"Algo es Algo": Poverty Fosters Local Support for Medical Voluntourism in Guatemala

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The medical volunteer tourism industry, an industry in which students travel to developing countries to volunteer in medical settings, is increasing in popularity. As it grows, studies that document the ethically questionable motives and practices of the volunteers have contributed to a predominantly critical literature on medical volunteer tourism. These studies focus primarily on the perspective of the volunteers and consistently neglect that of the local population that is directly affected by the volunteer tourism. Through interviews and participant observation conducted in Ciudad Vieja, Guatemala, I investigated the perceptions of the beneficiaries regarding the volunteer tourists. Contrary to the expectations perpetuated in the literature, beneficiaries expressed a high degree of support for the volunteer tourists, reporting more benefits derived from resources provided by volunteer tourists than losses. This suggests a need for a more nuanced discussion of the degree to which medical volunteer tourism is acceptable and supports the need for the inclusion of affected populations in the acceptance or rejection of medical volunteer tourist presence within their communities.

Yet another Guatemalan patient explained to me that he did, in fact, want the *gringo* volunteers in their community, and that, no, he was not bothered by their lack of medical training. I presented him with my Volunteer Tourism Information Pamphlet and asked him if he would be willing to read it and then answer a few questions. He agreed. The pamphlet included a basic definition and description of medical volunteer tourism, which, along with describing the obvious benefits, also outlined the ways in which volunteer tourism is problematic. The list of added risks to patients included the fact that volunteers would be forbidden from performing the same tasks in their own country, along with the fact that volunteer tourism perpetuates the Global South's dependence on developed nations. After spending several minutes going through my pamphlet, this patient met my eyes and chuckled.

"Well, what are your questions? Are you going to ask me if I now disapprove of these volunteers? Look, I understand that they are not ideal."[1] He paused to hand the pamphlet back to me. "But it is a wealthy person's luxury to be able to reject medicine or medical care on the basis of principle.

If someone wants to give us medicine for free, as a gift… We must take advantage of it."

While this man was unusually direct, many beneficiaries of the medical volunteer tourism industry, an industry that thrives in his Guatemalan community, echoed the idea that medical volunteer tourists offer valuable opportunities that should be appreciated. This response directly contradicts the expectation of many Western scholars who question the ethics of medical volunteer tourism. It is this very contradiction that makes this response and others like it very important.

To date, medical volunteer tourism ethics are predominantly discussed in a theoretical context or by using the testimony of former volunteers (Wearing, 2001). One scholar proposes the following scenario, which is representative of the prevailing sentiment:

> A foreigner sets up a clinic in your city. He does not speak much English. He will leave after a week or so and is not very likely to ever return. This foreigner tells you that he is a physician in his home country, but that he has never been to your community before and is not going to be communicating with your family physician or with any other head medical professionals in your local health care struc ture. Would you take your children to see him if you had no other choice? Maya Roberts (2006)

Though the author is presuming many would decline, her research neglects what is perhaps the most valuable informant base: the beneficiaries who are impacted by the volunteers. The beneficiaries of medical volunteer tourism happen to be the least studied component of the volunteer tourism dynamic (Kidder, n.d.). Though it is assumed beneficiaries would object to volunteer presence, researchers have yet to actually ask the beneficiaries. For residents of communities that have been systematically marginalized for centuries, the answer may not be as simple as most scholars suggest. As medical volunteer tourism becomes a more mainstream activity, there is a need for a thorough assessment of its usefulness and ethical tolerability. This assessment must include the position of the beneficiaries, but first, this position must be understood.

This study aims to address the absence of the beneficiary perspective by posing the following questions: *How do the beneficiaries of medical volunteer tourism feel about medical volunteers?* and*, What factors influence these perceptions and judgments?*

Medical Volunteer Tourism

Medical volunteer tourism refers to a service experience that takes place in a developing country in which the tourist performs volunteer work in a medical setting. Specifically, volunteer activities include coordinating educational health lessons, completing observational work, and performing medical tasks (Wallace, 2012). Both the observational work and medical tasks take

place in a clinic or hospital, some of which are government funded and others of which are private.

Medical volunteer tourism can be subdivided into two main categories: comprehensive and supplementary. Comprehensive medical volunteer tourism will be used to describe activities that offer medical services and resources to a community that would otherwise be without it. In this system, volunteers make up the complete medical staff and supply all of the necessary equipment and medicine. Supplementary medical volunteer tourism will be used to describe activities that include assistance in tasks at a public clinic that exists and functions regardless of volunteer support. That is to say, the volunteers only supplement the existing medical infrastructure. In this study, all research was conducted in a context of supplementary volunteer tourism.

