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■ Do you GASP? How pre-health students delivering babies in Africa is quickly becoming consequentially unacceptable

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Nobel-prize winner George Bernard Shaw pointed out an unfortunate paradox- “Self-sacrifice enables us to sacrifice other people without blushing.” Over the last decade advisors have noted an increase in pre-health students clamoring for international experiences especially in low and middle-income countries (abbreviated LMICs; also referred to as “developing countries”). Students’ motivations include bolstering medical and other health professions school applications, the desire for hands-on patient care experience, and in a misguided sense of wanting to help others by providing medical care.¹ Despite US Department of Justice affiliated guidelines that undergraduate students placed in health-related settings abroad “[limit] their patient-interaction to the same level of patient/community interaction that they would have in a volunteer position in the United States”, advisors hear all-too-common accounts of students undertaking activities that would not be allowed in domestic healthcare settings.² In the name of “helping” and “learning”, students are undertaking activities that put patients, the student, as well as sending and receiving organizations, in jeopardy.³

There is no doubt that there is a huge shortage of health care workers in many locations around the world. The argument that unlicensed international students can be used to augment the provision

of clinical care that results from this shortage is both naïve and potentially deleterious. There are many efforts at district, national, regional, and international levels to address Human Resources for Health (HRH) shortfalls throughout the world. There is no mention of undergraduate-level students from the US or anywhere, for that matter, being a solution to addressing these huge and important challenges.⁴ It is helpful to understand the global HRH efforts that are underway in order to challenge the logic that undergraduates are, at their current level of training, part of the solution to the dearth of physicians, nurses, and healthcare workers worldwide. Moreover, appropriate supervision of students at any level of training takes net time and effort compared to outputs by the trainee. This is due to necessary redundancies and supervision that anyone with trainee status requires. Making progress in community health status, individual patient care, and other health development requires concerted longitudinal engagement, professional level expertise, data collection and monitoring.⁵ In addition, many stakeholders have pointed out that students accessing hands-on patient care under the guise of learning or practicing that is beyond their educational level is unprofessional and goes against the very social justice principles that concerned students and enabling organizations purportedly aim to address.^{5, 6, 7} One recently created

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group is connecting the dots and educating stakeholders, particularly the health professions admissions communities, about the unintended motivators that encourage pre-health students to overstep professional, ethical, and patient safety boundaries abroad.

Convened in fall of 2014, the Working Group on Global Activities of Students at Pre-health levels (GASP) draws from 15 disciplines, within and beyond the health professions, and over 30 institutions.⁸ The aim of the Working Group is to educate health professions admissions' communities about guidelines and policies that exist for undergraduate pre-health students in international settings. GASP highlights approaches taken by select admissions committees that probe the nature of international activities undertaken at pre-health levels. These admissions committees scrutinize the competencies developed and ethical/professional boundaries either maintained or disregarded by the applicant.⁸ GASP also exposes how vague language promoted by medical school recruitment efforts and found on admissions websites and in outreach materials may give the impression that premature hands-on patient care abroad actually aids applicants in gaining admission.

In order to describe advisors' sentiments about international activities undertaken by pre-health students, the GASP Working Group has recently conducted a study. Preliminary results indicate that 85% of advisors surveyed have encountered pre-health students going abroad to obtain hands-on patient care experience. Additionally, 89% are somewhat or very concerned about pre-health students having hands-on patient care experiences abroad.⁹ Many advisors have stories attesting to the range of direct patient-care experiences undertaken by undergraduate students. The below table provides a few stories gathered by the GASP working group.

Advisors recount hands-on patient care and professional level activities undertaken by undergraduate students while abroad
I have had a student who traveled to Africa and, after observing 2 lumbar puncture procedures, was permitted by the physician in charge to perform more than 100 of these procedures on patients over a 6-week time period. I inquired whether or not any of her "patients" experienced complications from these procedures, and she admitted that she did not know the answer.

