is a reality that certainly was not present within my experience with Global Brigades, and is lacking in a large portion of development initiatives. Part of our answer may come from the insights of two brilliant philosophers—Paulo Freire and Mikhail Bakhtin.

Freire, a Brazilian educator and philosopher, was known to uphold a “profound ethical concern regarding the relationship between the self and the other” (Rule 928). Moreover, he was interested in how dialogue could contribute to authentic relationships between individuals, and how these relationships could spark social change. Bakhtin too, is greatly concerned with ideas of dialogue, and how it is innately bound to our experience as human beings. Bakhtin also goes on to describe how the relationships we form are not always easy or straightforward, stating, “the I-Thou relationship is not guaranteed; it is a task, a site of struggle, something that requires constant effort and renewal” (Rule 929). In this way, both Freire and Bakhtin began looking critically at the relationship between teachers and learners, and work to improve upon them.

In most cases, the teacher is thought to provide knowledge and insight for their students, and ultimately act as the driver for this relationship. Rachel Naomi would consider this to be a relationship centered on “helping” or “fixing,” in that it seems to

instill a sense of separation, rather than connectedness. Once again, we are presented with a clearly hierarchical way of thinking. Freire and Bakhtin look to reframe this form of dialogue and relationship, by rethinking the roles of each party. This becomes clear when considering Bakhtin's notion of boundaries. It is stated, "The boundary is not some kind of permanent and fixed line of division between teacher and learner, but is rather a permeable and shifting threshold of contact and communication which is present both between teacher and learner (Rule 938). This is an extremely important lesson when taking development work into account. In order to achieve more beneficial relationships, it seems critical that we learn to reshape the leadership dynamics between development practitioners and the people they serve. This should be done in a way that does not limit anyone to a position of inferiority or servitude. In other words, everyone must feel empowered to take on the role of a teacher, and also be willing to take on the role of the student. Here again, we see Lederach's "smart-flexibility," come into play, and the need to relinquish control becomes relevant once again. Within this willingness, comes a transformation of our relationships and our capacity for change. It is this process of bonding that will work to bridge development practitioners with the communities they practice in, and ultimately make development initiatives more meaningful and impactful.

Barriers at Home as Described by Wangari Maathai:

In order for successful relationships to form between development practitioners and the communities they work with, there first must be an effort to form solid relationships within those communities themselves. This is a topic that Wangari Maathai

addresses in her book, *The Challenge for Africa*. More specifically, she discusses the strained relationships between Africa's citizens and their leaders. She argues that the greatest barrier to change is the lack of "principled, ethical leadership" in Africa—that which is "motivated by a sense of service to the people." This type of guidance has the ability to transform societal direction, ultimately influencing the motivations and aspirations of a people. The deficit of this genuine and proactive leadership has instead caused Africa to succumb to corruption, dependency, and those intense feelings of helplessness that have previously been described.

Maathai presents three primary causes of the leadership crisis in Africa. The first cause deals with the legacy of colonialism. Africa became "carved into spheres" by powerful nations such as Great Britain, Germany, France, Italy, Portugal and Belgium, so that these powerhouses were able to campaign against one another, maintain their geopolitical dominance, and utilize Africa's raw materials. This, in turn, served colonialism, providing opportunity for white settlers. Africans were "civilized and Christianized," and the leadership dynamic began to shift in the favor of these outsiders. During this time, some Africans also took advantage of the situation, specifically outcasts. Those who aligned themselves with the colonialists were given powerful positions—causing another drastic shift in the leadership dynamic.

The second cause of the leadership crisis comes from post-colonial structure. Many African countries assumed that after their independence was won, Africa would undergo a transformation, finally moving them towards progress. Unfortunately, European powers still held much power over them, as they still required and essentially

demanding the use of Africa's raw materials. Maathai describes the gained independence as a mere "change of guards," rather than a retaking of leadership. The African leaders in power also became prone to corruption by aligning with these outside forces. The mission became more about satisfying personal needs than satisfying the needs of their own people. Lastly, the Cold war was yet another large contributor to the leadership crisis. As African countries were forced to take sides, they were subsequently pitted against one another. This too led to corruption.

