

# The Ethical Implications of Student Participation in Short-Term Experiences in Global Health

Rishi Bansal<sup>1\*</sup>, Corey McKibbin<sup>2\*</sup>

## Accepted

November 10, 2020

## Published Online

February 1, 2021

## Affiliations

<sup>1</sup>Michael G. DeGroote School of Medicine, McMaster University, Hamilton, ON, Canada

<sup>2</sup>Department of Philosophy, McMaster University, Hamilton, Ontario, Canada

\*NB: the authors contributed equally.

## Correspondence

rishi.bansal@medportal.ca

## Abstract

Student interest in short-term experiences in global health (STEGHs) has grown in recent years. Typically, students travel from high-income countries (HIC), standing to benefit from varied clinical exposure and participation beyond what is allowed in their home jurisdictions. Whether STEGHs benefit the hosting low- and middle-income countries (LMICs) are less clear.

We seek to mitigate the ethical implications of student participation in STEGHs by examining three domains: (a) the medical scope of practice for students; (b) cultural competency; and (c) reciprocal partnerships. These domains permit further elucidation of key issues relating to ethics, and public policy, to clarify how STEGH initiatives can be evaluated. Our analysis implicates that STEGHs can be described as post-colonial enterprises that perpetuate structural violence in LMICs and may cultivate hubris and savior complexes in learners.

Examination of these domains necessitates two points for further analysis and evaluation with respect to STEGHs: (1) a stronger idea of justice and distributive justice that includes considerations of structural violence and reciprocity; and (2) realignment of student global health priorities towards the communities being cared for as opposed to the benefits of high-income countries and volunteers. To improve global health knowledge transfer worldwide, we advocate for reciprocity between HIC and LMIC institutions and training in the colonial history of global health. We hope these changes will reduce eurocentrism within student global health and any potential harms.

**Abbreviations:** WHO, World Health Organization; STEGH, Short-Term Experience in Global Health; HIC, High Income Country; LMIC, Low- and Middle-Income Country; NGO, Non-Governmental Organization

**Author's Statement:** We would like to preface our discussion by acknowledging the position from which we are making this critique. Both authors are undergraduate students at a university in a high-income country. Neither student has been on a STEGH, though both have taken multiple courses to understand the neocolonial implications of medical voluntourism. The experts, research articles, and resources we consulted were also largely produced by those coming from high-income, Western backgrounds. Considering the above, we have done due diligence to make sure there are no biases in the presentation of facts, especially when discussing the benefits and harms to communities.

## Introduction

In recent years, interest in global health has been at an all-time high. Students, academics, industry, and governments are increasingly viewing global health as an important priority (1). This interest is manifested in a number of ways, including the short-term experience in global health (STEGH). This term encompasses a broad spectrum of clinical and educational activities lasting from weeks to months that are done in the interest of promoting global health (2). Global health itself has many definitions that encompass principles of health

equity, public health, and interdisciplinary collaboration, but often emphasizes the care of vulnerable populations in low-resource settings (1,2).

As of 2019, over a third of matriculating medical students in the United States had taken part in some form of international volunteering work (3); other surveys and anecdotal evidence point to large swaths of students expressing plans to engage in global health at some point in their careers (4,5). The majority of these students are from high-income countries

(HICs), and their global health participation frequently involves a form of STEGH taking place in low- and middle-income countries (LMICs) (6). These STEGHs present significant benefits to HIC students: they obtain exposure to a larger range of diseases, develop international networks, and engage in clinical activities more directly than would be permitted in their home jurisdictions (5-7). However, these benefits are uniquely accrued to the visiting student; it is much less clear whether STEGHs provide real, sustainable benefits to the hosting community (6,7). There are a number of ethical considerations that arise in these situations which are characterized by resource constraints, vulnerable populations, and cultural differences. In this paper, we will further unpack these considerations and examine the ethical implications of student engagement in short term global health experiences.

