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CRITICAL PERSPECTIVES

Teaching Corner: Child Family Health International

The Ethics of Asset-Based Global Health Education Programs

Jessica Evert

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Abstract Child Family Health International (CFHI) is a U.S.-based nonprofit, nongovernmental organization (NGO) that has more than 25 global health education programs in seven countries annually serving more than 600 interprofessional undergraduate, graduate, and postgraduate participants in programs geared toward individual students and university partners. Recognized by Special Consultative Status with the United Nations Economic and Social Council (ECOSOC), CFHI utilizes an asset-based community engagement model to ensure that CFHI's programs challenge, rather than reinforce, historical power imbalances between the "Global North" and "Global South." CFHI's programs are predicated on ethical principles including reciprocity, sustainability, humility, transparency, nonmaleficence, respect for persons, and social justice.

Keywords Global health · Education · Asset-based community development · Humility

Introduction

Nineteenth-century British judge Charles Bowen opined, "When I hear of equity in a case like this I think of a blind man in a dark room, looking for a black hat, which isn't there." The realities of inequities of resources, power, and influence between high-income countries (HIC) and low- and middle-income countries (LMIC) around the globe can either be reinforced or challenged by partnership dynamics between organizations in the "Global North" and "Global South." Child Family Health International (CFHI) is a U.S.-based nonprofit, nongovernmental organization (NGO) with more than 25 global health education programs in seven countries that annually serve more than 600 interprofessional undergraduate, graduate, and postgraduate participants through programs geared toward individual students and university partners. Recognized by Special Consultative Status with the United Nations Economic and Social Council (ECOSOC), CFHI utilizes an asset-based community engagement model to ensure that CFHI's programs challenge, rather than reinforce, historical power imbalances between the Global North and Global South. Meanwhile, CFHI structures its global health education programs through integration of learners into existing health systems and cultural immersion in local communities, facilitating an appreciation of the complexities underlying global health challenges and sustainable solutions. CFHI's programs are predicated on ethical principles including reciprocity, sustainability, humility, transparency, nonmaleficence, respect for persons, and social justice.

CFHI was founded in 1992 by Dr. Evaleen Jones, a family physician, propelled by her belief that exposure to resource-strapped, culturally diverse communities abroad is valuable for trainees from the Global North and that such experiences are a mechanism for

J. Evert (✉)
Child Family Health International and Department of Family and Community Medicine, University of California, San Francisco 995 Market Street, #1104, San Francisco, CA 94103, USA
e-mail: jevert@cfhi.org

economic and health development in host communities. Importantly, Dr. Jones insisted that the host community, rather than external stakeholders, have ownership of development projects and that local doctors, nurses, and community members are the experts in the equation. This elevation of local knowledge and experience as expertise and the designation of outsiders as "learners" and "admirers" have been key to defining and operationalizing CFHI's ethics. Consequently, CFHI's global health education programs shed light on health realities within LMIC communities through a local lens emphasizing assets, resourcefulness, capabilities, and other "riches" within contexts often labeled "poor." In doing so, CFHI has turned a light on in Bowen's proverbial room—providing global health education contextualized by a philosophy that challenges power imbalances and fosters respect.

CFHI provides two- to 16-week global health education programs operating year-round for individual students and university partners predominantly from the Global North; however, programs have drawn participants from more than 40 countries. CFHI has had more than 8,000 participants in its 22-year history. CFHI programs place learners in clinical, public health, and NGO settings reflecting salient themes in global health, such as end-of-life and palliative care (India), primary care and social medicine (Argentina), urban/rural comparative health (Ecuador), and realities of health access and inequities (Mexico). Participants live with local families in most communities and receive language instruction in Latin America. Importantly, CFHI prioritizes boundaries around hands-on patient care that reflect trainees' level, ethical best practices, patient safety concerns, and local regulations. While the shortcomings of short-term global health engagement are recognized (Friedman, Loh, and Evert 2014), CFHI aims to mitigate these pitfalls by integrating individual student and university partner engagement into a scaffolding of longitudinal relationships and development.

