CHA
Catholic Health Association of the United States

10TH ANNIVERSARY EDITION

Guiding Principles

for CONDUCTING GLOBAL HEALTH ACTIVITIES

Guiding Principles

for CONDUCTING GLOBAL HEALTH ACTIVITIES

CHA and its members have named six Guiding Principles for Conducting Global Health Activities. These principles bring to life the richness of Catholic social tradition. Based loosely on the Oath for Compassionate Service in the book *Toxic Charity* by Robert Lupton and insights from a special workgroup CHA convened to examine current international health program practice in light of our ministry's commitments, they are offered to help Catholic health care most appropriately conduct international programs.

PRUDENCE

Don't just do it

Good judgment requires controlling our enthusiasm to do good so that we also do it well, even in times of emergency. Technical expertise is necessary but not sufficient for action. International activity requires many things, including assessment, planning and evaluation.

AUTHENTICITY

Know yourself, know your partner

There are many motivations for U.S. and international organizations to engage in international health activities. An invitation from a true partner who is part of the local community and its health system, knowledge and understanding of our respective motives and full transparency regarding our goals are all necessary if we are to do our best work.

HONESTY

Trust is earned and learned

Meaningful partnership requires a high level of trust and multiple lines of communication. Both U.S. and international partners must recognize that the other likely perceives risks in being totally honest. Both must listen for things said and unsaid, which takes both time and practice.

PATIENCE

Build capacity, not dependency

We should neither conduct activities that a local community can do for itself nor participate in one-way financial giving. The process of getting to know your partner — in order to build capacity — often takes longer than expected and requires patience.

EXCELLENCE

Best intentions do not equal best practices

Something is not always better than nothing. Low-resource settings do not permit lower standards. The high standards we follow in the U.S. — in delivering health care and developing partnerships — should not be set aside when working abroad. The laws of the country must be followed, the men and women providing services must be competent in their roles, and outcomes must be measured by quality, not simply quantity.

HUMILITY

We all have something to learn

Partnerships marked by mutuality and respect build relationships where both the U.S. and international partners benefit and take away relevant lessons. True cultural competence is necessary for a two-way learning process in any development activity.

As we mark the 10th anniversary of the Catholic Health Association of the United States' (CHA) *Guiding Principles for Conducting Global Health Activities,* we reflect on the document's impact since its release in 2015. These Guiding Principles have been a cornerstone of CHA's initiatives, offering essential guidance to Catholic-sponsored health ministries in building ethical and effective global health partnerships.

The Guiding Principles' influence extends beyond Catholic health ministries, making a significant impact on higher education and global health partner organizations at home and abroad. For example, the 2024 *Enacting an Ethic of Care and Responsibility in Global Health Partnerships* study by the Uganda National Academy of Sciences cites the *Guiding Principles*. By providing ethical guidance and promoting collaboration, these principles have empowered numerous organizations to carry out their missions with integrity.

THIS DOCUMENT INCLUDES:

- A Modern Day Parable and Reflection Guide
- Video Resources for Group Discussion
- Guiding Principles for Global Health – Questions to Consider

We hope the Guiding Principles continue to inspire both veteran and emerging leaders to address evolving needs, reflecting the Catholic health ministry's commitment to the Gospel mandate of delivering compassionate, high-quality care to those most in need, including our global neighbors. These Guiding Principles navigate the emotions and goodwill of global health activities with the partnership and ethical guidance that can ensure good intent creates good outcomes for all involved in a partnership.

As we commemorate 10 years, CHA's Global Health Advisory Council is also struck by the alignment of our work with CHA's 2025-2027 strategic plan on behalf of the ministry, which envisions a reimagined health ecosystem in which health care is not a commodity but a human right integral to a just society and strong and healthy communities.

Sincerely,

BRUCE COMPTON
Senior Director, Global Health
Catholic Health Association of the United States

"I have come to understand that true progress can only be achieved through partnerships built on a foundation of trustworthiness, humility, care for one another, and shared responsibility for the investments in and results of our partnerships. The voices of those who do not have money, often marginalized in global health discourse, offer invaluable insights into the complexities of health challenges and the innovative solutions that emerge from communities on the front lines. Centering these voices and experiences sets us on a journey to discover equity in practice."

