Fostering Cultural Humility in Short-Term Missions

Laura B. Macias

School of Business and Public Leadership, Johnson University

April 6, 2023

Abstract

The trend of sending short-term mission (STM) teams to serve overseas began in the 1960s and 1970s with the help of Youth With a Mission (YWAM) and Operation Mobilization (OM), two pioneer mission agencies focused on youth ministries. What began over 50 years ago as a phenomenon has grown to over two million participants from North America. Since its early years, building projects, evangelism, and sports ministry have remained at the top of the list of activities. However, as with most movements, criticism has plagued STM trips. Given STM's deficiencies, such as self-promotion, ethnocentrism, and paternalism, cultural humility better prepares STM participants for serving across cultures. Although cultural humility emerged from medicine and nursing over 20 years ago, it has yet to surface in STM. In this paper, I will suggest that the cultural humility framework, which holds to a lifelong commitment to self-reflection and the redressing of power imbalances to build mutually beneficial relationships, can produce positive outcomes with STM participants.

Keywords: short-term missions, cultural competence, cultural humility

Fostering Cultural Humility in Short-Term Missions

Nearly 25 years ago, Tervalon and Murray-Garcia (1998) coined *cultural humility* as an alternative to cultural competency in multicultural medical education among health care professionals. In the seminal article, Tervalon & Murray-Garcia (1998) developed the concept of cultural humility after discerning that cultural competence training led to stereotyping and false assumptions about patients from diverse backgrounds. Hence, completing cultural competence training equated to becoming a cultural expert (Hook, 2014). Conversely, practicing cultural humility adheres to culture not being static or fixed but assuming a lifelong learner role through self-reflection and critique, lacking superiority while cultivating mutuality and developing respectful relationships (Yeager-Bauer-Wu, 2013).

The short-term mission (STM) movement also grew exponentially in the late 20th century (Zehner, 2013). From a small number of STM participants in the 1960s to over a million people 40 years later, STM teams crossed cultures in epic proportions (Priest & Howell, 2013). Twibell (2020) asserted that despite a voluminous number of participants engaged cross-culturally over the last decades, cultural awareness still lacks emphasis in the existing literature. In particular, cultural humility has yet to ascend even as leading scholars describe STM as replete with immeasurable potential.

The purpose of this paper is to explore the cultural humility framework within the context of STM and how a lifelong, learning-oriented approach to serving others from different cultural backgrounds, redressing power imbalances, and pursuing relationships that are mutually beneficial may result in positive outcomes for STM participants. The forthcoming discussion will distinguish cultural competence from cultural humility; highlight the role of cultural

humility in nursing student abroad programs; describe the pillars of cultural humility, and suggest how STM participants can serve with a reflective, process-oriented, humble approach.

Cultural Competence

Background and History

Shepherd (2019) asserted that diversity and multicultural training across health care and other industries date back to the civil rights legislation of the early 1960s. Shortly after Title VI of the Civil Rights Act (1964) was signed into law, one of its legislative measures was to minimize health disparities and provide effective delivery of health services to patients from diverse backgrounds (Beach et al., 2006). From its inception, Title VI legislation provided extensive legal grounds for forging culturally competent programs throughout industries and organizations (Saha et al., 2008). Whereas the immigrant population with limited English proficiency was initially the target audience of most culturally competent programs, by the late 1980s, the scope stretched to include ethnic and racial minorities, not solely immigrant groups (Saha et al., 2008). Thus, previously ignored linguistic and cultural barriers between patients and health care providers gave rise to a proliferation of cross-cultural education in public health and medicine due to the Civil Rights Act of 1964 (Stubbe, 2020).

Patient-centered care also surfaced alongside cultural competence to enhance health care quality during the 1960s (Beach et al., 2006). The patient-centered care framework advocated for the comprehensive practice of caring for patients that are informative, participatory, and meaningful to the individual patient and their families (Kalra et al., 2012). Hence, improving interpersonal care between health care providers and patients was paramount in promoting patient-centered care (Saha et al., 2008). Two decades later, patient-centeredness evolved from patient-provider emphasis to improvements between whole communities and health care systems

(Stubbe, 2020). In 1987, researchers from Harvard Medical School, on behalf of The Commonwealth Fund and the Picker Institute, sought to identify patient perceptions of patient-centered care at the institutional level (Levitan & Schoebaum, 2021). Consequently, the nine-year qualitative research defined essential dimensions for hospitals and medical centers to promote the delivery of patient-centered care, with particular focus given to the concerns and needs of patients (Beach et al., 2006). Among several dimensions described in the research, access to care, coordination and integration of care, and respect for patients' preferences, values, and expressed needs characterized salient principles for optimal patient-centered care (Levitan & Schoebaum, 2021). Rather than limit patient-centeredness to patient-provider interactions, health care systems also became integrated as part of the overall effort to provide high-quality care (Millenson et al., 2016).

