International Task Force on Volunteer Cleft Missions

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The International Task Force on Volunteer Cleft Missions was set up to provide a report to be presented at the Eighth International Congress of Cleft Palate and Associated Craniofacial Anomalies on September 12, 1997, in Singapore. The aim of the report was to provide data from a wide range of different international teams performing volunteer cleft missions and, thereafter, based on the collected data, to identify common goals and aims of such missions. Thirteen different groups actively participating in volunteer cleft missions worldwide were selected from the International Confederation of Plastic and Reconstructive Surgery's list of teams actively participating in volunteer cleft missions. Because of the time frame within which the committee had to work, three groups that did not respond by the stipulated deadline were omitted from the committee. The represented members and their respective institutions have undertaken more than 50 volunteer cleft missions to underdeveloped nations worldwide within the last 3 years. They have visited over 20 different countries, treating more than 3,500 patients worldwide. Based on the data collected and by consensus, the committee outlined recommendations for future volunteer cleft missions based on 1) mission objectives, 2) organization, 3) personal health and liability, 4) funding, 5) trainees in volunteer cleft missions, and 6) public relations. The task force believed that all volunteer cleft missions should have well-defined objectives, preferably with long-term plans. The task force also decided that it was impossible to achieve a successful mission without good organization and close coordination. All efforts should be made, and care taken, to ensure that there is minimal morbidity and no mortality. Finally, as ambassadors of goodwill and humanitarian aid, the participants must make every effort to understand and respect local customs and protocol. The main aims are to provide top-quality surgical service, train local doctors and staff, develop and nurture fledgling cleft programs, and, finally, make new friends.

Key Words: Volunteer, cleft missions

In underdeveloped nations, as a result of the scarcity of available surgical interventions, children born with a cleft lip and palate are expected to accept their condition and to live with the visual stigma of their disease in perpetual emotional and physical pain.1,2,4,5,6 They often hide themselves away and do not play an active and contributory role in society. Hence, there are large numbers of cleft patients in these countries waiting to be helped. It is hardly surprising that an ever increasing number of surgeons are participating in volunteer cleft missions to such underdeveloped nations. Not all these missions are organized by groups who have previously served in third world countries or are cleft care providers in their own home environment, however.

The intention of the participating teams can thus
range from humanitarian aid and service to the search for a patient population on which to “perfect” their surgical skills. In addition, the attitude of the participating teams can be influenced by various factors that may foster a decreased level of care when working in an underdeveloped country. Knowledge that the team will only stay for a short duration and will not have to care for any postoperative complications may tempt a surgeon to try a new procedure or take extra risks during surgery. Volunteer cleft missions may begin to take on the appearance of a “surgical safari,” with trainees being included so as to provide them with an opportunity to operate on a large population of cleft patients otherwise not available to them at their home institution. This has given rise to outcomes of cleft management that are less than ideal; hence, there is a need to critically evaluate the value of such missions, their philosophy, and the organization of such overseas volunteer cleft missions to underdeveloped countries.

This task force was set up to provide a report to be presented at the Eighth International Congress of Cleft Palate and Associated Craniofacial Anomalies on September 12th, 1997, in Singapore. The first aim of the report was to provide data from a wide range of different international teams performing volunteer cleft missions regarding organization, coordination, practices, and objectives. Thereafter, based on the collected data, the second aim of the report was to identify common goals and aims of such missions. Invitations were sent to 13 different groups actively participating in volunteer cleft missions worldwide. The groups were selected from the International Confederation of Plastic and Reconstructive Surgery’s list of teams actively participating in volunteer cleft missions. The selection was made so as to create a committee with as wide and diverse a background and experience as possible. The Task Force on Volunteer Cleft Missions represents 10 different national and institutional groups that responded to the request for information and agreed to be a part of the task force. Because of the time frame within which the committee had to work, three groups that did not respond by stipulated deadline were omitted from the committee (Interplast Turkey, Operation Smile, and the Sri Lankan Cleft Lip and Palate Project from England represented by Dr Michael Mars). In the last 3 years, the represented members and their respective institutions have undertaken more than 50 volunteer cleft missions to underdeveloped nations worldwide. They have visited over 20 different countries, treating more than 3,500 patients worldwide. Drawing on their collective experience, the goals of this task force were to review data on their volunteer mission activities over the last 3 years and to provide recommendations and guidelines for the establishment of future volunteer cleft missions.

