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INTERNATIONAL MEDICAL SERVICE TRIPS: COLONIALIST ROOTS AND ETHICS OF GLOBAL HEALTH TODAY

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**INTERNATIONAL MEDICAL SERVICE TRIPS: COLONIALST ROOTS AND
ETHICS OF GLOBAL HEALTH TODAY**

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Chapter 1: Introduction to Global Health

Medicine offers the potential to be used for the betterment of people everywhere. While this is true when it is being practiced correctly, when practices of medicine are skewed in favor of the physician over the patient, medicine can become harmful. New physicians when graduating from medical school often recite the Hippocratic Oath, pledging themselves to the medical philosophy of "Do No Harm." One of the most common aphorisms from Hippocrates states, "Wherever the art of medicine is loved, there is also a love of humanity," (Stone & Gordon, 2013). Most people would like to assume this aphorism is true. However, as the following chapters demonstrate, it is clear that this "do no harm" essence of medicine has been lost within the field of international medical service, especially in the U.S. When most people conjure images of international medical aid, they see doctors saving lives or helping marginalized people access medicine they would have never had. But the reality of the situation is that international medical practices continually harm people, families, and communities worldwide. This harm is hidden under the façade of providing medicine to people, leading to the glorification of the white savior. As a society, the U.S. has romanticized the idea of service trips, leaning into the image that we are helping to save the world (Bauer, 2017). Despite the attractive façade of medical service, its harmful impact is evident when examining the ethics, the history, and the assumptions underlying the field of international medicine

Before we continue, let us define some terms to aid in the understanding of the field of Global Health. A local community as used throughout this paper as the specific group of people, town, or location that an international service trip is traveling to. International medical service trips are short term service trips, ranging from a few days to months, when a group of people from a high-income country travel to a low to middle income (LMI) country to provide medical care (Sykes, 2014). The use of LMI counties over "developing" or "third-world" countries was chosen due to the terms being outdated and the negative connotation associated with them (Nkusi, 2018). These terms help to create the image that the countries that they are attributed to are less than so called "first-world countries". By using the updated term LMI countries helps to accurately represent the countries being discussed (Nkusi, 2018). White savior complex is defined as beliefs and practices that helps to support historical inequalities that validate white supremacy and privilege. These practices are based in racist assumptions that people with lighter skin are more capable and superior to people of color (Aronson, 2017) Social Medicine is an approach to medicine which considers a wider variety of factors outside of health when observing the progression of disease in LMI areas. These factors include the social and economic positions of the community being observed (Packard, 2016). "Western"/"Westernize" is the process of influencing a culture or ideologies of a non-"Western" group with the culture, economy, and/or political systems of Europe and North America (Oxford English Dictionary, 2020). Other is defined as a person who is part of an out-group, who is looked down upon and potentially discriminated against by the in-group (Staszak, 2008). Neocolonialism is the ideology still present in a place after a

country has been released from historical powers, but colonialist infrastructure is maintained by local governments and economic shortages (Horvath, 1972).

Increasing health disparities in the world have led to a rise of international medical service trips. Despite the seemingly good intentions, the reality of international medical service trips is considerably more harmful than most people realize. Even with constant innovations in technology and science, massive health disparities are still apparent in the world today. One example of these health disparities can be observed in Sub-Saharan Africa which features around a quarter of the world's disease load but only have three percent of the world's healthcare workforce (Snyder, Dharamsi, & Crooks, 2011). Another example is in India, where 66 percent of the rural population has no access to preventative medicine, and over half of the physicians accessible in these areas hold no medical credentials (Packard, 2016). These are just a few of many examples of the health disparities that exist throughout the world. It is estimated that there is a shortage of 2.4 million direct healthcare workers worldwide which does not even include medical technicians and support staff that are needed (Bashir, 2011). Even with today's technology and the increasing amount of international medical service, health disparities resulting from a number of issues are still as apparent as ever.

The number of short-term medical mission trips has risen greatly in the last few decades in conjunction with increasing awareness of global health disparities (Rozier, Lasker, & Compton, 2017). A history of colonization, power differences, and economic instability has led to current health disparities worldwide. The perpetuation of these damaging historical structures has allowed health inequalities to continue to remain

present throughout the world. This has resulted in high adult and infant mortality rates due to issues such as malnutrition, lack of clean drinking water, curable illnesses, birth conditions, and other treatable medical problems in several parts of the world (WHO, 2020; Packard, 2016). The medical issues caused by a lack of resources leads to a lifelong struggle with health for the people in these communities. Additional social consequences reverberate within these communities, leading to economic, governmental, and educational challenges. The inability to improve these conditions further overloads the healthcare systems in LMI countries due to issues such as poor labor conditions (Bashir, 2011). The economic and social factors that contribute to healthcare inequalities exacerbate broken healthcare structures (Bashir, 2011). It is a cycle of social factors contributing to health disparities and vice versa. In order to try and alleviate some of the apparent global health issues resulting from poor infrastructure, international medical organizations have increased their activity.

For the past several decades, service trips, hidden under the disguise of helping people, have entered communities and actively (albeit intentionally) harmed them through their activities resulting in the destruction of healthcare structures. As humans, it is our responsibility to reframe deficit narratives from harmful stereotypes and structures into something beneficial for local communities. A history of abuse and harm resulting from international service has led to the distrust of international health initiatives creating a larger gap in the ability to improve global health. Bridging the gap through conversation and practice is essential to improve global health as a whole. Dismantling the harmful infrastructures global health is built upon is vital. Without removal of these

harmful infrastructures and replacing them with sustainable, safe, and effective measures, global health will never be able to improve in the long term. At the center of this change and of medicine itself, is trust. When we go to the doctor, we fully trust that our physician is going to act completely in our best interest. We believe they are following the medical philosophy of "doing no harm." Yet internationally, medical service trips have breached communities trust for years because service trips are rarely conducted in a manner that truly serves the best interest of the local community. As a result, removal of harmful infrastructure and buildup of trust is needed in order to continue forward in the field of global health.

Society encourages international organizations to believe they have an obligation to help promote the welfare of communities worldwide without first communicating with and actively listening to these local communities (Snyder, Dharamsi, & Crooks, 2011). As pseudo attempts by the white savior to improve global health, service trips have become a prominent part of today's society. Realistically, service trips can act as form of neocolonialism reinforcing power structures of "Western" superiority and colonization (Bauer, 2017). We see large effects on local communities as a result. People in both the professional and academic world often jump at the opportunity to be able to travel through the lens of learning or working. Service trips are often framed as excursions to help marginalized or poor socioeconomic communities, but in reality, these trips end up being more about tourism and travel. Service trips, sponsored by organizations ranging from schools and churches to non-profits, are generally people from higher socioeconomic backgrounds traveling to lower socioeconomic communities. These

groups perform everything from surgery to health education, for a time period of a few days up to a few months (Rozier, Lasker, & Compton, 2017). The media is flooded with the narrative of the grandiose impact of these service trips on so called "poor" communities (Rozier, Lasker, & Compton, 2017). Resulting in the glorified image of the white savior perpetuating the destructive colonialist structures imbedded in the past of these already damaged communities.

Using the information obtained by examining the harmful models, we can create a checklist for global health initiatives that can be used to stop the perpetuation of harmful healthcare worldwide and assist with improving global health in sustainable ways. To find a better system for international medical service, we must examine the history of global health, current initiatives, and their outcomes. This examination can help us find the most effective, ethical, and least harmful international health service today. We can also see the reality of the impact of global health on the world and the harmful ideals it has promoted. It is our moral and social responsibility to find ways in which we can promote sustainable and positive global healthcare changing how international medical service is conducted.

Chapter 2: Global Health

A History of Global Health

I have elected to use *The History of Global Health: Interventions into the Lives of Other Peoples* by Randall Packard as a framework for this section. Dr. Packard is a professor of the history of medicine at John Hopkins University and one of the forefront experts on the field of global health. I choose to use this book a framework for the history of global health because it encompasses multiple sides of the field as well as exploring all formative events.

Before looking at current global health initiatives, we need to understand why global health disparities exist in the first place. The history of global health and international medical interventions can illuminate the trends that have been working against the development of basic-health systems for years (Packard, 2016). The first global health interventions often appear in colonial backdrops (Packard, 2016; Tiessen & Huish, 2013). The colonialist ideologies we see influencing the global health climate today arose from these colonial backdrops. One of the first places we see a rise in US international health interventions as we know them today is during the colonization of Cuba in the nineteenth century (Packard, 2016). During US military occupation of Cuba, an outbreak of yellow fever led to reinforcement of colonialist medical interventions. During the outbreak, there was direct involvement of US medical powers with the local people in order to eradicate the disease (Espinosa, 2009; Packard, 2016). The continued intertwinement of colonization and global health has led to a rift and mistrust of

"Westernized" medicine in LMI countries. Mistrust partnered with the racially biased perceptions of physicians lead to the belief that Indigenous people are uncooperative and superstitious (Bezruchka, 2000; Keller). These biased views have helped to perpetuate the deep-rooted historical issues with international medical service.

Continued involvement by US health authorities in other colonized areas throughout the nineteenth and twentieth centuries led to the formation of a consistent model for international health interventions (Packard, 2016; Palilonis, 2021). There was a massive reduction in debilitating diseases leading to the opportunity for economic growth by external first world countries in LMI countries as a result of this model. It eventually became known as the disease eradication model (Espinosa, 2009; Packard, 2016). One of the earliest instances of this model is with yellow fever in Central America. During the 1890's, the US attempted to eradicate yellow fever in Havana through aggressive sanitation and quarantine methods (Espinosa, 2009; Palilonis, 2021). The eradication method of yellow fever eradication was dependent on the cooperation of the local residents, despite the fact they were against the invasive activities being performed (Packard, 2016). Interestingly, the local people were unafraid of yellow fever since most of them were already immune. In fact, the disease was considerably more dangerous to newcomers. As a result, the colonial power in the area worked tirelessly to eradicate the disease helping maintain military control (Packard, 2016). This is just one version of the same story that appears throughout the history of the world.

Eradication practices resemble colonial medical activities throughout Central and South America, as well as Africa and South Asia (Bastos, 2007). One of the biggest

downfalls is that colonial powers focused on eradicating a single disease in self-interest and through coercion of the local population, rather than developing broader health services (Bastos, 2007; Packard, 2016). William Crawford Gorgas, an army official, was placed in Havana by the US to oversee the eradication of yellow fever. During this time, Gorgas rarely discussed or even interacted with the Indigenous populations living in the area. He viewed them as insignificant toward his goal of eradicating yellow fever. If he could fine and force anyone who resisted his regulations into following them, he could care less about them as human beings (Bastos, 2007; Packard, 2016). The eradication model eventually became the "gold" standard for international medical service leading to growing mistrust between people in LMI countries and medical service organizations (Packard, 2016).