Education and Training

As the minority population grew by the end of the 20th century and the demographics of the United States became increasingly diverse, programs addressing cultural competence soared in medical school and nurse training institutions (Fleckman et al., 2015). A primary thrust for developing additional culturally appropriate programs came after the Institute of Medicine (2002) released a report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, which revealed widespread racial and ethnic disparities in health care. The seminal report highlighted that ethnic minority patients received lower-quality health care than White patients, even when personal income and health insurance were the same (Institute of Medicine, 2002). Moreover, Kumagai and Lypson (2009) posited that health disparities among racial and ethnic minority patients would have gone unnoticed if the Institute of Medicine (2002) had not published its report.

In response to a growing minority population and research-based reports describing ethnic disparities in health care, the Liaison Committee on Medical Education (LCME) mandated that all medical schools in North America include cultural competency in their educational outcomes (Deliz et al., 2019). Furthermore, the American Association of Colleges of Nursing, the National Association of Social Workers, the Association of School of Public Health, and other similar associations recommended implementing cultural competency training in their respective educational institutions (Fleckman et al., 2015). Yancu and Farmer (2017) summarized cultural competency training as cultural awareness education composed of three parts: knowledge, attitudes, and skills. Knowledge would encompass the needs of minority groups, attitudes about valuing cultural differences, and agile skills for providing culturally appropriate care to diverse populations (Kools et al., 2015). However, two decades since LCME mandated cultural competency training for medical training institutions in the U.S. and Canada, no standard curriculum or program exists (Fleckman et al., 2015). Moreover, intermittent frameworks and a broad spectrum of strategies have surfaced since 2000, but comprehensive learning outcomes across educational institutions have not materialized (Deliz et al., 2019).

Shortcomings

Despite numerous resources, endorsements, and mandates devoted to cultural competency training and education, shortcomings have been identified (Yeager & Bauer-Wu, 2013). Content over a process-oriented approach, narrow-focused training, and scant evidence of positive outcomes are some of the critiques that persist (Foronda, 2019; Fleckman et al., 2015; Truong et al., 2014).

Content Over Process-Oriented Approach

Over 50 years ago, the U.S. Peace Corps created a series of cross-cultural training manuals for all participating volunteers (Wight et al., 1970). One of its chief recommendations for effective cross-cultural engagement for field workers was to avoid an overreliance on cultural knowledge alone. Even though information and knowledge are rarely a hindrance, an oversimplification of cultural learning so one can be a cultural "expert" is unrealistic (Levi, 2009). Furthermore, Lekas et al. (2020) described cultural competence training as content-oriented rather than relationally driven. The objective, therefore, is to increase the provider's knowledge, attitude, and communication skills with patients from diverse backgrounds (Foronda, 2019). Conversely, cultural learning does not end with a quantitative assessment; it is a way of being, a lifelong learning process (Foronda et al., 2016).

Kumagai & Lypson (2009) noted that although healthcare providers may be competent to read an electrocardiogram (EKG) or perform a biopsy, no individual achieves competency with a plurality of cultures despite good intentions. "Cultural competency is not an abdominal exam and not a static requirement to be checked off some list; it is something beyond the somewhat rigid categories of knowledge, skills, and attitudes" (Kumagai & Lypson, 2009, p. 783). Moreover, it is not uncommon for Asians and Hispanics to be categorized under certain cultural characteristics, with many generalized descriptions often succumbing to stereotypes (Yeager & Bauer-Wu, 2013). Even within each group identity, there are varied subpopulations with very different views on disease prevention and medical treatment (Yancu & Farmer, 2017). Thus, an individual or a patient's culture is seldom a single identity.

Narrow Focused Training

Without self-awareness incorporated into cultural competence, interacting with diverse patients implies a one-sided and narrow approach devoid of self-analysis and self-reflection

(Tervalon & Murray-Garcia, 1998). Like most individuals, healthcare professionals are often unaware of their personal stereotyping and prejudices (Fleckman et al., 2015). Yeager-Bauer-Wu (2013) asserted that modern medicine adheres to a scientific, analytical, and Western biomedical framework. Thus, the biomedical framework has its particular lexicon, values, and practices within the perspective of most physicians and physicians in training (Deliz et al., 2019). Logic, facts, and objectivity are commonplace, with a propensity to understand patients from diverse backgrounds under a similar lens (Frey et al., 2013). Shepherd (2019) cautioned healthcare providers from propagating cultural competence training that divides minority patients from majority culture providers. Kumagai and Lyspon (2009) suggested a more comprehensive approach to cultural engagement between patient-provider that expands the health care professional, the healthcare system, and the patient and their families.