One of my pre-medical students did not speak or understand the native language of the physicians, other local healthcare workers, or the patients. She was permitted to diagnose and write the prescription for this patient. She "thought" she had cleared the proper prescription dosage with the local physician; however, the dosage she had written was 100 times stronger than what should have been prescribed.
A group of undergraduates was put in charge of reading slides to diagnose patients with malaria. A couple days into the students doing this, it was realized that they were reading the slides incorrectly and had mis-diagnosed dozens of patients.
I have had an undergraduate student who was encouraged to scrub in and suture portions of the patient's harvested saphenous vein to bypass the blocked portions of the patient's coronary arteries during an open-heart bypass surgical procedure in India. One of his relatives procured this opportunity for the student upon learning that this undergraduate student hoped to eventually become a cardiothoracic surgeon in the US.
Having paid for a healthcare internship experience in a Caribbean country, I have had students assist in the vaginal delivery of babies who presented in the breech position. On occasion, these babies have died within a short period of time after the delivery.
A student was handed a newborn infant and given the job of performing the physical exam although she had never done one or been trained. She then stuck the infant 4 times to check the blood sugar and broke at least one needle.

Best practices, policies, and ethical standards exist that apply to undergraduate students in health-related settings abroad. However, not every sending, host organization, or university is aware of or adheres to these guidelines. The Forum on Education Abroad is the Department of Justice endorsed standard-setting body for international education. Their "Guidelines for Undergraduate Students in Health-Related Settings Abroad" are comprehensive and provide clear direction prohibiting the activities advisors are reporting.² Selections from the guidelines include the following requirements of programs that place undergraduates in health-related settings abroad:

- Match student capacity including knowledge, skills, and competencies with the capacity necessary for the experiences they are engaged in so patient and community well-being are not compromised;
- Ensure students receive training that articulates and limits their patient-interaction to the same level of patient/community interaction that they would have in a volunteer position in the United States;

- Ensure learning and development outcomes are appropriate for undergraduate students;
- Ensure learning outcomes focus broadly on professionalism, standards of practice, ethics, cultural competency, language proficiency, community health, patient safety and personal safety;
- Clearly distinguish between the learning role and the service role of students and ensure any student service is within their scope of training and education.

The American Association of Medical Colleges (AAMC) has also approved “Guidelines for Premedical and Medical Students Providing Patient Care During Clinical Experiences Abroad” which cautions students.¹¹ The American Dental Association passed resolution 31H-2010 which states that pre-dental programs should adhere to professional codes of ethics and that students must be properly trained and educated to perform procedures.⁶ Despite the existence of multiple guidelines and policies, these concerning activities continue.

There are many stakeholders involved in this very complex issue. Universities and colleges, study abroad offices, third party providers, host organizations, health professionals, pre-health advisors and even students are all actors. The GASP Working Group set out to identify the list in an effort to engage all stakeholders to achieve congruency between student actions and best practices. In an effort to understand the push and pull factors of each stakeholder, GASP is trying to describe the goals and motivations of each group.

Students often approach global experiences from a place of well-intended, but naïve, excitement. In a desire to help, they are routinely seeking experiences that allow them to directly engage with patients. In an effort to respond to the student demand, both university-based study abroad programs and third party providers want to attract and serve students and provide experiences that will be interesting and valuable. Some facilitating organizations are recruiting students by highlighting how they can provide clinical care and improve healthcare during programs abroad. Host organizations in-country are often trying to please students and nurture relationships with sending organizations. On occasion, host organizations are unaware of what types of experiences are relevant for undergraduate students or lack clarity on the level of education of each student. When host organizations identify opportunities for students in health-related settings, they are often assuming that the health professionals supervising the students (that is, if there are supervisors) know how to provide appropriate, safe and ethical experiences for students.