Ensuring Reciprocity and Sustainability Through Asset-Based Community Engagement and Development

The global health education community is challenged to "develop well-structured programs so that host and sender as well as other stakeholders derive mutual, equitable benefit" (Crump, Sugarman, and WEIGHT 2010, item 1 under "Guidelines: Sending and host institutions). Sustainability as an essential modifier is receiving increasing attention and emerging as an obligatory component of North–South partnerships (Seymour, Benzian, and Kalenderian 2012; Friedman, Loh, and Evert 2014). Multiple studies have elucidated the benefits of international medical electives for trainees from the Global North. These benefits include increased knowledge of public health, cultural competency, resource-consciousness, and dedication to underserved communities at home (Drain et al. 2007). Reciprocal benefits for host communities are less clear or guaranteed. Furthermore, the costs of such endeavors for hosts continue to go unrecognized in many cases, despite best practices outlined by the Working Group on Ethics Guidelines for Global Health Training (WEIGHT). WEIGHT guidelines suggest it is essential to recognize the true cost for host communities of educating visiting students (Crump, Sugarman, and WEIGHT 2010). Not unlike the realities for education programs and institutions in the Global North, teaching and caring for students in LMIC community settings is labor intensive and requires adequate support structures. CFHI was designed to prioritize strengths-based partnerships, sustainable reciprocal benefits, and clear recognition of costs incurred by host communities.

Notably, reciprocity and sustainability are central to CFHI's organizational approach, rather than afterthoughts or "nice to have" aspirations. CFHI's educational programs and reciprocal investment in host communities are based on an asset-based community engagement philosophy that is modeled after asset-based community development (ABCD) (Kretzmann and McKnight 1993). In ABCD, the role of the outsider is to support and enable the process of local asset mapping, organize assets around a mutual agenda, and build consensus toward a shared development goal. The underlying tenant is that focusing on strengths, rather than deficits, results in more sustainable impacts and community empowerment. Efforts adhering to this model enable "citizen power" as conceptualized by Arnstein's (1969) Ladder of Citizen Participation. Citizen power is akin to community empowerment, allowing for delegation of power, decision-making, and control to local communities, rather than keeping it in the hands of resource-rich outsiders. Utilizing ABCD and asset-based community engagement, CFHI is able to frame global health realities in LMICs through the lens of what communities are doing to positively

impact themselves and spotlight native passion and perseverance.

CFHI's engagement in communities allows for asset-based development through two formal mechanisms—social entrepreneurship and community health projects (CHPs). CFHI's global health education programs are a mechanism for social entrepreneurship in the host community—allowing hosts to create and administer educational programs that showcase their medical, public health, and social services. CFHI recognizes such efforts with honoraria for local preceptors, compensation for homestay families, and remuneration of community members for program coordination and leadership. In addition to the social entrepreneurship enabled by CFHI, the organization invests in professional development and CHPs.

CHPs are locally led initiatives that result in capacity building, health access expansion, and/or address social determinants of health. CHPs have varied focus but are consistent in their investment in local passion and agendas, rather than preconceived notions from CFHI or other outsiders. The sustainability of these projects lies in their local ownership, attachment to an ongoing funding source through relationship to CFHI's education programs, and focus on empowerment of native health care workers. An example of a CHP is an annual training of *parteras*, traditional midwives, in Southern Mexico. The annual training is the only formal education *parteras* receive and covers 12 topical areas including prenatal care, safe home birth techniques, and early response to birth complications. The training also serves to bridge the rural homebirth practices of the *parteras* with the formal health care system. The training is run in collaboration with the Ministry of Health and reflects its curriculum. CFHI participants are integrated into the training under the supervision of Ministry of Health personnel and local obstetricians. Evaluation of the training demonstrated that the *parteras* significantly improved their knowledge in five of 12 topical areas ($p<0.05$) (Friedman et al. forthcoming). Evaluation also uncovered apprehension on behalf of the midwives to perform basic life-saving maneuvers to urgently address maternal hemorrhage. Semi-structured interviews revealed that this apprehension was due to concern that if the *parteras* performed the maneuvers in the home they would be punished by health officials for delaying referral to a medical clinic. Importantly, this disconnect uncovered by CFHI participants and evaluative process led to a change in the language and instruction used by the Ministry of Health to avoid confusion and intimidation, giving the *parteras* permission to perform life-saving maneuvers to reduce maternal mortality.