While Gorgas' method of eradication became the most prevalent, it was certainly not the only model present around the same time (Packard, 2016). Angelo Celli, an Italian physician in charge of controlling malaria in Italy in 1901, argued that the problem underlying the disease was more about social welfare than the actual disease itself (Ferroni, Jefferson, & Gachelin, 2012). Celli believed the most effective method to improve disease outlooks was by building up the social infrastructure such as employment, education, and water management. This ideology not only addresses the disease itself but the social factors helping to cause health issues (Ferroni, Jefferson, & Gachelin, 2012). Celli understood that in order to make long term changes to global health we need to make changes to the societal infrastructure affecting it. Throughout the history of global health, there are a few instances of social welfare trips. Despite their

strong advocacy, they failed to take hold as a prominent model for international health service unlike the eradication method (Packard, 2016).

A paradigm shift from colonial health to international health came about in 1913 with the formation of the International Health Commission by the Rockefeller Foundation, a U.S. based organization. This change shifted health work from something only seen in colonialist areas to any area with poor health or high disease conditions. The Rockefeller foundation lasted until 1951 and during its time had health programs in over 80 countries (The Rockefeller Foundation, 2020). This commission was one of the first non-governmental agencies to engage in public health, moving international health service away from colonial backdrops and closer to what we know as health initiatives today. While the organization was not a colonial vehicle, it still operated through the same measures. During the initial development of the International Health Commission, they recruited directors for their programs directly from the colonial eradication campaigns (Packard, 2016). As a result, they employed the same measures to perform medical service as the eradication campaigns. The Rockefeller Foundation maintained the lack of cooperation with local people as well as the aggressive sanitation of their colonial predecessors. Part of the reason the eradication method was still effective without the cooperation of the locals is because the International Health Board decided to partner with the colonial power in the area (Bastos, 2007; Packard, 2016). This partnership allowed the International Health Board to employ the eradication methods and bypass the local population (Farley, 2004; Packard, 2016). In areas where there was no colonial power to enforce the eradication practices, the International Health Board was forced to

adapt and communicate with the local community to overcome their resistance. Despite

the obvious need for a change in methods, even these medical campaigns retained the

basis of the eradication method (Packard, 2016).

When examining historical accounts of global health initiatives, it is obvious that

there has always been a massive disconnect in communication between the service

organization and the local community. The International Health Board's sanitation and

eradication methods suffered largely in part due to a lack of communication and respect

of the local community (Farley, 2004; Packard, 2016). For instance, the locals

complained that the newly introduced toilets attracted mosquitos causing a spike in

malaria (Farley, 2004). In Mexico, the idea of wearing shoes to prevent reinfection of

hookworm made no sense to the locals (Packard, 2016). Even in these early service trips,

the group serving had a desire for rapid and effective impact even though this was not

realistic (Packard, 2016). On the other side, the International Health Board failed to

realize people were unable to afford things like shoes in places like Mexico

demonstrating the rift between the server and the local population that is still apparent

today (Packard, 2016). The perception of the people who helped run the International

Health Board's programs clearly highlights the colonialist ideologies that flood medical

service even today. International organizations viewed local populations as incapable,

superstitious, and unstable (Bezruchka, 2000; Packard, 2016). This led to the perception

that the local population was a burden on the progress of "Western" civilization, the

white man, and that they are incapable of their own healthcare (Packard, 2016; Pfeiffer &

Nichter, 2008), an idea that is still prevalent today.

In reality, the differences in thought processes, training, and ability demonstrate the differences in economic power. People in these LMI areas were, and some still are, at major economic disadvantages, resulting in a lack of education, resources, and infrastructure to adequately combat the rampaging illnesses (Packard, 2016; Pfeiffer & Nichter, 2008). Sadly, this reality has been ignored throughout history with the negative view of local communities perpetuated by training sites and medical schools propelling the negative colonial attitudes and practices into the future (Packard, 2016; Pfeiffer & Nichter, 2008).

The first time we see the acknowledgement of the importance of social medicine in global health was in 1932 at the Cape Town conference. A subcommittee made of African colonial territories, British India, and the Rockefeller Foundation met discussing rural hygiene highlighted five different attitudes of colonial health that needed reorganization to effectively combat health issues (Havik, 2020; Packard, 2016). These changes included a need for preventative (not just curative) health measures, cooperation between the health authorities and other administrative departments, economic improvement, increase in hygiene education, and the recruitment/employment of the local population to execute the health work (Packard, 2016; Pfeiffer & Nichter, 2008). These factors all address some of the widespread issues that affect health outside of the medicine itself. The committee believed that by employing these ideas there could be greater change in global health. Despite this, three years later, none of these major changes were incorporated into global health work. At a follow-up conference in 1935, these same changes were stressed again, with particular focus on the need for an

improvement of the economic status of Indigenous communities (Borowy, 2009; Packard, 2016; Solomon, Gill, & Bakker, 1944). While these conferences are the first instance of acknowledgement of the importance of the social side of medicine, they were only discussed but never put into practice (Packard, 2016). The actual incorporation of social medicine did not come until later (Bezruchka, 2000).

The next major change in global health came after World War I with the formation of the League of Nations Health Organization (LNHO). As part of maintaining peace, the founders of the League of Nations recognized the importance of improving social and economic welfare (Borowy, 2009; Packard, 2016). The LNHO was concerned with several different factors effecting global health. One major function of the Health Organization was that it acted as an advisor to countries hoping to change and improve their healthcare system (Packard, 2016). As advisors, the LNHO hoped to help countries to develop their own healthcare infrastructure in sustainable ways. Despite this, the organization faced great difficulties in areas with political or colonial tensions. In need of money to continue their mission, the LNHO went to the Rockefeller Foundation for support. As a result, both the LNHO and the International Health Board began advocating for similar health intervention methods through the 1920's (Borowy, 2009; Packard, 2016). During this time, the Great Depression was one of the biggest influences which changed the LNHO's ideas about global health (Packard, 2016; Solomon, Gill, & Bakker, 1944). The Great Depression placed people worldwide into poverty highlighting the importance of economics within healthcare. As economic decline became more prevalent during the depression, people began to observe a massive increase in malnutrition and

disease (Carter, 2019; Packard, 2016). This impact was especially hard in colonial and LMI areas because they depended entirely on income from sales of agricultural products. So, lack of sales during the depression caused disease and malnutrition to worsen (Packard, 2016; Solomon, Gill, & Bakker, 1944). During this time, the LNHO proceeded to build partnerships with other organizations such as the International Institute of Agriculture and the Red Cross (Packard, 2016). It was the formation of these partnerships which helped the LNHO to begin incorporating social factors into global health initiatives. Together these organizations highlighted the importance of good hygiene, clean living conditions, and effective medical assistance on health in rural areas (Packard, 2016; Solomon, Gill, & Bakker, 1944).

One of the biggest areas that the LNHO attempted to focus on to improve global health was nutrition (Packard, 2016). In LMI populations improving nutrition helps to strengthen individuals, thereby making them capable of fighting off illness (Packard, 2016; Tworek, 2019). The effect of nutrition on health was particularity obvious during the Great Depression due to people's lack of wages and inability to purchase sufficient or healthy food (Packard, 2016). After the Great Depression, the LNHO put out recommendations about nutritional standards. The LHNO met resistance to this in areas where governing powers did not want the LNHO to establish health requirements (Borowy, 2009; Packard, 2016). Nonetheless, in 1935 a document discussing nutrition and public health determined that colonial populations in particular are undernourished and that governments need to recognize and improve this situation (Packard, 2016). In 1937, a committee was formed with representatives of the LNHO, the International Labor

Organization, and the International Institute of Agriculture. The committee, while focused on countries with "Western" civilizations or their influences, recognized that malnutrition was and still is a major issue (Packard, 2016; Tworek, 2019). They even condemned colonial governing powers for failing to acknowledge this reality and the impact it has on people (Packard, 2016).

Even with the acknowledgment of the issue beginning in the mid-twentieth century, malnutrition persisted and is still one of the biggest issues facing global health today. In 1937, the LNHO committee recommended that nutritional information be available to all levels of society and governments work to increase food availability to all and provide access to food for people without sustainable incomes (Borowy, 2009; Packard, 2016; Tworek, 2019). An interesting observation was raised by this committee concerning the factors affecting nutrition in different locations. The first, as previously discussed, was nutrition is dependent on the income of the family and how they use that income (Carter, 2019; Packard, 2016). The second factor poses another major concern about global health practices today. When income is sufficient enough, and only when is it sufficient enough, lack of education causes the appearance of nutritional deficits (Bezruchka, 2000; Packard, 2016). This highlights the root of malnutrition is income but after income, education becomes just as important. A study by the World Health Organization found nearly 30 countries worldwide today have high adult mortality rates and 25 have high infant mortality rates due to issues such and lack of clean drinking water and food (WHO, 2020). This clearly illustrates that despite the direct

acknowledgment of social factors effecting health throughout history, even today, we continue to fail to address and change them.

Despite the change in attitude towards global health through the LNHO and partner organizations, the presiding existence of colonial methods were still very present. In the 1930's, the LNHO expanded social medicine ideas to other parts of the world, particularly in Asia (Carter, 2019; Packard, 2016). Sadly, this more positive outlook and method of global health initiatives was again met with great resistance. In 1929, new leadership in China developed a Ministry of Health and asked for assistance from the Rockefeller Foundation's International Health Board and the LNHO. Their assistance was met with great resistance from the British, French, and Japanese. These powers saw the LNHO's involvement in China as a threat to their colonial and economic interests in the area (Carter, 2019; Packard, 2016). A healthy and economically strong China meant an inability to use and manipulate the country in favor of their own interests. Once again demonstrating the continued negative influence and self-interest of colonial powers and "Western" ideals on global health initiatives. Despite this opposition, the LNHO was able to move forward with plans for rural reconstruction. In fact, the original plans by the LNHO in China is one of the first times the need for cooperation between local populations and the health agency was effective (Packard, 2016). While they understood working with the local population is a great way to help with global health, it often failed because it did not serve the colonial power's self-interest. When it was finally done effectively in China, it provided LNHO a great outlook for the future. Unfortunately,

since this cooperation failed to serve self-interest, the acknowledgment failed to cause change and the remnants of colonialist medical methods remained moving forward.

While there were several health initiatives worldwide over the years leading up to World War II, any progress that occurred was set back by the war. Following the war, numerous new organizations were established replacing older organizations like the LNHO (Packard, 2016). Organizations including the United Nations (UN) and the World Health Organization (WHO) resulted from this change after the war. In 1946, the UN held a conference in New York City to finalize the constitution of new health organizations. This conference established a broader image for both the UN and WHO when approaching global health (Packard, 2016; World Health Organization, 1946). Their constitution affirmed that health embodies physical, mental, and social health and that it is a human right to have high standard healthcare (Packard, 2016; World Health Organization, 1946). Despite this change in ideology after the formation of these organizations, there was a fast regression to the self-interested, eradication model of global health.