Members and Institutions

Drs Seng-Teik Lee and Vincent Yeow: Cleft Lip and Palate Association of Singapore (Singapore)
Dr John Barnett: Nepal Plastic Surgical Team (Australia)
Dr Mark Gorney: The Doctors’ Company (United States)
Dr Widanto Hardjowasito: Brawijaya University (Indonesia)
Dr Thomas Lambrecht: University of Basle (Switzerland)
Prof Gottfried Lemperle: Interplast Germany (Germany)
Dr Harold McComb: Interplast Australia (Australia)
Dr Nagato Natsume: Japanese Cleft Palate Foundation (Japan)
Dr Mirek Stranc: Health Sciences Center (Canada)
Dr Libby Wilson: White Memorial Medical Center (United States)

Mission Statistics

A database on the volunteer cleft missions undertaken by the 10 institutions was created. All the data were compiled through a comprehensive questionnaire that was filled out by the representative(s) of the participating volunteer cleft teams. The questionnaire also reviewed statistics of the last three missions undertaken by the respective teams.

Organizational Data

Of the 10 representative institutions, 8 were either private or nongovernmental (NGO) organizations. Seven institutions undertook fewer than 3 missions per year. The remaining three institutions participated in more than 10 volunteer cleft missions per year. Although 4 institutions visited one country only, 3 institutions had been to between three and six different countries, and 3 other institutions had visited more than five countries (Table 1).

Coordination between cleft teams and recipient nations or institutions were based on personal or institutional arrangements for the most part (Fig 1). A few missions were coordinated by NGOs or governmental agencies. Financial support for the cleft missions was obtained from the private sector as well as from personal funds for the most part. The remaining sources of financial support were NGOs, governmental agencies, Christian groups, and other
philanthropic organizations (Fig 2). Preliminary reconnaissance trips were found to be beneficial in establishing personal, bureaucratic, and logistical links before the missions proper. Organization of the missions was mostly done by the team leaders personally. Less often, the organization was left to NGOs or private institutions with input from the cleft mission coordinators.

Logistics

Logistical support for surgical instruments, anesthetic equipment, and consumables was obtained from donations, or equipment was privately owned (7 institutions) (Fig 3). Although two cleft teams relied purely on donations, one cleft team made do with personal equipment only. Donations were obtained mostly from the private sector. Other sources of donations were pharmaceutical companies and NGOs (Fig 4).

Objectives

Service, training, and, ultimately, the setting up of comprehensive cleft lip palate/cleft palate team programs were the major goals of all the institutions involved (Fig 5). Conversely, research was only listed as an objective by four institutions. The surgical service provided by the teams was limited only to cleft patients by two institutions. All other teams treated a variety of plastic surgical conditions. Training was directed almost entirely toward the local surgical staff. This essentially consisted of “on the spot” teaching and lectures. Only five institutions provided clinical attachments for the local medical staff at their home institution. The specialties involved were plastic surgery, anesthesia, orthodontics, oral surgery, speech therapy, and specialized nursing care. The time taken to establish a cleft program depended primarily on the extent of local involvement. Although two cleft teams reported only minimal (no local team counterpart) involvement, the others experienced an even mix of moderate to heavy local participation. Research was not usually undertaken during the cleft missions. The usual research projects were based on basic epidemiology and growth studies in the adult cleft population who had not undergone...
gone previous cleft surgery. Only four institutions were able to conduct research while on volunteer cleft missions. Funding, manpower, and time constraints were the reasons cited for the omission of research activities.

Mission Data

Statistical data based on the last three cleft missions undertaken by the 10 institutions were analyzed. The number of team members ranged from 2 to more than 10, with the majority of teams numbering 6 to 10 members. Although the composition of the teams varied, the most common combination was surgeons, anesthetists, and nurses. The other regular member was an orthodontist (5 teams). Although one team consisted of plastic surgeons only, three other teams regularly included speech therapists, pediatricians, general surgeons, oral surgeons, physicians, social workers, other ancillary staff, and medical students. All volunteer cleft teams stated that their numbers and composition were adequate for all the missions undertaken (Table 2).