Though Maathai clearly expresses the role of outside factors in the leadership crisis, she also places a great amount of responsibility on Africa as well. This is seen as she later contrasts Africa (as a whole) with the Maasi, a people who were resilient in their unwillingness to comply with colonial authorities, and held strong to their own way of life. In other words, they actively protected and maintained their culture, societal structure, and local relationships. Maathai argues that in order to resolve the crisis of leadership the African people must begin to take charge of their lives in a similar way, and become active drivers of development, but to do so requires a healthier relationship between the citizens and their leaders. What then is Maathai's solution to this crisis of leadership?

The "three-legged stool" is the metaphor that Maathai uses to describe an Africa that can adequately support and provide development to its people. The first leg of the chair represents a true democratic space for the community to engage in, the second embodies a sustainable and accountable management of natural resources, and the third includes cultures of peace (fairness, respect, compassion, forgiveness, recompense and

justice). Perhaps the most important take-away from this metaphor, is the need for the African people—and people in developing communities worldwide—to feel as though they are in an environment that allows and encourages active participation in the processes of development. Maathai states,

“[I]t is crucial to approach development from this perspective, in which an environment is created for citizens to engage productively. It is essential to recognize that... no matter how many funds are provided, in a country that is balancing on two, one, or no legs, the money may not only be wasted or have only a temporary effect, but may even contribute to the continuing instability of that society” (Maathai 58).

Ultimately, in order for development to be successful, there is a need to reform and heal the relationships within those developing communities. This should occur before outside forces become involved. After all, without a solid foundation, how can there be room for positive growth?

Development becomes even more difficult in areas of more severe conflict and violence. The UN’s development progress report for 2015 directly addresses the strain of conflict upon development work stating, “Conflicts remain the biggest threat to human development. By the end of 2014, conflicts had forced almost 60 million people to abandon their homes—the highest level recorded since the Second World War.” How can we achieve sustainable development work, if a stable environment is not available to a people? The task of improving a way of life becomes extremely difficult when considering a nomadic lifestyle, and moreover, when considering an environment of violence.

When looking at healthcare, this issue of conflict seems all the more relevant. Violent environments appear more conducive to superficial forms of treatment. Wound

and trauma care become the primary concern, and long term healthcare and education plans begin to lose relevance. Again, we are reminded of the severe need to resolve conflict if we hope to one day aid in the development of a people. Of course, conflict and violence will always have a presence within this world, but what is important is that we include means of conflict resolution in our plans for development. Without it, progress may become lost to us. In order to see the results of Maathai's three-legged stool we must begin nurturing an environment where it can stand—a solid foundation for the implementation of change.

Global Partnerships of the Past and Future

Our analysis of relationships thus far points to the extreme importance of social capital and how we build this infrastructure within our work. The social capital we seek is that which supports and solidifies collaborative networks and relationships. This is the very essence of work that is meaningful and impactful. So now that we have an understanding of what this looks like on a personal and local level, we can also consider how this has played out on a global scale.

The year 2000 marked a year of great promise for the field of development. At the Millennium Summit, the largest gathering of world leaders in history adopted the UN Millennium Declaration. This marked a commitment on behalf of each country to reduce the world's poverty, and was driven by a series of targets to be achieved by the year 2015. These targets would go on to be known as the eight Millennium Development Goals (MDGs). The goals acted as a way of “addressing extreme poverty in its many

dimensions—income poverty, hunger, disease, lack of adequate shelter, and exclusion—while promoting gender equality, education, and environmental sustainability” (UN Development Programme 2001). A look at the eighth goal, which aimed to “develop a global partnership for development,” provides insight into how we have aimed to foster large-scale relationships in the past.

This goal worked towards a variety of partnerships across the globe. This included, but was not limited to, developing improved trading and financial systems, addressing the special needs of the least developed countries, implementing strategies for decent and productive work for youth, working with pharmaceutical companies to provide affordable and sustainable access to medicine, and providing access to new technologies. As we move from considering micro to macro-scale relationships, we see a clear transition into a more business and statistical analysis. This is clear when viewing the MDG progress report, released in 2015. For example, through this, we are informed that official development assistance from developed countries increased by 66% in the past fifteen years, reaching \$135.2 billion dollars of monetary assistance. We also learn that the proportion of external debt service to export revenue in developing countries dropped from 12% in 2000 to 3% in 2013, and that 95% of the world's population is now covered by mobile-cellular signal technologies. Though there is clearly marked progress, can it be said that our mindsets towards the developing world have grown or changed? What marks the progress of constructive relationships or partnerships, and the dynamics that make them up? Are we still continuing to provide aid to a helpless people, or are we working collaboratively with them? These are notions that must be kept in mind as we

reflect upon the collected data. It is also important to consider what will be done moving forward, a question that now aims to be addressed by the new and improved goals and targets—the Sustainable Development Goals (SDG).