## What is at stake?

A primary aim of our study is to implicate that there should be a decrease in HIC dominated global health research, learning, and practice. In order to instantiate the aforementioned, the 'othering' that occurs during STEGH missions must be curtailed. Othering as a concept, is both: (a) a mode of differentiating one's own group of people from an alternate group; and (b) a way to develop one's self-conception - i.e., a mode of demarcating the self from the other (8). In the first sense of othering, there is potential room for "domination and subordination" (8 p254). Therefore, in practices such as STEGHs, there is a risk that students or volunteers from HICs can inadvertently increase the "marginalization, decreased opportunities, and exclusion" that are otherwise possibly experienced by the citizens of LMICs that they practice medicine on (8 p254).

The preponderance of HIC funded STEGHs is important to consider in three domains: the medical scope of practice of students, cultural competency, and reciprocal partnerships. These three issues have been selected for examination as they are most pertinent to student engagement. However, they only represent a small sample of the many concerns associated with STEGHs. By utilizing the methodology above to analyze these three issues, we will be able to better understand the "difficulties of evaluating missions [deriving] from the ostensibly altruistic impetus that drives humanitarian endeavours" (9 p347).

## Issue 1: Medical scope of practice

When embarking upon a STEGH, most medical and undergraduate students have the best of intentions; however, these good intentions do not guarantee a beneficial outcome for the patients they seek to help. Many students may not pause to consider whether they are qualified to provide appropriate care in the first place. The scientific

literature is now replete with case studies that elucidate the consequences of receiving care from under-qualified personnel operating outside their training and expertise (7,10). For example, volunteer programs may engage students in taking blood pressures or dispensing medications without appropriate training and an inability to follow up on any future complications (7). As a result, it is especially important to constrain the scope of practice of students engaging in STEGHs if we are to maintain respect for patients and protect at-risk populations (11,12).

There is often a palpable power imbalance between visiting providers and patients in low-resource settings (7). Patients may feel compelled to accept treatment, often without understanding what they are receiving (12). Some patients may also place more trust in visiting students, perceiving them to have more knowledge than they actually do (13). As a result, it is vital that students and medical personnel providing care in these settings are governed by the same ethical principles that would apply in their home country (13). Yet, many students coming from high-income backgrounds often have "inflated ideas" about their capabilities and the value of the care they are providing (14 p1456). In some cases, this has led to students engaging in activities that extend far beyond their training with minimal oversight (7,13,15). Moreover, supervisors may assign students responsibilities beyond their training due to a lack of personnel or resources (14). Even in cases where students have received some training, most lack the appropriate experience to provide quality care in a resource-poor setting (7,13,16). Without the appropriate tools, laboratory testing, and contextual understanding, it becomes increasingly difficult for students and trainees to ensure that their actions are appropriate and relevant (7). Most often, this compromises patient safety, as students are unable to fully understand what care can be provided in any given setting (15). Consequently, many students also develop feelings of guilt due to their actions (13,14,16).

Although some students may operate outside the scope of their training, these actions are most often justified by the commonly held belief that "any care is better than nothing" (7). Paradoxically, an ethical double standard arises in many of these situations, where the lack of care is used to justify a lower medical standard. The volunteer exudes an aura of benevolence and can feel as though their mission accomplished at least something, even if all they have done is given "useless tablets" to patients (7). This perceived acceptance of lower standards of care within STEGH missions taking place in LMICs seemingly "absolves" the volunteer of all potential consequences that are a result of negligent behaviour (7). As expected, this has led to a variety of examples where patients have been harmed as a result of inappropriate care. For example, even an aspirin prescription can have unintended consequences when the patient in question is at risk of bleeding from minor trauma

in the countryside (17). However, the short-term nature of these trips also acquits students of following up with patients to ensure beneficial outcomes in the long-term (7). In order to mitigate these concerns, current best practices published by the American College of Physicians mandate that STEGHs must show real benefit to the community with particular focus on sustainability (2). Students, residents, and fellows must also not exceed the limits of their training (2). By following these guidelines, students can ensure that their actions are being taken with the benefit to the patient and community as their primary concern.