Post-World War II, global development was again focused more on self-interest than real assistance and development of infrastructure. Leaders in the US and countries across Europe saw the need for financial resources for reconstruction or maintaining an efficient post-war economy. As a result, these countries looked toward Asia, Africa, and South America as sources for raw materials that could be used for economic gain (Carter, 2019; Packard, 2016). Pseudo assisted development of countries in these regions was the perfect excuse for entering these countries and allowing access to their resources. When

intervening in these countries, massive disease burden in LMI regions was perceived as a barrier to "progress," causing improvement of health conditions to be closely linked to the economic interest of intervening countries (Bezruchka, 2000; King, 2002; Packard, 2016). The intervention for the sake of self-interest became a competition between high income countries during the cold war. These developmental interventions were seen as imperialist influences by countries and developing grounds for ideologies during the cold war (Packard, 2016). The result was competition of rapid health interventions by the US versus Russia and each of their allies (Packard, 2016). This competition and rapid intervention once again made the focus of health interventions the intervening countries rather than the local populations.

Through the 1950's, 60's, and early 70's, global health maintained the eradication method without acknowledging the need for social and economic change. The eradication method allowed for rapid, cheap, and seemingly effective intervention if only for a period of time. The focus during this time was the eradication of malaria and smallpox, which will be discussed later (King, 2002; Packard, 2016). These eradication models further allowed the perpetuation of negative ideologies about global health into the future. In 1978, there was a conference by the WHO with over a hundred countries and nongovernmental agencies (NGOs). The goal of this conference was to establish that access to primary healthcare is essential for the development of global health (Brown, Fee, & Stepanovz, 2016; Packard, 2016). The need for an encompassing approach to global health including social and mental along with physical well-being as part of primary health was once again acknowledged. The conference also stated that it is a basic

human right to have access to healthcare and it is a government's responsibility to provide this access (Brown, Fee, & Stepanovz, 2016; Exworthy, 2008; Packard, 2016). While establishing this "new" primary healthcare goal as the gold standard for healthcare for years to come, the devotion to this goal quickly faded. Within five years, global health organizations returned to the eradication, self-interested method (Brown, Fee, & Stepanovz, 2016; Packard, 2016).

It is important to understand why these reinvigorated ideals from the 1978 conference failed and led us to the current state of international healthcare. One of the primary reasons for the failure were flaws in the conference itself. Due to external pressures, the conference happened prematurely, resulting in a lack of evidence or experience with implementing primary healthcare systems (Exworthy, 2008; Packard, 2016). Due to this, the plans proposed at the conference had two major drawbacks. The first was there was no discussion of the challenges that faced the implementation of primary healthcare leading to an inability to deal with the challenges that appeared during implementation. Intervention methods then began returning to the eradication method which was already well established. Second, there was little information about the need to develop models for primary healthcare (Packard, 2016). The strong establishment of the eradication model caused there to be no conversation about the need for a new method. Along with these initial issues, another barrier to the implementation of primary healthcare was the economic support and changes necessary to establish this new method. Medical authorities and the private sector had more money in the established methods, helping to maintain the old eradication methods (Exworthy, 2008; Packard, 2016). The

need for economic support resulted in very few countries being able or willing to address the issues that accompanied the implementation of primary healthcare. Another major inhibitor to the formation of primary healthcare initiatives was the eradication of smallpox. In December of 1979, the eradication of smallpox was finally successful (Ferguson, et al., 2003; Packard, 2016). This success allowed people to accept the eradication method, now called selective primary health care. It was less expensive than the encompassing primary healthcare methods and it allowed organizations to continue without real involvement of local populations (Ferguson, et al., 2003; Packard, 2016). This victory over the implementation of primary healthcare once again caused it to fade from global health.

The selective primary healthcare methods persisted until the early 1990's when there was a shift in the view of global health due to globalization. The ability of diseases to rapidly spread worldwide through travel forced people to acknowledge the importance of global health (Kirton, 2017). As a result, millions of dollars were flooded into global health throughout the 1990's and early twenty-first century (Packard, 2016). There was also a massive increase in NGOs involvement allowing global health to bypass governmental agencies. NGOs targeted specific health issues but also failed to build healthcare infrastructure in the communities they assisted (Olivier, Hunt, & Riddle, 2016; Packard, 2016). At the same time, governmental organizations like the WHO and UN persisted with selective primary healthcare methods. In the twenty-first century, there has been a massive increase in funding for global health development and initiatives (Packard, 2016). Sadly, most organizations, governmental or not, were mainly concerned

with the statistics that demonstrated their impact rather than assessing their actual impact on local communities (Olivier, Hunt, & Riddle, 2016). Once again, we see how this level of service focuses on the eradication of disease and has left basic health services lacking worldwide (Packard, 2016). These are the major models and initiatives that exist today. Whether NGOs or governmental agencies, the global health climate is still one of colonialist methods and lacking in larger development.

While the history of global health is one that leaves much to be desired, it is important to acknowledge the victories that have occurred. While the colonialist eradication model fails to consider the bigger picture of global health issues, it was still able to somewhat improve health (Packard, 2016). The eradication of smallpox and the reduction of malaria and other diseases worldwide has saved millions of lives and greatly improved the outlook of global health. This model has also allowed for massive funding in biomedical technology and vaccinations to eradicate disease more effectively (Kirton, 2017; Packard, 2016). Unfortunately, the lack of acknowledgement of larger health determinants resulted in the death of many people in LMI countries due to other diseases, lack of sanitation, malnutrition, and more.

The history of global health has been one of colonialist backdrops and methods that repeatedly fail to consider the larger determinants of health. The poor global health climate existing today is the outcome of the perpetuation of these roots. The current climate supports the idea that local communities are insignificant in terms of their own health improvement and that other determinants of health are unnecessary. It is essential we understand the roots of today's global health climate to understand the fragile nature

of current global health initiatives. These roots along with current global health organizations have allowed self-interest to control the global health climate and these organizations have helped maintain these ideologies today. As people of the global community, we need to begin examining these organizations and structures in order to dismantle and make real change to the global health climate.

Modern Global Health Organizations:

Many different global health organizations, both governmental and not, have had a hand in creating the climate we see in global health today. We will examine a few of the existing global health organizations in order to determine the status of global health today. It will also help provide us an understanding of what the future of global health can be.

World Health Organization:

The WHO was formed in 1948 in response to the need for global health interventions at the end of World War II (Tworek, 2019). Today it is one of the biggest global health organizations in the world. Post war the WHO, much like other organizations, saw the need for a more encompassing approach to global health interventions. Despite the written shift in ideologies post World War II, the new WHO still maintained the colonialist methods and ideals when approaching healthcare disregarding their stated ideals (Olivier, Hunt, & Riddle, 2016; Packard, 2016). In the early 1950's the WHO was aggressively working toward the implementation of new biomedical technologies to eradicate diseases. They were more focused on the improvement of specific diseases rather than focusing on the bigger picture of social

improvement. As a result, the WHO maintained a form of healthcare mirroring the eradiation campaigns of earlier health initiatives (Hopkins, 2013; Packard, 2016). Again, people of "Westernized" cultures sat in board rooms making decisions about the healthcare of people they had never spoken with or listened to. They made these decisions based on the idea that "Western" knowledge was superior to that of people in LMI countries (Borowy, 2009; Packard, 2016). This newly formed group still embodied the idea that these people are not capable of their own healthcare (Olivier, Hunt, & Riddle, 2016; Packard, 2016). The WHO, as other organizations before them, completely ignored social and economic factors as well as the need to develop health infrastructure as a part of health improvement.

Part of these methods and ideologies stemmed from the need for rapid intervention. Massive food shortages and spreading disease at the end of World War II could not wait for development of new programs allowing for social welfare. So instead, the WHO returned to earlier methods of global health to respond to the post-war crises because these methods were already well established (Tworek, 2019; Packard, 2016). One reason these methods continued to remain so effective was the development of new technologies. Massive medical advancement during World War II and after allowed for rapid responses to global health crises without the need for social development (Packard, 2016). These quick-fix solutions only further reinforced the colonialist ideals from "Westernized" countries on LMI areas. "Westernized" countries saw Indigenous populations as insignificant and incapable of their own healthcare and viewed themselves as heroes coming to save them (Bezruchka, 2000; Packard, 2016). Part of the reason that

these initiatives were so effective was because governments of LMI countries saw these methods as an opportunity. These governments had implemented policy changes and made economic promises that never came about. Most of the governments seized the opportunity and capitalized on the interventions of international bodies, leading to criticism and anger from local populations about the lack of real development (Harrington & Maria, 2019; Packard, 2016).

Another major influence on the early development of the WHO was US politics and the cold war. As the largest financial contributor to the WHO, the US was able to make changes to the original constitution without pushback from any other country. These changes allowed them to withdraw from the WHO at any point and placed a cap on the money they could give to the WHO (Harrington & Maria, 2019; Packard, 2016). The restrictions arose from conservative officials in the US not wanting to allow the WHO to have any control over the US's healthcare. Their financial influence over the WHO and these restrictions allowed the US to shape the direction of the organization, taking it further away from its original broader image. During the start of the Cold War in 1949, the Soviet Union and their allies withdrew from the WHO under the pretense that the organization served the United States interests alone (Packard, 2016). This controlling influence of the US led the Soviet Union to claim that the WHO was not doing enough to assist suffering Eastern European countries in the wake of World War II (Harrington & Maria, 2019). Withdrawal of Eastern European countries led to further distance from the encompassing social determinants of health as they were the only voices advocating for

these approaches (Packard, 2016). As the WHO continued forward, they returned to the

eradication campaigns that had been established earlier in the twentieth century.

Throughout the 1950's, 60's, and early 70's the WHO was involved in numerous

health activities, but the predominant activities of the organization were the eradication of

smallpox and malaria. While the eradication of smallpox succeeded in 1979, the malaria

campaign only succeeded in lowering rates of malaria. The two campaigns had very

similar methods which are still in existence today (Hopkins, 2013; Packard, 2016). Like

the name suggests, both campaigns drew their origins from the earlier eradication model

based on colonialist interventions. The reason the smallpox eradication was more

successful than malaria eradication was due to the disease itself (Hopkins, 2013; Packard,

2016). The availability of an effective smallpox vaccine allowed it to be easily targeted

and prevented, whereas pesticides and antivirals for malaria were not completely

effective and much more difficult to implement (Packard, 2016). Despite the differences

in outcome and method of eradication, the implementation of methods for each disease

was similar.