One noticeable difference between the MDGs of 2000 and the SDGs of 2015 is a drastic increase in the number of goals. We see a transition of eight goals in 2000, to seventeen marked goals in 2015. Like the MDGs, the SDGs aim to be fulfilled within a fifteen year time period. This time, it is goal seventeen that focuses on revitalizing the global partnership for sustainable development. It states,

“A successful sustainable development agenda requires partnerships between governments, the private sector, and civil society. These inclusive partnerships built upon principles and values, a shared vision, and shared goals that place people and the planet at the center, are needed at the global, regional, national and local level.”

Here, we see a more direct statement of the need for collaborative relationships, and respect for the voices at all levels of this collaboration. Certainly, the numeric and statistical data must be used to mark the milestones of progress, but I would argue that we must also regard the progress of relationships as an important identifier of change.

Until we stop seeing developing countries as a case for our charity, and often times our pity, these people will never truly leave behind the marks of poverty, helplessness, and an instilled sense of shame. Rather than take on these images of hopelessness, we must instead instill images of empowerment. Moreover, rather than see our differences as a barrier, we can utilize them as tools for more powerful and integrated successes. Though this is a process that will require much work, it is one that will be well worth our efforts. Ultimately, fostering relationships of equality and true collaboration

will be our greatest tool moving forward. There is so much that we can learn from one another, and so much power that can be achieved when we work together. If we are truly willing to unite forces in a collaborative way, the possibilities for positive change in the developing world are endless.

IV. Medical Work and Progress in the Developing World

Only after substantial groundwork has been laid—specifically in terms of the intent and relationships within development—can medical work begin to fall into place. This does not imply however, that our duties are simplified or lessened. To implement medical work that is sustainable, conducive to the local environment, and mindful of cultural practices, while also fostering positive and collaborative relationships is undoubtedly difficult. Before this is possible there is much to consider, specifically in terms of the barriers we are up against and how we plan to implement our plans for a better future.

The MDGs and SGDs of Health

Perhaps a good place to begin is with a consideration of global health initiatives, and how global health has improved over the last few decades. The MDGs of 2000 worked towards several health improvement goals. The first MDG, which dealt with eradicating extreme hunger and poverty, is the most basic representation of this. This goal worked towards halving the proportion of individuals whose income is less than \$1 per day, as well as halving the proportion of people who suffer from hunger between the years of 1990 and 2015. This laid a fundamental groundwork of working towards health improvements within the developing world. Other goals included reducing child mortality by two-thirds, improving maternal health, and combating HIV/AIDS, malaria, and other diseases. So what progress has in fact been made? The MDG progress report fortunately demonstrates some significant progress. For example the UN records that

extreme poverty has been marked by a significant decline—decreasing from approximately half of the developing world’s population living on less than \$1.25 a day in 1990, to 14% in 2015. Globally, the number of individuals living in extreme poverty has decreased from 1.9 billion to 836 million since 1990. Moreover, the number of undernourished people in the developing world has decreased by almost half since 1990. These are monumental improvements in the basic livelihoods of a people and must be considered as tremendous milestones. In terms of childhood mortality, we have seen numbers decrease by more than half – moving from 12.7 million in 1990 to 6 million in 2015. Maternal mortality ratio has also decreased by 45% globally during this time period. And lastly, there has also been great progress in terms of limiting the power of diseases such as HIV/AIDS, measles, malaria and tuberculosis. The progress report ultimately states, “As we reach the end of the MDG period, the world community has reason to celebrate... the MDGs have saved the lives of millions and improved conditions for many more.” These remarkable achievements do in fact show the progress that can be made. However, there is still much more to be done. For example, the report also acknowledges, “uneven achievements and shortfalls in many areas,” and moreover, “The work is not complete and it must continue in the new development era.” What then are the plans for the new development era?