Most volunteers share similar demographics. Many are between the age of eighteen and twenty-five, often unskilled college students from middle- or upper-class socioeconomic backgrounds (Wearing, 2001). Their motivations include a desire for cultural immersion, travel, altruism, personal growth, and professional development (Wearing, 2001; Wearing & McGehee, 2013). Though they have been found to have some degree of self-awareness, most volunteer tourists do not perceive themselves as tourists. Instead, they view their role as selfless "global citizenship" and often maintain a savior-like complex (Wearing, 2001).

Most of the beneficiaries of medical volunteer tourism fall below the international poverty line, and many of those fall below the extreme poverty line (Doyal & Banatvala, 1998). Though residents' attitudes toward volunteer tourism are seldom studied, one study found that beneficiaries report strong positive feelings toward general volunteer tourists and their service (Andereck & McGehee, 2009). This type of study is noticeably absent, however, within medical volunteer tourism.

Medical volunteer tourism has many benefits. Within the system of comprehensive medical volunteer tourism, residents who would otherwise lack access to health care are offered inexpensive or free medical consultations. Furthermore, the local population benefits from the volunteers' medical donations of resources like vitamins and medical instruments. In the supplementary system, those who have some access to healthcare benefit from meaningful cultural exchange, better-staffed health posts, and faster care (Doyal & Banatvala, 1998). They also receive benefits from volunteer program fees and increased clinic resources (Andereck & McGehee, 2008; West, n.d.).

Scholars agree that the volunteers' exposure to new cultures, different lifestyles, and profound poverty contributes to the tourists' personal development (Lyons, et al., 2012; Wearing, 2001; Wearing & McGehee, 2013). Additionally, many medical volunteer tourists participate in programs that relate to their career interests – often medicine – that can be listed on resumes and may make medical school applicants more competitive. As a result, volunteer tourists may have the opportunity to gain professional knowledge and exposure, as well as add a meaningful experience to their resumes (West, n.d.).

However, in addition to the benefits listed, a number of serious critiques exist within the volunteer tourism literature as well. The volunteers' age and lack of skills calls into question the extent to which they can contribute meaningfully to a community in a field in which they have little to no professional training (Lyons, et al., 2012; Wearing, 2001). Despite this lack of experience, volunteers have been involved in the diagnosis of ailments, the injection of vaccinations, the delivery of children, the dispensing of medicine, and more (Doyal & Banatvala, 1998; Meyer, 2006; Roberts, 2006; Wallace, 2012; West, n.d.).

In addition to putting the patients in physical danger, untrained volunteers who execute otherwise impermissible procedures perpetuate harmful power imbalances by affirming the idea that a life in an underdeveloped country is less valuable than a life in a developed one. Furthermore, in a developed country, patients are guaranteed the rights to privacy, the right to know the level of education of their healthcare provider, and the right to refuse to be treated by untrained volunteers. To deny these basic rights to patients in a country without the legal infrastructure to guarantee them is to deem those patients unworthy of ethical medical care. This denial of rights – which some academics argue is a denial of personhood – is hypothesized to result in feelings of shame or loss of dignity in some patients (Kass, n.d.).

Furthermore, because these market-driven, for-profit organizations are dependent on the tourist demand, the organizations must provide an experience that meets the needs of the tourists first and foremost (Wearing & McGehee, 2013; West, n.d.). Projects are designed not to maximize community benefits, but to appease volunteer tourists by evoking strong feelings of self-worth and having made a difference (West, n.d.). Other scholars argue that volunteer motivations are not altruistic at all, but instead reflect a desire for improved social status, exoticism, and adventure (Lyons, et al., 2012). Furthermore, the short duration of the vacation-like programs that tourists seek inhibits their ability to carry out sustainable projects (Citrin, 2010; Lyons, et al., 2012). This again supports the idea that volunteers are not assigned to tasks that are needed, but instead assigned work that the volunteer believes is meaningful (West, n.d.).

Given these criticisms, most scholars feel that the behaviors of some volunteers and their supporting organizations have consequences so grave as to denounce the medical volunteer tourism industry entirely. However, the findings of this study complicate this simplistic rejection of the industry by introducing the perspective of the beneficiaries.

Methods

Eight weeks of fieldwork took place in Ciudad Vieja and La Antigua, Guatemala, two neighboring towns with populations of roughly 25,000 and 35,000 respectively. The research aimed to study the attitudes of patients being served by Western volunteers in four public clinics in the two communities. The number gave me the opportunity to interact with nurses in communities of different demographics and to gather larger patient and volunteer sample sizes.