The duration of the mission trips ranged from 7 to 30 days, with the average being 12 days. Only two institutions had mission trips that lasted more than 2 weeks. All other institutions had mission trips that usually ranged from 1 to 2 weeks. The number of patients seen ranged from 40 to 1,000, with an average clinical caseload of 80 patients. As a result of the consultations and preoperative assessments, the surgical workload averaged 60 operations, with between 17 and 250 operations performed during each mission trip. Essentially, the surgical procedures performed were mostly primary lip and palate repair. Secondary cleft surgery was not as common and consisted of lip revisions and alveolar bone grafting. Only one group did not perform any secondary cleft surgery. Craniofacial surgery was only provided by three teams, and this was entirely dependent on the anesthetic and local intensive care support (Table 3).

Follow-up of postoperative patients was only achieved by seven institutions. Even then, the recall rate was poor and ranged from 5% to 35% of all patients previously operated on by the visiting volunteer cleft teams. Three institutions had no reported morbidity. The complications experienced by the other seven cleft teams were most commonly wound infections and breakdown of surgical wounds. Infrequently, there was complete wound dehiscence or postoperative bleeding. Only two institutions reported any mortality. Although one team had a death caused by an allergic reaction, another institution had three deaths caused by a blood transfusion reaction, pneumothorax, and aspiration, respectively.

Not all volunteer cleft teams had trainees or residents involved. Although half of the institutions did not believe that trainees had a place in the team’s composition, five other institutions allowed the inclusion of residents only if they were sufficiently senior. This was designed to expose them to the wide variety as well as the large surgical workload only seen in underdeveloped countries (Table 4).

RECOMMENDATIONS OF TASK FORCE

Having reviewed the data, the task force met in Singapore during the Eighth International Congress of Cleft Palate and Associated Craniofacial Anomalies to discuss the findings and determine the necessary recommendations. Based on the data collected and by consensus, the committee outlined certain recommendations for future volunteer cleft missions based on:

Objectives
Organization
Personal health and liability
Funding
Trainees in volunteer cleft missions
Publicity/public relations
OBJECTIVES

The task force emphasizes that the aims for all cleft missions fall into three categories. These are to provide a surgical service, to provide training for local medical as well as paramedical staff, and, if possible, to conduct research. Service to the host nations should be directed at three levels. The first level entails the provision of primary cleft care to these patients in their home environment. The next level deals with the treating of complex or complicated cases that are within the capabilities of the mission teams and the host hospital. The final level is reached when the local medical and ancillary personnel are trained independently to run their own cleft lip and palate program.

Many medical teams undertake maximal numbers of operations in a limited period of time. When working in a mass delivery surgical setting, there may be a tendency to lower the quality of care. The team might believe that their goal is to produce the most benefit for the most patients. Given the consequences of a complication in such a setting, it is advisable to adopt the aim of achieving the maximum benefit for each patient. Operating on too many patients for whom limited resources for follow-up care are available is a situation to be avoided.

At the end of the day, it is necessary to conduct a final walk through the wards to review the patients operated on. Interpreters should always be available for postoperative instructions. A call system for problems must be established. Therefore, it is necessary that explicit directions be left with the hospital staff so that the team and, in particular, the surgeon can be located if problems do arise.

Training must always be directed toward the local doctors and staff, with the singular goal of creating a future local cleft program. The extent of training and the duration necessary to develop local cleft teams are dependent on the degree of local involvement as well as on the efforts of the volunteer cleft team. Most local involvement is often surgically oriented. The institutions that were involved provided three different levels of surgical training, which ranged from “on the spot” teaching, through lectures and seminars, to the provision of clinical fellowships at their home institutions.