## Issue 2: Cultural competency

When travelling to a new location to deliver care, it is important to consider the cultural context within which students will be operating. While cultural competency is crucial for appropriate care delivery, students and trainees (undergraduates, medical students, etc.) often lack the requisite skills (16).<sup>1</sup>

When coding relevant literature, it was noted that there were implications that it was necessary for students and trainees to understand the importance of negative language, improper communication, and metaphorically pauperizing the patients they are helping during STEGH initiatives. Anji Wall notes in her qualitative research study that medical anthropologists label these features as modes of structural violence (19). Citing Paul Farmer, Wall defines structural violence as: “the combination of large scale social, economic and environmental factors including poverty, sexism and political violence that influence the poor health of people in developing countries” (19). Volunteers that go on STEGH initiatives regularly focus on quick fixes and ignore other culturally relevant issues that contribute to poor health outcomes in (oftentimes) developing countries (5,7). For example, one “informant” in a qualitative study done by Green et. al. aptly notes that surgical teams are unsuited to dealing with the root cause of medical issues, namely poverty (20). An official in the Ministry of Health in Guatemala stated that the “primary problem in Guatemala is a lack of public health infrastructure and a lack of primary care coverage due to a lack of financial resources” (20). A key point is that many citizens in Guatemala who travel to receive questionably beneficial care often take on additional financial burdens to do so (20). Without attempting to mitigate the

1 The authors recognize cultural competency to be the ability for health care systems “at all levels” to recognize the importance of: “culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs” (18). Please note that while there could be possible problems within the proposed definition, these conceptual difficulties are beyond the scope of this paper. When writing about how HIC volunteers should predicate their medical practices on cultural competency, we are not arguing that HICs lack culture. Rather, one of the goals for STEGHs should be that the volunteer develops an appreciation for alternative cultures from their own.

underlying political or economic implications of a poor health infrastructure, focus on sustainability, and improve local capacity, it is not unreasonable to apply the aforementioned definition of structural violence to STEGH initiatives.

This picture is further complicated by geography: many destinations for STEGHs are in LMICs, where many North American countries have long standing “political and economic interests” in mitigating health concerns (20). Short term medical work creates a clear power relationship via medical professionals between HIC and LMICs, thereby extending North American interests in a post-colonial, neoliberal era (9,20). Trainees who participate in STEGH initiatives often bring with them attitudes that “lack respect for local practitioners and local knowledge practices related to health” (20). Another study also surmises that volunteers positioned themselves as active agents who could bring about change in their patients’ lives, while the patients were passive recipients (9). Berry asserted that the “logical extension of this view was that the receiver was the proverbial “beggar” for whom something (be it aspirin or antibiotics) was better than nothing” (9 p348). The aforementioned implies that while charity work may have benefits, practitioners may often operate under the assumption that the people they are treating are viewed as lesser than.

The notion of structural violence in STEGH initiatives creates room for a lack of beneficence and nonmaleficence within these practices. John Jesus’ qualitative study shows that the concept of beneficence allows room for “trust and mutual respect” to flourish (12 p18). These attributes in the volunteer/patient relationship will allow for greater patient compliance and coming up with more useful modes of medical treatment (12). Similarly, the principle of nonmaleficence is violated if volunteers (or STEGH initiatives in general) do not take the proper precautions to ameliorate “miscommunication and misunderstanding” (12 p18). There is a responsibility for STEGH volunteers to understand, or at least be informed of, the local culture’s norms and rituals, especially in the confines of health practices (6,12,14). Volunteers’ ignorance of local languages may preclude informed consent, and easily-given prescriptions of ibuprofen can lead to stomach ulcers in patients with limited food intake (7,12). Moreover, acknowledging the customs of the land shows respect for the people, and the lands, STEGH members are working on. As Jesus clarifies, “meetings with the village chief on arrival to each village were cultural interfaces critical to obtaining consent to hold the clinic and treat willing patients the next morning” (12 p18). Rather than imposing and affirming the sentiments of the post-colonial era that were noted above, STEGH initiatives should follow the appropriate ways of the land such that volunteers acknowledge that they are temporary guests. One example which STEGHs can adopt to achieve the aforementioned is to develop something along the lines of a Cultural Competency Community Toolbox (21).

By adopting a Community Toolbox, participants of STEGHs can appreciate the differences that exist between HIC and LMIC residents. Use of a Community Toolbox can inform significant alterations to the “mission statement, policies, procedures, administration, staffing patterns, service delivery practices, outreach, telecommunications and information dissemination systems, and professional development activities” (21).