After forming relationships with the nurses at several of the clinics that accepted volunteer placements, I was allowed into consult rooms to watch patient-volunteer while simultaneously serving as a translator for volunteers and patients when needed. This participant observation allowed me to note interactions as well as converse casually with both groups. Additionally, I conducted post-consult, semi-structured interviews with thirty-one consenting patients directly after they had met with a volunteer. I explained to these patients that I was an anthropology student from the United States interested in volunteer tourists and that, with their permission, I wished to document their experiences with, and opinions about, the volunteers. In the interviews, each of which lasted between thirty and forty-five minutes and was conducted in Spanish, I asked participants to discuss trust, dignity and the volunteer presence.

The demographics of the patients interviewed were felt to be representative of population that the clinic served (see Appendix A). Eighteen of the thirty-one patients were female while the remaining thirteen were male. Participant ages ranged from eighteen to sixty-one, with an average age of twenty-nine. A majority of the participants (65%) had received education only through the fifth grade, though eight participants did have high school diplomas and a three were college educated. The study had roughly equal numbers of *ladino*[2] and indigenous (self-identified) participants (55% ladino, 45% indigenous). 26% of the participants reported an income below the international extreme poverty line, 61% reported an income below the international poverty line, and 13% reported an income above the international poverty line.

Photographs were used to ascertain patient preferences with regards to race and gender. The photographs depicted Guatemalan, male doctors, Guatemalan female doctors, Caucasian male doctors and Caucasian female doctors. Patients were asked to indicate their preference and then justify this choice with regards to both race and gender. Additionally, standardized objective informational pamphlet, written in Spanish, was given to subjects in order to assess the effects being educated about medical volunteer tourism. In cases of illiteracy, the contents of the pamphlet were read aloud. This pamphlet included information about the demographics of the volunteers, their motives, as defined by Stephen Wearing, and the positives and negatives of medical volunteer work, as defined by the body of literature on the subject (Wearing, 2001) (See appendix B). Patients were asked about their opinion regarding medical volunteer tourists before and after being presented with this pamphlet.

To supplement the information provided by the beneficiaries, I also conducted semi-structured interviews with eight members of the clinic staff, as well as three members of the staff of the organization Máximo Nivel, which places foreign volunteers in the public clinics. All semi-structured interviews were recorded, transcribed and then translated into English, when necessary.

Finally, to gauge the extent to which the volunteers in these clinics were representative of those characterized by the literature, I conducted informal interviews with nine volunteers and gathered thematic data based on forty-five public reviews written by volunteers who had been placed in Guatemalan clinics displayed on the Máximo Nivel website (See appendix C). The volun-

teers ranged in age from nineteen to fifty-five, with an average age of 24. 3% of volunteers had only a high school diploma and 52% had only some college education. Approximately 9% of volunteers had a college degree and 25% of volunteers were enrolled in a medical or nursing school but had not yet completed their degree. Finally, 6% of volunteers had a nursing degree and 3% had a medical degree. 72% of the volunteers were female and 28% were male. Volunteers spent an average of 2.3 weeks volunteering, with a range of one to eight weeks. The demographic information from both of these sources was pooled and found to coincide with the existing data described in the literature (Wearing 2001). Using interview coding, common themes present in these reviews were tabulated and analyzed. The themes chosen were *making a difference*, *growth, medical experience, local appreciation, language difficulty, self-awareness, and likelihood of return* (Figure 1). These particular themes were also found to match Wearing's data (Wearing, 2001). The volunteers were therefore seen as representative.

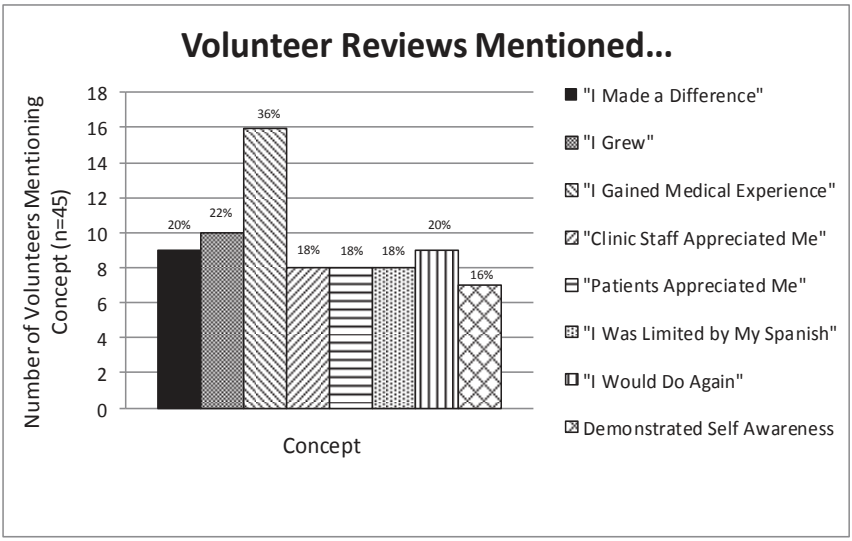

Figure 1: Themes mentioned without prompting by volunteers in informal interviews and online reviews regarding their experiences as medical volunteer tourists. Themes were referenced with similar frequencies to those observed by Stephen Wearing (Wearing, 2001).