The WHO organization was able to implement these methods similarly to their

predecessors: aggressive sanitation, vaccination, and quarantine. In both cases, the WHO

failed to acknowledge cultural and social impacts of their methods on local populations

(Harrington & Maria, 2019). For example, in areas where malaria was prevalent the

WHO officials required routine blood screening despite some Indigenous people's beliefs

that blood was a very sacred thing (Packard, 2016). Or in areas where local people would

avoid receiving vaccinations for smallpox, the local authorities would hunt people down

and coerce them into receiving vaccinations (Packard, 2016). This lack of cultural and social awareness led workers to envision themselves as empowered over the locals and believe they had the ability to do anything it took to complete their mission (Harrington & Maria, 2019; Olivier, Hunt, & Riddle, 2016). Any resistance that these workers faced was perceived as resulting from ignorance or primitive beliefs. The success of smallpox eradication alone helped to reinvigorate the eradication model as an effective method of international medical intervention (Hopkins, 2013; Packard, 2016). This caused the WHO to continue forward with new disease eradication campaigns and the perpetuation of these methods into other global health organizations.

One of the only places we see a disruption in these methods is during the 1970's. The results of the failed malaria eradication program forced the WHO to acknowledge the drawbacks of their method (Hopkins, 2013; Packard, 2016). In response to their failure, they proposed the integration of malaria eradication into local health services. This integration caused the WHO to realize the eradication methods they had implemented failed due to the lack of basic health services worldwide. A result of this realization was the conference on primary healthcare in 1978 and the rethinking of the WHO and other organization's goals (Harrington & Maria, 2019; Packard, 2016). However as discussed earlier, this rethinking of global healthcare also failed, causing selective primary healthcare to be the predominant method for global health through the 1980's (Packard, 2016). In the 1990's and 2000's, the WHO saw a refinement of these eradication methods to be supported by cost-effective evaluations and market driven solutions (Harrington & Maria, 2019; Packard, 2016). These methods are still the primary

ones used by the WHO today. Real infrastructure development is viewed as expensive

and it does not support the values of self-interested parties (Olivier, Hunt, & Riddle,

2016; Packard, 2016). As a result, the WHO still focuses on methods of disease

eradication rather than a larger health determinant approach.

Centers for Disease Control:

The Centers for Disease Control began in 1946 developing from a wartime

program aimed at limiting spread of malaria in military camps (CDC, 2018). Post-war,

the CDC developed into an organization whose focus was eradicating malaria and other

tropical diseases. The goal of the CDC was to lower the world's disease load by

coordinating and supporting local health work (Brencic, et al., 2017; Gershon, 2020).

Despite their statement focusing on a bigger approach to global health, they also followed

the disease eradication model of global health. Similar to the WHO, the CDC

collaborated with other organizations throughout history attempting to eradicate diseases

and their spread worldwide (De Cock, 2011).

Along with the eradication of disease, one of the major goals of the CDC is

disease surveillance. As part of this goal, the CDC trains staff worldwide on collecting

health related information to find ways to improve the disease load in the world (De

Cock, 2011). A major part of this process has been developing standard operating

procedures on how to approach global health (Brencic, et al., 2017). In more recent years,

the CDC has started searching for ways to improve public health capacity through

training and workforce improvement (De Cock, 2011). The CDC has helped to train

people worldwide in research, surveillance, and disease control (De Cock, 2011).

Compared to other organizations, the CDC has helped to create some global health

infrastructure despite their contribution to disease eradication campaigns. They have

helped to employ local populations in their own healthcare rather than forcing it upon

them like some other organizations. As a result, the CDC through collaboration with

partners across the world has helped to both reduce disease load and attempted to create

standard procedures to defend against disease outbreak (Brencic, et al., 2017). While this

infrastructure building by the CDC has been helpful, the CDC aims at emergency

management within global health (Brencic, et al., 2017). The result is the CDC fails to

help change the social factors impeding global health improvement around the world.

Rather, they focus on crisis management and massive disease outbreak instead of the

smaller, but just as important, factors of health. This demonstrates the complicated nature

of global health and how different organizations can have widespread impact in both

positive and negative fashions.

Medecins Sans Frontieres

Medecins Sans Frontieres (MSF) also known as Doctors Without Borders was

created in 1971, by French physicians to help with health relief during the Biafran civil

war in Nigeria. Their goal was to establish a band of doctors that could help suffering

people after disasters and they were founded on the belief that everyone has the right to

medicine (Doctors Without Borders, 2020). Over the years, MSF has provided medical

assistance to refugees, assisted with disease outbreak, and advocated for providing

medicine to LMI regions (Packard, 2016). Over time, with more practice, MSF became

adept at being able to provide rapid relief and they tend to operate in areas without any

other healthcare (Redfield, 2013). One of the defining qualities of MSF is their commitment to staying out of politics. While allowing them to maintain their right to work anywhere they are needed, avoiding politics can create a disconnect between the organization and the local government (Packard, 2016; Redfield, 2013). This disconnect often results from the fact MSF operates in areas where governments are weak and either will not or are unable to help improve infrastructure. As a result, MSF works more as an emergency response than an agency that can help make lasting change within these communities. While this is great for stabilization after major incidences like war or a natural disaster, it has a very small effect on long term outcomes of health.

The major downside to MSF is they are aimed at rapid response healthcare only. They fail to make long term sustainable healthcare changes in the countries they help (Packard, 2016). One example of this is that they employ local support staff but solely rely on medically trained volunteers from the "Westernized" world (Packard, 2016). Reliance on these volunteers highlights one of the major problems with international service today, where we enter communities under the goal of helping them, but we fail to train them so that they are able to further their own healthcare when an organization departs. Part of their need for rapid response also causes MSF interventions to rely on basic technologies and medicine for many settings. Interventions then have a basic "for all" structure rather than tailored for the specific settings that MSF is traveling to (Packard, 2016 Redfield, 2013). The MSF's service model leads to any programs and healthcare they set up to collapse over time due to lack of further support. This model for global health service is one of the most common models we see in the field today

especially with NGOs. What this method does is feed into the "white savior complex" (Aronson, 2017). It allows people from "Westernized" countries to travel to LMI countries after a disaster and fulfill their own emotional needs and career goals by taking pictures and handing out medicine to people in the local communities. It also allows the server to feel better about themselves and completely negates the local community (Aronson, 2017). These people then feel a sense of superiority and power over the local population as a result (Aronson, 2017). We need to move away from this form of international medical service removing these structures and ideas and moving toward methods that allow communities to build themselves and their infrastructure up.

During an academic conference, a prominent African scholar questioned MSF on their model of service (Redfield, 2013). Medical intervention as a result of an emergency while reducing human suffering and death, can also cause an impediment to internal infrastructure development by removing the immediate need for improvement. Due to this dilemma, MSF was asked why they do not just let people die if it traded off for a better future (Redfield, 2013). This called into question not just the moral fault of MSF but of all medical service. Medical professionals whose whole jobs are to help save lives are faced with the question of whether to let people die for a future tradeoff or not. This dilemma is one at the center of all medical service. It poses the question: how can we create long lasting change without some sacrifice of lives in the process?

Partners In Health

Contrasting the other organizations that have been discussed is the Partners In Health (PIH) organization. PIH started in 1987 by a group of physicians and health

activists who saw health as encompassing all the needs of a community. Similarly, to

other organizations PIH believes that access to healthcare is a right for everyone in the

world (PIH, 2020). They aim to provide healthcare that keeps the patients at the center of

their care (PIH, 2020). As part of this PIH directly advocates for social justice and change

rather than just for medical care (Redfield, 2013). Differing from MSF, PIH does not

operate in a rapid fashion to provide emergency medicine. Instead they operate slowly

and when they start a project, they maintain it for a long period of time, remaining in

partnership throughout that time (Redfield, 2013). This long-term commitment arises

from their goal to build sustainable health services in areas without any (Packard, 2016).

Similar to other organizations, PIH does not directly combat the social and economic

factors effecting health in LMI countries. Rather they aim to improve access to healthcare

through employment, sanitation, and assisting those in poverty (Packard, 2016; Redfield,

2013). Despite their lack of change to the widespread social determinants of health, they

have seen long term change in both Haiti and Rwanda through improving access to

resources. While the PIH model is great and has been extremely successful in these areas,

it is unclear whether PIH will be able to replicate these models elsewhere. The

organization aims to make each of their initiatives fit to the location specifically rather

than a one size fits all like other organizations. Despite this uncertainty, PIH gives a

hopeful outlook for global health to create systems that can have long term sustainable

change.

     These different organizations represent most approaches by both governmental

and nongovernmental agencies to global health today. While the views and values of

most organizations stem from the goal to improve health worldwide, the differing approaches have all had drastically different outcomes. In most cases, these organizations and approaches still fail to acknowledge the underlying social determinants of health still present from the colonial times. The long history of colonization, war, and self-interest leading to the global health disparities and the damaging structures we see today is currently reinforced through what is known as neocolonialism. A history of colonization and international powers abusing local populations has led to this reality. Neocolonialism occurs after a country is freed from its colonizer. Despite the physical and governmental freedom from the colonist, the people are still economically and socially dependent on them (Prasad, 2003). Dependency is then normalized through the legacy of the colonized body reinforcing the harmful structures and their remaining power over a people (Hanson, 2014). This is what we see happening in international medical service today. International bodies enter communities without prior permission and communication, reinforcing "Western" superiority through inappropriate medical intervention. Shedding light on these neocolonial relationships and structures helps to interrupt and create resistance against the racist idea of "Western" power and superiority (Hanson, 2014). Resistance is essential when finding ways to move forward with service trips in an ethical and meaningful way. Analyzing something like voluntourism with the knowledge of neocolonialist historical structures is fitting because both took a rise after World War II through the use of power and privilege structures by nations in control (Hanson, 2014).

Today we see how this history of colonization and reinforcement through numerous organizations has led to the clear disparities in global health. The most obvious

way we see these health disparities is through the lack of healthcare workers. It is

estimated that there is a shortage of 4.3 million health workers including doctors, nurses,

and support staff (Bashir, 2011). These shortages are in part due to the lack of

acknowledgement of the social factors affecting healthcare. The economic and social

downfalls in LMI countries stemming from a history of colonization has caused a lack of

infrastructure within healthcare. Insufficient labor conditions including low income, work

overload, and poor conditions alone are linked to insufficient healthcare (Bashir, 2011).

One of the major issues the lack of financial stability causes is known as "ghost" workers

(Bashir, 2011). When a person is incapable of paying for healthcare, it causes workers to

disappear from their jobs and work elsewhere where there are higher paying opportunities

(Bashir, 2011). This highlights the need for structural change where healthcare work is

enough of an incentive that communities can maintain it. Another contributor to ghost

workers includes poor working conditions. Poor working conditions causes health

workers to be unable to function at their highest level. These workers then to choose

emigration to higher income countries where they have a high salary and better working

conditions (Bashir, 2011). These are just a few of the ways that health disparities have

come about today as a result of the long and dark history of global health.