Through this analysis it becomes clear why it is essential for students/trainees to learn about cultural competency when partaking in STEGH initiatives.

### Issue 3: Equity and reciprocal practices

Global health as a field of study enshrines principles such as equity, sustainability, and bidirectional partnerships at its core (1,2,6). In practice, these principles are often harder to find. STEGHs often prioritize the needs of trainees and students, which can put additional burdens on local physicians and systems and undermine principles of distributive justice (5,13,14). For example, students often occupy the time and resources of local staff when the student is unable to complete a procedure for which they have not been trained but are asked to complete (22,23). Though volunteers may express concerns over the qualifications of team members, “none... expressed any unwillingness about performing procedures... that would require a specific health professional training in North America” in a study conducted by Loiseau et al. (23). Reciprocal programming, opportunities, and funding mechanisms are also scarce for students in low-resource settings (24,25). As a result, all aspects of global health opportunities, care provision, and research are dominated by those from high-income settings while principles of equity and reciprocity are often left behind (26).

Many students engage in global health activities for a number of reasons, including (a) a desire to help, (b) a desire for an ‘experience’ they would be unlikely to receive at home, and (c) a desire to make their resumes seem more appealing (5,7). Therefore, it is no surprise that many global health programs and organizations focus on the needs of their participants (7). There are a number of ways in which this manifests, including using local communities as “training grounds” for medical students or focusing on more gratifying primary care as opposed to long-term interventions like health education (1,2,10). These unilateral interests pose a significant concern and beg the question of who is intended to be the primary beneficiaries of STEGHs. Worse, supporting students on their trips also poses a significant burden to local systems hosting students. In many cases, local physicians must take time away from their own trainees and practices in order to supervise and train visiting students (5). Even the presence of visiting students may perpetuate the belief that foreign help is preferable to local providers (6,14). This can then reduce trust

in local systems which, over time, leads to a deterioration in those systems and increased reliance on foreign aid for basic care (5–7). Students engaging in STEGHs are right to hope for a positive experience during their engagement. It is when these needs are put before those of the local community that ethical concerns are realized.

Beyond considering the impacts of students on local communities, it is also important to consider whether students from low-resource backgrounds are afforded the same opportunities to travel to HICs. Bidirectional exchange of ideas and talent allows individuals from both high- and low- income settings to engage in a collaborative learning process that encourages “academic parity” (27). Furthermore, exchanging ideas and learnings recognizes that there are valuable practices and models in both HICs and LMICs; it is not necessary that one partner is a receptacle for care given by the other (28). Despite this, global health is “not reciprocal at all” (28). Many HIC organizations balk at the idea of hosting an international student due to the large logistical and financial burdens of doing so. According to current best practices, visiting students need to be housed and fed, supervised at all times, and taught the appropriate clinical, cultural, and language skills (27). Ironically, these are the same burdens that are inequitably taken on by host institutions in LMICs when hosting students from HICs. Visiting students from LMICs also face challenges in obtaining visas and may not have the resources to pay for their exchange (27,28). LMIC institutions are also largely underfunded and lack the ability to provide sufficient grants for their students to travel abroad (25). In summary, these challenges have precluded the existence of true bidirectional partnerships. Moving forward, addressing these gaps is paramount to preserve the core ethical principles of global health.

### Implication

In the analysis above, we examined the negative impacts of STEGHs in student global health contexts. This was done by examining the scope of medical practices that students ought to participate in, awareness of cultural competency, and the reciprocity these initiatives should aspire to (between host and travelling institutions).

One implication that our paper has highlighted is the potential misalignment in student global health priorities toward the benefit of HICs and volunteers as opposed to the communities which care is being delivered to. Similar to the above, the closeness in proximity and the oftentimes political and economic connections between countries in the global North and global South allow STEGH initiatives to act as discrete extensions of neoliberalism. For example, in Berry’s qualitative study there was an interview with a woman named Diana who chaired a non-governmental organization (NGO) that hosted local (within the country)

and national health practitioners who wanted to do STEGH initiatives in rural villages (9). When Diana found out from one of the nurses that a group of local physicians let a North American high school student wear a white coat and prescribe medications, she immediately cancelled their mission 10. In the same interview with Diana, Berry found out that some international groups who wanted to go on missions did not want to pay subsequent fees to the host NGO, which would include money for supplies (9). These kinds of requests take away valuable resources from NGOs that could otherwise be used to do patient follow ups after the missions are done, among other things (9).