Cultural challenges arose with the Guatemalan participants as they were hesitant to trust foreign investigators. This issue was minimized as I had spent six months in Guatemala prior to the study and even more time in neighboring El Salvador, resulting in Spanish fluency and general cultural competence. It was made explicit that these interviews were in no way in favor of or on behalf of the volunteers or of the volunteer organizations. Additionally, it should be noted that the conclusions drawn in this paper are limited by the short duration of the fieldwork and some difficulty gaining the trust of the some participants.

All participants interviewed were consenting and informed regarding the nature of this research. Consent was obtained prior to the initiation of audio recordings. To protect the identity of the subjects and organizations, pseudonyms are used with the exception of the Máximo Nivel staff members who requested that their real names be used.

Findings

A vast majority of the patients interviewed indicated strong support for the volunteer tourist presence in their clinic. While confidence in their medical provider's abilities seemed to contribute to the Guatemalan patient's acceptance of the tourists, far more often, economics was primarily responsible for the patients' attitudes toward the volunteers. When asked about this support, responses included themes like being saving money and time. These answers were supported by clinic data that showed a large increase in patient numbers during the volunteer tourist seasons (summer and winter breaks).

When patients were presented with the aforementioned information pamphlet, which includes several critiques of volunteer tourism that has caused most Western scholars to denounce medical volunteer tourism, they retain their support for the volunteers (Roberts, 2006). Explanations like the one given in the introduction were very common. As one man said:

> "I will always accept these volunteers and the gifts they bring. You have to remember that we in Guatemala do not have very much, very much money, so we take what is offered."[3,4] -Enrique, Patient

Similarly, another man responded "*algo es algo.*"[5] When I asked him to elaborate, he added the following:

> "If someone is coming and giving medicine… Well, I think I have to accept it, yea, because if someone wants to help out of his own good ness, well my only option really is to receive it. Because, you know, we do not all have so much."[6] -Joaquin, Patient

A Máximo Nivel staff member further explained the significance of economics as a motivator by describing the state of Guatemala's healthcare system:

> Guatemala is already very poor – it really struggles – and it is getting worse for the poorest right now, especially our healthcare system. [The government] just approved the new budget for the ministry of

> health and they decided to keep it the same as last year! While the prices of everything, like medicines and wages for doctors, are going up, the *puestos de salud*[7] have are not getting anything to cover those new expenses. So it is harder for the poor to get good medical treat ment, or even any medical treatment. -Jorge, Máximo Nivel

The director of the same organization made a similar comment:

> I think it's easy to poke holes in this volunteer work when you're from a country like the US or Europe or something, but the Guatema lan reality is just completely different because of the poverty. It's a country where life isn't a guarantee and people are focused on having enough to eat and not dying of disease, and literally everything else is extraneous. So everyone has different priorities. And those priorities mean that the resources provided by the volunteers, and the work they do at these clinics, is *huge*. It's huge to them. -Tricia, Máximo Nivel

Other sources also explained that the national hospitals, which, until recently had provided care completely free, recently began charging fees for consults and medicine. While the fees are small, they are significant for residents with so little income to spare.

Volunteers who provide comprehensive care are often a family's only medical resource, given the country's poverty rates – 53.7% of the population is impoverished - as well as the limitations faced by the country's Ministry of Health (World Bank, 2011). Volunteers who provide supplementary services contribute to the financial stability in a more subtle way, but several nurses at one clinic are adamant that the volunteers are, in fact, essential. The clinics are often under-staffed and over-crowded with packed waiting rooms and lines that frequently extend outside of the building. When the clinic closes at 4:00 pm, any patients, many of whom have already been waiting for hours, are asked to return the following day. According to these nurses, the volunteers speed up consults so dramatically that they are able to attend to almost twice as many patients than they are when they work alone. One nurse describes the way the volunteers are able to increase efficiency:

> While I am vaccinating, [the volunteers] are measuring and weighing and writing it all down. When I am finishing with one patient, they invite the next in and get their basic information. It makes everything much faster which is important because sometimes there are too many people. Sometimes, they get very upset when they are waiting or we do not have time to see them. Sometimes they yell, yes, sometimes they are very upset.[8] -Ana, Clinic Nurse

The nurses explain that, oftentimes, the time patients spend waiting for a consult prevents them from working, and this loss of income can be significant. When patients are sent home and asked to return, the losses suffered are even worse. Sometimes, they explain, patients are reluctant or unwilling to visit a clinic as they cannot afford to or are not allowed to miss work. Therefore, the increase in efficiency described by the nurses does seem to have a substantial impact on the health and economic well-being of a patient.