Scant Evidence of Positive Outcomes

Although it has been over 2 decades since cultural competence training catapulted to new heights, Lekas et al. (2020) noted significant irregularities in training and programs, including content and assessment. Various deficiencies, including nebulous definition, obscure guidelines, and ambiguous implementation, have beset its findings (Brach & Fraser, 2000). Furthermore, Yeager & Bauer-Wu (2013) construed that after a dozen published reviews, reports indicated a weak correlation between cultural competency and enhanced patient-provider outcomes, even after multiple interventions. Although published reports indicated that provider knowledge, skills, and attitudes increased after cultural competence training, overall patient satisfaction and health outcomes remained stagnant (Shepherd, 2019). The increase in cultural competency stemmed from reported self-assessments on the provider's part (Brach & Fraser, 2000). Thus, the

shortcomings of cultural competence undermine the hopes of reducing health disparities even after its development and implementation (Hughes et al., 2020).

Cultural Humility Framework

History and Background

Tervalon and Murray-Garcia (1998) described cultural humility as a framework for educating physicians in multicultural education while serving ethnically, racially, and culturally diverse populations in the United States. Although cultural competence laid the groundwork for cultural humility, the two frameworks are distinct, with cultural humility better suited for working with diverse patients and their families (Foronda et al., 2022). Furthermore, the alternative framework was in response to cultural competence training that emphasized mastering a set of skills to improve patient-provider interactions and measuring training outcomes that reflected cultural expertise in working with diverse patients. Thus, the proposed framework defined cultural humility as a "lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician-patient dynamic, and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations" (Tervalon & Murray-Garcia, 1998, p. 123). Since then, various disciplines such as education, psychology, nursing, and other health sciences have implemented cultural humility for successful outcomes (Foronda, 2020).

Given the deficiencies of cultural competency training in healthcare, including an overreliance on knowledge and skills, cultural misunderstanding and stereotyping, and relatively limited outcomes apart from provider self-reporting, cultural humility provides a framework germane to working with populations from diverse backgrounds in the 21st century (Kim, 2016).

The Pillars of Cultural Humility

Lifelong Commitment to Self-Reflection and Self-Evaluation

Practicing cultural humility requires an ongoing effort and commitment to self-reflection and self-evaluation (Tervalon & Murray-Garcia, 1998). It begins with the understanding that cultural learning is a lifelong process of active engagement with individuals and their respective communities. The ongoing process includes self-reflection and evaluation of one's sociocultural background, beliefs, and biases, implicit or explicit (Agner, 2020). Rather than assuming the posture of a cultural expert, a humble stance of learning from others who are themselves the experts in their own culture (Hook et al., 2013). Hence, the emphasis is on learning rather than knowing (Lekas et al., 2020). Foronda et al. (2016) underscored openness, self-awareness, egoless, self-reflection, and critique as attributes distinctive to practicing cultural humility. Although arduous and strenuous, cultural humility is a continuous journey of self-examination and transformation rather than a mastery of skills about particular cultural groups and identities (Foronda et al., 2022).

Redressing Power Imbalances

Building trustworthy relationships is integral to cultural humility (Agner, 2020). Tervalon and Murray-Garcia (1998) outlined the power imbalance inherited in the patient-provider relationship when health practitioners serve diverse populations. Although medical residents acquire new skills during residency, Clabby (2020) indicated that most trainees acknowledged feelings and attitudes of egotism and arrogance due to medical specialization and years of schooling. Therefore, redressing power imbalances remains elusive if power dynamics are left unrecognized (Agner, 2020). Yeager and Bauer-Wu (2013) posited that cultivating discussion through open-ended questions brings insight and perspective that otherwise would not be present

when mitigating power dynamics. The questions considered are that of a lifelong learner, stemmed from nonjudgmental active engagement, birthed from self-reflection and critique (Agner, 2020).

Mutually Respectful Partnerships

The culminating pillar of cultural humility includes developing mutually respectful partnerships (Tervalon & Murray-Garcia, 1998). Although individuals have the power to effect change, communities can also create a ripple effect of change and transformation (Sinclair, 2021). Therefore, Agner (2020) advocated empowering not only individuals but communities to solve and make their own decisions. Rather than one entity having all the wisdom and knowledge to decipher what is best, developing respectful partnerships is about coming together and addressing the challenges head-on (Beagan, 2015). Thus, the last pillar of cultural humility is acknowledging that both sides are co-experts, bringing distinctive experiences and skills that complement and respect the other (Tervalon & Murray-Garcia, 1998).

Cultural Humility and Study Abroad Programs in Nursing

The international landscape includes advances in communication, transportation, and technology. Hence, the world is more interconnected than ever. In response to the growing global health needs, nursing and other health professions are assisting developing countries and vulnerable populations by participating in study abroad programs (Foronda & Belknap, 2012). Nursing scholars asserted that the development of cultural humility takes root most often in study abroad programs (Ferranto, 2015; Fernandez, 2020). The depth from which to develop attributes of cultural humility such as openness, self-awareness, egolessness, supportive interactions, and self-reflection are acquired more readily with cultural immersion experiences (Ferranto, 2015).