Another important implication that is implied in our analysis is that there may be considerable ‘harms’ to the visiting students as a result of practicing outside their scope and deficits in reciprocity. While STEGHs are often focused on educational gains, students may also leave their experience having cultivated a saviour complex and considerable hubris (22). By putting students in positions of power regardless of their training, they are primed to overestimate their actual impact on the local community. These expectations are often betrayed, however, when the very real limitations of the health system interfere with their carefully constructed narrative. Following such an experience many students become conflicted and wonder “why they could not do more,” but rarely see the structural underpinnings of these issues (22); instead, they revert to the belief that something is better than nothing and remove any responsibility to engage in broader community-based change (22,29). In finding solace through this naive belief, students neither recognize the competencies they lack nor the colonial relationships they are directly reproducing. As put by Teju Cole, “the white savior industrial complex is not about justice. It is about having a big emotional experience that validates privilege” (29). Overall, the educational mandate of STEGHs is ultimately undermined by these harms that are inflicted upon learners who are usually vastly unprepared for their international placements. Unchecked, these dynamics can reinforce colonial mindsets and suggest that reciprocity is unnecessary in global health. In order to alleviate these concerns, our overarching recommendation is that STEGH groups who go from HICs to LMICs should make a larger effort to understand the hidden implications of their actions in a post-colonial era and work to actively grapple with underlying ethical and structural issues they uncover.

### Next steps

Based on the aforementioned implications of our study and the broad paper discussion, there are many next steps that could be taken to ensure a less harmful student led STEGH enterprise. Two of the most pressing matters which can be used to enhance future STEGH initiatives have been frequently alluded to in our paper: (a) a commentary on the

notion of reciprocity between home and host institutions and (b) the mitigation of contemporary colonial harms that can accrue as a result of ignorance toward the kinds of power going from a HIC to a LMIC entails.

Universities which offer global health programs must provide spaces for international students from LMIC that are also fully funded (30). Dr. Madhukar Pai, a prominent global health researcher, cites the NIH Fogarty Institute as a model for other institutes to co-opt in order to ensure these kinds of international programs are a success (30,31). Additionally, universities in HICs ought to implement online programs with reduced costs. The aforementioned would serve as a way to promote reciprocity in terms of distance knowledge sharing, and a way to prevent brain drain in LMIC due to high-achieving individuals feeling as though they have to leave their country to pursue success. These online programs should also be at a reduced cost (30). Leaders in the global health field argue that engagement in reciprocity should be an integral indicator when it comes to ranking, or the accreditation of, institutions (30). Another practical way of assuaging problems of reciprocity is to use STEGHs to reframe host countries as “model countries” rather than “struggling” (32 p78). In doing so, students are better placed to celebrate the successes of their host country, and the STEGH can act as a “starting place for social critique of both the student’s home country and the way progress is measured” (32). In viewing other countries as models for improvement, the white savior complex and possible colonial harms can be mitigated while students may appreciate that there are lessons to be learned that can be applied in their home countries as well.

Secondly, students (from all educational backgrounds) who wish to study, work in, or volunteer within global health settings (STEGHs or otherwise) ought to be required to complete at least one comprehensive course in the “colonial history of tropical, international, or global health” (33). Doing such a course will allow future global health practitioners to mitigate the power imbalances frequently mentioned within this paper. It will allow them to understand their potential role in ensuring that post-colonial contexts remain the same (i.e., the global North extending itself into the global South, with little reciprocity). Students should also undergo some cultural, historical, and language training that is specific to the location of their STEGH (34).