Dignity

This data could be interpreted as a conflict of priorities: economic stability and dignity, given that some scholars believe dignity is jeopardized when medical volunteers are "imposed" on patients. To test this hypothesis, patients in this study were asked to define dignity. Many of their responses were broad and general, including phrases such as "doing things that are respectable," and "being able to be proud of yourself and your behavior." However, when asked about the qualities or actions in themselves that were important in maintaining their own dignity as a human, as a father, as a mother, etc., their responses had common trends. One woman said:

> As a mother, I have dignity because I can feed my children and keep them healthy. I would not have dignity if I, for example, if my children suffered because I neglected them.[9] -Elba, Patient

Similarly, another man answered this way:

> I have dignity because I have stayed with my family and I am able to support them. A man who abandons his family, who does not earn enough for his family, who allows his children become unwell… that's a man without dignity.[10] -Juan, Patient

Some, perhaps primed by their surroundings and my previous questions about health, described their dignity as dependent on their ability to ensure their own health and the health of their family.

A small number of subjects were asked about the effect of the medical volunteer tourists on their dignity, given the fact that many were very young and some were untrained. None of these subjects interpreted their interactions with the volunteers as undignified. Though few elaborated, one provided this insightful answer:

> If they are willing to give me a gift… they give me vitamins for my baby at the like… I take advantage of this, I do not reject it. That is not dignity… Because then my baby might suffer, see? There is no dignity in rejecting a gift like that.[11] -Carmen, Patient

These answers suggest that the beneficiaries of medical volunteer tourism conceptualize dignity, as it relates to medical volunteer tourism, differently from Westerners who see the un-skilled volunteer work as potentially harmful to self -respect. The physical realities of the beneficiaries and the critics of volunteer tourism are markedly different with respect to economic standing. Because of the economic instability of these beneficiaries, there is no social status lost in the act of accepting charity, even if it is charity from untrained youth. Instead, status is gained by providing for one's family. By contrast, familial health is not likely at risk for most of the Western spectators, so the relationship between dignity and familial survival is less apparent.

Conclusions

While medical volunteer tourism increases in popularity among global consumers, it is increasingly criticized in both academic and non-academic circles. Medical volunteer tourism is condemned for its potential for danger, its unsustainable nature, and its counterproductive effects on local development. This study suggests that, based on the views of the patients themselves, and not the volunteers or other Western observers, there are reasons that the resident beneficiaries of the industry are supportive of the volunteer presence. This is not to say that the objections raised in the literature are invalid, but rather that the patients seem to prioritize their health and the health of their family over the common objections.

Because of increased trust in Western biomedicine, and because of the degree of poverty that exists in Guatemala, the patients viewed the volunteers as desirable. To paraphrase one man's observation: the moral nature of the arguments presented against medical volunteer tourism are voiced from a position of self-righteousness and privilege; to assume that these ideals are maintained by the impoverished population of a developing nation – that individuals living in profound poverty would choose to seek healthcare elsewhere, at the expense of their health – is an inappropriate presumption. While the privileged may be able to seek alternative health-care services, the populations who benefit from medical volunteer tourists often cannot.

Furthermore, though it could be expected that the beneficiaries of these medical volunteer tourists would feel less dignified as a result of being treated by untrained foreigners, patients of the medical volunteer tourists did not report feeling any form of shame. This lack of shame can be explained by the different views of dignity held by Western scholars and Guatemalan beneficiaries. While some populations may identify the acceptance of this form of "charity" as undignified, these beneficiaries spoke of their health and the health of their families as the primary factors that affect their dignity. The ability to provide for their family, regardless of the source, is a substantial source of dignity for them.

While these conclusions do not offer answers regarding the tolerability of medical volunteer tourism, they offer some explanation regarding beneficiaries' appreciation of and desire for the volunteers in their communities and clinics, and complicate the debate regarding volunteer tourism. Even when informed of the arguments against medical volunteer tourism, the beneficiaries' opinion remains unchanged. If informed and consenting patients choose to accept the aid of medical volunteer tourists, what right to critics have to deny them this choice?

