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Volunteer Tourism: Fulfilling the Needs for God and Medicine in Latin America

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Volunteer Tourism: Fulfilling the Needs for God and Medicine in Latin America

by

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A thesis submitted in partial fulfillment
of the requirements for the degree of
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Abstract

This study seeks to understand how short-term medical missions fulfill health needs for their recipients in Honduras, and how in turn, mission participants experience need fulfillment as well. By using the theoretical concept of co-construction of health to see how health needs are or are not met, I conducted a thematic analysis of the Baptist Medical and Dental Mission International (BMDMI) resulting in the following themes: 1.) Mission workers receive fulfillment from their experiences in the mission field. 2.) Mission recipients receive partial fulfillment of needs from the mission. 3.) Through a calling, missions are a means to an end. Through these themes, this project examines ethical stances on missions, communication about health in mission contexts, and whose needs are met, privileged, and silenced.

Chapter I:

Introduction

In 2014, I was asked to join a group of individuals traveling to Rio Negro, Honduras funded by churches in my home community, and the goal was to provide medical, dental, pharmaceutical, and general aid items (i.e., clothing, hygiene products, sleeping bags, reading glasses, toys, child care items, etc.) to Rio Negro. The name of the mission, which has a permanent compound in El Plan, Honduras, is the Honduras Baptist Dental Mission. During this trip, I was exposed to few religious events, including attending church services at the local cathedral with villagers, and a distribution of religious texts. Most of the time was spent focusing on patients who had come to seek medical and/or dental assistance. I saw religious moral principles such as brotherhood and kindness guiding the work of those in the mission. However, I saw very little implementation of the actual Christian word, or the teachings of the Bible, during medical or dental examination and care of the local people.

During my second trip with the same mission in 2015, however, my experience was quite different. In the time I spend with the mission group in Tomala, Lempira, Honduras, I saw the local community more exposed to Christian values and teachings by the mission staff. Beyond church services at a local church and distribution of the Bible, I saw Christian ideals, such as relying on religion as a means of healing, being promoted during the medical and dental services being offered. I felt very conflicted regarding the ethics of providing medical care to groups who

might not otherwise have access to such care through the guise and in the pretense of religion. Despite an invitation to return on the mission, I chose not to do so.

A guiding thought in health communication is that health has no universal definition, but rather means different things to different communities around the world. Through mission trips, such as the two I participated in, one group's definition of health is privileged over another, and the ways in which the unprivileged group makes sense of health might often be unacknowledged. This thesis explores how meanings of health are constructed by medical missions for marginalized communities in rural Latin America. According to an article in the *Journal of Nurse Practitioners*, [medical] "Mission trips are usually faith based, but there are nonreligious organizations that sponsor mission trips. Mission trips vary in length, depending on the location and organization. Most are 1 to 3 weeks in length" (Chapman, 2007).

The concept of co-constructing narratives (Dutta, 2010) will be important to understand how meaning making on health and illness happens in religious medical missions between the health care recipient and provider (Dutta, 2010). Given time constraints and volume of patients usually seen in mission scenarios, this may be a difficult goal to accomplish. However, I saw few attempts to incorporate such practices in the mission I participated in. Subaltern Studies, which seeks to work with those that live at the margins of society, will also likely guide my work. Subalterns are voiceless, or speak in a way that does not matter to us (i.e., subalterns are absent from the dominant discourse) (Spivak, 1988). Providing health aid coupled with religious undertones to a group which has no say in the dominant discourse is problematic to say the least.

In this thesis project, I will analyze the website content of Baptist Medical and Dental Mission International (BMDMI) to present an interpretation of how this organization's religious

medical missions construct meanings of health for the communities they serve in Honduras. This project is important, because unlike much of the existing literature on medical missions, it seeks to explore the intersection of health and religion more thoroughly from a prospective of two different types of a similar religion, Roman Catholicism, and Baptist, in which mission participants and mission recipients may act benevolently towards the missions goals. I will first present a review of literature on health and religious mission trips, and on theoretical ideas that guide this work. Then, I will explain my methods for inquiry and data analysis; finally, I will present my findings.

Chapter II:

Literature Review

In the following, literature review, I explore existing writings concerning short-term medical missions in Honduras. To situate the scene of the mission I will study, I provide some background into the religious history of Honduras, leading up to where the nation's current state of religious affairs. Then, I discuss ethics of short-term missions, including various ethical standpoints, including my own, and ethical challenges faced in the mission field. Next, I discuss the communication of health within the mission context, and conclude this chapter with the research question for this project.

Context

Indigenous peoples, such as the Mayans, originally inhabited Honduras. Native religions were practiced until the arrival of Spanish colonizers in the early 16th century. The Spanish made their presence known in many ways, colonization via religious conversion being one of them. Hondurans were converted to Roman Catholicism (the religion of the Spanish colonizers) in masses (Gonzalez & Gonzalez, 2007). Since that time, Roman Catholicism has been the primary religion of the nation. According to the U.S. Department of State, 47 percent of Hondurans identify as Roman Catholic (2017).

Honduras has a rich history of missionary presence, dating back to the 1500's when the Spanish first made their way to Latin America. Spaniards began mission efforts to convert native Hondurans, and the trend, though radically different in form, has never really stopped. There are accounts of missionaries traveling, largely from North America and Europe, to parts of Latin America, including Honduras, for several centuries (Pittman, Grimes, & Grimes, 1992). Many of these missionaries sought to bring different sects of Christianity to the people of Honduras. During the 20th century, missions to Honduras began addressing needs of local communities, such as healthcare, construction, animal care, and education in addition to propagating religious interests (Langer & Jackson, 1995). Slowly, this evolved into the current day missions we see now, which are largely comprised of teams of individuals from developed nations traveling to countries such as Honduras to spread religion, and address local resource needs.

Over the course of history, mission efforts have had imperialistic goals, such as creating societies that reflect European or Western likeness in education, in performance of self, and in religion. (Arnove, 1984). Religious missions have been, and still are, a very prevalent means of disseminating cultural information (Connolly & Brondo, 2010). One type of religious mission, medical missions, are a very popular type of volunteer tourism today, and typically last 2-3 weeks, unless working at a permanently established mission healthcare facility. The majority of these medical missions involve people from the West, or global north, traveling to the global south, to provide some form of healthcare (Seale, 1993). The recipients of missions are typically native peoples in developing nations. Often they are subaltern populations, or those who exist at the farthest margins of society (Spivak, 2006). Much like other types of missions, medical missions spread certain ideas, types of knowledge, and belief systems to their target population,

but unlike other types of missions, they rely heavily on the ideologies of Western medicine (Bartelme, 2015).

Western medicine practice and discourse is usually structured along the lines of the biomedical model of health, which privileges biological factors contributing to well being over culture, environment, and alternate means of approaching health and healthcare (Ott & Olson, 2011). Coupled with Christianity in medical mission contexts, this approach to health creates and defines meanings of what and who is and is not healthy in the context of these missions. To better understand how the processes of medical missions play out, ethical considerations must be acknowledged. Further, understandings and meanings of health as they play out in mission contexts must be explored. In the following sections of the literature review, I will explore ethical considerations regarding religious medical mission work, how healthcare is communicated for the recipients of medical missions, and then present an overarching research question that will guide this study.

Ethics and the Meaning Making on Health

In its most basic denotation, ethics are the moral principles that guide one's conduct (Merriam-Webster, 2017). When applied to the medical mission context, however, ethics become more specific. There are two major seemingly separate, but intertwined, fundamental ethical ideas guiding most medical mission trips. One is the medical code of ethics, which includes doing no harm, and other specific principles in the Hippocratic Oath (Miles, 2005). The other is the Christian set of ethics, which includes serving, sharing the teaching of Christianity, and additional points from the Bible. Most missions have an ethical code set forth that can be found on their website or applications. Though these two sets of ethics work together in the

medical mission context, there are additional ethical principles at play. Each person involved in a medical mission likely has his or her own personal set of ethics, which may derive from specific teachings such as Christianity, or a personal philosophy. It is these ethics that guide the individual actions taken by missionaries and healthcare providers on medical missions.

There are several ethical concerns surrounding medical mission work. To begin, short-term missions as a whole may face ethical dilemmas. Even missions purely focused on evangelism, construction, or education may be perceived as neocolonial in intent (Arnove, 1984). When volunteers perform tasks that could be done by residents of the host country, a form of subordination is instated. Additionally, pushing the missionary religion on the host culture is problematic. It is not that resident workers are incompetent, or that native religions are failing people, but rather that an imperialistic Western outlook is imposed on these situations (Perold, et al., 2013).