Isaacson (2014) conducted a study to explore the outcomes of a cultural immersion experience with senior nursing students on a Northern Plains reservation during an academic year. The dozen participating students attended a private Christian liberal arts college in a large metropolitan city. The mixed-methods study included a cultural competence assessment (Campinha-Bacote, 2007) and reflective journals before and after the immersion experience. Although the nursing students initially reported being culturally competent before their immersion experience, their reflective journals contained racial bias and stereotyping of Native Americans such as poor, lazy, and prone to drug and alcohol abuse. However, through reflective writing, small group discussion, and guidance of faculty on the tenets of cultural humility, the study indicated positive student outcomes when cultural immersion and cultural humility are linked (Isaacson, 2014).

Even though for nearly 25 years, cultural humility has permeated various spheres of medicine, nursing, and other healthcare fields, scholarly work connecting cultural humility and short-term missions has not emerged. The following section of the research paper will explore ways cultural humility may provide positive participant outcomes in short-term mission trips.

The Landscape of Short-Term Missions

A Brief Overview

The cascade of short-term mission (STM) teams descended beginning in the 1960s as mission agencies such as Operation Mobilization (OM) and Youth With A Mission (YWAM) recruited young people to join summer outreach teams (Fanning, 2009). The youth-oriented pioneer agencies were responding to the expansion of the airline industry that made international travel more accessible and affordable and the sociopolitical environment of the civil rights movement (Morgan, 2016). Similarly, the Peace Corps burgeoned during this same period,

signaling a message to young adults that personal and spiritual growth could come about if they ventured outside their comfort zones (Howell, 2012). Although the mission agencies deployed a few hundred young people for up to a month or longer in evangelistic campaigns worldwide, the number has skyrocketed since the early 1970s (Priest & Howell, 2013). It is estimated that nearly 2 million participants travel annually for two weeks or less on international trips, ranging from 3 to 5 billion dollars annually (Priest & Priest, 2008).

As the number of STM participants grew, missiological research rarely gave the phenomenon much attention with adverse comments about a movement fraught with novice pioneers and a shallow understanding of world missions (Twibell, 2020). Priest and Howell (2013) posited that it was not until the late 1990s and early 2000s that scholarly research began to emerge. Preventing harm to the host community and learning to serve well cross-culturally has become a priority in the body of literature (Corbett & Fikkert, 2012; Huang, 2019). Nevertheless, due to the financial resources needed to facilitate trips, STM teams remain predominantly North Americans (Livermore, 2012).

Global Mission Trends

The height of the modern missions movement reached its peak during the last two centuries when Western churches sent missionaries to Latin America, Africa, and other parts of the developing world (Jenkins, 2012). Morgan (2016) noted that as a result of the sacrificial church planting efforts, the expansion of new churches gave birth to more churches around the world; therefore, the missions movement is no longer carrying the catchphrase from “West to the rest” but is now “From everywhere to everywhere.” Consequently, the Global South’s exponential church growth has altered old paradigms from pioneer missions to partnering with Global South church leaders and nationals (Bendor-Samuel, 2020). Even though Western

churches struggle to recruit long-term missionaries, Brazil and South Korea are galvanizing new career missionaries in record numbers (Morgan, 2016). Hence, this new era of cross-cultural mission requires the amalgamation of preparedness and critical reflection, including STM (Twibell, 2017).

Applying the Pillars of Cultural Humility to Short-Term Missions

By nature, STM is episodic and pragmatic (Livermore, 2012). Wuthnow (2009), a leading sociologist of religion, accounted for the majority of STM trips as two weeks or less, with teams ranging from a handful to a hundred or more participants in a team. Furthermore, $1,500-$2,000 is the average cost per STM participant, with transportation, food, and lodging consuming most of the travel costs (Priest & Priest, 2008). As a result of the significant investment of time, talent, and money on the part of the STM participant and the sending church, pressure mounts to maximize the STM experience (Livermore, 2012). Therefore, time and resources are not to be squandered.

STM trip destinations are often described without a reference to culture and history, emphasizing the experience and projects rather than relational connections given the context (Howell, 2012). Therefore, Howell (2009) contended that an effective STM is characterized by *being* with people over *doing* a task for them. Rather than looking at the learning opportunity to gain wisdom and appreciation from local believers and church leaders, the scheduled projects take precedence over relationship building (Koll, 2010). Intentional steps underpinned by lifelong learning and self-reflection are central to the cross-cultural experience (Twibell, 2017).

Lifelong Learning and Self-Reflection

The intrapersonal component of cultural humility begins with an awareness of the boundaries and limits of one's cultural reference (Hook et al., 2013). Elmer (2006) posited that

humbly serving across cultures is unattainable unless one acknowledges one's biases and negative stereotypes. Although pre-trip training is replete with packing lists, cultural dos and don'ts, and fundraising letters, careful consideration of what it means to serve others humbly is an ongoing process, not a one-time event (Nagel, 2021). Ver Beek (2006) indicated that a top priority for STM teams is to affirm the dignity and value of the host community by recognizing and valuing the assets and strengths already in existence.

