

THE GUIDING PRINCIPLES: MORE THAN SENTIMENT

Through its global health initiatives, the Catholic Health Association works to assist its members, our church partners and the greater global community to promote and implement goals supported by our deepest religious and ethical values. These goals are spelled out in the *Guiding Principles for Conducting International Health Activities*. Developed in collaboration with CHA members and published in 2015, the principles call for accountability, authentic partnership and evaluation.



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But do they matter? Five years after publication, are the *Guiding Principles* relevant, recognized and part of conversations? I feel that the answer to all three questions is “yes,” and I base this on feedback from colleagues across the globe and of many faiths who feel a connectedness to the points they convey and a desire to share our

work more widely. Consequently, this column is the start of a series in which CHA members and global partners will highlight one of the six *Guiding Principles* in the context of their own global efforts.

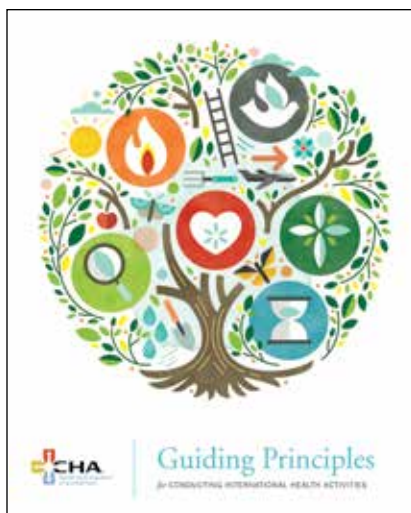
The series should underscore the rallying cry I frequently hear in meetings with global actors including our members, staff of the World Health Organization, the National Academies, USAID, and so many more. It is a call for all efforts to be more sensitive to the realities on the ground, understanding of the local culture and respectful of the authority that exists, and the call continues to get louder. Not everyone is crying or listening, but it is becoming a topic in the media domestically and internationally; in conversations with development experts in high-income countries; with health professionals who travel as part of their work; and most importantly, among the many voices of those who host or receive the mission trips in low- and mid-

dle-income countries, including faith-based collaboratives and ministries of health.

In an opinion piece from Goats and Soda, National Public Radio’s regular blog on global health and development, author Abraar Karan, said: “Today, the field of ‘global health’ strives to create equitable and just relationships between wealthy and impoverished regions, places and peoples. But it is still a field with markedly unequal power dynamics: racism, classism and many of the residual exploitations of a terrible colonial past. I fear that this point often goes missed or ignored, possibly because we are subconsciously or consciously engaged in a neo-colonial narrative in which wealthy people are ‘saving’ poor people even as they build their own careers. It is not a relationship in which Western visitors and local people are collaborating equally — or perhaps even more appropriately, where local leaders take the dominant role.”¹

That’s tough to hear. We position our work on that of our founders and foundresses — and we know they focused on breaking down the structures that create poverty and dependence.

Yet, in the current format, even when we’ve been going to a place for decades, do we see real progress in the population’s health? Can we clearly show that the host community’s medical providers — no matter how differently that is defined in the norm of that community from how we define health care providers in the U.S. — are involved,



actively participate and openly evaluate the successes and failures?

Those being served through or participating in medical missions include patients and their families, and their voices too are rising. When foreign medical mission teams come in, locals have high expectations for the health care to be provided. While appropriate care is offered to many, stories are coming to light when physicians have practiced well beyond their scope and specialty, or incidents when medical and nursing students were involved in clinical procedures even though they had no certifications that allow them to practice medicine. This is addressed in the *Guiding Principles*, which outline such situations as opposed to both our standards for ethical behavior and our social tradition for excellence in each encounter as a ministry of the church.

Be assured that our means and methods will be coming under closer scrutiny in years to come by governments around the world. It is already happening, and it is affecting the way Catholic health care continues these efforts. Governments are developing policies in low- and middle-income countries to address such quality issues. Local health providers whose careers are affected both positively and negatively by the work being done, as well as members of the World Health Organization and others expecting more empowerment and capacity development of the local providers are participants in those conversations.

An example of the key stakeholder voice related to donations is in Kenya, where the government now requires inspections of all donated equipment and supplies before they leave the U.S. and again upon arrival to ensure that the items being delivered are in working order and will not immediately go into storage or junk piles.

Another situation in which an African government stepped in occurred in Uganda in 2019. In August of that year,

American Renee Bach — who created a charity nutrition center in that country — was sued by parents of children who died in her care. It's a complicated story, but in the end, Bach had no clinical experience and 105 of her nearly 1000 "patients" died; it was an Ameri-

very existence and through faith-filled people wanting to do good by doing good that will be addressed in the upcoming series of articles, they will provide us with opportunities to see one another's perspectives and learn from others' experiences as we tweak

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can nurse volunteering at the center who stepped up and became a whistleblower.² While this is an extreme case, we must look at the duties of our own mission trip volunteers. Are we asking people to willingly practice outside of their scope — and sometimes entire career field — in the name of "mission"? The case in Uganda is an opportunity to broach the subject, and the *Guiding Principles* include questions for reflection to pursue important conversations.

The principles also call for partnership. Thankfully, there is progress in this vein. USAID Administrator Mark Green has said, "We could help our partners by prioritizing programs that show measurable impact, incentivize reform, diversify our partner base, foster local capacity-building and mobilize their own domestic resources."³ After a recent meeting with USAID, I can say that the *Guiding Principles* are well-regarded. As USAID undertakes its New Partnerships Initiative, Catholic health care and our partners globally could work toward receiving funding, particularly if we can show use of the guidance relating to evaluation and upholding self-sustainability.

Overall, the *Guiding Principles* cannot make any one group assess their international programs. They cannot end shipments containing unusable materials or machines from being shipped, and they cannot rein in potential medical malpractice. But, by their

existing or develop future global health initiatives. We have progressed since the *Guiding Principles* were shared in 2015, and we hope this series helps them become more of the lived experience in global health in the decade to come.

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NOTES

1. Abraar Karan, "Opinion: It's Time to End the Colonial Mindset in Global Health," *NPR*, Goats and Soda, December 30, 2019, https://www.npr.org/sections/goatsandsoda/2019/12/30/784392315/opinion-its-time-to-end-the-colonial-mindset-in-global-health?utm_source=npr_newsletter&utm_medium=email&utm_content=20200102&utm_term=4318241&utm_campaign=goats-and-soda&utm_id=47309513&orgid=
2. Nurith Aizenman and Malaka Gharib, "American with No Medical Training Ran Center for Malnourished Ugandan Kids. 105 Died," *NPR*, Goats and Soda, August 9, 2019, <https://www.npr.org/sections/goatsandsoda/2019/08/09/749005287/american-with-no-medical-training-ran-center-for-malnourished-ugandan-kids-105-d>.
3. New Partnerships Initiative, USAID, <https://www.usaid.gov/npi>.

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