Beyond mission ethics, providing short-term healthcare abroad comes with its own set of considerations. There is often a language barrier, which requires that translators be used (Godfrey, 2012). This may prevent healthcare from reaching its optimal potential due to lapses in translation or understanding. Resources may also be an issue. Healthcare providers that are accustomed to a typical American healthcare facility are likely to find resources scarce when practicing in developing nations (Asgary & Junck, 2013). Equipment that is too large to be transported may be unavailable, which can influence diagnosis or treatment. This could mean a possible breach in bio ethics, such as the Hippocratic oath, which encompasses the ethical practices of doing no harm, and attempting to save lives at all cost (Miles, 2005). When there are limited resources in healthcare abroad, healthcare providers sometimes feel as though they need

to turn away patients, directly violating their oath. Unfortunately, the patients most frequently turned away are those in the most dire need of medical attention (Hunt, Schwartz, Sinding, & Elit, 2014).

Short-term healthcare abroad raises another ethical question: that of sustainability. Often in short term healthcare situations, patients are given fixes like prescriptions for problems such as chronic conditions, infections, and other disorders (Bartelme, 2015). However, these fixes are often only temporary. When the fix runs out, patients are left in the same condition as they were prior to the medicine or treatment, or possibly worse if a dependency was formed (McLennan, 2014)

Another issue with short-term healthcare is who is providing the care. Often physicians working on short-term medical trips are medical students or residents. Regulations in foreign nations may not be the same as they are in the United States or Canada (the two largest senders of medical students to developing nations). Further, the regulations set in place in the nation may not be enforced and supervision may be inadequate. This may result in healthcare providers practicing medicine that is beyond their skill level or training (Martiniuk, Manouchehrian, Negin, & Zwi, 2012).

Medical mission work includes additional ethical considerations. To begin, why people choose to go on medical missions may be called into question. There is an allure to help with problems of others, particularly in places that are exoticized by a Western gaze (Martin, 2016). The problems of others in developing nations may be seen as easily fixable by people in developed nations, who may view them as resulting from a lack of knowledge about health that they could provide (Martin, 2016; Van Engen, 2000). Medical mission trips tend to be

particularly enticing to young people in or aspiring to be in the healthcare field. These trips can provide an extra line on a CV, and give students an advantage by being able to claim experience in global healthcare without a lengthy commitment (DeCamp, 2011). Further, medical mission trips may be a destination trip, or an opportunity “to go to a third world country,” an increasingly glamorized concept, that is supposed to help people “learn about themselves,” and “learn to appreciate the things we take for granted” (McLennan, 2014, p.166). Of course there is also the compelling egotistical inspiration (or “call” in religious terms), to help those less fortunate than one’s self (McLennan, 2014). These self-serving motives come with high price tags—an expense that ultimately does little good for the recipient population, by spending funds that could be used to aid existing healthcare facilities and local physicians (Van Engen, 2000).

In a particular medical mission to Honduras, the travel and housing expenses for a group of American healthcare providers and students for one week, was over half of the annual budget for the permanent healthcare facility in which they volunteered (Van Engen, 2000). Volunteer medical missions may enhance the ego and experience of missionaries and healthcare providers, but take away money that could be utilized to deliver more or advanced healthcare to the local population, and pay the salaries of local healthcare providers (Langowski & Iltis, 2011). Medical missions may also displace local physicians, contributing further to the poverty of the recipient area (Perold, et al., 2013).

Given the ethical considerations of short-term missions, it is important to consider how missions and mission participants communicate about health to their recipients.

Communication of Health

How health is communicated during medical missions is also an ethical consideration. Healthcare professionals traveling to developing nations tend to practice medicine using the framework of the biomedical model of health (Ott & Olson, 2011). This model of health gives the utmost credence to biological factors contributing to health (Borrett, 2013). By privileging biological factors, however, the biomedical approach simultaneously ignores alternative methods to approaching health. Using the biomedical model also devalues additional factors that influence health, such as culture, tradition, geographical location, and more (Racine & Petrucka, 2011). Employing this approach in itself could be an act of violence, because it fails to recognize the part structural violence plays in shaping health in resource deprived communities. It is additionally violent, because it evaluates recipients of health care based on a predetermined, biological scale that does not account for the effects of the governmental, social, or environmental situation in which recipients might live. Structural violence is the political, socioeconomic, environmental, racism, and sexism factors that inflict violence upon, and play an influential role in shaping the health of, those in developing nations (Farmer, 2005). When these factors are not given due consideration, sustainability is even more questionable, because the need for food or clean water over medication, or patriarchal forms of subordination may outweigh or outlast short-term medical care (Wall, 2011).

Sustainability is further threatened by this approach to short term care, because of how it goes about determining success. Measuring success in the short-term medical mission context is usually based on how many patients were seen and treated (even temporary treatments), versus

how the problems in health were addressed (Montgomery, 1993). The emphasis on turnover rate rather than long term prevention reifies a Western, biomedical model of health, which privileges biological elements of health, while silencing other possible dimensions. Further, healthcare providers and missionaries may not be aware of non-biomedical approaches to health (Hunt, Schwartz, Sinding, & Elit, 2014). Non-biomedical approaches to health may include any means that does not privilege the Western, biomedical model of health. This may include spiritual, homeopathic, herbal, physical, and other types of approaches that may differ or not be recognized as legitimate or as worthy of attention by the biomedical model of health. This focus on the biomedical model may reflect an ethnocentric outlook, or may privilege Western healthcare, because the approaches of the local community are absent from dominant ways of speaking about health. The latter is particularly true when providing healthcare to subaltern populations.

Subaltern populations, or those who live at the furthest margins of society, are often the targets of medical mission intervention (Racine & Petrucka, 2011). Subalterns are subordinated to the extent that we do not hear their narratives. Their ways of thinking, being, and approaching the world are not important to the dominant discourse (Spivak, 2006). Subaltern ways of addressing health may be silenced when they are confronted with medical mission work (Racine & Petrucka, 2011). Further, not paying attention to local meanings of health in medical mission context may ignore the population's understanding of how health and religion work synergistically. For example, some subaltern populations may prefer seeking the guidance of a spiritual healer before seeing a physician regarding their health concerns. Others may desire consulting both a physician and spiritual healer (Basu & Dutta, 2007). These and other methods

to addressing health may be the way a particular set of people have understood health, which, when confronted with medical mission health care, may be diminished or lost.

Medical missions would not be what they are sans religion. Historically, conversion has been a main goal in medical missions (Good, 1991). Some writers argue that in current day medical missions, the desire for religious conversion is outweighed by the Christian principle of being a good and helpful Samaritan (Connolly & Brondo, 2010). Regardless of intent, religious healthcare typically reflects an ethnocentric way of approaching medical missions. An article in the International Bulletin of Mission Research refers to mission recipients in developing nations by using language such as “primal,” and describes their world view as “sacral,” using exotic terminology that makes inferences that they desire for and depend on the religious and medical assistance of the West (Staples, 1982). This train of thought reinforces the importance of the biomedical model of health, claiming that mission recipients are unable to place value where it “belongs,” caring more about factors other than the spread of infection and other biological determinates (Staples, 1982).

By prescribing a Western, biomedical outlook on health to mission recipients via medical missions, missionaries are not only constructing the meanings of health, and health coupled with religion, but they are also simultaneously defining who is and is not healthy in the population (Racine & Petrucka, 2011). The Western construction of health can encompass ideas that may not be traditionally reflected in the recipient culture, such as ideas about hygiene and preventative medicine. This reflects ethnocentric assumptions that medical and religious approaches used in the Western world are also appropriate for the recipients of medical missions

(McLennan, 2014). These assumptions can lead healthcare providers and missionaries to make decisions that contradict social norms of the local community (Montgomery, 1993).

Assumptions about local meanings of health that breach social norms of the community also occur because healthcare providers and missionaries do not work with the local community to co-construct narratives of health. Co-constructing narratives of health is a means by which healthcare providers and missionaries may work with the local community to come to mutual understandings of what health means (Dutta, 2010). Co-constructing health involves having a culture centered approach, which means that the culture in which the mission is taking place should be regarded, and located centrally to understanding health (Dutta-Bergman, 2005). When this approach is implemented, and the ideas of the local community are valued, it likely becomes easier to attain the best desired health outcome (Dutta, 2010). In the medical mission context, however, co-construction of health narratives may be absent, because missionaries and healthcare providers place more emphasis on accomplishing their goals of ministering and patient turn over, than on understanding what health means for the local community (Bartelme, 2015).

Additionally, we must consider what it really means to co-construct health with subalterns. This goes beyond simply speaking with community members. Since subalterns speak in a way that we do not hear, or a way that is absent from dominant discourse about health, listening is central to the entire endeavor (Spivak, 2006). However, listening alone is also not good enough. It is critical that we listen to subalterns in a way that matters. This means that we do not simply ask questions and receive answers in a transactional form, but rather that we truly attempt to listen to their narratives, their understandings, and what health means to them. To co-

construct narratives of health with mission recipients is to listen to what they have to say and learn from it. It is from this theoretical perspective that people participating in short term medical missions and mission recipients can begin to work together to achieve desired health outcomes.