Other stakeholders include the health professions admissions committees, staff and processes therein. Many health professions schools articulate admissions requirements in a way that suggests applicants need clinical or patient-care experience. For example, one admissions website answers the question “How to be a Competitive Candidate” by saying “[you] should show that you have learned about the profession through clinical experience with patient contact.”¹² These terms are rarely, if ever, defined, leaving students to arrive at their own conclusions. Pre-health students, in turn, make incorrect assumptions about the types of experiences they should have and seek opportunities to practice beyond their level of training and expertise. Moreover, clinical shadowing is a common requirement of medical school admission. While shadowing opportunities in the US become increasingly difficult to secure, students seek to fulfill shadowing requirements abroad. Unless very closely regulated, shadowing experiences abroad can turn into hands-on patient care experiences for a variety of reasons including less bandwidth to enforce limits, lower provider to patient ratios, and a desire by hosts to excite students.

The most important stakeholder in this entire situation is the vulnerable and unsuspecting patient. This becomes particularly apparent when US students travel to under-resourced communities where patients are unaware that pre-health students are not actual health professionals (very often pre-health students are even wearing white coats or scrubs). Patients rarely give consent for the student to be present or involved. The patients put trust into these young, US students assuming that they will be cared for with the same quality of care or better care than they receive from their own healthcare providers. These patients are vulnerable and trusting - often across cultural and language barriers.

When students perform activities for which they have not been formally trained, they put patients, themselves, their institutions, and global relations at risk. Students overstepping boundaries is the result of a perfect storm. The perfect storm is made up of the following factors:

- Driven students
- Unclear admissions criteria
- Resource-limited health settings
- Lack of clarity about students’ level of training
- Lack of oversight for visiting students
- Providers marketing of voluntourism and embellishing the impact students can have and clinical activities that they can take part in
- Faculty and advisors feeling impotent or not knowing what to do to support students and/or how to

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encourage ethical and safe limits around clinical activities.

Advisors have the potential to play an important role to influence this *perfect storm*. Tactics advisors can use to inform students and re-direct misplaced good intentions include:

1. Self-educating on this issue: Using the many resources that are available to advisors, including the open-access Advisor Toolkit for Global Ambassadors for Patient Safety at the University of Minnesota.
2. Educating pre-health students that there are many domestic opportunities to observe clinical care for multicultural, underserved populations in settings where there is appropriate enforcement of boundaries to prioritize patient safety, student safety, and ethics.
3. Emphasizing the privilege of observing in clinical settings anywhere, educating students to understand the intimacy of the patient-doctor/provider relationship and how engaged observation is a very special opportunity.
4. Encouraging any pre-health student who is undertaking an international health-related activity to complete the Global Ambassadors for Patient Safety (GAPS) modules that are free and online through the University of Minnesota.¹⁴ The modules culminate with an oath that students must sign.
5. Highlighting for students the existence of inter-professional global health competencies for undergraduate students that provide a map to guide student development through global health activities and focus beyond clinical care in 11 domains of competency, including communication, burden of disease, and ethics.¹⁰
6. Pointing out the existence of best practices and guidelines to students, including those from the Forum on Education Abroad, American Association of Medical Colleges, and American Dental Association.
7. If students have participated in international programs and breached professional, patient safety, and/or ethical boundaries, advisors can encourage honesty, facilitate reflection, and encourage students to express sincere humility and reframe their experiences to reflect what they have learned.

Advisors are uniquely positioned to advocate for changes that will both result in appropriate pre-health student learning abroad and expose the unnecessary risks for patients and students alike in the current dynamic. Advisors can and should be a collective voice to influence the variety of stakeholders. Advisors can support the work of GASP by calling for admissions website language that has greater clarity with regard to desirable and appropriate pre-health

professions experience. Secondly, advisors can point out to students the best practices, guidelines and policies that exist, emphasizing that embodying professionalism is a must for future health care providers. Advisors are well positioned to raise awareness of interprofessional global health competencies and target knowledge, skills, and attitudes for anyone concerned about global health. Lastly, advisors can call on health professions admissions committees to be careful to not inadvertently incentivize unethical, unprofessional, or illegal activities either during the written application or interview processes.