HON. DR. JANE RUTH ACENG OCERO
Minister of Heath Republic of Uganda
From the Forward of *Enacting an Ethic of Care and Responsibility in Global Health Partnerships: A Consensus Study of the Uganda National Academy of Sciences* 2024

Reflection Resources for Global Health Outreach

CHA is pleased to provide tools designed to foster self-reflection and meaningful group dialogue for individuals and teams planning global health mission trips and outreach programs. These resources include A Modern Day Parable — offered in both written and video formats — and a series of case studies featuring real-world scenarios. Together, these tools encourage thoughtful introspection and open discussions, helping to ensure outreach efforts uphold Catholic health care's commitment to human dignity and the common good.

REFLECTION QUESTIONS

Parables are always imperfect lessons, yet they still inform who we are and what we do on many levels. For example, a key lesson of the original Parable of the Sowing is God's generosity in scattering seed even where it is unlikely to grow. While generosity would be a great lesson for international health work, this modern parable has a different focus. In reflecting on it, you are encouraged to not just analyze it intellectually, but to give time to the emotional and spiritual insights that emerge from its reading.

- What are your initial reactions to this parable? Intellectually? Emotionally? Spiritually?
- Can you see yourself in this parable? With whom do you identify?
- Have you experienced or heard of similar struggles as these volunteers? What goes unseen after they leave?
- Where have you seen true progress or reward in international health work? What does that look like?
- Are you and your colleagues open to the possibility that this work may require change from what you have done in the past? What are the barriers to this change?

VIDEO CASE STUDIES

CHA has developed several video case studies on topics related to global health and medical surplus recovery. Meant to open conversations and to illuminate some of the feedback from CHA's research on surplus recovery and short-term medical mission trips, the case studies shed an ethical light on practices and some of the mentality behind a desire to serve to do good for others.

Access the case studies at chausa.org/globalhealth or via the QR code below.

A Modern Day Parable Video

Video Case Studies

A Modern Day Parable

An Adaptation of Matthew 13:1–23, Mark 4:3–20, Luke 8:4–15, *The Parable of the Sowing*
By Michael Rozier, SJ, Ph.D., MPH

We often imagine what it will take to build healthier communities in both the U.S. and abroad. But let us engage our imagination in the way that Jesus often challenged his disciples. A simple parable opens us up to both the promise and peril of the good work of international health projects.

When a great crowd gathered around, he said in a parable:

A group of volunteers traveled halfway around the world to restore a failing orchard. As they worked, they saw the trees grow in health and returned home with renewed spirit. They told many stories of their success and began gathering volunteers for the following year. But they did not see what became of the trees once they were gone.

Some of the trees that were watered by hand during their time and looked so strong had no source of continued water after they left, so the fruit never grew.

Some of the trees had low branches trimmed. The higher branches could not be reached by the local workers who were given no ladders of their own, so the fruit grew but withered and died on the tree.

Some of the trees were uprooted and replanted in another part of the field that looked better but that local workers knew often had terrible windstorms, so the fruit grew but was blown off before it ripened.

But some of the trees remained in the part of the field recommended by local workers, had an irrigation system built with local materials and were trimmed in a way that the workers could still access all the branches long after the volunteers returned home. These trees bore fruit a hundredfold and the community had more to eat than ever before.

And he said, "Let anyone with ears to hear listen!"

Then those closest to him asked what this parable meant.

He said, "To you has been given the secret of curing the sick. The

volunteers are well-intentioned medical professionals. The orchard is the community where they volunteer or send supplies.

"The trees that were watered for a while but were left to dry out are the patients who were given short-term fixes to long-term problems. It seems better to give them medication or donate whatever supplies are available. But sometimes, something is not better than nothing.

"The trees that had fruit wither and die on the high branches because the local workers had no ladders are the patients who had complications arise after the volunteers left. The volunteers get praise for the good, and the local health workers get blamed for what goes wrong after they leave.