Because of the underdeveloped nature of the medical infrastructure in the host nations, specialist paramedical care in the form of orthodontics and speech therapy may be scarce or unavailable. Although basic dental and occasional orthodontic local involvement is available, training and education of the local dental practitioners in cleft orthodontics and dental care are of prime importance for the volunteer missions. The lack of facilities at the local hospitals often results in most teams providing only

Table 2. Mission Statistics

<table>
<thead>
<tr>
<th>Name of Institution</th>
<th>Number of Team Members</th>
<th>Composition of Team</th>
<th>Duration of Mission (days)</th>
<th>Patients Seen</th>
<th>Number of Operations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleft Lip and Palate Association of Singapore</td>
<td>7–10</td>
<td>PRS/ANAES/NU/ORTH</td>
<td>7–14</td>
<td>80+</td>
<td>50+</td>
</tr>
<tr>
<td>Nepal Plastic Surgical Team (Australia)</td>
<td>&gt;10</td>
<td>PRS/ANAES/NU</td>
<td>7–14</td>
<td>65+</td>
<td>60+</td>
</tr>
<tr>
<td>The Doctors’ Company (United States)</td>
<td>6–10</td>
<td>PRS/ANAES/NU</td>
<td>7–14</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Brawijaya University (Indonesia)</td>
<td>&gt;10</td>
<td>PRS/ANAES/NU/ORTH</td>
<td>7–14</td>
<td>80+</td>
<td>70+</td>
</tr>
<tr>
<td>University of Basle (Switzerland)</td>
<td>3–6</td>
<td>PRS/ANAES/Others</td>
<td>7–14</td>
<td>120</td>
<td>50+</td>
</tr>
<tr>
<td>Interplast (Germany)</td>
<td>6–10</td>
<td>PRS/ANAES/NU/Students</td>
<td>14</td>
<td>200+</td>
<td>130+</td>
</tr>
<tr>
<td>Interplast (Australia)</td>
<td>5</td>
<td>PRS/ANAES/NU</td>
<td>7–14</td>
<td>70+</td>
<td>40+</td>
</tr>
<tr>
<td>Japanese Cleft Palate Foundation</td>
<td>6–10</td>
<td>OMS/ANAES/NU/Others</td>
<td>&gt;14</td>
<td>40+</td>
<td>20+</td>
</tr>
<tr>
<td>Health Sciences Centre (Canada)</td>
<td>1–2</td>
<td>PRS</td>
<td>7–14</td>
<td>50+</td>
<td>25+</td>
</tr>
<tr>
<td>White Memorial Medical Center (United States)</td>
<td>3–5</td>
<td>PRS/SP/ANAES/ORTH</td>
<td>7–14</td>
<td>50+</td>
<td>30+</td>
</tr>
</tbody>
</table>

PRS = plastic surgeon; ANAES = anesthesist; NU = nurse; ORTH = orthodontist; OMS = oral maxillofacial surgeon; SP = speech pathologist.
rudimentary training on-site, however. Clinical attachments and short-term fellowships are often arranged based on available funds to allow concomitant development of the orthodontic aspect of cleft care in the host nations.

Speech therapy is found to be even more wanting in the majority of these host nations. Speech evaluation and subsequent therapy of these cleft patients treated by the visiting teams are unavailable more often than not. The inclusion of a speech therapist on the volunteer team serves to provide speech assessment of previously treated patients and also allows instruction of rudimentary speech therapy for the patients of the program. The absence of speech therapists in these host nations is indicative of the socioeconomic factors that govern the targeting of health expenditure toward disease prevention or the treatment of acute diseases. The luxury of speech therapy for the management of a non-life-threatening problem is often not given much, if any, consideration. With the development of the local cleft program, however, steps must be taken to incorporate speech as a vital facet of cleft care. Plans must be made for funds to be set aside for the training of local speech therapists either within the host nation or at the visiting team’s home institution in the form of attachments or fellowships.