Co-construction of health narratives also requires that those involved practice reflexivity. There are factors exterior to the individual that have pertinent implications for the meanings of health. Social, political, economic, and other factors are important considerations when creating and co-creating what health means (Lupton, 1994). These are considerations that must be made regarding everyone involved. Those working in the mission must consider where they are positioned in relation to the structures that surround them, and how these structures affect their definitions of health. Missionaries and healthcare providers from the United States and other nations in the global north should reflect on their access to healthcare, their socioeconomic position, anything that has hindered or promoted their access to healthcare, and how their cultural and personal understandings have shaped the ways in which they think about, speak about, and understand health. It is also important that they think critically about how they came to find themselves in the position in which they occupy in the mission field. What sources of privilege have allowed them to be where they are, providing care or materials? What types of power come with this position? What significance does this hold for the ways that they approach and are approached by those who they are attempting to serve? Likewise, when associating with those who are receiving medical mission care, it is paramount that missionaries and healthcare providers consider the same factors surrounding their recipients. Those receiving mission healthcare and provisions are positioned a particular way within their community and nation, and have cultural and socioeconomic factors that contribute to their understandings about health. Missionaries and healthcare providers should think and inquire about the space in which they are

volunteering. How has the particular community given its culture and socioeconomic position contributed to how mission recipients understand and talk about health? What structures¹ in place have resulted in them being recipients of this type of philanthropy? What might their perceptions of the mission be? Beyond considering these factors, however, it is of utmost importance that missionaries and healthcare providers listen when mission recipients speak to them about their understandings of health.

Also important to co-constructing narratives of health is ethics. Given that ethics are the moral principles that guide actions, the concept of ethics is consequently central to working with mission recipients and co-constructing health with them.

Since ethics are not universal, however, they may be called into question, and considered critically, particularly when working with vulnerable populations. It is thus imperative to this project that my own position on ethics be clear. Consideration of multiple perspectives is one of my fundamental ethical beliefs. It is necessary for me to think of the ways in which my actions, the actions of others, and the actions of structures surrounding me affect people beyond myself. This includes all actions, but is specific to support of policy and propagating of ideas. Further, my ethical code includes civility that is unconditional. Refusing to be civil towards or to help a fellow human due to conditional factors such as their attitude, beliefs, etc., is a violation of my ethics. From my ethical standpoint, I make observations based on whether or not these ethics are upheld by others and myself.

Called by religion, and armed with the desire to fix the impending health problems of others, medical missions become a task often taken up by Westerners, or those from the global

¹ Arrangement of institutions by which those in a population interact with each other and their surroundings (Encyclopedia Britannica, 2017)

north, eager to fulfill the desires of their savior complex, and go “help” those in the global south (Marin, 2016). After reviewing how religion and medicine work to create certain meanings for mission recipients, I realized that existing literature focuses largely on either what religious medical missions are, or the ethics of short-term healthcare. This does not fully account for the ways that religious medical missions, as religious entities, and as short-term healthcare providers, are intertwined, and how the two distinctive parts, religion and healthcare, work together to communicate meanings and satisfy needs. These factors considered, I pose the following research question:

RQ: How does a medical mission, in this thesis, the Baptist Medical & Dental Mission International, work to meet needs, specifically health needs for their participants and recipients in Honduras?

Chapter III:

Methodology

Medical missions have largely been studied by focusing on mostly the religious aspect, or the ethical aspect of short-term health care. As I discovered in writing the literature review, the two major aspects of medical missions, ethics and religious communication of health, were not thoroughly explored as a cohesive force. Once I arrived at my research question, I started considering what type of sample would most accurately represent both religion and short-term healthcare within a medical mission context.

Sample

After reviewing literature regarding medical mission work, I began to narrow down the type of medical mission that I would like to focus on. Given my experiences with medical mission work, and my religious upbringing, I decided that I would focus on a medical mission that was funded primarily by a religious group. I selected Christianity as the religion for my topic, because I have had years of experience in Christian environments, and have knowledge of the inner workings and teachings of the religion. I started my internet search by viewing the site for the mission that I personally attended, Honduras Baptist Dental Mission. I chose not to analyze this particular organization, because I felt that it was a conflict of interests since I

already have formed opinions about the mission from my experience participating in it. Looking at the mission's site, however, gave me a good idea of what a mission's website might reflect in comparison to the actual mission experience. I found that the site was thorough in communicating the goals of the mission, and was quite clear regarding its religious affiliations. It had an updated, professional layout that was easy to navigate. With these concepts in mind, I began searching for a similar organization.

I started by searching for "religious medical missions" on Google. This returned a number of results, and I looked at quite a few of them. Eventually, I found a site that had a long list of religious medical missions with a link to each one's site, and I went down the list exploring every site that had connections to Latin America. I chose to search for missions in Latin America because my medical mission experience took place in Latin America, and I want to know more about missions to this region, and the local populations. From this site, I narrowed my choices down to ten different medical missions, all well designed, easy to navigate, and incorporating at least one mission within Latin America. I then narrowed the selection pool to three missions, eliminating the others on the basis of limited religious material, more focus on areas outside of Latin America, and large corporate interests. Following deliberation, I chose the Baptist Medical and Dental Mission International (BMDMI) website. I selected this mission because it encompassed all of the components I was looking for: a religious focus, large presence in Latin America, easy design, and comparable to the site of the mission in which I had participated in. Even more advantageous, is that this mission is based on a denomination of Christianity that I am familiar with. Even though I was previously unfamiliar with this particular mission, it is headquartered very near my hometown. This probably allows me to better understand the culture of the people who work for the mission. For example, I am familiar with

missions working from Mississippi, and the ways in which religious organizations located there typically ask for participants and donations. Further, I am well versed in the language used in this geographical location, commonly referred to as the “Bible Belt,” which allows for an advantage in interpreting meanings from the data. I also have an understanding of cultural nuances in the language, which appear in places such as the mission’s video. Additionally, the site allows viewers to search for specific areas in Latin America.

Data Collection

I began collecting data by reading the website’s various sections. The website is content rich, and has multiple sections devoted to different aspects of the mission’s work. I started by reading the following sections and sub sections: the home page tab, including newsletters, and newsroom; our story tab, including history, our team, and BMDMI statement of faith; our ministry tab, including BMDMI ministry, short term mission teams, ministries to children, school ministries, Centro Medico Clinic & Guaimaca Ministries, Bible institutes, project life; our needs tab, including BMDMI giving community; our missionaries tab, including missionaries to Honduras; and the resources tab, including resources, missionary newsletters, and BMDMI FAQs. Additionally connected to the homepage is the mission’s Facebook and Twitter accounts. The mission’s Twitter account may be viewed without ever leaving the homepage of the website, and the Facebook page allows for several day’s worth of content to be viewed on the homepage before linking to the actual Facebook site. I viewed each of these accounts going back to November 2016, searching specifically for information pertaining to the mission’s work in Honduras. These pages were full of pictures and posts with various sentiments depicting volunteer’s experiences. Another resource available on the site is an archive of past newsletters

written by missionaries in the field. This archive goes back typically two to four newsletters per missionary.

After reading and rereading the content on the pages, I selected the following items for analysis: site homepage <http://bmdmi.org/> (pictured at end) mission history, statement of faith, three newsletters from missionaries in Honduras, two brochures called “one week in your life,” four Facebook posts with pictures, three Tweets with pictures, and a video titled “BMDMI Short-Term Team Mission.” I then transcribed the images from the Facebook and Twitter posts, and transcribed the text and visual images from the video. The video is four minutes and eight seconds long. These transcriptions will be material for my analysis just like the newsletter text. The following is a 46 second excerpt transcribed from the video:



Figure 1: Short Term Mission Video

“Before anyone can come in and see a doctor, before they can come in and get clothing, before they can come in and get rice and beans, before their children can be seen by a doctor, they must go to an evangelistic service. Everything we would do for BMDMI, is about getting them into that evangelistic service. That is the most important thing we do. Everything else we do here in the village, we want that to be what draws them in, but we want them to hear the gospel message of Jesus Christ.”

“After they’ve been through the worship service, then they’re able to come see the doctors, and they’re able to go to the pharmacy and get medicines that they need. If they need eye care, they can go and get reader glasses, sunglasses, prescription glasses even. If they need dental work, they can get dental work done. We have a clothing store where they can get rice and beans and clothing items, shoes.” -Mark, team captain

During this section of the video, a man (Mark, team captain) speaks while lines of people are waiting outside of a building. The video then switches to Mark speaking interview style, with the village blurred as the background, Next, the video switches to show villagers attending evangelistic service, as Mark continues to speak. It also shows a band playing at the service, and a man speaking to the crowd with a book in his hand.