"The trees that were replanted in a seemingly promising but ultimately devastating part of the field suffer because the volunteers failed to recognize that the local workers know vital information about their own communities. Good intentions are not enough when people's lives are at stake.

"But as for the trees that remained in place, were irrigated properly, and could be tended by local workers, these are the patients whose health improved and remained strong for years to come. The volunteers used their expertise to do great work, but they respected the unique knowledge of local workers. They donated supplies that were useful, they provided care with the long-term in mind, and they built capacity by ensuring local health workers were strengthened and not undermined by their work.

"A hundredfold bounty is just the beginning. There is good work to be done, and with God, all things are possible."

THE GUIDING PRINCIPLES

Questions to Consider

PRUDENCE

Don't just do it

Good judgment requires controlling our enthusiasm to do good so that we also do it well, even in times of emergency. Technical expertise is necessary but not sufficient for action. International activity requires many things, including assessment, planning and evaluation.

What is the history of international health activities within the organization?

- Know the international locations where the organization has had good partners and partnerships.
- Identify the international locations where barriers have been experienced and dig deep to fully understand any barriers.

Who are the various stakeholders in the organization?

- The many stakeholders can come from the sponsoring body, former congregational sponsors, clinicians, marketing, formation leaders and other groups.

What is the main motivation for conducting international work? What are secondary motivations?

- There are many motives for international projects. They can include: answering a personal call to do this work, the formation of clinicians and associates, providing access to services and creating sustainability/capacity building for a given population.
- Motivations must be surfaced. If the program is about helping associates and clinicians renew their commitment to health care or find personal renewal, it might be unwise when promoting the activity to primarily highlight the number of patients seen or pounds of items donated.

Is the international project part of the organization's strategic plan?

- International activities should be supported by the board and an explicit part of the organization's strategic plan with appropriate measures of accountability.

What organizational resources are available to conduct the international project and how were they determined?

- Determine the human resources, financial assistance and in-kind donations that are available for each specific international health project.
- In human resources, be sure that any persons participating are competent in the roles in which they are placed. An accountant should not be dispensing medications.

Can resources be changed as assessed needs are determined?

- Conducting a needs assessment that places the requests of the international partner at the center could require an adjustment to any current or future project and could require different resources than those determined as being available.

Are resources "dependent?"

- Before starting an international project, ask if the project is dependent upon one person's championing, participation or administration.

THE GUIDING PRINCIPLES

Questions to Consider

AUTHENTICITY

Know yourself, know your partner

There are many motivations for U.S. and international organizations to engage in international health activities. An invitation from a true partner who is part of the local community and its health system, knowledge and understanding of our respective motives and full transparency regarding our goals are all necessary if we are to do our best work.

How did the project come to be?

- No project should be conducted without an invitation — even in times of emergency.

Was the invitation from a partner who is part of the local community?

- The person issuing the invitation should be a local partner who is a part of the community. This reflects the U.S. Catholic health care experience in which the foundresses and founders came at an invitation, and came to stay permanently in service to that community.
  - Even in times of emergency, it is essential that we not assume permission to operate locally.

Is the partner who made the invitation part of the local health system?

- While the local pastor may be enthusiastic about the project, local health providers must also be involved from the beginning.

Are the multiple motivations of the local partner known?

- Just as U.S. partners have multiple motivations, so, too, might the local partner. The local partner may want not only the health services provided but could also be looking at the economic benefits, such as the purchases from local vendors and the hiring of local staff.
- Talking through the projected outcomes of any project can surface motivations and create a more transparent and trusting relationship.

Has a local needs assessment been conducted and were local partners involved?

- Sometimes the first time organizational staff are actually overseas in the local partner's community is when they arrive to run a clinic or donate supplies. This could indicate that an assessment of local abilities was not conducted and might negate the building of relationships of trust.

Has a local asset assessment been conducted and were local partners involved?

