MISSION INTEGRATION IN AN INTERNATIONAL CONTEXT

Thinking about mission integration in international outreach creates more questions for me than answers. It is easy to connect international health activities to the mission of Catholic health care. We provide help and hope to those most in need, those who are most poor and vulnerable, as Jesus did and, later, as did the founding religious who came to the United States in service to that mission. But when we look at our international activities through the lens of mission integration, the picture changes.

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Merriam Webster defines integration as "the act or process or an instance of integrating: incorporation as equals into society or an organization of individuals of different groups (as races)." Ascension Health, on its Web page for mission integration, has a wonderful explanation: "The work of Mission Integration deepens the capacity to live our identity as a Ministry, both organizationally and personally."[1]

The two definitions, when merged together, provide me with a picture that dovetails Catholic social tradition with what CHA has heard from international partners. Those who host our activities or receive our goods and services often say that what is most needed in their experiences with U.S. health care are respect and understanding, which leads to incorporation as equals (brothers and sisters) to deepen the capacity to help them improve their own communities.

In this column, I offer some questions and considerations on mission integration as I relate that term to international health activities. I admit that I'm using the term loosely and not completely in context with how "mission integration" is used in a health care organization. I also admit that I come to you with blind spots, misgivings about some of the things I have seen and heard, as well as things I have personally done in my years of working abroad.

I come with insights gained through several years of research projects that CHA has conducted on medical surplus recovery and short-term medical mission trips, as well as from my experience on an Institute of Medicine forum on public-private partnerships for global health and safety. And most importantly, I come with an optimistic point of view — one that doesn't use blinders, but instead, acknowledges that the work being done by U.S. Catholic health care in low- and middle-income countries flows from a heart for helping and a tradition of quality.

What does cultural competency look like when the mission is integrated?

There is quite a difference between cultural competency and logistical insights. Cultural competence in health care is defined as "the ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients."[2] In international health activities, orientation programs can include information such as the typical diet of a region, the climate, the geography, the median income, the dominant religion of the people. These all are important pieces to understanding a community, but having a long-standing commitment to and relationship with someone who lives in the community is an imperative.

The religious communities that founded U.S. Catholic health care provided the best example of mission integration in a developing country. They came — leaving behind their homes and families — to become a part of the community where they were serving. Oftentimes they became the community's innovators and the group to which others looked for leadership. They didn't come to the U. S. for a few weeks to help with scarlet fever or to teach a few classes and then return home,

thankful for their experiences. They stayed. They partnered. They built the grandest legacy our country knows in both education and health care.

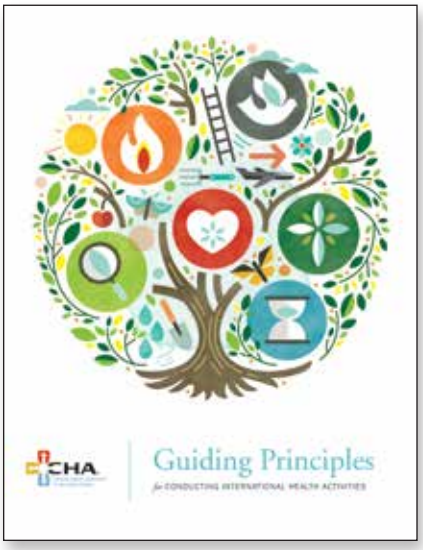
This becomes clear in the new CHA resource, *Guiding Principles for Conducting International Health Activities*. In it, there is a modern-day parable, along with six guiding principles and related questions that organizations should ask when assessing current or considering new activities. The *Guiding Principles* resource, including facilitation guides for use in orientations and with executive teams/boards/sponsor bodies, are available at www.chausa.org/guidingprinciples.

Is there a mission to integrate — a single mission — when working with a community in a different country?

Wouldn't it be interesting if before every short-term medical mission trip there was a process by which representatives from the host country and the leaders of the U.S. volunteer group sat down and created a mission statement together — or looked at their respective mission statements and fleshed out the meaning in their own cultural contexts?

If the groups had to present a joint mission statement, I could imagine both parties wording it roughly the same way: to provide the community with much-needed access to medical services. But I feel that the individual underpinnings would include many points of differentiation, such as:

- Would the host country want to include the phrase "poor and vulnerable" in reference to themselves and their neighbors? What is the litmus test for poor and vulnerable — the U.S. standard, or the local lived experience? I once saw a young lady on a flight going back to the States from Haiti. She had on a shirt that read: "Bringing hope to the hopeless." Her work was one that came from pity and not parity.



- Would anything about justice or dignity be part of the conversation to create a mission statement and then, as it should, be integrated with the mission of the local health workers, patients and the U.S. contingent? If they aren't equals, our friends whom we are trying to help often feel disempowered and relegated to being recipients versus taking their rightful place as the local experts.
- I wonder about the "who" part of the equation. Who would be providing access to medical services? Based on short-term medical mission trip research CHA conducted, those who host medical volunteer groups have a strong desire for far more educational opportunities during a medical mission trip than they receive. Not education the volunteer groups believe they need, but, rather, education around topics or procedures the hosts have identified. Too often, short-term medical mission groups don't even ask, or they dismiss the answer. Local context gained from a relationship of equals is critically important in order to attain the best results.

CHA's short-term medical mission trip research resulted in 20 "Recommendations for Practice" — many of which relate to the questions I pose. The recommendations are published and available, as are the full research results. You can find these resources in the international outreach section of www.chausa.org.

As you consider integrating the mission in an international context, please draw on the rich tradition of Catholic health care as well CHA resources developed to spark discussion and, if necessary, rethinking. In addition to *Guiding Principles* and research on medical surplus recovery, available at www.chausa.org/internationaloutreach/medical-surplus-recovery, CHA has developed several video scenarios and video responses. They provide a case study for personal or group reflection on surplus recovery, disaster response and short-term medical mission trips. Access them at www.chausa.org/international-outreach-video-scenarios/home.

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NOTES

1. Ascension Health, "Mission Integration," www.ascensionhealth.org/index.php?option=com_content&view=article&id=345&Itemid=288 (accessed Feb. 3, 2016).
2. Joseph R. Betancourt, Alexander R. Green and J. Emilio Carillo, *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches*, Commonwealth Fund Field Report, October 2002. www.commonwealthfund.org/usr_doc/betancourt_culturalcompetence_576.pdf (accessed Feb. 3, 2016).

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