Next, Mark’s voice is over a video of a man having his blood pressure checked in a school desk. It then shows a line of people standing and waiting to enter a door. The video then shows an ocular test being performed, a procedure being performed, and the clothing and food

store boxes being arranged. This segment of the video ends with a child being fitted for a shoe by a white hand with a watch and jewelry.

During the section in which Mark says, “Everything we would do for BMDMI, is about getting them into that evangelistic service. That is the most important thing we do. Everything else we do here in the village, we want that to be what draws them in, but we want them to hear the gospel message of Jesus Christ,” I am reminded of colonizer missions, whose main intent was religious conversion (Good, 1991). This exists in contrary to an article by Connolly and Brondo (2010), that explores how principles of brotherhood and being a Good Samaritan may nowadays outweigh conversion aimed missions of the past (2010). Further, this passage reflects how medicine in medical missions is presented to subaltern populations in the guise of religion. BMDMI’s typical short-term mission recipient may be considered subaltern, because they live at the farthest margins of society, often in high, secluded mountain villages that are very difficult to access, and that even other residents of the country may not know exist (McLennan, 2014).

Data Analysis

I use an inductive thematic analysis to analyze the information present in the Baptist Medical and Dental Mission International website. The website offers broad information on its homepage, which may be refined by selecting information about the desired country of exploration that the mission focuses in. Viewers may choose from Guatemala, Honduras, South Asia, Nicaragua, and the United States. For this paper, I selected Honduras.

An inductive thematic analysis is a method of qualitative research in which themes and patterns in a data set are analyzed, interpreted, and written up (Bernard & Ryan, 1998).

Qualitative research is a type of research that lets researchers or observers make sense of the world around them in ways that quantitative research may not allow. Qualitative research may incorporate observations of text, pictures, interviews, words, sounds, and field notes, that are not constrained by numerical order and structure, but rather are defined and made sense of by interpretation (Nkwi, Nyamongo, & Ryan, 2001). Researchers using qualitative methods make sense of data by analyzing the ways people understand and assign meanings to particular phenomena (Denzin & Lincoln, 2005).

Further, inductive analyses within qualitative research exists in contrast to research that begins with a hypothesis. An inductive analysis allows for a research question to be explored without preexisting or predetermined codes (Guest, MacQueen, & Namey, 2011). This approach starts from the bottom up, where data is generated, then explanatorily read and re-read in order to produce codes (Lindloft & Taylor, 2010). From this, the research question may be modified or take shape. Likewise, a hypothesis may be derived from an inductive analysis. This approach may be guided by constructivist grounded theory. Grounded theory allows for data to be understood from the ground or bottom up, and acknowledges that meanings are socially constructed (Charmaz, 2006).

Inductive thematic analysis focuses on the meaning of themes within a given text, in this case, the website content of Baptist Medical and Dental Mission International. Several steps exist in thematic analysis, including familiarizing oneself with the data, producing codes, selecting themes, and reviewing (Thomas & Harden, 2008). Themes are patterns within data that reflect something significant regarding the research question (Braun & Clarke, 2006).

I began my analysis by familiarizing myself with the data. Once I transcribed the data, I reassessed it to make sure it was useable, by reading and rereading it (Smith, 2015). After this step, I began generating initial codes. The first step in coding, or open coding, is a means by which a researcher begins inquiry, and starts to open the interpretation into categories. From the data, I generated 22 open codes. Each code represented an idea that was reoccurring throughout the data. While many of these codes came from textual data, others, specifically from the video and social media samples, were largely derived from verbal and visual messages. Some codes were specific to individual messages, such as the idea of “one week,” which pertained specifically to the short-term mission brochures, or the idea of being “the one,” which was an idea exclusive to the social media samples from Facebook and Twitter. Other codes, such as “serving,” “saving,” “love,” “believing,” and “sharing” are concepts that can be seen throughout all of the data. Additionally, the mission’s slogan “More than Medicine,” was a code that permeated the entirety of the data.

The next step in data analysis involved searching for themes. In this step, codes and data are scrutinized in order to search for patterns (Yardley, Donovan-Hall, Francis, & Todd, 2006). These patterns, or themes, are subjects of meaning, which, in this case, are patterns that illustrate how the meaning of health is constructed by the BMDMI. After initial themes are selected, they are reviewed in order to make sure that they are cohesive and make sense. It is in this phase that the researcher may combine, divide, or remove themes from the data set (Guest, MacQueen, & Namey, 2011). Lastly, themes are named after each theme has been analyzed in detail, and its meaning has been determined (Braun & Clarke, 2006).

To begin this process, I started by identifying commonalities between my codes. For example, I examined the relationships between codes such as “calling,” or the idea that one is called by God to perform a specific task like going on a mission, and the code “servitude,” which is the concept that as Christians, people are compelled to serve God through means such as going on missions. By doing this, I was able to see interconnectedness and patterns manifest in my codes. Using co-construction of health narratives as the theoretical grounding to view these relationships between codes, three themes emerged: 1.) Mission workers receive fulfillment from their experiences in the mission field. 2.) Mission recipients receive partial fulfillment of needs from the mission. 3). Through a calling, missions are a means to an end. Though these themes are listed in a way that appears that each stands by itself, they all exist in conversation with each other. In the following chapter, I will analyze each theme and the ways in which they relate.

Chapter IV:

Results

In this chapter, the themes 1.) Mission workers receive fulfillment from their experiences in the mission field; 2.) Mission recipients receive partial fulfillment of needs from the mission; and 3.) Through a calling, mission are a means to an end, will be discussed at length. Additionally, connections will be made from the literature, and the themes will be put in conversation with each other.

Mission workers receive fulfillment from their experiences in the mission field

Every artifact of data that I analyzed, including the site homepage <http://bmdmi.org/>, mission history, statement of faith, three newsletters from missionaries in Honduras, two brochures called “one week in your life,” four Facebook posts with pictures, three Tweets with pictures, and a video titled “BMDMI Short-Term Team Mission,” mentions that giving money or time to the mission would be a fulfilling philanthropic endeavor. Perhaps one of the most salient concepts from all of the output of BMDMI, this theme functions in several different ways. To begin, the idea of fulfillment and self-satisfaction is linked, particularly in Western society, to giving (King, 2006). Throughout every section of the data, there is at minimum one means by which people may give to BMDMI. At the end of each newsletter, there is a link where viewers

may make a monetary donation to the mission and full time missionaries. This not only helps those who donate feel as though they have done a good deed by giving to mission recipients, it also helps them feel as though they are helping serve by proxy through the full-time missionaries who live in Honduras. How this money is allocated, however, seems of little consequence, which can be seen in the Luke family newsletter, where monetary donations were used to purchase a vehicle for the missionaries.

Likewise, the newsletters also encourage viewers to consider physically participating in the mission by “giving their time.” In the “one week “ brochures, there is an entire page explaining why people should participate, and how they can help. This page, which is a letter from BMDMI’s president concludes by asking, “Would you be willing to give up one week of your life to go to Honduras...?... If so read on! You will bless many and be blessed yourself.” Additionally, the “One Week” brochures, and the short-term mission video all begin with the sentence, “One week of your life could change theirs.” One of the brochures even adds the word “forever” at the end. This sentence is meant to stand out, as it is presented in the brochures in large, distinctive font, and in the video by standing alone on the screen preceding any verbal messages, while music and the powerful image of a vast sky with fast moving clouds add backdrop. This phrase works to persuade viewers that by giving up one week of their normal life, they can make a difference in Honduras. It also connotes that one week of going on a mission trip will change the entire life of a person in a developing nation. In one way, this is a persuasive tactic by the mission to gain labor, but in another, it is what Martin calls the “reductive seduction” of the issues faced by mission recipients in Honduras (2016). This sentence insinuates that by participating in a short-term mission with BMDMI, missionaries and healthcare providers have the power to change lives.

While I believe it is possible that mission participants may make an impact on the lives of some of the people in which they interact with, which may be positive, negative, or neutral, the simplicity of the idea expressed in the website content seems to imply that if you participate in the mission, you will change the entire life of a mission recipient. This perspective fails to take into account systemic issues that factor into why mission recipients are in the positions in which they are, such as structural violence, socioeconomic disadvantages, etc. By giving money or time to BMDMI, those involved in the mission are satiating their need to belong to the culture of giving. However, this is just the tip of how their participation gives missionaries and healthcare providers fulfillment.

Viewing this theme through the Christian lens, participating in a short-term mission with BMDMI is fulfilling to participants by allowing them to perform a service, along with being called to that service. The idea of serving is a concept that appears many times within the Christian religious text, the Bible. In the book of Romans written by the apostle Paul, it states that followers of the doctrine should, “Never be lacking in zeal, but keep your spiritual fervor, serving the Lord” (The Holy Bible, NIV). There are several instances of the idea of servitude in the Bible, and is also reiterated at the end of most religious services, where the leader typically concludes with the Benediction phrase “Go in peace to love and serve the Lord.” It has been interpreted by a number of theologians and biblical scholars that serving the Lord encompasses the component of serving fellow humans (Graafland, Kaptein, & Mazereeuw-van der Duijn Schouten, 2007).