Of the seventeen new Sustainable Development Goals of 2015, there are four that deal directly with healthcare initiatives. The first, works towards a world that is devoid of poverty in all its forms by the year 2030. Not only does this imply that there is a need to increase household incomes, it more importantly describes a need to improve upon the

livelihoods of the individuals living within developing communities. This includes but is not limited to, “hunger and malnutrition, limited access to education and other basic services, social discrimination and exclusion as well as lack of participation on decision making.” Here we see that the first SDG provides a framework for overall change within the developing world. The second goal, works towards achieving a world without hunger. This inherently implies the need to move toward gaining a stronger sense of food security, improving nutrition, and promoting sustainable agriculture. Goal six is another fundamental aspect of creating healthier lives and wellbeing. This goal encompasses the need for access to clean water and sanitation for all. It is stated,

“There is sufficient fresh water on the planet to achieve this. But due to bad economics or poor infrastructure, every year millions of people, most of them children, die from diseases associated with inadequate water supply, sanitation and hygiene.”

This is a specifically relevant goal, due to the fact that in the near future, countries affected by chronic or recurring shortages of fresh water is expected to increase drastically. For this reason, the importance of setting up more sustainable and constructive measures are extremely important for the long-term health of a people. Lastly, and perhaps most relevant of all, is the third SDG, titled “Good Health and Well Being.”

Similar to the MDGs, the third SDG of Good Health and Wellbeing hopes to decrease child and maternal mortality rates, decrease the risks of various diseases, and provide better access to treatment and medications. However, this SDG digs much deeper and further explores what exactly makes up a healthy reality for individuals. Unlike the MDGs, this SDG also considers topics such as reducing substance abuse, mental health

problems, traffic accidents, and the effects of hazardous chemicals in the air. It also goes on to include the need for “financing and the recruitment, training and retention of the health workforce in developing countries.” Here, we begin seeing an important transition—that is, from *providing* medical aid, to ensuring that developing communities can provide this aid *themselves*. In other words, we see a transition from dependency to more independent sustainability. This will perhaps be one of the most important aspects of effective change in the future.

As the MDG progress report demonstrates, there are many improvements that have been made in the past fifteen years and many more that will be achieved in the next. However, this does not imply that our methods of reaching these goals are not flawed and in need of improvement. There are many factors that must be considered in terms of approach. Our own roles—as development workers, short-term volunteers, or even as bystanders—must be examined if we hope to escalate and improve upon our methods.

Seeing Beyond the Science and Quantifiable Data

Pursuing far-reaching and all-encompassing approaches to health requires that we sometimes take a step away from the scientifically driven methods we have grown accustomed to. Though scientific analyses of health are extremely important, they fail to give us the whole picture. If we are truly to pursue lasting change, we will need more than this to guide our healthcare efforts. So what exactly are we lacking? And what does a more holistic thought process include?

As one of its efforts to bring quality healthcare to the developing world, the World Health Organization has created a list of essential medicines. The core list presents the minimum medications needed for a basic health-care system. Though these medications are undoubtedly important, this will work to provide an example of how our notions of health solutions can be lacking.

One of the fundamental medications found on this list is ibuprofen, an NSAID (non-steroidal anti-inflammatory drug) that we know to be utilized as a pain reliever. As a pre-med student, I would surely be taught the mechanism of this drug. I would discover that when cells are damaged, they work to release a tuning chemical called arachidonic acid. Next, two enzymes—COX-1 and COX-2—will break this arachidonic acid down and form prostaglandin H₂. This then goes on to produce multiple other chemicals that cause body temperature to rise, inflammation to occur, and acts to lower the body's pain threshold. When specific nerve cells called nociceptors receive pain that is above this threshold, they send signals to the brain to notify it that something is wrong. In this way, we feel pain. It is at this point that ibuprofen becomes useful. After it has been consumed and absorbed by our body, it will attach to the COX-1 and COX-2 enzymes, preventing them from breaking down the arachidonic acid and ultimately preventing pain for a limited amount of time.

For this reason, the WHO has chosen ibuprofen as a fundamental drug needed for basic health-care systems. A student such as myself might also go on to learn the mechanisms of other medications found on the list such as morphine, diazepam, epinephrine, and so on. In fact, anyone studying to become a pharmacist or medical

doctor would at some point be held accountable for knowing these processes by heart. Though I do maintain that there is a clear need for this type of education, it has become increasingly clear is that this is not enough. In truth, this is a lesser part to the larger whole of medical development work. If we truly hope to transform health and the health systems of a people, we must begin to educate ourselves in more important ways.

In a similar way, medical development has too commonly been driven by quantitative data. For example, this is true even when we look at the SDGs for the year 2030. We see the staggering numbers that present information on maternal mortality ratios, infant mortality, life expectancy, and so on. These numbers do in fact reflect the reality for many individuals on earth; however, they are also somewhat lacking in the information that they provide. Because of this they can act as dangerous misrepresentations of a people. In other words, to define a people based on numbers is to lose a sense of their truer identity. Overly scientific and quantitative approaches ultimately provide another example of how our intentions can become misdirected, and how relationships with developing communities can be neglected. These mentalities therefore represent lacking methodologies of development. So what are the other components of improving the health and health systems of a people?