Chapter 3: Medical Service Trips

There are many kinds of medical service trips, differing in their goals, the way in which they plan and operate, and their sources of funding. International medical service can encompass everything from governmental agencies, non-governmental agencies, volunteer work, disaster aid, international health training, and much more (Bauer, 2017). Differing goals cause massive changes in the outcome of long-term health in the community's people are trying to support. While the intentions behind service trips are often good, the poor design and execution of the trip are when issues arise (Packard, 2016). Through the examination of these service trips, we can find the root of where indirect harm stems from in order to be able to identify it in the future. Studying practices that have succeeded in helping a community in the long term can be used to distill a method through which future service trips can follow improving global health in sustainable ways. Two of the most prevalent types of service trips are voluntourism and building capacity trips. These trips differ in a number of essential ways and have significantly different outcomes. This certainly doesn't mean that one is perfect and the other is not. By placing these two service trips in contrast, we can examine how different methods of service trips can greatly affect local communities long-term and form a hybrid through which a potential model can be based.

Voluntourism

Overall global health today is the product of the colonialist methods that it was founded on. These colonialist influences still reign supreme in the world today. It is

through these facets that the construction of the "Other" has formed from outdated

stereotypes and ideologies arising from colonialist times. Tourism, especially healthcare

related voluntourism, encourages a lack of self-reflection by tourists abroad causing a

failure to realize their negative reinforcement of colonialist stereotypes and structures

(Hanson, 2014). It is this continual colonialist-like interaction by the tourist that

maintains the negative relationship between the tourist and the perceived other. Not only

this, but it was found that areas in Africa that had a history of colonial medical campaigns

have a higher prevalence of low vaccine rates and high mistrust of medicine (Lowes, &

Montero, 2020).

Voluntourism gives rise to several ethical challenges within international health

work when done incorrectly. Medical service trips tend to be selfish, do not meet

expectations, fail to address real issues, damage local facilities, and are sometimes

unnecessary (Suchdev. Ahrens, Click, Macklin, Evangelista, & Graham, 2007). The

Oxford English Dictionary defines voluntourism as, "tourism in which travelers spend

time doing volunteer work on development projects, usually for charity," (OED, 2020).

This definition of voluntourism encompasses a wide variety of medical service trips

including religious, academic, and professional based service trips. While this definition

seems harmless, under the surface voluntourism has much deeper implications.

Physicians who participate in such trips view themselves as a contributor to a

humanitarian tradition of giving medical care to desperate communities in LMI countries

(Snyder, Crooks, & Turner, 2011; Stanley, 2020). Voluntourism has been repeatedly

found to reinforce unequal power relationships and harmful stereotypes (Hanson 2014).

This type of service trip is one that feeds into neocolonialist power differences, helping to reinforce a local community's dependence on external resources (Hanson 2014). One example of voluntourism is in Guatemala where the damaged healthcare infrastructure has left rural communities without the resources to maintain a healthcare system. Instead, the people in these communities are dependent on different service trips in order to provide their medical needs. When these trips stop going to a specific area, there is a spike in mortality and sickness resulting from no healthcare services being available (Green, Green, Scandlyn, & Kestler, 2009). A major issue that arises with voluntourism is that the trip is often more about the volunteer's interests than that of the local community (Hanson, 2014; Stanley, 2020). As a result, there is a massive burden placed on the local community in exchange for a benefit to the volunteer. While this is harmful in general when it comes to any kind of service trip, it can be far more detrimental when it comes to medical service trips.

Voluntourism helps to create greater structural inequality in the societies that service trips visit. Service trips that are based in neocolonialist frameworks see the communities that they are visiting at an irrelevant part of what they are doing (Pastran, 2014). Medical schools have developed several global health programs to attract funding, professionals, and students (Wilson, Merry, & Franz, 2012; Watson, Cooling, & Woolley, 2019). These global health programs are then used as a platform to teach instead of giving effective medical care (Bauer, 2017). Rather than understanding the needs of a community, to build up and train their own healthcare professionals, physicians come into places with students and use the local population as guinea pigs for

medical students to practice on (Sykes, 2014). It is common for medical students to think of a temporary residency in a low-income country as a rite of passage (Packard, 2016). In North America, around 30 percent of medical students participate in a global health initiative (Snyder, Dharamsi, & Crooks, 2011). Medical students typically use these vulnerable populations abroad to practice new clinical skills (Snyder, Dharamsi, & Crooks, 2011). These students then return home and boast about their ability to practice a skill they are not yet licensed to do in their home country. This boasting causes an increase in voluntourism abroad by medical students eager to practice skills that they are untrained for, thus placing the local and vulnerable population at even higher risk (Snyder, Dharamsi, & Crooks, 2011; Tiessen & Huish, R2013). In other cases, medical professionals will enter local communities with their students without prior communication with the community. These groups will then go to local doctors and force them to accept unwanted help in exchange for needed supplies (Bauer, 2017). This type of service trip causes great harm under the pretense of helping people far more often than is realized.

One example discussed by Bauer in Nepal is two physicians who expressed their anger about doctors who appear out of nowhere to "do good". Bauer explains when these doctors appear and set up clinics with "Western" medicine under the pretense that it is better, they cause significant damage and setbacks to the local healthcare infrastructure (Bauer, 2017; Tiessen & Huish, 2013). This is not only reinforcing colonialist superiority ideologies in these communities, but it is further damaging the communities' already broken medical infrastructure. The damage they leave in their wake can range from legal

issues to local infrastructure becoming entirely dependent on foreign "humanitarian" aid (Bauer, 2017). Repeated harmful interaction in these communities can eventually abolish the broken infrastructure that exists in these places leaving the community without any kind of consistent healthcare (Bauer, 2017). These students and professionals go abroad to these communities without first thinking about their impact on cultural values, sustainability, and patient safety. Without acknowledgement of these realities, the medical student, without realizing it, is negating the ethics they learn to follow as a physician. The romanticized image of helping LMI communities hides volunteers and the organizations they're working for from long-term harm they are causing.

In a lot of cases, students who go abroad on medical service trips go as pre-medical or high school students without any training at all (Bauer, 2017). This alone puts the community at even higher risk when these students are given power with no prior training (Stanley, 2020). Most of the time the students who attend service trips end up being mainly tourists rather than volunteers. They spend most of their time doing recreational activities rather than actually contributing to the community. At the end of these trips not only did the student do nothing to assist the local community but they barely learned anything themselves (Bauer, 2017; Tiessen & Huish, 2013). Changing the way we engage with local populations is essential in order to assist with student learning during the trip and to effectively assist the community. When voluntourist trips like this happen, it is not only fruitless for both parties, but it effectively wastes resources that could be put to better use by investing in local healthcare infrastructure (Bauer, 2017). Trips like this show the unimportance of the volunteer when they are not actually

assisting the community. Some people may argue against this reality saying that the education that the student receives from being abroad and interacting with a local community, even if it is small, is worth the economic loss. The reality is that while the student may be gaining some level of education, they are still perpetuating the harmful infrastructures that exist in the community by placing educational importance over people's basic health needs.

Voluntourism, while harmful in most cases, stems from a demand for more ethical and less harmful tourism products than strictly recreational tourism (Hanson, 2014). In a way, voluntourism helps the tourist feel better about the negative impact their tourism can have on a community. While this is true, some would say that voluntourism's original goal was to escape traditional tourism, allowing those participating to help where it is needed through love and compassion (Hanson, 2014). This in fact is true in most forms of medical service trips. Their goal is to enter a community, give medicine and aid, and improve global health. While zoomed in on the instantaneous impact on the community, it seems as though this is helpful. Leading most people to believe that voluntourism is beneficial and better for a community than the alternative of normal tourism. But the reality is that when you zoom out on the scope of these trips, they end up having long term detrimental impacts on the community's health.

International medical service trips not only have damaging impacts on the health of the local community, but it can also have wider spread effects. This can include a loss of jobs for locals, burdening the community, halting local efforts to improve infrastructure, and more (Bauer, 2017). The majority of the time voluntourism trips

reinforce colonialist power structures over the local people. Most of these lower socioeconomic communities are unable to handle the deficit caused by this form of service trip. What people performing these trips do not realize is that by entering these communities and providing medicine without helping to set up long term infrastructure, these communities become dependent on external powers to provide continuous resources (Bauer, 2017). Eventually service trips stop attending to these communities as overall health has seemingly improved. As a result, the health in these communities' crumbles due to the abolishment of healthcare infrastructure caused by the harmful service trips (Bauer, 2017).

These trips are indifferent to the harm they are causing to the people in these areas; they are self-serving trips to solely benefit participants. This selfish outlook leads to the inability to provide effective care. How can you provide care to someone when you are only looking out for yourself? Often when service trips enter communities, they are entirely unaware of people's culture, language, religion, and more. When physicians enter communities without this essential knowledge about the people, they are unable to give effective and good care (Wilson, Merry, & Franz, 2012). Culture is an essential part of this improper healthcare. You need to understand someone and their views before you can treat them in a way this respectful to them and still effective. Along with this, the history of colonialism in different areas has a massive effect on why these people need health care in the first place. When acknowledgement and understanding of these past harms is absent, the structures that caused the poor health in communities are reinforced.

Without some level of understanding, a physician is unable to give care in a way that can improve quality of life.

In the worst cases, these service trips perpetuate poor healthcare and cause worsening health in the communities that they visit (Bauer, 2017). Some communities become dependent on foreign bodies to provide them the care they need. Not only does the community become dependent but local governments often see these medical trips as a way to save money by preventing local investment in healthcare infrastructure. Consequently, when service trips stop coming to a community, the people have no way of supporting themselves due to an already crushed healthcare infrastructure (Bauer, 2017). The inability of voluntourism to consider the number of ethical issues it poses in the communities where implemented, creates a need for expansion in the scope of medical service. Scopes of service must include the steps necessary to support communities in the long term (Snyder, Crooks, & Turner, 2011). Without building up a community's healthcare infrastructure for it to one-day function on its own, there is no way the health of the people within the community will improve long term.

In order to move away from negative voluntourism, there are some essential differences that come into play taking it from a harmful body to a sustainable one. The biggest one is education. While this seems obvious, it is the essential difference between an effective and sustainable healthcare service trip and a harmful one. By educating the visiting party about the colonial history, harmful structures, culture of the community, and how to build the community up in a sustainable way, you can change the outcome of the service trip (Hanson, 2014). Not only does this change in education help change the

outcome of the service trip but it equalizes the harmful neocolonialist relationships previously established between tourist and the perceived "Other". Without the direct addressment of the negative motivations and thought processes of the volunteers about the superior helping the inferior, there is still a perpetuation of harmful ideas between the volunteer and the local people (Hanson, 2014).

Lack of education is one of the major enforcers of these harmful ideals that the unexperienced "Westerner" can provide medical "development" to so called "developing" countries. This thought process makes the volunteer seem as though they are in a position of power over a community to teach them without any knowledge of the local life and people (Hanson, 2014). Eventually these ideas lead to the perception that the volunteer has power and intelligence over the local people. Therefore, through accurate education, the harmful stereotypes that assist in propagation of harmful medical service trips can be removed. This is extremely important for medical students when they participate in international service trips. By dismantling the façade of the power over the local people, it forces medical students to examine what it means to be socially responsible when interacting with the larger world (Snyder, Dharamsi, & Crooks, 2011).