Hook et al. (2013) asserted that an accurate view of self is foundational to cultural humility. Hence, viewing one's culture, beliefs, and values as superior contrasts with cultural humility. Similarly, a humble approach is other-oriented versus self-focused, expressed by respect for others and a lack of superiority (Hook, 2014). An open and fluid process of self-examination in tandem with consideration of the diverse experiences of others is paramount in STM trip planning (Nagel, 2021). Construction, evangelism, and Vacation Bible School (VBS) are the most common activities for STM participants (Priest et al., 2010). However, a one size fits all mindset in STM is misguided (Koll, 2010). Although door-to-door evangelism may apply in one culture, another may find it intrusive and cult-like. A humble approach is to inquire how the host community conducts ministry and follows their lead (Corbett & Fikkert, 2012). Moreover, bringing the latest fad sport, such as pickleball, without considering the cultural relevance of the latest trend to the host community may do more harm than good. Although the activities may attract young people to play with the North American teams, the supply of sports equipment may not be easily replaceable once broken or in need of repairs. Thus, a one-time event becomes a lifelong learning opportunity, and innovative proclivities are tapered by self-examination and critique as one considers the perspective and needs of others (Elmer, 2006).

Mitigating Power Imbalances

The exorbitant number of resources surrounding sending STM teams for a brief cultural encounter has been a subject of much debate (Fanning, 2009). The lofty investment and funding associated with STMs range from airline travel and lodging to procuring mosquito nets for sleeping and water purification tablets to offset discomfort and possible disease. Corbett and Fikkert (2012) maintained that the power differential in STM trips is inescapable given that the average participation cost could employ indigenous workers or local hosts for an entire year. Although most STM participants are middle class, from the perspective of the lost host in the developing world, the STM team parallels the lifestyle and income of the rich. Thus, being cognizant of the power dynamics begins with recognizing there is room to mitigate perceptions of power and self-importance (Hook, 2014).

A survey conducted among mega-church congregations noted that Guatemala, a country with a significant Pentecostal population, was the country most visited by STM teams (Priest et al., 2010). Although prodigious amounts of resources have been channeled into the country for evangelism and leadership development, North American teams often remain in control of STM projects (Koll, 2010). Thus, leadership is still in the hands of Western churches. Similarly, Livermore (2012) urged STM teams not to confuse generosity with power, especially in brief interplays with other cultures.

Redressing power imbalances is more than just about money. Borthwick (2012) remarked that North America is the epicenter of prestigious higher educational institutions, including seminaries and private Christian colleges. Africa follows Latin America as the second most visited destination by STM teams, even as Christians are the dominant population in the region (Priest et al., 2010). Crouch (2013) advised STM teams not to use their educational pedigree to influence national church leaders with groundbreaking leadership strategies to strengthen their

respective churches. Cutting-edge teaching, no matter how well-meaning, often cannot replace learning and listening to what is working and not working at the local church level (Johnson, 2012). Furthermore, Borthwick (2012) advised asking questions rather than pontificating. Offering a listening ear rather than lecturing to a vast crowd of mature Christian pastors aligns with a posture of humility away from self-importance and naiveté. As reflective practitioners committed to lifelong learning, STM participants gain wisdom and understanding by building trust as a result of being together rather than performing a task on their behalf (Crouch, 2013).

Mutually Beneficial Partnerships

Fostering cultural humility in STM can come to a halt without the formation of mutually beneficial partnerships. Due to the largest concentration of Christians currently living in Africa and Latin America as of 2018, new paradigms need to emerge regarding how to define respectful partnerships given our present realities (Zurlo et al., 2020). The demographic relocation of Christianity to the Global South means that STM teams have a compelling opportunity to collaborate with cultural humility by experiencing the freedom of not having to be the ones with all the answers (Johnson, 2012). Consequently, establishing relational reciprocity amid economic disparities will deepen the partnership between STM teams and the host community (Borthwick, 2012). “We need to learn to receive as well as give; materialism and achievement influence our thinking that we, the rich, go to help you. Reciprocity teaches us that our brothers and sisters are rich in many other ways” (Borthwick, 2012, p. 129). Hence, interdependence surfaces as local hosts and STM teams learn to partner as equals (Morgan, 2016).

Lough and Oppenheim (2017) maintained that for international volunteers to develop relational reciprocity with their international partners, STM participants must first acknowledge that newly formed relationships are frail and precarious until trust and solidarity evolve.

Furthermore, host communities reported improved relationships with North American teams when visits were recurring and longer than the average 8-day STM trip (Lough, 2016). Subsequently, enhanced levels of communication increased while trust and solidarity also rose (Lough & Oppenheim, 2017). Conversely, brief and sparse visits with nominal communication between the host community and the STM team produced a fragile and often paternalistic partnership (Nagle, 2021).