Attending a Jesuit institution has provided me with fortunate insight into what exactly this search for greater understanding might look like. This is largely due to the Jesuit characteristic of *cura personalis*, a phrase that translates to “care for the whole person.” This acts as a reminder that the missions of medical practitioners must reach beyond the use of scientific knowledge or quantifiable data. Moreover it teaches us that

medical work is not simply about providing health solutions for the physical body, but for the *entire* person. To achieve this medical practitioners must learn to open their minds to things that cannot necessarily be memorized or conveyed through a textbook. In truth, health improvements will never come down to a scientific mechanism or recorded number. Not only does this require us to re-channel our intent, and to form closer relationships with patients, but also to actively seek an education that cannot be provided in the classroom. So what else must be taken into account? What else must be learned?

The *social* determinants of health are an often forgotten topic when considering the health of developing communities. When thinking about health, we often limit ourselves to those fundamentals—sickness, medication, and treatment. We therefore fail to acknowledge the deeper roots of poor health, which can largely be attributed to social factors that define groups of people. This is a fact that the UN Platform directly addresses in its plans for future healthcare initiatives. It is stated,

“Health inequities are unjust and avoidable. In order to reduce health inequities, there is a need to address the wider socioeconomic and structural factors—the conditions in which people are born, live, grow and age—that influence how people become sick, what risk factors they are exposed to, how they access services, and how they use those services.”

This platform goes on to encourage the need for policy changes. Not only does this include health policy changes, it also involves a consideration of governance, environment, education, employment, social security, food, housing, water, and transport energy. Here, we are reminded of yet another way the SDGs must be pushed forward. Not necessarily in the ways we initially imagine, but on a grander and more far-reaching scale. This ultimately comes down to “linking social and health services.” In order to be

successful in our efforts, we must look at the connections made across all sectors of peoples' lives, and only then can we work to decipher a greater understanding of what meaningful solutions should look like.

Tackling the Devastating Effects of Poor Health:

As Jeffery Sachs states, "Good health stands at the center of sustainable development. It is at the center of wellbeing and is vital for everything else that we hold dear" (275). In developing communities, the devastating impact of disease and poor health stands in direct opposition to achieving goals of development. In the past, we have had several ways of addressing this problem.

One of the most common forms of addressing poor health has been that of a vertical approach. This involves a top-down disease specific method of improving the health of a people. In other words, this type of approach aims to eradicate people of a specific disease and then move on. Vertical approaches are appealing in that they are easy to measure and clearly indicate whether or not good results have been achieved. For this reason, they are particularly appealing to donors of development work as well. This ultimately implies that these types of approaches rely heavily on outside resources, monetary funds, and knowledge. Examples of successful vertical approaches include polio and smallpox eradication as well as general immunization campaigns.

Although this vertical approach has certainly provided monumental successes in the past, and remains an important tactic for future health endeavors, it already seems at odds with the understanding of development that we have come to know thus far. This

type of process relies more on outside aid and expertise, and fails to encourage long-term collaborative efforts for healthcare improvements. Moreover, it is an extremely narrow approach to health efforts, and fails to look at the larger health issues at hand. It seems to be more aligned with those scientific and quantifiable solutions that are largely lacking. For this reason, it is also important to consider the alternative *horizontal* approaches to healthcare initiatives.

Horizontal approaches represent a more ideal development process. They work to form a more comprehensive and sustainable form of care. This is largely due to the fact that they take the time to look at deeper and more complex causes of health problems. In this way, they seek out the greater roots of disease and poor health by taking into account those additional issues of economic opportunity, education, environment, safety, social support, nutrition, and so on. Acquiring this type of in-depth knowledge requires strong relationships and a sense of understanding between development practitioners and people within developing communities. The downfall of this type of healthcare approach is that it takes a greater amount of time, and is also much more difficult to quantify the results and impacts. Regardless of this truth, horizontal approaches are extremely important to true medical development work and must be further considered. So what exactly would this type of approach look like in the field?