- Locally trained health workers or locally sourced equipment and supplies could be overlooked if only the needs of the community are assessed. Assets/human resources can only become known if sought out and surfaced.

Has a contract or Memorandum of Understanding (MOU) been signed?

- The same due diligence and business acumen applied to U.S. partnerships should be a part of any international health project.
- Understanding who is responsible for what in any interaction is important. In the case of international health projects, lines of accountability for any services provided, needed follow-ups and liability issues that arise must be clear.

For current projects, is it time for a new assessment?

- Assessments should be done regularly. If a ministry has been working in or donating to a community for several years, new assessments should be conducted with the hope that progress has been made. If the needs of the community haven't changed nor the local assets/capacity increased in the years of a program, the project should be re-evaluated to surface gaps and root causes.

THE GUIDING PRINCIPLES

Questions to Consider

HONESTY

Trust is earned and learned

Meaningful partnership requires a high level of trust and multiple lines of communication. Both U.S. and international partners must recognize that the other likely perceives risks in being totally honest. Both must listen for things said and unsaid, which takes both time and practice.

Is there a difference between the needs the U.S. partner perceives and the needs that the local community partner has identified?

- If the needs identified by the local and U.S. partners are not the same, an agreement must be made before proceeding. Resolving the discrepancy in the identified needs and determining the core source of problems must be done in a culturally sensitive manner which includes deference to local knowledge in many instances.

Do the organizational resources identified in the U.S. partner's self-assessment actually meet the prioritized needs voiced by the local partner's community?

- It is possible that the true needs of the community are outside of the U.S. partner's expertise or resources available for the project.

What liabilities does this bring to the organization?

- Lines of accountability must be drawn and understood by both partners. If a medical mission team performs a surgery, and three weeks later the patient dies, both partners need to have already understood who is accountable.
- If medical mission team personnel hand carry donations of medications (expired or other), this could be in violation of local and international laws.

What liabilities does this bring to the local partner?

- External presence may compromise the potential of growing a local economy in the wake of a disaster or sideline local health providers if the activities are not at the invitation of and understood by all involved in the community.

What is measured? Are impact measures identified, or only measures of inputs and/or outputs?

- The amount of money donated or the number of patients seen is less important than the impact the interventions are meant to have.

Are practices and procedures appropriate for the local context?

- The local partner should know the competencies of the local staff and community and plan activities to dovetail with their capacity.

What is considered a "successful" project?

- Outcomes and not motivations should drive evaluation.

How will "failure" be dealt with?

- International health activities require transparency in communicating the challenges experienced and lessons learned, as well as an ability to reassess continued activities.

Are long-term or short-term measures being monitored?

- When a piece of equipment is given to a facility, the actual usage for a full year after donation and its impact on the health of the community should be evaluated.

"Where there is no work, there is no dignity."

POPE FRANCIS, on the Island of Sardinia, September 2013

PATIENCE

Build capacity, not dependency

We should neither conduct activities that a local community can do for itself nor participate in one-way financial giving. The process of getting to know your partner — in order to build capacity — often takes longer than expected and requires patience.

What needs to be done in order to fulfill the need?

- Generate discrete lists of appropriate interventions to be conducted, and appropriate resources needed for those interventions.

What cultural aspects are built into orientation for anyone participating in an international outreach activity?

- Cultural competency should be a core component of all orientation programs.
- Make sure participants in the project understand before any interaction that small gifts to individuals or families can create division within the local community.
- Offering free candy or other items could undercut local vendors of such items.

How will impact be measured, monitored and communicated?

- List key outcomes, and determine what can be measured and monitored before work begins.

How will decisions be made when interventions need to be changed?

- Situations in-country may require modifications to planned activities but should not be decided unilaterally by the U.S. partner.

What do local health workers say they would like their U.S. partners to understand about their medical practices and procedures?

- Local community members best understand their needs and the potential success of many proposed interventions. Never assume to know more or better. For example, they may know that malaria bed nets are used more for fishing than as bed nets and that the in-country efforts should be focused on education before distribution.

How is follow-up care coordinated?