Future work should be done to further assess the ethical implications of medical volunteer tourism. To begin, a comparative study would help address questions of what systemic factors may impact beneficiary perception of medical volunteer tourism. For example, neighboring countries in Central America differ in just a few areas (government ideology, economic prosperity, tourism rates), creating a natural experiment to explore the ways in which each

of these areas affect medical volunteer tourism. It is also possible that there are long-lasting effects on the volunteers that may lead them to behave more generously throughout their lives. There is some evidence to suggest that the experience of volunteer tourism remains with volunteers for several years, but a longitudinal study that considers volunteer tourism and its relationship with philanthropy and other future charitable work is needed (Wearing, 2001). The results of this type of study could further complicate the acceptability of medical volunteer tourism.

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Notes

1.) Original quote: "Si pues, cuales son sus preguntas? Me vas a preguntar si ya no apoyo los voluntarios? Mira, entiendo que no son ideales. Pero es una persona con riqueza que puede rechazar medicina, o la consulta, por una pregunta de principio. Si alguien nos da medicina gratis, debemos aprovecharlo."

2.) Ladino: common term used in Guatemala to identify the mestizo population (those with a mixture of Spanish and Native American descent).

3.) The use of an asterisk denotes a quote that is verbatim. Quotes not followed by an asterisk are believed to be extremely close to the original, but were not recorded verbatim.

4.) Original Quote: "Siempre aceptaré los voluntarios y los regalos que traigan. Tienes que recordar que, aquí en Guatemala no tenemos mucho, mucha plata, entonces aceptamos lo que nos ofrecen."

5.) "Algo es algo" is a common Spanish phrase that translates literally to 'something is something' and is used colloquially to mean 'It is better than nothing.'

6.) Original quote: "Si alguien esta viniendo y esta dando medicina… Pues, pienso que tengo que aceptarlo, si, porque si alguien nos quiere ayudar por su propio bondad, pues, en realidad, es el único opción aceptarlo. Porque, ya sabes, no todos tenemos tanto."

7.) Puestos de salud: literally meaning health posts; refers to the Guatemalan government funded public clinics used by most Guatemalans.

8.) Original quote: Mientras que yo los vacuno, ellos están tallando, están pesando, están anotando todo. Cuando termino con un paciente, ellos invitan la próxima paciente y anotan la información básica. Todo va más rápido… algo bien importante porque a veces hay bastante gente. A veces se enojan cuando han estado esperando o cuando no tenemos tiempo para la consulta. A veces gritan, si, a veces se enojan."

9.) Original quote: "Pues, como madre, tengo la dignidad porque puedo dar comida a mis hijos, porque tienen la salud. No tendría la dignidad si… por ejemplo, si mis hijos sufrieron por el descuido."

10.) Original quote: "Tengo mi dignidad porque he quedado con mi familia y los apoyo. Un hombre que abandona la familia, que no ahora para la familia, que deja que sus hijos sean mal… él es hombre sin la dignidad."

11.) Original quote: "Si están dispuestos a darme un regalo, me dan vitaminas para mi bebé o así… Yo lo aprovecho, no lo rechazo. Porque mi bebé podría sufrir, no? No hay dignidad al rechazar un regalo así."

12.) The quetzal is the Guatemalan currency. A yearly income of 3200 quetzales is roughly 1.25 USD per day and a yearly income of 6600 quetzales is roughly 2 USD per day. Extreme poverty is defined as an income from 0 to 3200 quetzales per year. Poverty is defined as between 3200 to 6600 quezales per year. Above Poverty Line is defined as a minimum of 6600 quetzales per year.

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Patient	Age	Gender	Highest level of Education	Ethnic Self-Identification	Income Bracket
1	22	Female	Elementary School	Ladino	Poverty
2	24	Female	Elementary School	Indigenous	Poverty
3	31	Female	Elementary School	Indigenous	Extreme Poverty
4	28	Male	High School	Ladino	Withheld
5	25	Female	Elementary School	Indigenous	Extreme Poverty
6	18	Female	Elementary School	Indigenous	Poverty
7	28	Male	University	Ladino	Above Poverty Line
8	21	Female	Elementary School	Ladino	Poverty
9	20	Male	Some University	Ladino	Above Poverty Line
10	54	Female	Elementary School	Indigenous	Extreme Poverty
11	31	Male	Elementary School	Ladino	Extreme Poverty
12	19	Male	High School	Ladino	Poverty
13	25	Male	University	Ladino	Above Poverty Line
14	22	Female	High School	Ladino	Poverty
15	47	Female	Elementary School	Indigenous	Poverty
16	49	Male	Elementary School	Ladino	Poverty
17	23	Female	High School	Indigenous	Poverty
18	32	Female	Elementary School	Indigenous	Poverty
19	61	Male	High School	Ladino	Poverty