The GASP Working Group is the product of a pre-health advisor who said “You can talk ‘til you are blue in the face about ethics. But as long as students think these activities will get them into medical school, they will keep doing them.” As a community that cares about the integrity of future health professionals, the well-being of patients, and the improvement of health for communities both at home and abroad, pre-health advisors can be a force to shed sunlight on this perfect storm.

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June 18, 2016 8:00-10:30pm at the NAAHP National Meeting



■ Developing Global Ambassadors for Patient Safety

■
 Tricia Todd, MPH, and Shailey Prasad, MD, MPH

This session was presented at the 2015 CAAHP meeting in Kansas City.

Ms. Todd is Assistant Director, Health Careers Center and Instructor, School of Public Health, University of Minnesota.

Dr. Prasad is an Associate Professor in the Department of Family Medicine and Community Health at the University of Minnesota.

He is also the Associate Director of North Memorial Family Medicine Residency, and Director of the Global Family Medicine Pathway. This session was presented at the 2015 CAAHP meeting in Kansas City.

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Abstract:

Advisors are in a unique position to help students prepare for a health profession. As students become more and more creative in building a portfolio that allows them stand out from the competition, we find them crossing potential ethical boundaries – particularly as they relate to global health experiences. These experiences are often putting students and patients at potential risk. Therefore advisors have the opportunity to teach students how to be “Global Ambassadors for Patient Safety”. The University of Minnesota Health Careers Center has created a number of tools available to support advisors and students to prepare to have safe and ethical experiences abroad. The primary message in all of the tools is if you cannot do it in the United States, you should not do it abroad.

Competition among students interested in entering health professions continues to increase. In an effort to gain experience and make themselves competitive candidates, an increasing number of students are choosing to go abroad for direct patient care experiences. This is possibly because they recognize that there may be fewer limitations on what they can do, particularly in under resourced communities. These experiences often put them and others at potential risk. Because study abroad experiences are important for student development (Hadis, 2005), we encourage students to find safe, ethical and healthy experiences. Therefore, instead of telling students they should not go abroad, it is important that sending institutions and advisors have the opportunity to teach students how to be “Global Ambassadors for Patient Safety”.

When done correctly, good study abroad programs allow students to build self-awareness, improve intercultural communication and even develop a foundation for global

health competencies. On the other hand, according to Dr. Jess Evert, a leading advocate on this issue, “the risks of poorly designed programs include, but are not limited to:”

1. Harm to patients caused by students practicing hands-on medical care beyond their level of training
2. Disempowerment of local healthcare providers who are easily sidelined by visitors from the Global North
3. Harm to students in the form of moral distress, threats to health/safety, and ignorance of professional standards
4. Mischaracterization and oversimplification of ‘global health.’ (globalsl.org/cfhi/)

Not all global experiences are equal, and students often find themselves in settings that may not have the same health and safety protocols or adequate oversight of activities as they would encounter in the U.S. Dr. Evert explains that “these experiences can potentially do more harm than good for

Developing Global Ambassadors for Patient Safety *(continued)*

many stakeholders, including participants, patients, local healthcare systems, and providers.”

There are a variety of push and pull factors that are contributing to this issue. One factor is the lack of clarity from medical schools regarding the types of experiences students should have in their portfolio. The message students are hearing from admissions committees is that to be competitive they need “patient or clinical experience.” With no additional explanation of what that means, students take it upon themselves to define what admissions committees are looking for. Combining that with limited education or preparation, students often find themselves in situations where they have either been able to or perhaps invited to participate in direct patient care. Wanting to distinguish themselves from others in the competitive pool combined with their focus on building a resume of interest leads students to say yes, even when they have no training or knowledge to support them.