This idea of servitude appears throughout the website content as well. The mission history page states that the mission was started when its founders were serving in Honduras.

Likewise, in the newsletters, the missionaries classify their work as serving, and one of the newsletters refers to mission participants as servants. This same newsletter ends with the persuasive appeal “Please join us in serving the people of Honduras.” Additionally, in one of the “one week” brochures, the president of BMDMI says that the web content is to “prepare you to serve...”, and also says that “We are called to serve or support those that do. In the same brochure, the description of BMDMI missions to Honduras begins, “Each mission team is assigned a village in which to serve.” One of the social media posts asks of viewers, “Would you be willing to give up a week of your life and serve them?” It is thus to achieving this teaching of servitude that many participate in missions with BMDMI. In the video, a speaker who is a mission volunteer, says,

“We are compelled, we are commanded to share the gospel with all nations.”

With the previous excerpt in mind, this idea of giving and serving can be seen doing several things for Christians. It allows them to fulfill their need for servitude, it boosts their Christian moral, and it allows them to share their beliefs. Part of the idea of serving one’s fellow human is to serve them by presenting them with what many Christians call “the truth,” or information about Christ and his teachings. The short-term mission video makes this clear as the team leader states that Jesus Christ is “is the one truth.” In the Mission History page, this idea, is explained. It notes, “As the Lord provides and makes clear, and as servants are sent into the fields, BMDMI will continue to expand the Gospel message of Jesus Christ.” In the short-term mission video, Mark, the team captain, notes:

“We live in a dark world, we live in a world where there’s not a lot of truth. We come here to Central America to bring truth. We bring the physical things that they need, we

bring medicine, we bring clothing, we bring rice and beans, but the most important thing we bring to them is the hope of Jesus Christ.”

His excerpt shows that to the participants of BMDMI, sharing this message is the most important goal of the mission, even above providing healthcare. This is reinforced throughout the content, including in the mission history, which claims that the mission’s founders promised the Lord that “the physical care the mission offered would never overshadow the spiritual care it seeks to provide...” While I believe they are well intentioned, and attempting to provide salvation to mission recipients, this approach to philanthropy leaves no space for listening to what the mission recipients have to say. Listening is a key component of working with others to co-construct narratives of health, lived experiences, values, and concerns of marginalized or subaltern people.

I argue that the fulfillment that mission workers receive in the mission field is also self-serving in the religious context. By doing what is asked of them in the Bible, mission participants are meeting their need to feel like a better Christian, which is exemplified as the mission president states in one of the “one week” brochures, “You will bless many, and be blessed yourself.” In my experience, there is a desire to get better as a Christian—to gain an upward mobility in the faith. For example, team pastor, Cliff, states in the video:

“There’s nothing like experiencing God on the mission field, encountering him, presenting the gospel uh, to people, people who’ve never heard it. And uh, it does something for them, but it does something for you as well, and you’ll never be the same.”

The idea of being changed as a person, while also serving one's fellow human is an attractive idea, but not one that is entirely selfless. It is in this way that the mission can be seen as a consumer good, a way to buy an experience that will elevate one's worth as a Christian.

Viewing the idea of mission participant fulfillment from a more humanist dimension, I want to believe that missions serve to help participants feel that they are doing good in the world, such as what one of the brochures and BMDMI's twitter profile claims its does. It says, "Baptist Medical and Dental Mission International exists under the Lordship of Jesus Christ to evangelize the lost, disciple the saved, and minister to the needs of the poor." The mission president reiterates this in the other brochure by saying that participating in BMDMI will help "meet the physical needs of the poor living in the world," and calls Honduras "one of the poorest nations in the world." Beyond the culture of giving, there is a concept that helping people is a generally good task to perform. Examples of this date back to the mission's beginnings, when the founders were reportedly "constantly heartbroken as they saw people suffering..." I argue that this help is also not selfless, as many serve other sectors of personal satisfaction as well, such as professional and monetary advancement. For healthcare providers who go on medical mission trips with BMDMI, the trip doubles as an opportunity to practice unconventional types of medicine and gain experience worthy of a line on a CV or resume. Additionally, in some cases this donation of time and medical expertise may be tax deductible, which is economically fulfilling.

Missions are further fulfilling for mission participants, because of the "appreciation" that, in my personal experience, and much of the literature I reviewed, comes with giving up items associated with everyday life in most developed nations. For example, many young people report after missions that they are more grateful for possessions such as cell phones, tablets, television,

and other amenities (McLennan, 2014). This appreciation, however, would not be possible without the exploitation of those who do not have access to them. While I have experienced the excitement that many mission participants feel when they share things such as their devices with a mission participant, I have noticed what I also feel is a type of reinstatement of what I identify as a pre-existing superiority complex.

Within the idea of giving one's time and money to travel to Honduras to participate or serve in a mission, is an encompassing knowledge that those who participate possess more tangible items, higher socioeconomic status, formalized education, and perceived knowledge of Christianity than those who are mission recipients. I maintain that this creates, whether consciously or subconsciously, a superiority complex, which is already in motion before participants departed from their homes. Superiority may or may not create a type of fulfillment. Additional factors contributing to this perception of superiority seen in the data include social media posts featuring Honduran children and Honduran adults waiting in lines with captions such as "They are waiting" and "Be our hero!" This complex seems to be intensified when mission participants begin their fieldwork. The data reflects this assertion. Alyse, a tem volunteer, says this in the short-term mission video:

"What I have come to realize is that many of them have a knowledge of Christ, as we do in the States, or where I'm from, um, but they, they lack the relationship, so we're able to show them what a relationship with Christ looks like,"

Accompanying this verbal message in the video is a visual image of mission recipients crowding around an area in which missionaries are taking pictures of and with them with what appears to be professional photography equipment. Ideas such as mission participants are to be

the model for mission recipients; mission participants are able set restraints on what mission recipients must do in order to gain medical services; mission participants are the providers the medical care; and mission participants enjoy sharing their items with recipients who would not otherwise have them, work to reinforce a superior- inferior dynamic.

A superiority complex may be defined as a psychological complex, which exists in contrast to the idea that another is inferior, and is used as a defense to protect one's perceived superiority (Mehta, 2014). I argue that this superiority complex felt by mission participants is largely responsible for an absence of co-constructed narratives about health. In order to maintain perceived superiority, the inferior party is given less credence as a reliable source. If this is considered in terms of the concept of co-constructing narratives, the mission recipient may not a credible resource to listen to, as none of the web content speaks of working with locals to understand health. In one of the missionary newsletters, the missionary writes that as missionaries and health care providers, they go into the field to evaluate nutritional and medical needs. Additionally, throughout all of the web content, including the short-term mission video, the mission history, the mission brochures, and the other newsletters, the needs of mission participants seem to be already defined as "physical" and "spiritual," but seem to be written only by mission participants. This perception also creates a type of internal noise that acts as a barrier to listening to mission recipients. As long as this idea exists, the thoughts, feelings, and experiences of the mission recipients remain absent from the dominant health discourses created by the mission.

Further challenging to the idea of co-construction, is the vulnerability to co-optation. When the voices of mission recipients are not listened to, their voices are susceptible to being co-

opted, or taken up in a way that is not an accurate representation of their experiences. The data reflects co-optation of recipient's voices in a social media post featuring a line of Honduran children with the caption "We are waiting" [for missionaries]. This trend exists in the data again in the mission's history, in which the author claims that "The Hondurans mourned the loss of a spiritual father..." in reference to the death of the mission's founder. Increasingly problematic, I contend that mission participants gain a type of fulfillment from the idea that they have helped give voice to mission recipients, which is a dangerous when their original voices were not heard by mission participants putting recipient's photos social media. Speaking further to this point is the use of stories of mission participants. For example, in newsletters, there are personal stories of the experiences of mission recipients being evangelized while receiving health care. One particular story of a 10 year old boy, Jorge, even begins with the author of the newsletter, who is a BMDMI missionary speaking briefly about stories that she has seen in the mission field, then, "But one story I would like to tell you about is a young man named Jorge." This story about Jorge exists as it is told by a mission participant rather than the mission recipient.

As mission participants leave the mission field feeling fulfilled by their experiences, it is important to consider those who receive care from the mission. The next theme discusses the ways in which mission recipient's needs are addressed, and the dimensions surrounding their need fulfillment.

Mission recipients receive partial fulfillment of needs from the mission.

As part of the mission statement on the website, BMDMI president, Jason C. Green, states, "At BMDMI, our heart is to share the love of Jesus, and meet the physical needs of the poor living in the world."