Patient	Age	Gender	Highest level of Education	Ethnic Self-Identification	Income Bracket
20	28	Male	Elementary School	Indigenous	Poverty
21	25	Female	Elementary School	Indigenous	Extreme Poverty
22	23	Female	Some High School	Ladino	Poverty
23	50	Male	Elementary School	Ladino	Poverty
24	29	Female	Elementary School	Indigenous	Extreme Poverty
25	18	Female	High School	Ladino	Poverty
26	36	Male	Elementary School	Ladino	Poverty
27	20	Female	Elementary School	Indigenous	Extreme Poverty
28	26	Female	Elementary School	Indigenous	Poverty
29	21	Male	Elementary School	Ladino	Poverty
30	Unknown; est. > 70	Female	Elementary School	Indigenous	Extreme Poverty
31	19	Male	High School	Ladino	Above Poverty Line

Table 1: The demographics of the thirty-one patient participants who participated in semi-structured interviews. Income bracket is based on estimations given by participants.[12]

Appendix B: Medical Voluntourism Pamphlet (English)

Medical Volunteer Tourism

Medical volunteer tourism refers to a foreigner travelling to an underdeveloped country to participate in an experience in which the volunteer serves in a medical setting and also is a tourist within the country.

Who volunteers?

- Americans, Australians and Canadians are the three most common nationalities of volunteers
- Ages are most often between 18-25
- Most often, volunteers are college students with plans to study medicine or medical students
- As a result, most volunteers spend only 1-2 weeks volunteering
- A majority of volunteers are from middle or upper class backgrounds and of high social status
- Many students have never travelled to the country

Why do they volunteer?

- Altruism
- Medical Experience
- Professional Development
- Travel
- Adventure
- Leisure
- Personal Growth
- Cultural Exchange
- Learning
- Self-Expression

Positive Impacts

- Improvement of the quality of life for targeted individuals and host communities
- Volunteer tourists may have a more positive economic impact on host communities than mass tourists through more direct injections of resources into communities and less leakage
- Volunteer tourists are able to subsidize social programs in areas with minimal government and private financial resources
- Volunteer tourists provide services in areas that do not have a culture of voluntourism among local residents
- Cross-cultural interaction between volunteer tourists and the voluntoured can result in increased understanding for both groups
- Volunteer tourists may better see the connection between local actions and global effects
- Volunteer tourists may increase their understanding of international issues by seeing them directly (border issues, environmental issues, etc.)
- Volunteer tourists may return home inspired to get more involved in social issue organizations

Negative Impacts

- If individuals stay home and volunteer, they can save the travel costs and put those resources (both time and money) towards local volunteer efforts as well as eliminate the environmental impact of travel
- Volunteer tourists may drain valuable resources that might otherwise go to local residents
- If not properly briefed before visiting, the behavior of volunteer tourists can negatively impact the culture of local communities and offend residents
- Medical tasks carried out by untrained volunteers may harm patients
- Volunteers rarely speak the language of their host community, resulting in communication barriers
- Volunteers perpetuate power imbalances by positioning themselves as superior givers and host communities as inferior receivers
- Short visits are unlikely to affect lasting change
- Volunteer tourist activities may be conducted in a way that undermines the dignity and self-esteem of local residents
- An environment of dependency may arise as residents begin to rely on volunteer tourists to provide economic support for their communities
- The dependency may manifest at the state level, absolving the local government of its responsibility to provide basic health care

Adapted from Wearing et. al. 2001 and 2008

Medical Voluntourism Pamphlet (Spanish)

Voluntariado Medico Turista

Voluntariado médico turista se refiere a extranjeros viajando a un país subdesarrollado que participan en la experiencia donde el/la voluntaria ayuda en un ambiente médico y también es turista en el país.

¿Quiénes son voluntarios?

- Personas estadounidenses, australianos y canadienses son las tres nacionalidades más comunes entre voluntarios
- Edades entre 18-25 años,
- Comúnmente, voluntarios son estudiantes de universidad que planean estudiar medicina
- Como resultado, la mayoría de voluntarios solamente pasan 1-2 semanas,
- La mayoría de voluntarios son de clase media o clase alta y de estatus social alto,
- Muchos estudiantes no han viajado al país antes

¿Por qué se ofrecen como voluntarios?