- Local health workers should be trained to look for expected side effects, and the U.S. partner should anticipate the resources that may be needed to deal with complications after they leave.

Are the capacities of the local partners identified in the needs/asset assessment?

- Locally trained health promoters can be used to deliver culturally sensitive educational messages on any number of topics, such as the benefits of immunizations and vaccines.

"The new word for peace is development."

POPE PAUL VI, *Populorum Progressio,* 1967

EXCELLENCE

Best intentions do not equal best practices

Something is not always better than nothing. Low-resource settings do not permit lower standards. The high standards we follow in the U.S. — in delivering health care and developing partnerships — should not be set aside when working abroad. The laws of the country must be followed, the men and women providing services must be competent in their roles, and outcomes must be measured by quality, not simply quantity.

Is appropriate orientation being done for those involved in international projects?

- Orientation should be designed and facilitated in a manner that provides participants time for personal discernment and knowledge that leads to cultural competency appropriate for the tasks assigned.

Is safety as seriously attended to abroad as in U.S.-based facilities?

- Dispensing of expired medications or the dispensing of medications without child-proof containers to homes with children would not happen in the U.S. and should not happen in international projects.

Are the same professional standards being used in international projects?

- A volunteer should not be fit into any given slot. For example, an untrained relative should not assist with a surgery, or an accountant should not serve as the pharmacist if they would not be allowed to do so in the U.S.

Are the global standards associated with health systems strengthening incorporated into international project metrics?

- Impact on the local health workforce and local health system finances can often go overlooked, even though short-term interventions can impact them greatly.

Are any of the skills of the U.S. partner volunteers, leadership or administration transferrable?

- Providing education around administrative policies to the leadership and governance of your local community partner or continuing medical education to the clinical staff can promote long-term capacity building.

What kind of infrastructure can be built to address root causes?

- Water-borne illness may be treated effectively with medications in the short-term, but a long-term infrastructure plan can be incorporated into a group's use of resources.

How many people in the organization know the local language?

- Trusting relationships with the local community partner are more likely to be built if some of the U.S. personnel can speak the local language.

THE GUIDING PRINCIPLES

Questions to Consider

HUMILITY

We all have something to learn

Partnerships marked by mutuality and respect build relationships where both the U.S. and international partners benefit and take away relevant lessons. True cultural competence is necessary for a two-way learning process in any development activity.

Are impact measures evaluated, or are only inputs and/or outputs being measured?

- The amount of money donated or the number of patients seen is less important than the impact the interventions are meant to have.

Are long-term measures established, or are only short-term measures assessed?

- When an x-ray machine is given to a facility, an attempt to assess its actual usage and its impact on the health of the community should be made a full year after the donation.

Is there a fear by the international partner that feedback perceived as negative could result in the loss of the partnership and the related funding, goods and/or services?

- An international partner may claim everything went well rather than provide negative feedback during a formal evaluation and risk alienating the U.S. partner.

Is there fear by the U.S. partner that robust evaluations create a risk that some activity might be lost or ended?

- If a group has been doing the same work for 10 years, it may be easier to continue the work than to assess it formally and risk finding out community health has not improved over that time.

With whom, what and how do we communicate about the outreach program?

- If the interaction is self-formational in nature, the language used in a press release should reflect this reality rather than the number of patients served or pounds of materials donated. All volunteers should be asked to consider the same emphasis for individual communications.

With whom and how do we communicate our lessons learned?

- Even though it may not be in a press release, we should have a way of honestly sharing the strengths and weaknesses of the program with other entities within or connected to the hospital/health system.

In future planning, what needs to change in the way that we proceed?

- How we promote the activity, our partnership agreement, the training of volunteers or the metrics used may need to be modified based on the experience and outcomes.

Conclusion

Many still believe that all global health activities are worthwhile as long as they are motivated by good intentions. We hope that this document has provided you with a stimulating reflection on the reasons that belief can be misleading. Just as an initiative to improve the health of communities in the U.S. is a complex process that is not always successful, improving the health of a community in a low – or middle-income country requires the right human resources, a good business strategy, authentic partnership and constant re-examination.