Taken in the correct perspective with the overall goals and where funding, manpower, and allocated time are available, research can be directed toward epidemiology, craniofacial growth in adult cleft patients who have not undergone previous surgery, and documentation. Often, however, the volume of the patient load coupled with the short duration of the mission trip obviates the feasibility of research being a major part of these programs. The ethical issues of conducting research while on such volunteer missions to provide service and training also need to be considered. Although the general feeling is that service, training, and development (in that order) are the necessary initial steps to take when working in an underdeveloped nation, the importance of research must not be forgotten. Nevertheless, it is the committee’s opinion that funds and manpower should first be allocated toward service provision followed by training and development of the host nation’s cleft program. Research is a luxury that is only feasible with adequate funds and man-

<table>
<thead>
<tr>
<th>Name of Institution</th>
<th>Cleft Lip</th>
<th>Cleft Palate</th>
<th>Second Cleft Surgery</th>
<th>Craniofacial</th>
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<td>Cleft Lip and Palate Association of Singapore</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Nepal Plastic Surgical Team (Australia)</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>The Doctors’ Company (United States)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Brawijaya University (Indonesia)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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<td>University of Basle (Switzerland)</td>
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<td>Yes</td>
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<td>White Memorial Medical Center (United States)</td>
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Table 3. Types of Operations

<table>
<thead>
<tr>
<th>Name of Institution</th>
<th>Follow-up</th>
<th>Morbidity</th>
<th>Mortality</th>
<th>Trainees</th>
</tr>
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<tr>
<td>Cleft Lip and Palate Association of Singapore</td>
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<td>Yes</td>
<td>1</td>
<td>Yes</td>
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<tr>
<td>Nepal Plastic Surgical Team (Australia)</td>
<td>No</td>
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<td>The Doctors’ Company (United States)</td>
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<td>Brawijaya University (Indonesia)</td>
<td>Yes</td>
<td>Yes</td>
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<td>Yes</td>
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<tr>
<td>University of Basle (Switzerland)</td>
<td>Yes</td>
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<td>No</td>
<td>No</td>
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<td>Interplast (Germany)</td>
<td>Yes</td>
<td>Yes</td>
<td>3</td>
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<td>Interplast (Australia)</td>
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<td>Health Sciences Centre (Canada)</td>
<td>Yes</td>
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<tr>
<td>White Memorial Medical Center (United States)</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Table 4. Morbidity and Mortality

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power as well as a stable and functioning local health care infrastructure.

It is perhaps wiser to tackle each issue in the order of its priority. As previously mentioned, the task force emphasizes that service to the host nations should be directed at three levels. The first level deals with the most emergent need, which is the provision of primary cleft care to these patients in their home environment. When the final level is reached, the local medical and ancillary personnel should be adequately trained to run their own cleft lip and palate program. Once the local infrastructure is established and stable, funds and efforts for joint research with the local cleft team can be fully instituted.

As a volunteer cleft team, we must aim literally to do ourselves out of a job. Training the local staff, sorting out their organization, and finally setting up the local cleft program must be the ultimate goals for the volunteer cleft team.

“Give someone a fish and you feed him once; teach him to fish and he will feed himself the rest of his life.”

Organization

The task force believes that personal contacts play an important role in the initial coordination and subsequent organization of all volunteer cleft missions. The other avenues of approach are national specialist bodies, local health authorities, NGOs, and governmental departments. Although some agencies in certain countries are more willing to work together with the mission team toward a common goal, in other countries, there are local bodies that are of no assistance or, even worse, are opposed to foreign aid of any sort. Despite the varied responses experienced, it is fundamentally important and necessary to involve the local agencies through their academic institutions, health authorities, or specialist bodies. This will contribute toward the success of the mission by ensuring, first, that patient notification and registration are undertaken, and, second, that continued care by the local medical staff using the techniques and management protocols taught to them by the cleft mission team is possible after the departure of the team. In this way, mutual understanding, benefit, and better coordination are achieved. All this will contribute to the success of future missions and, ultimately, to the establishment of local cleft lip and palate programs.

The task force also emphasizes that communication and coordination are necessary for the proper timing, arranging, and scheduling of the mission. Flight details, food, and lodging as well as immigration and customs coordination are of prime importance to ensure that the mission goes ahead without any mishaps. Local coordination is also paramount so as to make sure that patients are notified and, if possible, screened and prepared for possible surgery. This will make the volunteer cleft team’s task of triage and clinical assessment a much easier one. With the list of patients prepared, operating schedules can be organized much more easily.