- Altruismo,
- Experiencia médica,
- Desarrollo profesional,
- Viajar,
- Aventura,
- Ocio,
- Desarrollo personal,
- Intercambio cultural,
- Aprendizaje,
- Libre expresión

Impactos Positivos

- Mejora de la calidad de vida para las personas a las que son dirigidas y comunidades anfitrionas.
- Turistas voluntarios pueden tener un mejor impacto positivo en la economía de las comunidades anfitrionas que turismo en masa a través de inyecciones directas de recursos a las comunidades y menos fuga.
- Turistas voluntarios pueden financiar programas sociales en áreas con recursos mínimos del gobierno y/o privado.
- Turistas voluntarios dan servicios en áreas que no tienen una cultura de voluntariado entre los residentes locales.
- La interacción intercultural de voluntarios turistas y persona que están recibiendo la ayuda del voluntario puede resultar en una mejor comprensión para ambos grupos.
- Turistas voluntarios podrían reconocer mejor la conexión entre las acciones locales y los efectos globales.
- El turista voluntario incrementaría su entendimiento de problemas internacionales al verlos directamente (problemas de fronteras, problemas ambientales, etc.)
- Turistas voluntarios regresarían a casa inspirados a colaborar más en organizaciones de situaciones sociales

Impactos Negativos

- Si los individuos se quedaron en casa y se hicieran voluntarios, ahorrarían gastos de viaje que podrían usar esos recursos (de tiempo y dinero) hacia esfuerzos locales de voluntariado y también eliminar el impacto ambiental de viajar.
- Turistas voluntarios drenan recursos valiosos que de otra manera podrían ser utilizados hacia residentes locales.
- Sin indicaciones apropiadas antes de la visita, el comportamiento de los y las voluntarias turistas pueden impactar negativamente en la cultura de las comunidades locales y ofender a los y las residentes.
- Tareas médicas practicadas por voluntarios que no han sido entrenados pueden dañar a los pacientes.
- Los y las voluntarias rara vez hablan el idioma de la comunidad que les hospeda, lo cual crea barreras de comunicación.
- Voluntarios continúan manteniendo el desequilibrio de poderes, posicionándose como dadores superiores y las comunidades huéspedes como beneficiarios inferiores.
- Es improbable que visitas cortas generen un cambio perdurable o permanente.
- Las actividades de turistas voluntarios pueden ser realizados de manera que socave la dignidad y autoestima de los habitantes locales.
- Puede surgir un ambiente de dependencia cuando los habitantes empiezan a esperar que turistas voluntarios proporcionan ayuda económica para sus comunidades.
- La dependencia se puede manifestar a nivel del estado, absolviendo el gobierno local de su responsabilidad de proveer asistencia básica de salud.

Adaptado de Wearing et. al. 2001 y 2008

Appendix C: Volunteer Tourist Reviewer Demographics

Volunteer Reviewer	Age	Gender	Nationality	Highest level of Education	Duration of volunteer experience (weeks)
1	20	Male	Australian	Some College	2
2	21	Female	Australian	Some College	3
3	24	Male	Australian	Some Medical School	1
4	19	Female	Canadian	Some College	4
5	39	Female	United States	Nursing Degree	1
6	21	Male	United States	Some College	2
7	21	Female	United States	Some College	1
8	26	Female	United States	Some Nursing School	3
9	22	Male	Mexican	Some College	2
10	19	Female	Canadian	High School	2
11	23	Female	United States	Some Medical School	2
12	26	Female	Canadian	College	2
13	19	Female	United States	Some College	1
14	21	Female	United States	Some College	3
15	20	Male	United States	Some College	1
16	21	Female	United States	Some College	1
17	31	Male	Australian	College	1
18	24	Male	United States	College	2
19	25	Male	United States	Some Medical School	2
20	19	Female	Australian	Some College	3
21	20	Male	Canadian	Some College	4
22	28	Female	Chinese	Some Medical School	1
23	19	Female	Sri Lankan	Some College	1
24	21	Female	Chinese	Some College	3
25	20	Female	Australian	Some College	6

Volunteer Reviewer	Age	Gender	Nationality	Highest level of Education	Duration of volunteer experience (weeks)
26	20	Male	United States	Some College	1
27	21	Female	United States	Some College	8
28	22	Female	United States	Some College	1
29	20	Female	United States	Some College	1
30	21	Female	United States	Some College	1
31	19	Female	United States	High School	1
32	21	Male	United States	Some College	2
33	23	Male	United States	Some Nursing School	2
34	41	Female	United States	Medical Degree	6
35	22	Female	United States	Some College	4
36	27	Female	United States	Nursing Degree	2
37	55	Female	United States	Medical Degree	3
38	20	Female	Canadian	Some College	2
39	25	Female	United States	Some Nursing School	6
40	21	Female	United States	Some College	2
41	23	Female	United States	Some Medical School	6
42	22	Female	United States	Some Nursing School	2
43	23	Male	United States	College	3
44	21	Female	United States	Some College	2
45	25	Female	United States	Nursing Degree	1

Table 2: The demographics of the forty-five reviewers who were placed in the Guatemalan clinics in which the study took place. These reviews were featured publicly on the Máximo Nivel website.