Sociologists have referred to social capital as social and organizational relationships that facilitate collaboration as trust builds, enabling other trusting relationships (Putnam, 2000). In *Freeing Congregational Mission*, Farrell (2022) described how social capital could mutually benefit the STM team and the host community. For STM participants, bonding social capital could burgeon relationships as fellow sojourners partake in a pilgrimage experience. Consequently, self-discovery in a cross-cultural setting with mission companions sharing the same agenda creates bonds of cohesion, particularly in an intergenerational STM. Similarly, Priest (2012) asserted that host communities benefit from linking social capital due to STM teams' visits. As North American teams collaborate with nationals on various projects throughout the community, civic leaders and stakeholders who would otherwise not be interested in religious activities will connect directly with the local church due to the visiting group's partnership with the local hosts (Wuthnow, 2009). Moreover, Twibell (2020) highlighted that even amid the differences in culture and financial resources, the host community may leverage the STM visit by increasing their visibility in the community, and STM participants can grow spiritually by meeting believers from other cultures with significantly fewer resources. Thus, cultural humility reflects mutual gain and respect for partnerships by incorporating attributes such as self-awareness, openness, and supportive interaction, among others.

Practical Implications for Fostering Cultural Humility in Short-Term Missions

Study abroad programs in nursing highlighted the positive effects of cultural humility on nurses in training (Foronda & Belknap, 2012). Fostering cultural humility with STM participants can also result in positive outcomes with intentionality and well-designed training. Reflective journaling, small group discussion, and daily debriefing emphasizing cultural humility were a few of the examples from the study abroad programs that may be useful with STM (Isaacson, 2014). However, taking on a humble approach has broader implications as cultural humility also applies when working with diverse populations at home, including immigrants and refugees (Johnson, 2012).

Conclusion

As the epicenter of Christianity has shifted to the Global South, STM continues to target destinations with a growing and thriving Christian population (Jenkins, 2012). This growing trend in global missions requires a new framework more suitable to the current realities (Farrell, 2022). Therefore, cultural humility invites STM participants to a new way of being, one of lifelong learning and self-reflection, recognizing power imbalances and minimizing their effect on relationships while pursuing respectful and mutual partnerships from a stance of humility and self-awareness.

References

Agner, J. (2020). Moving from cultural competence to cultural humility in occupational therapy: A paradigm shift. *The American Journal of Occupational Therapy, 74*(4),1-7. https://doi.org/10.5014/ajot.2020.038067

Beach, M.C., Saha, S., & Cooper, L.A. (2006). The role and relationship of cultural competence and patient-centeredness in healthcare quality. *The Commonwealth Fund*. https://www.researchgate.net/publication/265149563

Beagan, B. (2015). Approaches to culture and diversity: A critical synthesis of occupational therapy. *Canadian Journal of Occupational Therapy*, *82*(5), 272-282. https://doi.org/10.1177%2F0008417414567530

Bendor-Samuel, P. (2020). Covid-19, Trends in global mission and participation in faithful witness. *Transformation: An International Journal of Holistic Mission Studies, 37*(4), 255-265. https://doi.org/10.1177%2F0265378820970225

Brach, C., & Fraser, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Review and Review, 57*(1), 181-217. https://doi.org/10.1177/1077558700057001s09

Campinha-Bacote, J. (2018). Cultural competemility: A paradigm shift in the cultural competence versus cultural humility debate. *Online Journal of Issues In Nursing, 24*(1), 1-10. https://doi.org/10.3912/OJIN.Vol24No01PPT20

Clabby, J.F. (2017). Enter as an outsider: Teaching organizational humility. *The International Journal of Psychiatry in Medicine, 52(*3), 219-227. https://doi.org/10.1177%2F0091217417730285

Borthwick, P. (2012). *Western Christians in global missions*. InterVarsity Press.

Civil Rights Act of 1964, Pub.L. No. 88-352, 78 Stat. 241 (1964).

Corbett, S. & Fikkert, B. (2012). *When helping hurts: How to alleviate poverty without hurting t he poor and yourself*. Moody Publishers.

Crouch, A. (2013). *Playing God: Redeeming the gift of power*. InterVarsity Press.

Deliz, J.R., Fayola, F.F., Jones, K.E., Tobat, J., & Ross, W.R. (2019). Cultural competency internventions during medical school: a scoping review and narrative synthesis. *Journal of General Internal Medicine, 35*(2), 623. https://doi.org/10.1007/s11606-019-05547-w

Elmer, D. (2006). *Cross-cultural servanthood: Serving the world in Christlike humility*. InterVarsity Press.

Fanning, D. (2009). Short-term missions: A trend that is growing exponentially. *Trends and Issues in Missions, 4*(1), 1-29. https://digitalcommons.liberty.edu/cgm_missions/4

Farrell, B.H. & Khyllep, S.B. (2022). *Freeing congregational mission: A practical vision for companionship, cultural humility, and co-development*. InterVarsity Press.