In addition to tangible benefits, research into the impacts of CFHI programs in host communities demonstrates an increased prestige for local health professionals when framed as experts as well as an increase global connectedness for lay and professional community members (Kung 2013). Evaluation of participants in CFHI's global health education programs reveals they develop a broadened sense of determinants of health and increased appreciation for the cultural influences on health and health care (Evert 2013).

Humility and Transparency as Essentials to Recognize Local Experts and Complexities of Global Health

Jack Coulehan, a thought-leader on humility in medicine, defines humility as "unpretentious openness, honest self-disclosure, avoidance of arrogance, and modulation of self-interest" (Coulehan 2011, 206). Humility is at the core of global health ethics for trainees. CFHI advocates that humility is as applicable to sending institutions as it is to program participants. Humility manifests itself in the organization's messaging and the boundaries placed on participants' interactions with patients in-country. Humility, and the transparency it requires, is fundamental to ensuring that the organization and participants operate with ethical rigor within medical, public health, and NGO host settings.

If humility is prioritized, it is essential to avoid "overstating" the role of the organization or trainee participants within the host LMIC community. Overstating the role of short-term visits by foreign trainees breeds ignorance of the complexities involved with addressing global health challenges. Given the short-tern nature of CFHI programs, the emphasis is not on the individual student as change agent. In accordance with best practices, the focus is on the student as a learner (Crump, Sugarman, and WEIGHT 2010; Forum on Education Abroad 2013). Local impacts, as discussed in the preceding section, are a result of cumulative effects of many program participants over time, as well as continuity inherent to locally led projects, and long-term partnership. Lacking humility and transparency can lead to program participants getting an

oversimplified impression about what it takes to make dents in global health and breeds ignorance of the importance of novel cultures, language, histories, health systems, and geopolitical realities.

CFHI's motto is "Let the World Change You"—an intentional challenge to the prevailing notion that the role of individuals from the Global North is to "change" the Global South. Rather, CFHI characterizes its programs as stepping-stones toward understanding complex realities in global health. CFHI believes that trainees must first understand reality and context before trying to go about changing it. This understanding alone is an admirable goal for a short-term educational experience abroad. By clearly delineating students as "learners," rather than change agents, and organizing programs around global health curricular themes, the organization makes room for this anthropologic understanding as an explicit and sufficient goal of the experience abroad.

Nonmaleficence and Respect for Persons to Ensure Patient and Participant Safety

Nonmaleficence, better known as "first do no harm," is perhaps the most relevant of the traditional bioethical principles for CFHI's global health education programs. The principle of respect for persons compliments nonmaleficence, as it implies avoiding using others for one's own means. In the context of global health trainee programs, nonmaleficence requires that appropriate boundaries be set up to ensure patient and participant safety (Crump, Sugarman, and WEIGHT 2010; Forum on Education Abroad 2013). It is critical to ensure that students are not "practicing" beyond their level of training and that programs are set up with such cautions in the forefront of the minds of sending organizations, hosts, students, and faculty. In addition, respect for persons demands that participants not use vulnerable patients in LMIC contexts for their own gains. Examples of undesirable self-serving activities include undertaking invasive procedures that have not been previously mastered, acting without adequate supervision, or foraying into novel areas of patient care to boost one's resume.

CFHI borrows the adage from *Alice in Wonderland*—"Don't just do something, stand there"—to challenge participants to consider their options. Efforts, such as the University of Minnesota's Global Ambassadors for Patient Safety (GAPS), highlight this issue and frame it through the lens of patient safety (University of Minnesota Health Careers Center 2012). Importantly, efforts to curb potentially harmful acts by students in international settings recognize the need to equip students with the tools to say "no, thank you" in ethically hairy situations, while acknowledging the moral distress that students can face. CFHI recognizes that not all global health care settings are appropriate for the placement of learners. Host partners must be able to provide adequate boundaries, supervision, and a shared vision for the valuable safety-conscious learning that is possible within clinical settings and the greater community.