Transporting one’s operating supplies and equipment may be fraught with hazards and customs difficulties. It is important that a proper manifest of all equipment be prepared for customs inspection as well as to keep inventory of all drugs and equipment. Time must be set aside each day to take inventory as well as to prepare instruments and consumables for the next day’s operating session. Consumables not expended may be left as donations for the local medical team to use.

Personal Health and Liability

Native health care workers all too often have little or no concern when handling blood products and sharps. The task force believes that the visiting cleft team must protect themselves with gloves and strict needle precautions. Before traveling, all team members should be made aware of local health hazards or endemic diseases. Adequate prophylaxis should be carried out and vaccines should be administered before setting off on any volunteer mission.

In terms of liability, all members of any volunteer cleft mission are essentially responsible for the provision of their own personal travel and accident insurance. It is essential that prior arrangements and coordination with the local health and governmental authorities be made to ensure that medicolegal coverage is provided for the patients treated by the visiting volunteer cleft team. Certain groups such as Interplast (Australia) provide comprehensive personal as well as medical insurance.

Funding

The next important consideration is funding. Funding is the engine that drives the volunteer cleft mission programs. Funding may be obtained from personal assets, private donations, NGOs, governmental agencies, or recipient na-
tions or institutions. Despite donor contributions, it is believed that recipient nations or institutions should also contribute partially to the food, lodging, and hospital facilities for the volunteer cleft teams. Because of the low priority given to health care in most underdeveloped countries, any further form of funding is often unavailable. Usually, the bulk of the funds will be obtained from personal assets, private donations, and NGOs.

Trainees in Volunteer Cleft Missions

The task force is equally divided on whether trainees/residents should be included in the composition of the volunteer cleft team. Those in favor of the inclusion of trainees advise that only senior residents at the end of their training should be allowed to participate in such volunteer missions. After all, they are the team leaders of the future. This allows them to see and experience a spectrum of cleft conditions that is rarely found in the developed world today. Any surgery performed by the residents must be closely supervised to ensure that there is no compromise in the end surgical result. The task force members who are not in favor of trainees being part of the cleft team state that the best possible care must be given to the patients assembled. At no time must it seem that the mission trip is a training camp for residents, as this will only create a negative impression on the part of the local doctors and population. They believe that suboptimal results and unwanted complications must be avoided at all costs. It is without doubt, however, that

"if the time honored principles of supervision and progressive responsibility are practiced, the results both educationally and surgically, can be expected to be spectacular."

Publicity and Public Relations

Volunteer cleft missions invariably generate a great deal of publicity both at home and in the recipient nation or institution. Publicity can be a double-edged sword, however, especially in the host nation. In countries where there are already personnel trained to deal with cleft patients, self-promoting publicity is often detrimental to relations with the local medical staff. Public relations should be promoted along the lines of humanitarian aid to the local patients and should not infer that the visiting cleft team is superior in any way. Therefore, publicity at the recipient institution should be left to the discretion of the local authorities. In this way, the level of publicity generated is commensurate with the efforts of the local authorities, and any animosity is avoided.

In contrast, public relations at home should always be maximized. The benefits of such publicity are that it will generate awareness and also help in the raising of funds and sponsorship. All efforts must be made toward inculcating goodwill and support for the volunteer missions. This will go a long way toward encouraging active participation and support from private agencies, pharmaceutical companies, NGOs, home institutions, and governmental agencies as well.

CONCLUSION

The task force believes that the following criteria form the basis for a successful mission. First, all volunteer cleft missions must have well-defined objectives, preferably with long-term plans. Second, it is impossible to achieve a successful mission without good organization and close coordination. All efforts must be made, and care taken, to ensure that there is minimal morbidity and no mortality. Finally, as ambassadors of goodwill and humanitarian aid, the participants must make every effort to understand and respect local customs and protocol.

In conclusion, going on a mission is not like participating in a surgical safari. The aim is to provide top-quality surgical service, train local doctors and staff, develop and nurture fledgling cleft programs and, finally, make new friends. Therefore, in mending lips and closing gaps, we are not merely giving “lip service” but providing an experience for all involved that is worthwhile, memorable, and exhilarating. Participating in a volunteer cleft mission can be a truly rewarding and enriching experience.

REFERENCES