CHA's Strategic Plan

2025-2027

Throughout our history, Catholic health care has been guided by the tradition of our founding congregations to carry forth the healing ministry of Jesus. Today, we continue to be graced by and called to that same innovative spirit of our Catholic sisters, brothers, clergy and laypersons. This apostolic heritage has guided Catholic health care's commitment to human dignity and the common good and impels us to care for the whole person from conception to natural death. Through our loving God, we are intrinsically connected with one another and all of creation.

We, the Catholic Health Association, are compelled to ensure access to **care for all** so everyone has opportunities to reach their full potential. We know that business as usual is no longer acceptable or sustainable. We envision a **reimagined health ecosystem** in which health care is not a commodity but a human right integral to a just society and a strong, healthy national community. Our strategic plan creates the groundwork for our commitment to fostering human flourishing by **uniting our members** and all people of goodwill to prioritize the dignity of each person and the common good.

CARE FOR ALL

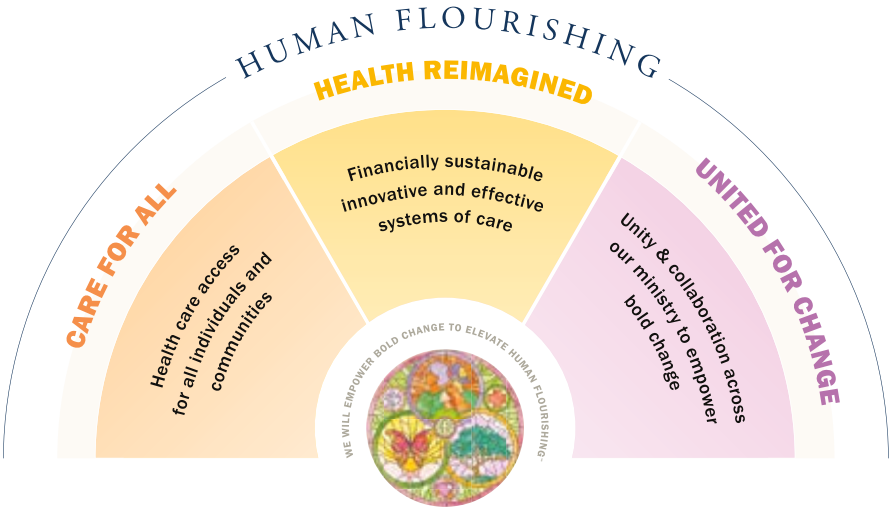
Reflecting Catholic health care's commitment to human dignity and concern for the poor and vulnerable, we will advocate for access to health care for all individuals and communities consistent with our faith tradition.

HEALTH REIMAGINED

Reflecting Catholic health care's commitment to justice and stewardship and guided by all our values, we will lead and advocate for the development of a financially sustainable and innovative system of care that enables optimal health for individuals and communities.

UNITED FOR CHANGE

Reflecting Catholic health care's commitment to the common good and pluralism, we will strive to unify members and our ecclesial partners; and foster greater collaboration with others to empower the change necessary to elevate human flourishing while preserving the mission of Catholic health care.



OUR MISSION

CHA advances the
Catholic health ministry of the United States
in caring for people and communities.

OUR VISION

We will empower
bold change to elevate
human flourishing.

"Once we start to think about the kind of world we are leaving to future generations, we look at things differently; we realize that the world is a gift which we have freely received and must share with others. Since the world has been given to us, we can no longer view reality in a purely utilitarian way, in which efficiency and productivity are entirely geared to our individual benefit. Intergenerational solidarity is not optional, but rather a basic question of justice, since the world we have received also belongs to those who will follow us."

POPE FRANCIS, *Laudato Si',* 2015

CHA
Catholic Health Association of the United States

St. Louis Office
4455 Woodson Road
St. Louis, MO 63134
(314) 427-2500

Washington Office
1625 Eye Street NW, Suite 550
Washington, DC 20006
(202) 296-3993

chausa.org

Printed in the United States of America.