A relevant example is introduced in the Taylors' work *Empowerment on an Unstable Planet*. This example begins with a woman by the name of Rima Langbia, and a development initiative that began in Palin, India on the heels of a cholera outbreak. One of the first health improvement projects introduced was one that emphasized women's

education. A group of women, including Rima, were taught simple preventative health techniques as well as treatment plans should someone fall ill. These techniques were often simple changes to daily routines, but were incredibly impactful. As time went on, the group of women became more educated, confident, and proactive in fighting problems within their community. Their success story branched onwards through Rima, who later moved onto Bameng, India, and began another woman's group with common goals and very remarkable achievements. Rima's story emphasizes the truth that "yes, certain diseases and challenges require specialized attention and technology to address. But before that, there is a lot you and your community can do" (Taylor 89). This approach was unique in that it did not require outside money or have to introduce incentive. Rather, the women's group "changed the context of village life by facilitating connections into new behaviors," and moreover, "what [Rima] taught caused women, then men, to recognize what they could do" (Taylor 8). So perhaps the true answer lies in a *diagonal* approach—one that incorporates both the vertical and horizontal approaches to health and therefore provides more holistic care. Ultimately, the main idea here is to heavily incorporate the empowerment of people within their current circumstances, rather than practice sole reliance on the "quick-fixes" of outside medication and disease eradication. It is about understanding the deeper causes of poor health, and working to rectify them in more comprehensive and participatory ways while still maintaining the importance of vertical approaches as well.

Reimagining Global Health

Though our efforts to create a healthier world are derived with good intentions and high hopes, these efforts often fall short of the meaningful and sustainable solutions that we seek. For this reason, there is a great need for us to continue reexamining the processes of our work and to continue reshaping how exactly global health might be achieved. Perhaps a good place to begin is by defining the over-arching goal of medical work. In his text *Global Health 101*, Skolnik describes public health in the following way:

“[Public health can be defined as] the science *and* art of preventing disease, prolonging life, and promoting physical and mental health through organized community efforts towards sanitary environments; the control of infections; the education of the individual in principles of hygiene; the organization of medical and nursing service for the early diagnosis and treatment of disease; and the development of the social machinery to ensure to every individual in the community a standard of living adequate for the maintenance of health” (Skolnik 5).

This definition certainly encompasses many of the successes we seek and the goals that the medical world should continue to strive for. In addition, we also hope to foster meaningful and collaborative relationships that can act as the foundation for such successes. But if this is true, and these are in fact the goals that we seek to achieve, how can medical development practitioners reshape and rethink their methods in order to truly do so? Perhaps one of the best examples of how this process of improvement can be found in Paul Farmer, Jim Yong Kim, Arthur Kleinman, and Matthew Basilico’s work *Reimagining Global Health*.

At the heart of this work is the quest for a truly multidisciplinary and holistic approach. The authors argue that this requires us to combine fields of “resocializing

disciplines” such as anthropology, sociology, history, and political economy, with other fields such as epidemiology, clinical practice, and molecular biology. Moreover, if this venture of global health is “to be ‘more than just a hobby,’ it must embrace the training challenges on both sides of the rich-poor divide. For every Harvard student trained, there must be at least a dozen more in the developing world who would benefit from the training” (Farmer et al xvii). In other words, we are in deep need of that truly horizontal approach to healthcare initiatives. Unfortunately, the techniques described make up an approach that is continually neglected by the drivers of development.

For these reasons, the creators of this development ideology worked to address this problem through educational initiatives in a Harvard University undergraduate course. The foundation of this course was in the consideration of “biosocial analytical approach” to global health, which could then be used to improve methods of medical services, especially for those living in poverty. Too often medical practitioners fail to utilize social theory in their approaches, and therefore provide unbalanced and unsuccessful services. Though these social considerations cannot directly or immediately provide a physical cure for the diseases or pains of the developing world, they can help to clear a path for improvements to be made. Strategies for a genuine and effective solution must utilize an integrated approach. The ease with which we separate career disciplines, educational training, or personal backgrounds is something that must come to an end. The doctor must begin to work collaboratively with the sociologist, the engineer, the local peoples and so on, in order to gain better ability to act upon issues of health. This example provides just one of many movements for improving global health initiatives.