Implied in the name, Baptist Medical and Dental Mission International, it seems simple to deduce that the primary goals of the mission is to provide medical and dental care to its recipients in need. However, as the data states, ministering about Christianity is of paramount importance to BMDMI. The mission history page reiterates this idea claiming that,

“Since the Mission’s foundation, the leaders of BMDMI promised the Lord that the physical care the Mission offered would never overshadow the spiritual care it seeks to provide; and the Lord has blessed the ministry in a great way for abiding by this promise.”

To begin examining the theme “mission recipients receive partial fulfillment of needs from the mission,” it must be noted that there are no accounts that come directly from mission recipients, but rather interpretations of accounts and statistics derived from the data.

National Geographic identifies Honduras as one of the poorest nations in Latin America, in which devastation of resources is abundant (National Geographic, 2017). In the website content, BMDMI recognizes Honduras as one of the “poorest nations in the world.” Given the economic disadvantage faced by much of the population in Honduras, it is one of the most popular destinations in the world for missionaries and other philanthropists. BMDMI expounds upon these needs in a “one week” brochure, which begins with “Ministering to those in need” in large bold font. Physical needs listed within the data include access to quality healthcare care, surgery, public hospitals, medical and dental care, eye glasses, pharmaceuticals, clothing items, and hygiene items. There is no account of how this list of needs was derived, and whether or not co-construction of narratives with local populations was used in order to come to this list. Due to the lack of knowledge regarding the list’s background, the list will be treated as the authority in

this project for evaluating whether or not fulfillment of physical needs are met. Needs of mission recipients extend beyond physical needs. As team volunteer Alyse explains,

“When we think of third world missions, a lot of times we think of a physical need, but what we have to be mindful of is that people in third world countries need Christ, they need the gospel, they need something that’s life changing, um, eternally, and not just momentarily.”

Implied within the excerpt, is the idea that only Christ and the gospel have the power to change life eternally. In turn, it implies that the physical need is only life changing momentarily, which I maintain is an accurate assessment in mission contexts due to sustainability concerns. BMDMI’s short -term missions last seven days, in which a typical 45-55 person team comprised of missionaries and healthcare providers see an average of 2,000-3,000 mission recipients. During this time, recipients attend evangelical services, and are then eligible to see a healthcare provider and receive the recommended care, along with additional tangible items, such as clothing and hygiene products. It is at this point that BMDMI considers physical needs to be fulfilled, but I argue that this is only a partial fulfillment. While I agree that it is possible for almost all of the aforementioned objectives designated by BMDMI to be met within the seven-day time frame, I contend that it is highly likely that, as Alyse said, these are momentary fixes. It seems improbable that teams would be able to provide sufficient pharmaceuticals to last someone with a chronic illness the appropriate length of time. Similarly, it seems unlikely that hygiene products will last very long either. Given existing literature and my personal experience, sustainability is one of the biggest barriers to mission recipient’s pre designated physical needs being met in full. To elaborate on this, during my trips to Honduras, I repeatedly saw pharmacist

issue limited amounts of medicine to recipients. For example, prenatal vitamins were issued to pregnant women; however, due to the volume of pregnant recipients, only those late in their pregnancies were given enough vitamins to sustain them until the end of their term. Likewise, those with chronic illnesses were only able to acquire enough medicine from the mission to meet their needs for a limited amount of time. Due to the mission leaving typically within seven days, those with chronic illnesses would be unable to have their prescriptions refilled. I also witnessed sustainability issues as I worked distributing hygiene and clothing items to mission recipients. As I gave out car bag, which were premade bags containing soap, a comb, a toothbrush, toothpaste, and a few other items, I repeatedly heard recipients ask for more or different items to suit the needs of their family. For example, I heard one woman ask to have four toothbrushes and more soap, because she had three children. Due to the packages being premade, however, this was not possible, and she left with an inadequate amount of toothbrushes, and not enough soap to sustain her family for very long.

Additionally troubling to the fulfillment of BMDMI's list of physical needs is again the concept of co-construction. Given my previously outlined personal ethics, I cannot conclude that mission recipient's needs are being met if I do not know whether or not they played a part in defining the needs. In viewing the data, it is unclear if mission recipient's understanding of health contributed at all to the mission's construction of needs. In my personal experiences, I saw no co-construction of health during this phase of the mission. Rather, need fulfillment resembled a fast-food transaction, in which the need was briefly mentioned, but already expected, and a fix was quickly dispensed in order to meet time constraints and to move on to the next consumer. For example, during one of my trips, a nurse told me that almost every woman the medical staff saw had a urinary tract infection. After the first few female patients the nurse saw complained of

this, she did not continue listening to each patient's experience. Rather, to save time, she assumed that they had a UTI, or were at risk for contracting one, and just prescribed them the medicine no matter what, and moved on to the next patient. In a social media post on BMDMI's website, there is an image of two healthcare providers in surgical attire posing over someone on a surgical table smiling. The caption of this image reads: "In 2016, 5,721 patients were seen and treated by surgery teams in the Centro Medico de Especialidades in Honduras #morethanmedicine." Additionally, in the newsletters and the website, teams reflect on how many patients were seen, how many prescriptions were filled, and how many people were receptive to the evangelistic services. This focus on numbers seems to reflect my previously mentioned experience, and the value typically placed on numerical turnover rates in the mission field.

Beyond physical needs, spiritual needs of the mission recipients are of significant concern for BMDMI. This is made evident throughout the data, but is exemplified by the mission's Twitter profile and a "one week" brochure, which read, "Baptist Medical & Dental Mission International (BMDMI) exists to evangelize the lost, disciple the saved, and minister to the needs of the lost." Choosing the word "minister" as the verb to describe how needs are met, illustrates the emphasis put on spiritual needs, an emphasis so strong that it permeates every sector of needs. It is a principle requirement outlined in the BMDMI short term mission brochure, that includes the following needs: vacation Bible school, general evangelist services, children's ministry, sharing the gospel, praying, teaching truth and God's word, ministering, bringing news, and introducing people to Jesus Christ.

I argue that the same issue is present with this list of objectives, in that the output of BMDMI does not allow viewers of the website to know if mission recipients were able to express what their spiritual needs were. However, I find it unlikely given the data, which states repeatedly that recipients “need to know Jesus,” “need to be ‘introduced’ to the gospel,” and “need to be told the truth.” The use of the word “introduced” denotes that there was not a prior knowledge, which implies that it the probability that recipients expressed their desires regarding spiritual needs is little. The use of the word introduction is further troubling considering that nearly half of Hondurans identify as Roman Catholic, a religion that uses the same religious text and worships the same God as other Christian denominations (U.S. Department of State, 2017). Additionally, substantial section of the Honduran population already identifies as Christian, so missions would not be introducing gospel, but rather reinforcing its messages.

The word partial is key within the theme “mission recipients receive partial fulfillment of needs from the mission,” because of a seeming lack of involvement of mission recipients in defining what needs they have and would like to have fulfilled. Moreover, as need fulfillment pertains to spiritual needs, there is no means by which to measure whether or not the need has been fulfilled.

In understanding that there is at least partial need fulfillment for both mission participants and mission recipients, it is clear that missions do serve purposes. The next theme will explore how missions come about, and through what means missions present opportunities to meet the end goal of fulfilling needs.

Through a calling, missions are a means to an end.

In the Christian context, the idea of being called to do something means that one feels compelled via a message from God to perform a certain task or service (Scheitle & Adamczyk, 2016). According to the mission history, BMDMI was started after the founders sought a solution to the problems they saw in Honduras. This mission history page states, “The Lord gave them a vision of what today we know as ‘short-term mission teams’— Christian volunteers traveling to the mission field, paying their own expenses to serve the poor and sick.” Since 1974, this original “calling,” has caused many others to feel called to go on short-term missions with BMDMI as well. This calling has caused missions to take their current form, a form that I argue is a means to an end.

The slogan “More than Medicine” appears throughout the website, and on all of the mission’s site, social media, and video content. Beyond a slogan, it is used as a hashtag in social media posts (#morethanmedicine), and as a catch phrase during the “one week” video. Here are some excerpts:

“BMDMI is much more than medicine.”- Mark, team captain

“More than medicine.”- Freddy, team volunteer

“It’s more than medicine.”- Cliff, team pastor

“BMDMI is much more than medicine, it’s no cliché, but we really are the hands and feet of Jesus Christ.”- Bob, team doctor

“More than Medicine” denotes that the work of BMDMI extends beyond medical care, which is also seen as the content on the BMDMI website repeatedly states that evangelism, not medical care, is of utmost importance. However, I contend that more than medicine also implies that there are dimensions to the mission that cannot be understood from just the statements that spiritual factors are the most important. There are additional factors situated beyond the literal messages that contribute to the “more” in the “More than Medicine.”