Social Justice as a Cornerstone of Global Health Education

Social justice is defined as the ability of people to reach their potential within the society in which they live (Rawls 1971). Paul Farmer and others encourage global health to envelop social justice and pursue a historically deep and geographically broad understanding of gross inequities, power imbalances, and underlying causes of ill health (Pinto and Upshur 2009). It is estimated that clinical health care accounts for only 10 percent of what influences premature death (Schroeder 2007). CFHI's programs are composed of competency-based curricula that emphasize not only clinical medicine but also culture, history, social determinants of health, environmental factors, and much more. Through this broad educational agenda, participants are able to explore the multi-sectorial, complex nature of global health realities. CFHI's approach of integrating students into existing health systems and immersing them in the culture with local families is key for nurturing an understanding of social justice. CFHI's integrated model leads to increased understanding of community health, public health, continuity of care, and cultural immersion (Rassiwala, Vaduganathan, and Kupershtok 2013). Through this exploration of social justice, participants begin to consider their role of individuals from the Global North as advocates, allies, and accompaniers for global health equity.

Conclusion

CFHI's global health education programs challenge participants to "Let the World Change You"—laying the foundation for global citizenship and shaping future professionals who appreciate the complex realities that contextualize the quest for global health equity. The unique successes of CFHI's approach hinges on integration of learners into existing health systems. This integration fortifies the opportunity to see "global health," an arguably Western-centric concept, through the eyes of local communities. In turn, participants and the organization are able to embrace humility, while local health professionals provide in-country mentoring and program leadership. CFHI's asset-based engagement and development approach embeds students from the Global North into long-term North–South partnerships and sustainable, locally led development efforts, thus ensuring reciprocal benefits for host communities in recognition of the transformative educational opportunities afforded to program participants. CFHI prepares trainees to engage with communities in ways that counteract many of the criticisms of short-term international medical activities, nurturing a global state of mind and serving the health equity movement at home and abroad.

References

Arnstein, S.R. 1969. A ladder of citizen participation. *Journal of the American Planning Association* 35(4): 216–224.

Coulehan, J. 2011. A gentile and humane temper: Humility in medicine. *Perspectives in Biology and Medicine* 54(2): 206–216.

Crump, J.A., J. Sugarman, and Working Group on Ethics Guidelines for Global Health Training (WEIGHT). 2010. Ethics and best practice guidelines for training experiences in global health. *The American Journal of Tropical Medicine and Hygiene* 83(6): 1178–1182.

Drain, P.K., A. Primack, D.D. Hunt, W.W. Fawzi, K.K. Holmes, and P. Gardner. 2007. Global health in medical education: A call for more training and opportunities. *Academic Medicine* 82(3): 226–230.

Evert, J. 2013. CFHI: Impact on participants. Paper presented at the Forum on Education Abroad, April 3, in Chicago, Illinois, USA.

Forum on Education Abroad. 2013 Guidelines for undergraduate programs abroad. www.forumea.org/documents/ForumEA-GuidelinesforHealthProgramsAbroad2013_000.pdf. Accessed July 20, 2014.

Friedman A., I. Gossett, I. Saucedo, et al. Forthcoming. Partnering with parteras: Capacity building for lay midwives in Mexico. Submitted for publication.

Friedman, A., L. Loh, and J. Evert. 2014. Developing an ethical framework for short-term international dental and medical activities. *Journal of the American College of Dentists* 81(1): 8–15.

Kretzmann, J.P., and J. McKnight. 1993. *Building communities from the inside out: A path toward finding and mobilizing a community's assets*. Evanston, IL: Center for Urban Affairs and Policy Research, Neighborhood Innovations Network.

Kung, T. 2013. *Voices of international host healthcare providers: The impact of global health education programs*. Stanford: Stanford University.

Pinto, A., and R. Upshur. 2009. Global health ethics for students. *Developing World Bioethics* 9(1): 1–10.

Rassiwala, J., M. Vaduganathan, and M. Kupershtok. 2013. Global health educational engagement—a tale of two models. *Academic Medicine* 88(11): 1651–1657.

Rawls, J. 1971. *A theory of justice*. Cambridge, MA: Harvard University Press.

Schroeder, S. 2007. We can do better—improving the health of the American people. *The New England Journal of Medicine* 357(12): 1221–1228.

Seymour, B., H. Benzian, and E. Kalenderian. 2012. Voluntourism and global health: Preparing dental students for responsible engagement in international programs. *Journal of Dental Education* 77(10): 1252–1257.

University of Minnesota Health Careers Center. 2012. Global ambassadors for patient safety. www.healthcareers.umn.edu/online-workshops/gaps/. Accessed July 23, 2014.