The ultimate lesson seems to be that medical development work is a journey that requires long-term—if not lifelong—commitment and willingness to persevere. This means that the weeklong service trips of Global Brigades and other such organizations will no longer make the cut. Moreover, it is imperative that we continue to understand vertical approaches while simultaneously engaging in horizontal, diagonal, and more far-reaching efforts. This involves building close and meaningful relationships that push us to understand the deeper roots of health problems in the developing world and allow us to pursue collaboratively driven solutions. Taking the time to see beyond the scientific and quantitative data and dig deeper at the health of a people is critical. This too, requires that we engage in inter-disciplinary work that is integrated and truly holistic. If we agree that good health is central to development, we can also understand that this improved methodology is absolutely essential to seeing positive change in a shared world.

V. Circling Back

At this point, the need for change in the field of medical development seems clear. The failure of medical missions to produce large-scale and sustainable improvements in the developing world *should* be enough to encourage change in our methods of service, but unfortunately this has not been the case. Though progress has been made—a truth that is demonstrated MDG progress report of 2015—we still fail to see quality healthcare for all. Moreover, we continue to see the devastating effects of preventable diseases and poor health, and their impact on the global population. These are facts that define our reality, yet instead of transforming our methodology medical work continues to be driven by short-term initiatives that often lack the long-term components that true change requires. It is because of this that we see our intent, relationships, and medical techniques to be lacking. It is time for the stakeholders of development to recognize that medicine alone will never be enough to heal a people and fleeting work cannot produce lasting impacts. Because of this, we must recognize that changing the state of health in this world requires large-scale reform.

A Matured Reflection on Global Brigades:

Almost two years have passed since I entered into the rural mountain villages of Nicaragua. To this day, I consider my time there as an integral aspect of my growth and understanding of development. I am now able look upon organizations such as Global Brigades with a matured perspective—one that is more confident and better able to tackle my concerns and doubts. Most importantly, I am now able to more fully consider Global

Brigades' claim of being "the largest movement for global health and holistic development." In other words, I can now give voice and reason to my frustrations as well as to my hopes for a better future.

Perhaps this process of analysis should begin with a consideration of what exactly *holism* means in the context of development. Global Brigades roots its notion of holism in six ways: research and evaluation, community partnership, program preparation, and interdisciplinary brigades, staff follow-up, and sustainable transition from communities. The research and evaluation portion boasts the use of "program monitoring tools" that measure impact of the work that is done. These methods of evaluation however, remain unspecified. Though I was not directly involved in this portion of the preparation or evaluation process, I can only assume this analytic survey to consist of two things: the number of people served by the medical clinic and the amount of medication administered. Because the ultimate objective of our clinic was to prescribe medications, the administration of these prescriptions would be the only meaningful "impact" to be recorded—an objective that I now recognize to be insufficient to improving the health of a people.

The next pillar of holism that Global Brigades claims to uphold is that of community partnerships. In its holistic model, Global Brigades states that work is done "with" and not "for" community members. In this way, community leadership and local incentive becomes engaged. Though I agree that this is an integral aspect of development, I find difficulty connecting these statements with my own experience in Nicaragua. Though I cannot speak for the program directors—who spend a contracted two years in

their assigned country—my experience certainly failed to engage long-term meaningful partnerships. As we have established, relationships in development require strong bonds between equal members. It requires that we know the narratives and histories of a people, and that we utilize this in our work. None of this was true of my own experience.

Moreover, the argument that work should be done *with* community members, rather than *for* them, did not hold true for the clinic. Though there were local Nicaraguan doctors that helped to administer patient consultations, this was the only instance of collaboration present in the clinic. It must also be noted that these doctors were not from the rural villages, but were instead from the larger cities of Nicaragua. Like us, they too were outsiders at least to some extent. Ultimately, my experience acts as a reminder that true partnerships and collaboration cannot be sustained through one-week brigades, and they must reach far beyond the context in which I experienced them.

The last aspect of holism that I will evaluate is that of the interdisciplinary brigades. This is perhaps the greatest argument for Global Brigades' holistic approach. That is, they are efficient in engaging a wide variety of entry points into their work. They provide the opportunity to engage in nine different brigade choices. This includes business, dental, engineering, environmental, human rights, medical, microfinance, public health, and water brigades. Here we see a direct push for the interdisciplinary work that is key to development. This is the aspect that I find most difficult to criticize, as it shows a genuine attempt at integrated service. So why is it that I remain unconvinced of this holistic claim?