To reiterate a meaning advanced within the first theme, missions allow mission participants to feel better about themselves as Christians. By highlighting the idea of giving, be it giving of time, money, resources, or expertise, BMDMI’s web content plays upon the cultural value of giving. “Would you be willing to give a week of your life to go to Honduras...?,” asks BMDMI president in a “one week” brochure. When mission participants take part in giving, they are reaffirmed as good, Christian servants. Additionally, mission participants are able to stimulate their superiority complexes. It is through the means of being on the mission, that the end result of a heightened perception of religious morale and personal worth is attained.

Part of this perception of self-worth is derived from Westerner’s access to goods and services such as medical care. It is the provision of these goods and services that is another means to an end. By traveling to the mission field under the pretense of providing healthcare that would be otherwise inaccessible to mission recipients, mission participants gain access to the population for additional purposes. It is here that medicine can be viewed as the catalyst to begin a discussion rooted in fundamentally religious principles. This idea is reflected in several instances on the BMDMI website, such as one of the “one week” brochures. An excerpt from the brochure reads like this:

“Healthcare professionals, along with pastors and non-medical volunteers, join together with the ultimate goal of meeting physical needs in order to introduce people to Jesus Christ— the ultimate Healer, Provider, and Savior!”

During the short-term mission video, this idea is reestablished. Mark, team captain states:

“Everything we do for BMDMI is about getting them into the evangelistic service. That is the most important thing we do. Everything else we do here in the village, we want that to be what draws them in, but we want them to hear the gospel message of Jesus Christ.”

The idea that “we want that [healthcare] to be what draws them in,” seems to imply a type of luring, as if recipients are brought to the mission under false pretenses of being provided with healthcare services and products they desire. This bears great resemblance to my personal experience, during which missionaries and healthcare professionals inquired about the religious status of mission recipients repeatedly, even within the clinical consultation. Whether or not the messages of the missionaries and healthcare providers about Christianity is received by mission recipients, it is imperative that recipients undergo at least minimal exposure to evangelism as a means by which to fulfill the end of receiving the healthcare services and goods they came to acquire.

Similar to the seeking of goods and services sought out by mission recipients, it is possible to view those who participate in missions as seeking goods as well. According to the data, the average cost of going on a mission to Honduras through BMDMI is between \$1,700-\$2,000 per person. This cost includes BMDMI team fee, airfare, and additional team expenses. In terms of monetary expenses then, the mission itself becomes a consumer good. This good is

purchased for a number of reasons, including the afore mentioned ego driven need to elevate one's status within the religion, and also to heighten perceived self-worth.

Additionally, missions are a type of trip. A trip is defined by the Cambridge English dictionary as “an occasion on which someone goes to a place and returns from it, or the act of traveling from one place to another” (Cambridge Dictionary, 2017). Common trips are entities such as vacations, tours, or other journeys in which individuals spend money for an experience. It is for this reason that I argue that missions function as a type of volunteer tourism, in which individuals spend money for a particular experience. Such experiences reflect previously mentioned need fulfillment of mission participants, including economic benefits, occupational reference, and an appreciation for items not commonly possessed in developing nations.

The cost of these experiences, however, exceed monetary value, as I maintain that they are attained at the expense of the exploitation of mission recipients, and of labor which already exists within Honduras. As pointed out by literature, the average cost of one individual traveling from a developed nation to a developing nation for the purpose of a medical mission typically mirrors half the annual budget of an established healthcare facility in a developing nation such as Honduras (McLennan, 2014). Further, medical brigades providing healthcare at no costs other than attendance of evangelical services is likely to detract from the clientele of pre-established healthcare facilities with trained healthcare workers within Honduras. This exemplifies another means by which the end result of participating in volunteer tourism is met. This means, however, fails to account for existing systemic issues within the Honduras's economy, and likely takes away from possible ways of stimulating it, such as employing existing healthcare providers and clinics.

I argue that the fault of failing to account for systemic issues does not lie fully on those who are mission participants, or those who are employed by BMDMI to create persuasive output to foster giving. Rather, I contend that this is the result of long standing Western imperialism that, in order to maintain its dominance over the developing world, enacts the aid of privatized entities such as BMDMI. Countries such as the United States count on the reliance of developing nations as a means to attain the end desire of economic superiority. According to Farmer (2013), it is common in foreign aid endeavors for funds to be misallocated. This misallocation may exist in the context of federal funds or privatized funds, such as the case with BMDMI. Unfortunately this misallocation typically results in efforts only providing temporary solutions to problems faced by nations such as Honduras, like in the case of medical care that is not sustainable. In turn, this creates a dependency of the developing nation on the developed nation. In this way, private missions such as BMDMI may unconsciously act as a substitute for government efforts that act with neocolonial intent.

Each of the preceding themes addresses ways in which mission function to serve specific purposes. By heightening their sense of superiority, and playing upon the Western and Christian values of giving, mission participants gain a sense of fulfillment as people and Christians through participating in missions. Through the inclusions of healthcare, food, and hygiene items, into the mission field, mission recipients are having some of their needs fulfilled. Additionally, mission recipients have a need that is prescribed to them, the need for evangelism, fulfilled. Given the first two themes, missions can be seen as a means through which the end goal of need fulfillment is at least partially met. In the following section, I will present a discussion of missions from these three themes, ethical views, and theoretical standpoints.

Discussion

Under the pretense of fulfilling medical and hygiene needs, short-term missions consist of people from developed nations traveling to developing nations for the ultimate purpose of fulfilling a different “need”— evangelistic servitude and ministering. Baptist Medical and Dental Mission International (BMDMI) is one such mission that sends mission participants to various countries, including Honduras, to provide healthcare services and tangible goods with the desire of spreading the message of Christianity. My analysis of the content on BMDMI’s website, points to the fact that there are, possibly, competing ethical stances at work within the need fulfillment of short-term missions. Mission participants feel as though their work is magnifying their religious prerogative, while mission recipients are receiving some form of care.

To reiterate the personal set of ethics by which I evaluate my surroundings, I value accountability regarding my actions, the actions of others, and the actions of structures surrounding me and people beyond myself. This value includes including my support of policies and the propagating of ideas, such as those shared with mission recipients by the participants and missionaries of BMDMI. Considering this, it is simple to deduce that I do not condone the undertones of BMDMI’s work in Honduras as upholding my personal ethical standards.

Embedded in my interpretation of the data from BMDMI’s website is not only my ethical standpoint, but my experiences with short term missions, my positionality as someone who was raised with Christian values, and my status as someone who was born, raised, and lives in a developed nation. This interpretation does not encompass the verbatim expressions of mission participants or mission recipients. It is possible that I misinterpreted the mission participants as I claim they misinterpret their recipients in Honduras.

In this project, I have written mission participants as those who provide healthcare through a religious guise, but have not written their possible alternative interpretations of the mission. It may be that, like my own experience, there are mission participants who do not fully reflect the ideas of BMDMI, or may feel ethically challenged by what they encounter in the mission field. Similarly, there may be mission participants who do not feel a sense of superiority, or are bothered by it if they do. The culture of giving and serving that is Christian missions may reflect good or benevolent intentions that may be genuinely felt by mission participants. Further, mission participants do perform actions that I support when in the mission field. In my personal experience, I found that those working in the part of the mission that gives away hygiene items are typically those who may have the best opportunity to relate to mission recipients with less superiority, because the intimidation factor of medical equipment and authority is not present. This may result in mission efforts that I embrace, such as spending time with people from other cultures, and giving items that mission recipients may request. With possible misinterpretations in mind, however, I continue to theorize my interpretations from the perspective that I have adopted, and will discuss this in the following paragraphs.

As stated, the Subaltern Studies project involves the study of those who live at the farthest margins of society (Spivak, 2006). Subalterns are often the recipients of medical mission work due to their remote location and typical lack of access to medical facilities. Additionally, because their ways of thinking and being are not listened to and valued within dominant health discourses, they have historically been the recipients of messages from the dominant health and religious discourse (Racine & Petrucka, 2011). When medical missions target subalterns, it is common that what subalterns have to say is not listened to in a way that matters. I saw this happen first hand in my personal experience, when a mission recipient was dismissed in a short

time frame in order to dispense a quick fix, but was asked about her religious beliefs. The recipient sat across the table from the healthcare provider with several children, all of who were young and scurrying around while she attempted to speak to the healthcare provider. As she tried to describe the needs—her and her children’s, the nurse quickly filled out a few prescriptions and gave them to the recipient before she had ever finished speaking. “Here,” the healthcare provider said cutting the recipient off. The recipient, understanding from this that her time was up, got up to walk away. As she gathered the children, the healthcare provider said, “By the way, have you heard the word of the Lord Jesus Christ?” I thought that the recipient appeared shocked that she was being addressed again after her concerns had just been cut off. I witnessed a similar situation when a woman was trying to acquire hygiene products for her family from mission participants. The missionary collected the products, but then inquired about the woman’s religious status. When the woman replied with fear that she was unsure, the missionary began explaining to her that she was in need of Christianity, and without professing religion she was “lost,” and ultimately faced immanent eternal turmoil. Despite the woman’s attempt to express why she was doubtful or fearful, her words went unheard. This speaks to the needs of mission recipients as not being fulfilled in their entirety.