### Conclusion

At the beginning of our paper, we mentioned that the primary aim of our study was to accentuate the fact that there should be a less euro-centric focus on research within student global health. By scrutinizing three influential arguments within the broad field of global health the authors hope that this paper further clarifies how to properly evaluate STEGH initiatives. Our paper is written under the guise that the “ostensibly

altruistic impetus that drives humanitarian behaviours” has been further elucidated, and the potential harms that go along with such behaviour are reduced (9 p347).

## Acknowledgements

We would like to acknowledge the support of Dr. Madhukar Pai and Kristin Hendricks from the McGill Global Health Programs for providing some resources that were used in the writing of this paper.

## References

- Koplan JP, Bond TC, Merson MH, Reddy KS, Rodriguez MH, Sewankambo NK, et al. Towards a common definition of global health. *The Lancet*. 2009 Jun;373(9679):1993–5.
- DeCamp M, Lehmann LS, Jael P, Horwitch C, for the ACP Ethics, Professionalism and Human Rights Committee. Ethical Obligations Regarding Short-Term Global Health Clinical Experiences: An American College of Physicians Position Paper. *Ann Intern Med*. 2018 May 1;168(9):651.
- Association of American Medical Colleges. Matriculating Student Questionnaire: 2019 All Schools Summary Report. Association of American Medical Colleges; 2019 Dec. (Matriculating Student Questionnaire).
- Porter RS. Why Med Students Pursue Global Health Experiences [Internet]. Merck Manuals Professional Edition. 2018 [cited 2020 Mar 27]. Available from: <https://www.merckmanuals.com/en-ca/professional/news/editorial/2018/03/29/14/14/global-health-experiences>
- McCall D, Iltis AS. Health Care Voluntourism: Addressing Ethical Concerns of Undergraduate Student Participation in Global Health Volunteer Work. *HEC Forum*. 2014 Dec 1;26(4):285–97.
- Melby MK, Loh LC, Evert J, Prater C, Lin H, Khan OA. Beyond Medical “Missions” to Impact-Driven Short-Term Experiences in Global Health (STEGHs): Ethical Principles to Optimize Community Benefit and Learner Experience. *Acad Med*. 2016 May;91(5):633–8.
- Bauer I. More harm than good? The questionable ethics of medical volunteering and international student placements. *Trop Dis Travel Med Vaccines*. 2017 Mar 6;3(1):5.
- Johnson JL, Bottorff JL, Browne AJ, Grewal S, Hilton BA, Clarke H. Othering and Being Othered in the Context of Health Care Services. *Health Commun*. 2004 Apr 1;16(2):255–71.
- Berry NS. Did we do good? NGOs, conflicts of interest and the evaluation of short-term medical missions in Sololá, Guatemala. *Soc Sci Med*. 2014 Nov 1;120:344–51.
- DeCamp M. Scrutinizing global short-term medical outreach. *Hastings Cent Rep*. 2007;21–3.
- Global Network of WHO Collaborating Centres for Bioethics. *Global Health Ethics Key Issues*. Geneva: World Health Organization; 2015.
- Jesus JE. Ethical challenges and considerations of short-term international medical initiatives: an excursion to Ghana as a case study. *Ann Emerg Med*. 2010;55(1):17–22.
- Elit L, Hunt M, Redwood-Campbell L, Ranford J, Adelson N, Schwartz L. Ethical issues encountered by medical students during international health electives. *Med Educ*. 2011 Jul 1;45(7):704–11.
- Crump JA, Sugarman J. Ethical Considerations for Short-term Experiences by Trainees in Global Health. *JAMA*. 2008 Sep 24;300(12):1456–8.
- Ahmed F, Grade M, Malm C, Michelen S, Ahmed N. Surgical volunteerism or voluntourism – Are we doing more harm than good? *Int J Surg*. 2017 Jun 1;42:69–71.
- Bozinoff N, Dorman KP, Kerr D, Roebbelen E, Rogers E, Hunter A, et al. Toward reciprocity: host supervisor perspectives on international medical electives. *Med Educ*. 2014;48(4):397–404.
- Jobe K. Disaster relief in post-earthquake Haiti: unintended consequences of humanitarian volunteerism. *Travel Med Infect Dis*. 2011;9(1):1–5.
- Betancourt JR, Green AR, Carrillo JE, Ananeh-Firempong O. Defining Cultural Competence: A Practical Framework for Addressing Racial/Ethnic Disparities in Health and Health Care. *Public Health Rep*. 2003 Jul 1;118(4):293–302.
- Wall A. The Context of Ethical Problems in Medical Volunteer Work. *HEC Forum*. 2011 Jun 1;23(2):79–90.
- Green T, Green H, Scandlyn J, Kestler A. Perceptions of short-term medical volunteer work: a qualitative study in Guatemala. *Glob Health*. 2009 Feb 26;5(1):4.
- University of Kansas. Chapter 27: Working Together for Racial Justice and Inclusion | Section 7. Building Culturally Competent Organizations [Internet]. Community Tool Box. [cited 2021 Jan 10]. Available from: <https://ctb.ku.edu/en/table-of-contents/culture/cultural-competence/culturally-competent-organizations/main>