Social responsibility becomes essential when practicing medicine during international service trips not just for medical students but for anyone in the volunteer position. When interacting with patients in international settings, especially in vulnerable communities, they need to be given complete transparency about their health and evaluation. Transparency is important so that these patients can make complete informed decisions about their health (Snyder, Dharamsi, & Crooks, 2011). In international

medical settings, it is common when engaged in the neocolonialist environment that the patient feels intimidated and below the person providing medicine. So, they will often do whatever the doctor says without asking for an explanation. Due to this, the person providing healthcare needs to the patient is transparent about everything regarding their health, not just to make sure the patient is making an informed decision but also to help dismantle the power differences reinforced by neocolonialism.

The other essential piece in changing harmful medical voluntourism is communication. It has been found that by providing the volunteer with the ability to communicatee with the community they are trying to engage with it increases awareness (Hanson, 2014). Voluntourist medical service trips tend to take a charity-based approach rather than collaborating with the local community. This lack of collaboration causes the trip to not address the base causes of health inequalities within the community and as a result have no lasting impact (Snyder, Dharamsi, & Crooks, 2011). Communication increases awareness about the inequalities and injustices faced by the local communities, as well as the complex social issues faced by the communities. Increased communication allowed the volunteers to understand that it takes more than a week long trip to create permanent change within a community (Hanson, 2014). This realization also sheds light on one of the biggest issues with some medical voluntourism, the fact that these trips are usually some kind of one-time, short term trip. What is actually needed is repeated long term assistance to support the local community in setting up their medical infrastructure so they can be self-sustainable once international medical service is stopped. Therefore,

building capacity medical service trips tend to be a much more effective model for sustainable international healthcare.

Building Capacity

Building capacity medical service trips attempt to remedy the issues we see in voluntourist medical service trips. Like voluntourism it is people from high socioeconomic countries traveling to low socioeconomic regions (Bashir, 2011). These service trips attempt to improve medical service practices through the improvement of sustainable public health infrastructure in order to address local health issues (Watson, Cooling, & Woolley, 2019). Capacity building can have several different approaches to develop public health including, training sessions, online consultation, and technical assistance (Watson, Cooling, & Woolley, 2019). Several organizations including the World Health Organization and the Center for Disease Control have recently begun to work on developing capacity building interventions (Watson, Cooling, & Woolley, 2019). Building capacity is one of the few types of service trips that attempts to consider the importance the social factors of medicine (Crisp, 2000). Part of this stems from the inclusion of experts outside of health alone. The inclusion of other disciplines allows capacity building to take a wider approach to international healthcare that voluntourism fails to acknowledge (Bashir, 2011). As a result, capacity building service can range from service to individual communities to entire nations (Crisp, Swerissen, & Duckett, 2000). It is increasingly difficult to create medical service trips that are sustainable and assist community's growth in the process. The World Health Organization defines capacity building as, "The development and strengthening of human institutional resources,"

(WHO, 2020). Healthcare capacity building, while difficult, is more effective when it comes to medical service trips and is sustainable for the impacted communities. In a study performed on the efficacy of medical-service trips in rural Guatemala, medical researcher Tyler Green found that the local community perceived Capacity Building trips in high regard and saw a major improvement of health within the area compared to previous types of service trips (Green, Green, Scandlyn, & Kestler, 2009).

Capacity building while taking a larger approach to healthcare also has some similarities with other types of service, like voluntourism. The biggest similarity is that capacity building also involves the provision of financial and other resources from international organizations (Crisp, Swerissen, Duckett, 2000). This is essential because it has been seen that it is difficult or impossible for infrastructure to develop on its own (Crisp, Swerissen, Duckett, 2000). Where capacity building differs in terms of resource provisions is that they aim to provide resources that will have immediate and long-term benefits. The idea is the healthcare infrastructure that is built will hopefully out last the international service. Part of this is ensuring that the local community does not become dependent on external finances or resources (Crisp, Swerissen, Duckett, 2000). As a result, capacity building is a slow process that can take several years. Despite this, improving a community's faculties and providing them with resources that they can sustain allows long term change (Crisp, Swerissen, Duckett, 2000). Through effective communication, the international group can assist a community get what they need to be able to sustain themselves.

One of the major differences between other service trips and capacity building is that it is a partnership. Voluntourist trips tend to be a group entering a community with little, if any, prior communication, and there is no interaction with the local healthcare structures. Whereas capacity building acknowledges the fact that LMI communities have health experts (Bashir, 2011). Capacity building does not want the external provider to control the projects, rather through partnership they hope to allow the community to become self-sustaining (Chavis, 1995; Crisp, Swerissen, Duckett, 2000). These local health experts have a better understanding than any outsider of the local community, their culture, and needs. Building capacity service allows for these voices to have a seat at the table with their international partners (Bashir, 2011). This helps not only to make sure a community gets what they really need, but it creates leadership within a local community that can sustain the healthcare system after the international partners leave (Bashir, 2011). The aim of capacity building is to improve public health practices and infrastructure to address local health problems (DeCorby-Watson, et al., 2018). By helping to create leadership and people within the community, there can be long term change in health. Capacity building requires a lot of planning to provide continuous training in order to assist a local community member in achieving the qualifications they need to help maintain healthcare infrastructure after the service trip (DeCorby-Watson, et al., 2018). Capacity building training can take several approaches including consultation, in-person training, online training, guidance materials, and skill-based courses (DeCorby-Watson, et al., 2018). Through training and aid, capacity building hopes to empower a local community so they can sustain their own health (Crisp, Swerissen, & Duckett, 2000).

There are four different approaches to building healthcare capacity. The first approach is known as the bottom-up organizational approach. This approach begins by creating a core of well-trained individuals within a community to decrease external reliance and create a strong base on which to build the healthcare infrastructure (Crisp, Swerissen, Duckett, 2000). This is the most common type of service that we see. It is usually performed by NGOs from high-income countries partnering with small local communities in LMI countries (DeCorby-Watson, et al., 2018) It tends to be the most common type of service trip that is linked to schools and other educational facilities because it allows international students to get direct contact with local people and communities rather than larger institutions facilities within LMI countries. The biggest goal of this type of capacity building is to train or broaden local health workers skills and abilities (Crisp, Swerissen, Duckett, 2000). This training benefits the person being trained and the larger community they serve. It also allows these newly trained people to pass their training onto other communities, hopefully creating larger change in health (Crisp, Swerissen, Duckett, 2000).

The second approach is known as the top-down organizational approach. In this approach, capacity building begins at an institutional level. It starts at the governmental and judicial level to change policy, thus effecting greater change in healthcare (Crisp, Swerissen, Duckett, 2000). The development of universities, research centers, and government institutions can assist LMI countries to build their internal resources (Bashir, 2011). Building up these internal resources can help to bring people from many disciplines together to assist in solving their health issues (Bashir, 2011). This approach

to capacity building helps to remedy some of the broader issues with health in LMI countries. It acknowledges the need for institutional and policy changes that have reinforced colonialist ideals and aims to empower the people within the country (Bashir, 2011). This approach to capacity building hopes to surpass the previously discussed approach because it can impact entire regions rather than single communities (Crisp, Swerissen, Duckett, 2000).

A third approach for service trips that builds healthcare capacity is through partnerships. In healthcare capacity building, it is important to have a base rooted in partnership with the community being served. Without collaborating with the community, it is impossible to understand what they need to help themselves (Crisp, Swerissen, Duckett, 2000; Suchdev et al., 2007). Understanding the culture and the people that make up a community is required to provide healthcare that has a lasting effect. (Bauer, 2017; Chavis, 1995). By understanding a community's culture, service groups can begin to create partnerships within the community they are trying to build healthcare capacity. Without partnerships, there cannot be sustainable healthcare (Chavis, 1995; Sykes, 2014). Listening to the voice of the people in the communities that are being built up is vital to building up healthcare capacity. When their voice and view is absent, service trips in any capacity can be dangerous and detrimental. Through created partnerships, service groups can help to educate since capacity building at its core is educating. As part of this type of capacity building, international organizations will sometimes partner with other organizations to approach the needs of a community (Crisp, Swerissen, Duckett, 2000). This acknowledges that there is a possibility for a two-way flow of knowledge to assist in

creating a stronger health infrastructure (Crisp, Swerissen, Duckett, 2000). The

partnership model for capacity building is an approach that allows for a more

encompassing attempt at building up healthcare infrastructure.

One of the best proposed ways to approach capacity building is through

institutional partnerships. This combines the second and third methods of capacity

building. It aims at improving policy and institutions through partnerships. Medical

schools and students are eager to participate in global health (Bashir, 2011). As

educational institutions, they can partner with educational infrastructure in LMI

countries. Through these partnerships they can hopefully improve the education and

training within the country (Bashir, 2011). This can help to create future policy makers

and healthcare leaders within the country. These partnerships can drastically improve the

healthcare infrastructure within countries by having trained professionals that know how

to interact with different local communities. It also leaves behind professionals that

continue improving healthcare after international service stops (Bashir, 2011). While

often this kind of capacity building is between a high and a low-income country, more

recently there have been more partnerships between low- and middle-income countries

(Bashir, 2011). These newer partnerships allow for lower cost and more equitable

partnerships without the lower income country being overshadowed. The only downside

to this is that high-income countries often bring valuable expertise to the partnership that

middle-income countries are lacking (Bashir, 2011). Another partnership that is currently

being studied at is known as triangulation. This is when there is a partnership between a

high-. middle-, and low-income country. The multiple levels of partnership will hopefully

allow for a model that can leverage the strengths and weakness of all the countries. Based on other institutional partnerships outside of healthcare, this model has a good outlook. It involves a long-term financial commitment which allows for sustainable change and allows for enough time to create self-reliance. It also helps to acknowledge the need for institutional change and strengthening and is based on an ethical approach where each countries values, cultures, and perspectives are respected (Bashir, 2011).

The final approach to healthcare capacity building is the community organizing approach. In the community organizing approach, a group works with all community members to solve health issues. This approach really aims on turning the community into active participants in their health (Crisp, Swerissen, Duckett, 2000). It allows communities to have nearly full control over the building of their healthcare infrastructure. It also helps to provide local people with new skills and jobs, which in turn addresses some of the larger social determinants of health. The only issue with this approach to capacity building is that it requires that more community members stay invested (Crisp, Swerissen, Duckett, 2000). This has been seen to be a potential downfall in areas where a larger amount of community members cannot stay committed due to other social and societal factors (Crisp, Swerissen, Duckett, 2000).

