



Guiding Principles

for CONDUCTING INTERNATIONAL HEALTH ACTIVITIES



“It’s not enough to give a sandwich if it isn’t accompanied by the possibility of learning to stand on one’s own feet. Charity that does not change the situation of the poor isn’t enough.”

POPE FRANCIS, speaking at the Rome headquarters of the Jesuit Refugee Service, September 2013





Compelled to continue Jesus' mission of love and healing today, U.S.-based Catholic health care organizations are reaching out to our brothers and sisters around the world to improve their health status and quality of life. This tradition of international ministry is a testament to the commitment of associates from across Catholic health ministry to live up to the Gospel mandate to provide compassionate care, with special attention to those most in need.

International projects, like those in the States, call for careful consideration. Through technological advances, increasing travel infrastructure and even social media, we are making more global connections. These tools may make it appear as though it could take no more than passports and plane tickets to provide medical services, deliver surplus equipment or provide financial support to communities halfway around the world, but we know better. Ours is a ministry with deep roots in assessment and evaluation as important components of responding to identified needs.

This document offers Catholic health ministry six Guiding Principles for Conducting International Health Activities. The principles were developed by gathering wisdom from many sources, including Catholic social tradition, and are offered to open up conversations around why and how we conduct international projects.

THIS DOCUMENT INCLUDES FOUR SECTIONS

- I. Guiding Principles for Conducting International Health Activities
- II. A Modern Day Parable
- III. Guiding Principles — Questions to Consider
- IV. Conclusion

We hope the content will engage you, your leadership team and those who serve in international projects in a robust dialogue.

BRUCE COMPTON

Senior Director, International Outreach
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The World Health Organization, in its summary document issued in May of 2010, *Key Components of a Well-Functioning Health System*, defines what a well-functioning health system can do:

“A well-functioning health system responds in a balanced way to a population’s needs and expectations by:

- + Improving the health status of individuals, families and communities
- + Defending the population against what threatens its health
- + Protecting people against the financial consequences of ill-health
- + Providing equitable access to people-centered care
- + Making it possible for people to participate in decisions affecting their health and health system

“Without strong policies and leadership, health systems do not spontaneously provide balanced responses to these challenges, nor do they make the most efficient use of their resources. As most health leaders know, health systems are subject to powerful forces and influences that often override rational policy making.”

Guiding Principles

for CONDUCTING INTERNATIONAL HEALTH ACTIVITIES

CHA and its members have named six Guiding Principles for Conducting International Health Activities. These principles bring to life the richness of Catholic social teaching and 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. They include:



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 thyself, know thy 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.



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

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.



QUESTIONS TO REFLECT ON THE PARABLE

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?

“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.



AUTHENTICITY

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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 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.



HONESTY

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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

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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, 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 be assisting 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.



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 be improved over that time.

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

- + If the interaction is self-formatinal 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 international 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.

We leave you with some food for thought from the Hebrew prophets and Catholic social tradition ...

“... and if you spend yourselves on behalf of the hungry and satisfy the needs of the oppressed, then your light will rise in the darkness, and your night will become like the noonday.”

[Isaiah 58:10](#)

“And what does the LORD require of you? To do justly, and to love goodness, and to walk humbly with thy God.”

[Micah 6:8](#)

“Each one has a natural right to procure what is required in order to live.”

[Pope Leo XIII, *Rerum Novarum*, 1891](#)

“Interdependence must be transformed into solidarity, based upon the principle that the goods of creation are meant for all.”

[Pope John Paul II, *Sollicitudo Rei Socialis*, 1987](#)

“There are collective and qualitative needs which cannot be satisfied by market mechanisms. There are important human needs which escape its logic.”

[Pope John Paul II, *Centesimus Annus* \(On the 100th Anniversary of Pope Leo XIII's *Rerum Novarum*\), 1991](#)

“Development is impossible without upright men and women, without financiers and politicians whose consciences are finely attuned to the requirements of the common good.”

[Pope Benedict XVI, *Caritas in Veritate*, 2009](#)

“To serve means to work alongside the neediest, first of all to establish a close human relationship with them, based on solidarity. ... To serve means to recognize and welcome the demands for justice, for hope, and to seek ways together, a concrete path of liberation.”

“... The poor are also privileged teachers of our knowledge of God; their fragility and simplicity will unmask our egoisms, our false securities, our pretenses of self-sufficiency, and guide us to the experience of the closeness and tenderness of God, ...”

“... True mercy, which God gives and teaches us, calls for justice, for a way in which the poor can find a way out of poverty. It calls for ... a situation in which no one is in need of a soup kitchen, of a homeless shelter, of legal assistance to have his right to live and to work recognized, to be a whole person.”

[Pope Francis, speaking at the Rome headquarters of the Jesuit Refugee Service, September 2013](#)

“That is the purpose of our mission: to identify the material and immaterial needs of the people and try to meet them as we can. Do you know what agape is? It is love of others, as our Lord preached. ... Love for one's neighbor — that leavening that serves the common good.”

[Pope Francis, published interview in *La Repubblica*, October 2013](#)

“Our commitment does not consist exclusively in activities or programs of promotion and assistance; what the Holy Spirit mobilizes is not an unruly activism, but above all an attentiveness which considers the other ‘in a certain sense as one with ourselves.’ This loving attentiveness is the beginning of a true concern for their person which inspires me effectively to seek their good.”

“... We need to grow in a solidarity which ‘would allow all peoples to become the artisans of their destiny’ [157] since ‘every person is called to self-fulfillment.’”

[Pope Francis, *Evangelii Gaudium*, 2013](#)

“Our faith in Christ, who became poor, and was always close to the poor and the outcast, is the basis of our concern for the integral development of society's most neglected members.”

[Pope Francis, *The Church of Mercy*, 2014](#)

“There is a kind of ‘service’ which truly ‘serves,’ yet we need to be careful not to be tempted by another kind of service, a ‘service’ which is ‘self-serving.’”

[Pope Francis, celebrating Mass in Havana's Revolution Square, September 2015](#)

“Our efforts must aim at restoring hope, righting wrongs, maintaining commitments, and thus promoting the well-being of individuals and of peoples.”

[Pope Francis, addressing the U.S. Congress, September 2015](#)



“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





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CHA advances the Catholic health ministry of the United States in caring for people and communities. Comprised of more than 600 hospitals and 1,400 long-term care and other health facilities in all 50 states, the Catholic health ministry is the largest group of nonprofit health care providers in the nation. Every day, one in six patients in the U.S. is cared for in a Catholic hospital.

Website: www.chausa.org

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Printed in the United States of America.