22. Huish RL. The Ethical Conundrum of International Health Electives in Medical Education. *J Glob Citizsh Equity Educ* [Internet]. 2012 Apr;2(1). Available from: <http://journals.sfu.ca/jgcee/index.php/jgcee/article/download/55/29>
23. Loiseau B, Sibbald R, Raman SA, Benedict D, Dimaras H, Loh LC. 'Don't make my people beggars': a developing world house of cards. *Community Dev J*. 2016 Oct;51(4):571–84.
24. Rohrbaugh R, Kellett A, Peluso MJ. Bidirectional Exchanges of Medical Students Between Institutional Partners in Global Health Clinical Education Programs: Putting Ethical Principles into Practice. *Ann Glob Health*. 2016 Sep 1;82(5):659–64.
25. Crane JT, Andia Biraro I, Fouad TM, Boum Y, R. Bangsberg D. The 'indirect costs' of underfunding foreign partners in global health research: A case study. *Glob Public Health*. 2018;13(10):1422–9.
26. Muir JA, Farley J, Allison O, Stephen H, Martin K, Morrison SJ, et al. *Global Health Programs and Partnerships: Evidence of Mutual Benefit and Equity*. Lanham, MD: CSIS Global Health Policy Center; 2016 Mar.
27. Arora G, Russ C, Batra M, Butteris SM, Watts J, Pitt MB. Bidirectional Exchange in Global Health: Moving Toward True Global Health Partnership. *Am J Trop Med Hyg*. 2017 Jul 12;97(1):6–9.
28. Pai M. Reciprocity In Global Health: Ain't Easy But Vital [Internet]. *Forbes*. 2020 [cited 2020 Mar 26]. Available from: <https://www.forbes.com/sites/madhukarpai/2020/03/01/reciprocity-in-global-health-aint-easy-but-vital/>
29. Cole T. The White-Savior Industrial Complex. *The Atlantic* [Internet]. 2012 Mar 21 [cited 2021 Jan 19]; Available from: <https://www.theatlantic.com/international/archive/2012/03/the-white-savior-industrial-complex/254843/>
30. Pai M. Reciprocity In Global Health: Here Is How We Can Do Better. *Forbes* [Internet]. 2020 Mar 6 [cited 2020 Mar 27]; Available from: <https://www.forbes.com/sites/madhukarpai/2020/03/06/reciprocity-in-global-health-here-is-how-we-can-do-better/>
31. Reingold AL, Pai M. This NIH program is crucial to global health. And its future is in danger. *STAT News* [Internet]. 2017 Mar 29 [cited 2020 Mar 27]; Available from: <https://www.statnews.com/2017/03/29/fogarty-international-center-global-health/>
32. Nordmeyer K, Bedera N, Teig T. Ending White Saviorism in Study Abroad. *Contexts*. 2016 Nov 1;15(4):78–9.
33. Pai M. 10 Fixes for Global Health Consulting Malpractice [Internet]. *Global Health NOW*. 2019 [cited 2020 Mar 27]. Available from: <https://www.globalhealthnow.org/2019-08/10-fixes-global-health-consulting-malpractice>
34. Lasker JN, Aldrink M, Balasubramaniam R, Caldron P, Compton B, Evert J, et al. Guidelines for responsible short-term global health activities: developing common principles. *Glob Health*. 2018;14(1):18.