In all these approaches to capacity building, providing healthcare education to a community is the first step in building up a sustainable long-term healthcare infrastructure. Education of the community one is trying working with allows them to perform their own healthcare later (Suchdev et al., 2007). This is crucial so that the community is not and will not become dependent on outside sources for health care.

While education is vital for creating a sustainable future for a community's healthcare, the education should begin long before a group arrives at their destination. When developing an effective program, the trip participants should be receiving an education long before traveling. In order to build a community's capacity for healthcare, volunteers need ongoing training to ensure they understand and are prepared for the culture they are heading into as well as what they will be doing (DeCorby-Watson, et al., 2018). This can help to create a stronger and better relationship between the international body and the local community based on mutual respect (Suchdev et al., 2007). Along with this, it helps to remove the harmful colonialist stereotypes that are perpetuated in other types of service trips. It shows that the local community and people are entirely capable and assists in removing harmful power structures that are apparent in other types of service (Hanson, 2014)

Capacity building projects, while considering the larger social determinants of health also have a few drawbacks. The biggest drawback of this model is that is under studied. Due to capacity building being a newer model for international medical service there has been less research done on its efficacy (DeCorby-Watson, et al., 2018). Most research done about capacity building is focused on individual service events and fails to study the lager scope that capacity building aims to assist (DeCorby-Watson, et al., 2018). This is partially because financial resources going into capacity building projects is substantially less than other kinds of service trips (DeCorby-Watson, et al., 2018). Despite these potential concerns with capacity building, evidence shows that these small-scale trips have had a positive and long-term impact on the communities they assisted

(Green, et al., 2009). Another downside that critics highlight with capacity building

service is that it tends to take several years before a community is self-sustaining (Crisp,

Swerissen, Duckett, 2000). While this is true, the long-term commitment to service

allows for a community to become self-dependent and creates lasting healthcare

infrastructure (Crisp, Swerissen, Duckett, 2000). This is far better in comparison to what

is seen in other types of service trips where after a service group leaves, the local

community is left without any resources and it can lead to worse health outcomes (Bauer,

2017). Therefore, while capacity building does take longer than other types of service, it

has a greater and a longer impact. The biggest risk with this long-term trip though is

funding. Often funders have a difficult time supporting these trips because it is long-term

(Crisp, Swerissen, Duckett, 2000; Doocy, & Chapin, 2010). This means that the

commitment appears to be a lot larger than other types of service trips. Sometimes when

they do start funding this type of service, it results in them feeling trapped because they

think if they remove their funding the service will fail (Crisp, Swerissen, Duckett, 2000).

What most funders do not realize is that because capacity building is a sustainable service

model when successful, a community will no longer need funding after the service trip is

complete (Crisp, Swerissen, Duckett, 2000). If this model became more prevalent, it

could allow for a massive reduction in funding over time. Instead of having to continue

funding more short-term trips over time to the same area, there would be a functioning

sustainable healthcare system.

In international medical capacity building trips, we often see a combination of the

approaches and methods we have discussed. Sadly, there is a massive absence of capacity

building style service in the global health field today. It is flooded with trips modeled

after colonialist methods which reinforce the negative structures that already exist.

Capacity building trips are one potential improvement to the prevalent models of service

trips that we see today. By helping them to become more widely spread and researched,

we may be able to start to make long term changes in the global health climate we see

today.

Chapter 4: Is Any International Medical Service Ethical?

Before we discuss what we should be looking for in service trips, it is essential that we ask the question is any medical service ethical? As we have seen, the history of global health is intertwined with colonialist ideals and harmful power structures. Despite the idealistic image that continually appears around improving global health and its infrastructure, we see international medical service regress to its colonialist roots. Medical service in any sense is complicated, but in the international setting it can become increasingly complicated. This creates the dilemma on whether any international medical service is ethical. In most cases, physicians or volunteers have little to no training in the potential ethical and moral issues that arise when doing international medical work (Iserson, Biros, & Holliman, 2012). As a result, physicians fail to alter their methods to help alleviate any of the ethical issues that arise (Iserson, Biros, & Holliman, 2012).

Even in the best models of international medical service, physicians tend to be biased in the way they train the local healthcare workers (Iserson, Biros, & Holliman, 2012). In developing clinical training methods, it is often assumed that the local physician practices in the same way as the international physician. This can lead to the practices being unrealistic or unhelpful to the people that are supposed to be continuing care (Iserson, Biros, & Holliman, 2012). An example of this is developing a vaccination registry in countries that cannot afford to vaccinate its children (Iserson, Biros, & Holliman, 2012). If a community cannot even afford to vaccinate its children, then how is

a registry even necessary or helpful? Another issue that can arise from this is even when there is a mutual respect between international personnel and the local community there can be conflicts of care. This typically arises when international physicians make decisions or try to train a community with methods they are uncomfortable with. An example of this is drawing blood in Indigenous populations that believe blood is sacred (Packard, 2016). These cultural beliefs can cause community members to forgo lifesaving measures (Iserson, Biros, & Holliman, 2012). These differing beliefs can create a divide between the local population and the international body. Instead of allowing divides to form, we need to help bridge the gaps with methods or technologies that all people are willing to partake in.

Another dilemma that can arise with international medical service is a question of resources. Even the best service trips provide some level of resources to a community. The hope is that a community can become self-sustaining over time and no longer need resources from external sources. In fact, capacity building relies on the idea that a community does not become dependent on external resources (Crisp, Swerissen, Duckett, 2000). Part of the process of building up healthcare infrastructure is acknowledging the resources that are in fact available. Every resource is limited and the use of something has an identifiable cost to other patients that may have received that medicine (Iserson, Biros, & Holliman, 2012). The issue arises when international workers attempt to aggressively develop existing systems and local people are ignored in favor of care that international workers believe is the best (Iserson, Biros, & Holliman, 2012). As a result, they overload the current healthcare system, which then becomes reliant on outside resources to

maintain the same level of care. This dilemma is very difficult for physicians coming

from high-income countries to accept. They want to provide care that they would in their

home country without the resources to sustain it. This begs the question that if standard of

care is not to the highest standard is international service ethical? Or should other options

be considered.

Negative impacts from medical service have been made apparent, whether

stemming from colonialist roots or arising from other places. The negative impacts are so

apparent in global health today, it forces us to ask if international medical service is

ethical or not. In many cases, it is not. In voluntourist and other similar service trips, we

see a blatant lack of ethics in the reinforcement of negative power structures. Even in

some capacity building trips issues can arise due to cultural and ideological differences.

Reminiscent of the question asked of the MSF, "Why do we not just let people die," this

begs the question of whether we should be performing medical service in the first place

(Redfield, 2013). Before we answer that question, let us inspect the impact left behind by

different types of service. While services like the eradication model and voluntourist trips

have harmful ideological structures, they have been able to make a difference in global

health. The eradication of smallpox and the reduction of malaria prevalence worldwide

helped to reduce morbidity and mortality rates around the world. Even the attempt at

eradicating HIV allowed for some relief of the disease across the globe (Packard, 2016).

While this has failed and, in most cases, reinforced the harmful structures that help

maintain health disparities, it has still helped to improve the global health outlook over

time. Even capacity building trips that have issues, allow for massive shifts in global health.

So, returning to the question of whether medical service is ethical and if it should be done, the answer must be yes. Everyone has the right to the highest attainable healthcare that they can access –even if that is not the "Westernized" healthcare that may come to mind. Service trips help to provide a platform through which healthcare infrastructure can be developed. It helps maintain the routes and partnerships on which we can improve to help further the outlook on global health. It is often difficult or impossible for infrastructure to develop without external assistance (Crisp, Swerissen, Duckett, 2000). Even harmful and less than ethical trips help to provide some level of necessary base on which trips can be improved. This improvement is what needs to be focused on. While voluntourist and other similar types of service trips are unethical, it does not mean that they need or should remain that way. We have newer models that need to replace the unethical trips that are so prevalent today. Capacity building trips, while not perfect, are a major step in the right direction for global health. By helping to shift the way we do international medical service toward models like capacity building, we can hopefully begin to create sustainable changes for communities everywhere. We need to stop putting resources into trips that reinforce harmful structures and start supporting trips that help change them. It is our responsibility as members of the global community to help make these changes to more ethical and sustainable methods. By making these changes now, we can continue to further change and correct new models to make them the best they can possibly be.

Chapter 5: What Should You Look for in a Service Trip?

While it is easy to say that we need to make changes in the way we do medical service it is important to know how. We need to remove the harmful stereotypes of LMI communities and remove the romanticized image of service trips from people's heads. People from high income countries need to stop idealizing the image of the white savior in their head to fulfill their emotional needs (Aronson, 2017). We need to expand the field of medicine to incorporate disciplines other than health itself so that students and professionals understand how to be an ethical participant in the field of global health. By incorporating social medicine into the field of global health, we being to make sustainable changes (Carter, 2019). One of the biggest ways we can being to do this by supporting more ethical trips like capacity building service trips. Either through financial support or participation, by supporting only ethical service trips they can start to become more prevalent than more harmful service trips. This will help to not only increase research and information about sustainable service trips, but it will begin to make larger changes in global health. The basis of this process is being aware of that service trips can be harmful. Awareness helps to demolish the façade that romanticizes medical service trips as saving the world. It helps us to acknowledge the flaws of service trips so that we can continue to improve them. Other than awareness, it is important to know what to search for in a service trip, in order critically examine it.

The first thing to examine is the mission of the service trip. What is the end goal for the trip? This can be one of the best determinants of an ethical service trip. For most

trips, the end goal will be to reduce health disparities but, in some cases, you can get a deeper image of the trip. Mission statements often outline the goals of a service trip. It can help highlight whether they are aiming to build up infrastructure like capacity building trips or provide resources and travel like voluntourist trips. Part of this includes determining if the trip considers the larger social determinants of global health or not. Missions that take this wider scope are often going to be better than other trips. A great example of a service organization that attempts to encompass this is Partners In Health. The creator of PIH, Dr. Paul Farmer, discusses how he has seen that social determinants of health get into the body (Brink, 2020). Being in partnership with these people and accompanying them through their hardship is the best way that he has found to help provide the best care to these communities (Brink, 2020). These ideologies placed by PIH are exactly what we should be chasing after in global health. By partnering with these communities and facing the other determinants for health, we can hope to make more positive changes in the healthcare of people worldwide.