Co-construction of health is a process by which we actively listen to how others make sense of health in a way that matters to our dominant medical discourse. In mission contexts, this means that mission participants should listen to mission recipients while attempting to truly hear and understand what the recipients have to say. Due to the fact that mission recipients are typically subalterns, what they have to contribute to health discourse typically goes unheard and unvalued. For example, the woman I spoke of that was dismissed was attempting to speak about how she understood health, and the health of the children that were with her. Because the

healthcare provider had already made a mental assessment of the situation and the woman's needs, her contribution to understanding health or what she needed was not heard or valued.

Missionaries and healthcare providers may not practice co-construction for several reasons. First, missions are constructed over a short amount of time, for BMDMI's purposes, only seven days. When mission participants are attempting to reach a high turnover rate and evangelize mission recipients as BMDMI repeatedly claims to do, it is likely that they do not find the time to listen to mission recipients in a way that matters. This can be seen in the example of the healthcare provider that told me she quit listening to UTI complaints, and rather began prescribing UTI medicine to almost every woman. The individual experiences that make up the way this illness is understood was barely listened to. If a female recipient even mentioned something that might be about a UTI, she was dismissed with UTI medicine, because the healthcare provider felt that this was what she needed. In this way, the healthcare provider did not listen to the patients in a way that mattered, but rather prescribed her own outlook that she felt was more appropriate to the scenario. The healthcare provider did not listen to recipients in a way that mattered in order to understand what their needs might be. I find it most probable that the listening mission participants do engage in pertains mostly to the direct questions that they ask, and little that surrounds anything else, including different understandings and interpretations of health.

Second, the concept of ethnocentrism also plays a significant role in why co-construction may be absent from the mission field. In addition to the ethnocentric concept of superiority of mission participants versus inferiority of mission recipients, is the idea that mission participant's approaches are correct, and their solutions are what mission recipients need. Most healthcare

providers on mission trips adhere to the traditionally Western biomedical model of health, valuing biological components of health over other contributing factors. By implementing only this model of medical practice into the mission field, there is no space for other approaches. It is also likely that there is not even inquiry about other approaches, which is counter-productive to the idea of co-constructing what health means. Further, it is difficult to listen to co-constructed ideas of health, when health is not the primary focus. For example, Bob, a team doctor, states in the BMDMI short-term mission video,

“The gospel is the same, whether it’s in America, or Central America. The core need is always the same, and that’s for Jesus Christ in your heart. Without that, as you all know, we’re all lost.”

Because providing for health needs is not the primary goal of missions, particularly BMDMI, religion may overshadow co-construction of health. It is entirely likely that in missions, listening to mission recipients is not a priority, but rather a means by which to begin a conversation regarding religion. Listening in this way is still not co-construction, however, because it does not account for the feelings, understands, and ideas held by mission recipients. It is not listening in a way that matters, such as truly taking in the recipients’ narratives in an attempt to understand what health means to them, what needs they would like to have met, and how there can be heightened participant-recipient communication and understanding about needs and health. When the ideas of mission recipients remain absent from dominant health discourse, the idea of superiority is yet again reinforced, and thus, particular meanings of health are constructed and given more credence and value than others. It is in failing to practice co-

construction of health that mission participants such as those at BMDMI work to create meanings of health for their recipients in Honduras.

Since co- construction, however, does not exist without “co,” it is crucial to examine whether or not mission participants are being listened to as well in order to determine if their needs are being met. Given the power dynamic instated by missions such as BMDMI between mission participants and mission recipients, it can be deduced that mission participants are likely listened to by mission recipients regarding particular elements such as healthcare, prescriptions, and the presentation of religious material. Whether or not these things are listened to and imbibed cannot be accounted for by the data. It is also important to consider if mission participants are listened to by other entities. For example, how was the format and information of and about BMDMI constructed? Does BMDMI’s information meet the needs of mission participants? It is not known if participants are considered within the makeup of this information, and if the ideas reflected in it are shared by all participants. Speaking from experience, I did not personally share the same values as those set forth by the mission I attended, and it is possible that some that attend missions with BMDMI and other organizations do not as well. The need that I felt to provide healthcare relief free of stipulation was not met. It is mandated by the organization that each participant profess and uphold the mission values as seen in the “one week” brochure, but how this is enforced is unclear. Similarly, it is necessary to consider if mission participants are listened to at more systemic levels of being, and if their expressions of political and social choices reflect values upheld or condemned by their faith and the organizations in which they chose to participate. This is important to consider, because it is likely difficult to listen to the needs of others, such as mission recipients, if one does not feel that their needs are being met in the first place, by this mission they are attending.

Further important to this project is my positionality within it. As someone who has been a participant in two medical mission trips, my interpretations of their inner-workings are embedded within my personal experiences. I contend that my views of all medical missions are not inherently and dismissively negative. I feel that those on both sides of the mission, participants and recipients, may be misunderstood. As I can speak to first-hand, not all mission participants set out with imperialistic goals and mindsets, even if they are ultimately carrying it out due to the outlook of the organization that they are affiliated with. In a similar fashion, not all mission recipients are frightened, and some I feel genuinely embrace the evangelistic messages as well as feel that their needs are met. I also argue that missions are influenced by structures external to the individuals themselves, of which they may or may not be aware. For example, political influences may play a role in influencing missions. Additionally, I have witnessed firsthand what I consider to be ethical dilemmas within missions, such as the advancement of religion as top priority, and the absence of co- construction of health narratives, and I have been complicit in such matters.

How health is constructed within medical missions, whether or not needs are met, the ethics of missions, concern for subalterns, and the content of messages of BMDMI, have no concrete resolution. Rather, these are abstractions that provoke thought instead of answers. The existence of missions extends far back in history, and though their shape and appearance has morphed, it is not likely that they will soon perish, particularly within volunteer tourist destination countries such as Honduras, where there appear to be particular health and resource needs. If missions must continue to exist, however, I argue that there are ways they could do so within a more ethical framework.

For missions to exist more ethically, they must first abandon the dynamic of superiority-inferiority as addressed within the first and third themes. Regardless of where people live, the society in which they were born into, their sexuality, gender, race, position within structures of socioeconomic status, or religion, they are still people; and, if missions are truly designed to provide need fulfillment, this must be a central idea. Religion as the central focus is not providing for health and other physical needs, and must be placed secondary to physical need fulfillment unless it is what the recipient population expresses a need for. Additionally, there must be a common understanding of what recipient needs are. This can only take place through implementation of co- construction of narratives between mission participant and recipient. Mission participants must be listened to by the mission organization, so that their views and needs are cohesive and reflected in their work in the field. Also, mission recipients must be listened to by mission participants so that the actual goal of need fulfillment may be met. However, they must be listened to in a way that matters. This extends past simply inquiring and awaiting an answer, to encompass actually listening to recipient narratives; so as to accommodate them in the narratives of the mission and its participants. While these ideas remain silenced, so will different yet valuable ways of approaching and understanding health and meeting health needs. When they are listened to, optimal health outcomes may be attained, needs may be met, and people may begin to learn from each other.

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Appendix I

BMDMI Homepage



Baptist Medical & Dental Mission International

11 Plaza Drive | Hattiesburg | Mississippi | 39402

Phone: 601-544-3586 | Fax: 601-544-6508

[Home](#) [OUR STORY](#) [OUR MINISTRY](#) [OUR NEEDS](#) [OUR MISSIONARIES](#) [RESOURCES](#)

Baptist Medical and Dental Mission International (BMDMI) exists under the Lordship of Jesus Christ to evangelize the lost, disciple the saved, and minister to the needs of the poor. We accomplish this mission by serving thousands in Honduras, Nicaragua, and South Asia with love of Jesus Christ.

Many around the world lack the basic necessities of food, shelter, medical and dental care, and education. That's where the work of BMDMI comes in to meet physical needs while presenting the Gospel of Jesus Christ, the ultimate Healer.

Our flagship ministry is Short-Term Mission Teams, which sends more than 100 teams across the world each year to meet physical and spiritual needs. Our volunteers are making a significant difference in the lives of thousands of people each year – we would love for you to join us in this work!

In addition to Short-Term Teams, BMDMI provides quality theological preparation for pastors and church leaders, offers quality education to children in need, provides loving and safe environments to abused, abandoned, and orphaned children, and offers adult vocational training that impacts generations.

BECOME INVOLVED! We pray that you will consider becoming involved with the work of BMDMI

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