Additionally, due to the student demand for these types of opportunities, new organizations are emerging daily, courting students and selling opportunities to have hands-on patient care experiences in exotic settings. These same trips often combine “patient-care experience” with side trips into the jungle, the beach, or the hottest nightlife. Most of these are a form of *voluntourism*, often in an under-resourced community where organizations can set up temporary clinics that provides students with the opportunity to put on a white coat or scrubs, and provide care to patients in that community who unsuspectingly believe they are being treated by health professionals. Often these programs are set up in such a way that students believe they are providing the only healthcare in the vicinity. These programs are often very short-term, and the organization providing the student experience has limited or no ties to the community.

In some situations, students are participating in study abroad experiences that place students into community hospitals and clinics. When these are located in under-resourced communities, the host may actually welcome an extra set of hands to help out. The challenge from a study abroad perspective is to assure that the host understands that the student is not there to augment the healthcare workforce, but rather is there to learn in the context of a broader study-abroad experience. The message being sent to hosts and students alike is if students are not allowed to do it in the United States, they should not do it there. This not only protects the patients and communities, but helps assure that sending institutions are following best practices that assure the safety of students who are going abroad.

On occasion the host may not understand the student’s capacity or role. In part, this is because medical education in the U.S. is different than in most other parts of the world. In most countries, students can go directly from secondary school into medical school. In the United States, students need to have a bachelor’s degree before entering medical school. Therefore, a 21 year-old from the U.S. may be at a very different place in their education than a 21 year-old from a European school. To complicate matters even further, the U.S. refers to post-secondary education as undergraduate education. When students enter medical school here, it is referred to as undergraduate medical education – as it is in most parts of the world. Therefore when an undergraduate student from the U.S. shows up in a community in Africa, Asia, South America or even Europe and refers to himself as “pre-med” they are often mistakenly thought of as being in undergraduate medical education. And when asked if they are in undergraduate medical education, the students themselves often think they are and answer yes.

In 2009, staff at the University of Minnesota began discussing concerns about students participating in direct patient care experiences while abroad. After hearing and reading stories about students delivering babies, giving vaccinations, drawing blood, assisting in surgery, suturing, and even performing a lumbar puncture, the health professionals working at the Health Careers Center (HCC), at the University of Minnesota, started asking questions of their colleagues in the Learning Abroad Center. As a result of the conversations, the Health Careers Center in collaboration with the Learning Abroad Center and other international partners developed the Global Ambassadors for Patient Safety online education tool. The tool is an open-access tool, and can be used by anyone. The primary purpose is for students to access information ranging from the benefits of a global experience to choosing the right type of program, and even how to apply what they learn when applying to a health graduate program. The content is intended to help students learn ethically while abroad. Upon completing the workshop, students take a quiz, and then receive an Oath that they can sign to bring with them, explaining their level of training, and that they will not participate in direct patient care because they are global ambassadors for patient safety. This Oath was developed in response to University students explaining that they were uncomfortable saying no, when they were being invited to do things that they were not trained to do. The students themselves were unaware that the hosts often viewed them as medical students.

The tool has been used in a variety of ways. The tool is open access and found on the Health Careers Website www.healthcareers.umn.edu. A number of colleges and

universities use the workshop, either for working directly with students, or embedding the workshop into an existing course or orientation for study abroad. At the University of Minnesota, the Learning Abroad Center developed a policy that requires any student who participates in a health-related study abroad program to complete the workshop as part of the formal preparation for departure.