Fernandez, K.R. (2020). Developing cultural humility during short-term study abroad immersion. *International Journal of Studies in Nursing, 5*(3), 48-53. https://doi.org/10.20849/ijsn.v5i3.764

Ferranto, M.L.G. (2015). A qualitative study of baccalaureate nursing students following an eight-day international cultural experience in Tanzania: Cultural humility as an outcome. *Procedia-Social and Behavioral Sciences, 174*, 91-102. https://doi.org/10.1016/j.sbspro.2015.01.631

Fleckman, J.M., Dal Corso, M., Ramirez, S.M., & Johnson, C.C. (2015). Intercultural competency in public health: A call for action to incorporate training into public health education. *Frontiers in Public Health, 3*(1).). https://doi.org/10.3389/fpubh.2015.00210

Foronda, C., & Belknap, R.A. (2012). Transforming learning through study abroad in low-income countries. *Nurse Educator, 37*(4), 157-161. https://doi.org/10.1097/NNE.0b013e31825a879d

Foronda, D., Baptiste, D.L., Reinholdt, M.M., & Ousman, K. (2016). *Journal of Transcultural Nursing*, *27*(3), 210-217. https://doi.org/10.1177%2F1043659615592677

Foronda, C. (2020). A theory of cultural humility. *Journal of Transcultural Nursing*, *31*(1), 7-12. https://doi.org/10.1177%2F1043659619875184

Foronda, C., Prather, S., Baptiste, D.L., & Lucktar-Flude, M. (2022). Cultural humility toolkit. *Nurse Educator*. https://doi.org/10.1097/NNE.0000000000001182

Frey, R., Powell, L., & Gott, M. (2013). Care vs. care: Biomedical and holistic worldviews of palliative care. *European Journal of Integrative Medicine. 5(*4), 352-364. https://doi.org/10.1016/j.eujim.2013.02.004

Hook, J.N., Davis, D.E., Owen, J., & Worthington Jr., E.L. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal in Counseling Psychology*, *60*(3), 353-366. https://psycnet.apa.org/doi/10.1037/a0032595

Hook, J.N. (2014). Engaging clients with cultural humility. *Journal of Psychology and Christianity, 33*(3), 277-281.

Howell, B.M. (2009). Mission to nowhere: Putting short-term missions into context. *International Bulletin of Missionary Research, 33*(4), 206-211. https://doi.org/10.1177%2F239693930903300411

Howell, B.M. (2012). *Short-term mission: An ethnography of Christian travel narrative and experience*. InterVarsity Press.

Hughes, V., Delva, S., Nkimbeng, M., Spaulding, E. & Turkson-Ocran, R.A. (2020). Not missing the opportunity: Strategies to promote cultural humility among future nursing faculty. *Journal of Professional Nursing, 36*(1), 28-33. https://doi.org/10.1016/j.profnurs.2019.06.005

Institute of Medicine. (2002). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: The National Academies Press. https://doi.org/10.17226/12875

Isaacson, M.J. (2014). Clarifying concepts: Cultural humility or competency. J*ournal of Professional Nursing*, 30(3), 251-258. https://doi.org/10.1016/j.profnurs.2013.09.011

Jenkins, P. (2012). *The next Christendom: The coming of global Christianity*. Oxford University Press.

Johnson, J. (2012). *We are not the hero: A missionary's guide for sharing Christ, not a culture of dependency*. Deep River Academic Books.

Kalra, S., Megallaa, M.H., Jawad, F. (2012). Patient-centered care in diabetology: From eminence-based, to evidence-based, to end user-based medicine. *Indian Journal of Endocrinology and Metabolism, 16*(6), 871-872. https://doi.org10.4103/2230-8210.102979.

Koll, K.A. (2010). Taking wolves among lambs: Some thoughts on training for short-term mission facilitation. *International Bulletin of Mission Research, 34*(2), 93-96. https://doi.org/10.1177%2F239693931003400208

Kools, S., Chimwaza, A., & Macha, S. (2015). Cultural humility and working with marginalized populations in developing countries. *Global Health Promotion, 22*(1), 52-59. https://doi.org/10.1177%2F1757975914528728

Kumagai, A.K., & Lypson, M. (2009). Beyond cultural competence: Critical consciousness, social justice, and multicultural education. *Academic Medicine, 84*(6), 782-787. https://doi.org/10.1097/acm.0b013e3181a42398

Lekas, H.M., Pahl, K., & Lewis, C.F. (2020). Rethinking cultural competence: Shifting to cultural humility. *Health Services Insights, 13*, 1-4. https://doi.org/10.1177%2F1178632920970580

Levitan, S.E., & Schoenbaum, S.C. (2021). Patient-centered care: achieving higher quality by designing care through the patient's eyes. *Israel Journal of Health Policy Research, 10*(1), 21. https://doi.org/10.1186/s13584-021-00459-9

Livermore, D. A. (2012). *Serving with eyes wide open: Doing short-term missions with cultural intelligence*. Baker Academics.