Though I cannot speak for the other brigades, I do know that the work we completed in our weeklong visit cannot be defined holistic. Truly holistic medical work not only requires long-term relationships, but also requires a greater system of healthcare education and collaboration. Moreover, it must work to improve the *overall* health and well being of an individual. This includes mental and emotional health, as well as an individual's perceived ability to pursue a life unhindered by health problems. The ibuprofen and parasite medication that was prescribed to these individuals remains incapable of achieving this goal. Likewise, the educational Charla—which taught local children how to brush their teeth—was clearly insufficient in teaching the powerful and long-term behavioral changes that are required for truly improving health. So if I can say with certainty that the medical brigade was not holistic, what does this say about the over-arching goals of global brigades? Can a holistic system be built upon insufficient and non-holistic building blocks? I would argue that a truly holistic system would require a much stronger foundation.

Overall, I value the holistic mission that Global Brigades has aimed to incorporate into its work, and strongly believe in each of the goals it sets out to achieve in this respect. I agree that the seven pillars of holism that they set out to achieve are absolutely essential to development work. Unfortunately though, my experience in Nicaragua did not reflect these pillars, and therefore should not be considered as true holism.

Finally, I am left with a consideration of whether or not Global Brigades can be thought of as a development organization, and moreover as a leader of global health initiatives that can sustainably transition communities. As I reflect upon my time in the

clinic the answer to this question becomes quite clear. One of my most memorable moments came while I was conversing with a fellow brigade volunteer. As we sat sharing stories from throughout the day, she recounted her experience at the Pap smear station. As a woman patient lay writhing in pain, her sample was taken. The doctor would later inform my friend that this woman most likely had cervical cancer. Though she was referred to a specialist, the doctor sadly admitted that the woman would never receive further care. Moreover, she would never have the access or resources required to treat such a disease. So what had we actually done for her? For all of the patients? We had set up a clinic, examined over 1,500 individuals, sent them home with small short-term prescriptions, and taught the children how to brush their teeth. Maybe this work was good, but it ended with us nonetheless. There would be no transformational change in the health or the reality of these people once we left. Even if a group of students followed us into this community, and set up another weeklong clinic in the coming months, there would never be true or lasting change. For these reasons, I now know that the work done by this organization cannot be considered true medical development.

The question now becomes about whether or not short-term medical work as a whole can in some way *contribute* to the practice of true development. The primary problem seems to be that service trips such as this encompass a more charity/aid-based approach. That is, they work to alleviate the immediate health needs of a people, and are therefore unable to implement long-term change. They are the Band-Aid, but certainly not the cure. They are also continually lacking in form of the genuinely collaborative

relationships development requires. So what are the pros of this type of service if transformational change cannot be achieved?

First and foremost, short-term medical work, and the willingness of aspiring medical practitioners to participate, demonstrates a remarkable willingness of people to help one another. It shows that medical workers uphold a genuine and remarkable desire to serve others. Unfortunately though, this desire to serve is often ignorant of true development work and is therefore directed towards ineffective and unsustainable missions. How then, can the vocations of these individuals be redirected towards better work? Can non-development practitioners contribute to meaningful change, and if so, what is their role? These are questions that I will continue to grapple with as my education in development continues.

A Place to Begin

Though my trip to Nicaragua may have been unsuccessful in transforming the health and health systems of the Nicaraguan people, it *was* successful in transforming my own perspective on medical work in the developing world. Moreover, it has pushed me to pursue a new vocation of *true* medical development. Parker Palmer's work *Let Your Life Speak* provides great insight into this inner change in vocation. He states,

“Our deepest calling is to grow into our own authentic self-hood... As we do so, we will not only find the joy that every human being seeks—we will also find our path of authentic service in the world” (Palmer 16).

The sense emptiness and frustration that I felt following my return from Nicaragua acted as an extremely important turning point in my life. It prompted the realization that my vocation was not to medicate a people. Not only would this leave me unfulfilled, it would

never be able to transform the lives of those in the developing world. Through much reflection, and through my education in Regis University's Master of Development program, I have come to understand development as a truer calling and as something much greater than the short-term work of Global Brigades.

I will now propose a definition of development that portrays my matured understanding and hopes, and is a result of the reflective and collaborative process of the MDP program: Not only is development a system that aims to cultivate the freedoms, aspirations, and overall wellbeing of a people. Development is a *process* that is complex, contextual, relational, educational, and cyclical. It has many entry points, drivers of change, and underlying motivations, and is a means for individuals and communities of diverse backgrounds to come together and communicate in a co-creation development process (CFI Learning community 2016). Ultimately, this process of growth has given me a place to begin pursuing a newly found vocation, and a way to begin working towards the greater medical development goals of the future.

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