Next it is important to understand the specifics of the trip itself. This includes several aspects that can make the difference between an ethical and unethical trip. The first thing examine is who they allow to volunteer on the trip. Do they require people with previous training or is anyone allowed to help with the trip? More importantly is there any kind of required training prior to the trip itself. If they allow people or students without any training to attend the trip, it is important that they receive training from the service organization. Without any kind of prior training these people can help to reinforce negative ideologies and are likely to harm the community further. Without teaching the

people attending the trip about the culture and the people that they are serving; the attendees will likely maintain negative "Western" superiority ideologies that have been marginalizing people for years. A huge part of this is understanding what kind of training they provide. Training for international medical service should include learning about the culture and history of the community that is being served. This helps to create understanding and mutual respect between the community being helped and the international service group. Without this mutual respect, understanding, and permission there cannot be effective cooperation between the local community and international group. Cooperation is essential to making sustainable changes. If a local community is not communicated with and engaged as an equal partner from the start, they will likely further mistrust international bodies and the service trip will be pointless. Part of this education is dismantling the white savior complex some people adopt when attending a medical service trip. The attendees need to understand that they are not better than the people they are serving. Education at its core is the best way to bridge the disconnect between a harmful and a helpful service trip.

Next it is important to see if the organization is collaborating with the local community. This includes communication prior to and after the trip itself. Collaboration is essential for long-term meaningful change to occur. It is essential to have input from the local community in order to make sure that the service being done is in line with their values, beliefs, and their health needs. Another part of this collaboration to look for is whether the international body provides training to local community members or not. This is another aspect of international medical service that is essential to maintain

sustainable healthcare. By training local community members to provide healthcare, it allows for a community to continue providing healthcare once the international group leaves. Part of this collaboration is whether or not a service organization fully understands what a community requires. Identifying what types of resources the international group is providing to the local community is an important aspect of this. These resources should be accessible to the local community after the international group leaves. Without accessibility, it can create a dependency on external resources which in turn can harm the community in the long-term. The international group should only be providing resources that a community is able to access after they leave, or it can leave a vacuum in terms of resources and health. This is one of the hardest attributes of service trips to determine. Service trips idealize the idea that by bringing in all the medicine and technology a community needs they are helping. Realistically it just creates a dependency on external resources.

An organization that takes an interesting approach on collaboration is the International Volunteer HQ. Rather than allowing the organization to control what a local community needs, the local community is in control. This organization rather than sending resources and money to community, provides support staff to local organizations and infrastructures (International Volunteer HQ, 2021). Volunteer HQ lets the local physicians and medical infrastructure dictate their needs and the organization only provides the support staff that many LMI countries are lacking (International Volunteer HQ, 2021). The downside to this is that these volunteers could be potentially taking jobs away from local community members. As discussed earlier, however, many of these

would-be local staff members tend to be ghost employees. While this organization has both good and bad aspects, they pose an interesting model to consider when transitioning from a harmful service area to a more sustainable one. Volunteer HQ allows the opportunity for support while building up infrastructure so that the support is unnecessary. The downside to this organization is that they are potentially reaffirming the belief for the most part the local communities outside of the physicians are incapable of their own healthcare.

Finally, you should examine the format of the trip. It is important to know the time period in which the service is supposed to take place. If it is a short-term trip, are they planning on returning to the same place? Without long-term interaction, whether through multiple short-term trips over many years or one trip over a long period of time, a service organization cannot hope to effectively build up a community's healthcare infrastructure. A number of different organizations have different timelines depending on the location of service and budget. MSF, for example, varies its time commitment depending on the community they are helping or the disaster they are assisting with (Doctors Without Borders, 2020). CDC and WHO sponsored trips also have differing timelines depending on numerous factors. Understanding this timeline and the goal of the organization within this timeline is important to gauge whether a trip is aiming for a long-term impact or a transient presence.

This short outline to examine international service trips will hopefully help people to understand and know what to look for in trips. Its use will hopefully help to support more ethical service trips and in turn help them to become more prevalent. Increasing the

prevalence of more ethical service trips will help to remove harmful power structures that have been present since colonial times and begin to effectively build up healthcare infrastructure. Through this examination, we can start to make changes in the way we conduct service trips. These changes will hopefully help to reduce the health disparities in the world today and in turn help to improve the health outlook worldwide. As part of this discussion, let us examine a few international service trips that aim to fit within these guidelines for medical service.

A commendable example of a sustainable service trip organization is the Child Family Health International (CFHI) organization. CFHI aims to provide community oriented global health education. They aim to create reciprocal partnerships and build up local communities through health education (Child Family Health International, 2021). The main approach that CFHI takes to international service is education. They understand the importance of the need to take a broad approach to global health initiatives. Through education, they are attempting to address social factors including poverty, politics, history, culture, and the complicated nature of health (Child Family Health International, 2021). CFHI does an amazing job at removing voluntourist structures and makes their trips truly about the all-encompassing approach to global health. They fit well within the outline above by aiming for partnership and education above all else. Overall, CFHI is one of the best international service organizations today by helping to breakdown the damaging structures of global health through education.

Another organization that falls within the outline we have set is Global Vision International (GVI). GVI is an international outreach organization that works in several

fields encompassing everything from sustainability to global health (Global Vision

International, 2021). In order to maintain ethical practices, GVI has ten objectives that

they believe are at the center of responsible and sustainable development. Within these

outcomes they state the foundation of their projects includes locally driven collaborative

projects, defined sustainable outcomes, and avoiding external dependency (Global Vision

International, 2021). These are just a few of the core values of GVI, demonstrating how

they aim to maintain sustainable long-term change in communities worldwide. In their

ten core values, they highlight numerous ethical concerns about international service that

has been discussed throughout this paper. GVI embodies the ideologies that should be at

the center of not just international medical service but all service. They are striving for

the best practices within the global community and repeatedly monitor their impact and

ethics in communities worldwide. This organization aims to keep the community first and

make sure that all participants are well educated and understand the long-term impact

they can have. GVI overall has to be one of the best organizations that successfully

maintains ethical service and continually strives to do more.

     While organizations like PIH, GVI, International Volunteer HQ, and CFHI are

great organizations for international medical service, they can still have their downsides.

All these organizations while striving for ethical international medical service can still

have instances where they fail in that mission. People are not perfect and there can be

instances of white savior complex or reinforcement of colonialist ideologies. This does

not mean that they should stop trying. Clearly when looking at the field of international

medical service it is not as black and white as people believe it to be. Throwing medicine

at the problem cannot change the world of global health. In actuality, it takes committed people who see the opportunity to improve the field and continue growing towards change. As we have seen, the history of global health has its ups and downs and it will continue to do so, but we need to start considering our role in changing global health. We need to start supporting international service that maintains ethical and sustainable beliefs and throw away the old model.

Ethical international medical service is a complex issue with several different sides and approaches. Clearly, the history of global health is one of colonialism, self-interest, and unequal power structures. That history has given rise to the global health climate we see today, including medical service trips performed by people who are undereducated and do not understand the complexities of the service they are providing. These people are there as voluntourists, jumping on the opportunity to travel and fuel their emotional needs. This service creates long term harm for local communities by damaging already week infrastructure and creating dependency on external aid. In order to continue moving forward in the field of global health, we need to move away from this historically damaging type of service and move toward capacity building and other types of service that account for all social factors of medicine. Through support and participation in organizations like PIH and GVI and these more encompassing types of trips, we can begin to make long term sustainable change in communities worldwide. I have provided below a flow chart to use when evaluating service trips (Figure 1). It is our responsibility as global citizens to make this change now and help change the field of global health.

Figure 1:

Flow Chart for Evaluating Medical Service Trips
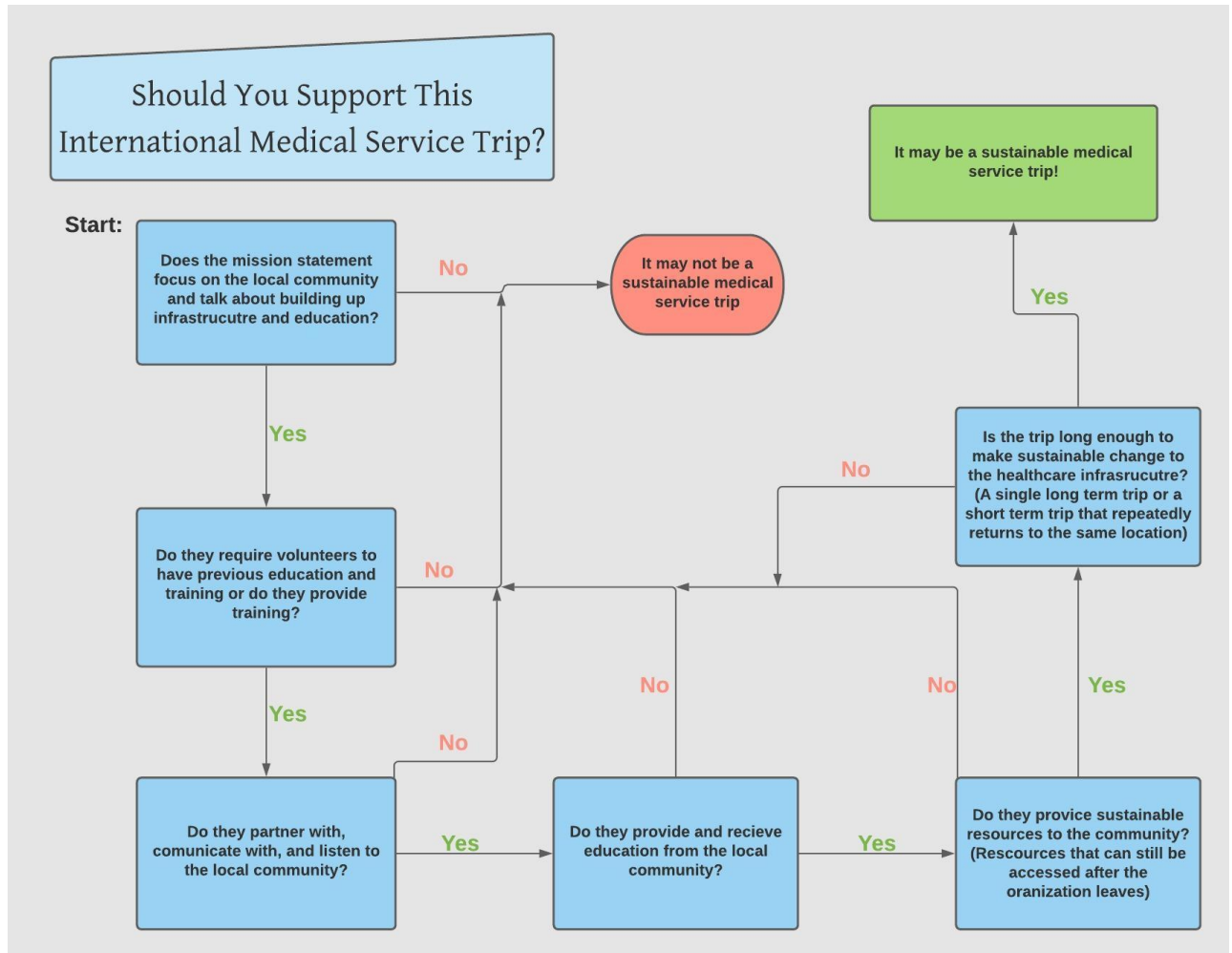
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