Lough, B.J. (2016). *Global partners for sustainable development: The added value of Singapore International Volunteers.* Singapore: Singapore International Foundation. http://dx.doi.org/10.13140/RG.2.2.12884.40324

Lough, B.J. & Oppenheim, W. (2017). Revisiting reciprocity in international volunteering. *Progress in Development Studies, 17*(3), 197-213. https://doi.org/10.1177%2F1464993417713275

Millenson, M.L., Shapiro, E., Greenhouse, P.K., & DiGioia, A. (2016). Patient and family centered care: A systematic approach to better ethics and care. *AMA Journal of Ethics, 18*(1), 49-55. https://doi.org/10.1001/journalofethics.2017.18.1.stas1-1601

Morgan, J.R. (2016). Global trends and the North American church in mission: Discovering the church's role in the twenty-first century. *International Bulletin of Mission Research, 40*(4), 325-338. https://doi.org/10.1177%2F2396939316664693

Nagel, C. (2021). Christian short-term missions: Creating global citizens? *Geopolitics, 26*(5), 1286-1306. https://doi.org/10.1080/14650045.2018.1529666

Nagel, J.M. (2021). Forming a new normal: Serving learning and short-term mission post COVID-19. *Religious Education, 116*(5), 506-520. https://doi.org/10.1080/00344087.2021.2004027

Priest, R.J., & Priest, J.P. (2008). "They see everything, and understand nothing": Short-term mission and service learning. *Missiology: An International Review, 36*(1), 53-73. https://doi.org/10.1177%2F009182960803600105

Priest, R.J., Wilson, D., & Johnson, A. (2010). U.S. megachurches and new patterns of global mission. *International Bulletin of Mission Research, 34*(2), 97-104. https://doi.org/10.1177%2F239693931003400209

Priest, R.J. (2012). *Effective engagement in short-term missions: Doing it right!* William Carey Library.

Priest, R.J., & Howell, B.M. (2013). *Introduction: Theme issue on short-term missions. Missiology: An International Review, 41*(2), 124-129. https://doi.org/10.1177%2F0091829613475744

Putnam, R.D. (2000). *Bowling alone: The collapse and revival of American community*. Simon and Schuster.

Saha, S., Beach, M.C., & Cooper, L.A. (2008). Patient centeredness, cultural competence and healthcare quality. *Journal of the National Medical Association, 100*(11), 1275-1285. https://doi.org/10.1016/S0027-9684(15)31505-4

Shepherd, S.M. (2019). Cultural awareness workshops: Limitations and practical consequences. *BMC Medical Education, 19*(1), 1-15. https://doi.org/10.1186/s12909-018-1450-5

Sinclair, M. (2021). Practicing cultural humility. *Evangelical Missions Quarterly*, *57*(3).19-23. https://missionexus.org/emq/emq-archives/

Stubbe, D.E. (2020). Practicing cultural competence and cultural humility in the care of diverse patients. *The Journal of Lifelong Psychiatry*, *18*(1), 49-51. https://doi.org/10.1176/appi.focus.20190041

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved, 9*(2), 117-125.

Truong, M., Paradies, Y., Priest, N. (2014). Interventions to improve cultural competency in healthcare: a systematic review of reviews. *BMC Health Services Research, 14*(1), 99. https://doi.org/10.1186/1472-6963-14-99

Twibell, S. (2017). Short-term missions: Making a long-lasting difference in today's world. *Faculty Scholarship-Christian Ministry*. https://digitalcommons.olivet.edu/cmin_facp/10

Twibell, S.M. (2020). Contributions, challenges, and emerging patterns of short-term missions. *Missiology: An International Review, 48*(4), 344-359. https://doi.org/10.1177%2F0091829620937418

Ver Beek, K.A. (2006). The impact of short-term missions: A case study of house construction in Honduras after Hurricane Mitch. *Missiology: An International Review, 34*(4), 477-495. https://doi.org/10.1177%2F009182960603400406

Wight, A.R., Hammons, M.A., & Wight, W.L. (1970). *Guidelines for Peace Corps Cross-Cultural Training-Part III.* Office of Training and Support, Peace Corps. https://files.peacecorps.gov/multimedia/pdf/library/T0087_culturematters.pdf

Williamson, J. (2021). Re-thinking mobilization. *Evangelical Missions Quarterly, 57*(3), 39-41. https://missionexus.org/emq/emq-archives/

Wuthnow, R. (2009). *Boundless faith: The global outreach of American churches*. University of California Press.

Yancu, C.N., & Farmer, D.F. (2017). Product or process? Cultural competence or cultural humility? *Palliative Medicine Hospice Care, 3*(1), 1-4. https://doi.org/10.17140/PMHCOJ-3-E005

Yeager, K.A., & Bauer-Wu, S. (2013). Cultural humility: Essential foundation for clinical researches. *Applied Nursing Research, 26*(4), 251-256. https://doi.org/10.1016/j.apnr.2013.06.008

Zehner, E. (2013). Short-term missions: Some perspectives from Thailand. *Missiology: An International Review, 41*(2), 130-145. https://doi.org/10.1177%2F0091829612475169

Zurlo, G.A., Johnson, T.M., & Crossing, P.F. (2020). World Christianity and mission 2020: Ongoing shift to the Global South. *International Bulletin of Mission Research*, *44*(1), 8-19. https://doi.org/10.1177%2F2396939319880074