In addition to developing the Global Ambassadors for Patient Safety workshop, the University of Minnesota worked with the Forum on Education Abroad to develop guidelines for the development and implementation of Undergraduate Health-Related Programs Abroad (www.forumea.org/guidelines-for-undergraduate-health-related-programs-abroad). Those guidelines can be found on the Forum website. The guidelines are especially useful when working with pre-health student groups. Advisors can help students understand that not all organizations follow the same ethical guidelines and may provide experiences that are inappropriate for untrained undergraduates. In addition to the Forum Guidelines, the Working Group on Ethics Guidelines for Global Health Training (WEIGHT) has also created guidelines that are relevant for both undergraduate and medical school students (Crump and Sugarman, 2010.)

Finally, the HCC is developing an online toolkit for health professions advisors, study abroad advisors, study abroad programs, and even host sites – including sites that may host pre-health students in hospitals or clinics. The toolkit is designed to provide information to help raise awareness and educate each other on topics associated with pre-health study and experience abroad. The toolkit can be found on the HCC website, and is also an open access tool.

There continues to be many discussions at both the undergraduate as well as professional level as to what students and trainees should be allowed to do or not do. In this country there are many rules that restrict direct access to patients by untrained individuals. As pointed out previously, many other countries, especially under-resourced communities, lack the same level of oversight.

This lack of oversight should not be construed as an invitation for untrained students to treat patients elsewhere in the world. This is indeed an opportunity to teach our students about important ethical considerations, especially when working with vulnerable populations. It is also an opportunity to begin to enlighten our students to global health ethics, professionalism, scope of practice and other issues they will need to recognize as health professionals.

It is with the knowledge that there is an increasing number of health issues that transcend national boundaries and require solutions from health professionals who have had global health experiences that we encourage students to study abroad. However, we encourage students to recognize that a) practicing any form of healthcare without a license is both unethical and most likely illegal; b) gaining a global perspective and learning about culture and health does not need to be accomplished in a healthcare setting; and c) to be competitive for a future health profession program, start building the skills expected of professionals who recognize and follow both a code of ethics, and knowledge of working within a defined scope of practice.

Finally we call on health professions advisors to recognize their own responsibility in guiding students in making good, ethical choices when choosing experiential activities abroad.

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ARTICLES

GLOBAL HEALTH ETHICS FOR STUDENTS

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Keywords

global health,
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 education

ABSTRACT

As a result of increased interest in global health, more and more medical students and trainees from the 'developed world' are working and studying in the 'developing world'. However, while opportunities to do this important work increase, there has been insufficient development of ethical guidelines for students. It is often assumed that ethics training in developed world situations is applicable to health experiences globally. However, fundamental differences in both clinical and research settings necessitate an alternative paradigm of analysis. This article is intended for teachers who are responsible for preparing students prior to such experiences. A review of major ethical issues is presented, how they pertain to students, and a framework is outlined to help guide students in their work.

CASE

Lara is a first-year medical student who is interested in global health. She does not know much about the field or how she can become involved. She also has never traveled to a developing country but feels drawn to help if she can. She hopes to be exposed to such issues while in medical school, possibly through taking part in the research initiatives she has heard about. She attends a presentation by a public health researcher on youth in South African townships and is intrigued by an ongoing project to assess HIV/AIDS risk factors and preventative measures. Upon hearing that a student position is available that may involve both clinical and research experience, Lara wonders if this is her chance to become involved in global health.

INTRODUCTION

Global health, or the health of disadvantaged populations internationally, is an area of research, practice and activism that involves a growing number of students. More and more trainees in the health professions are pursuing experiences in developing countries or plan to work in such areas in the future.¹ An increasing number of diverse experiences are available and the level of funding for such work is growing steadily.²

¹ D.A. Shaywitz & D.A. Ausiello. Global Health: A Chance for Western Physicians to Give-and Receive. *Am J Med* 2002; 113: 354-357.

² D. James. Going Global. *New Physician* 1999; 48: Available at: <http://www.amsa.org/tnp/articles/article.cfx?id=290> [Accessed 1 July 2007].

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This trend is paralleled and driven by an awareness of the importance of global health, both out of a sense of beneficence and self-interest.³ In our globalized international community there is an increasing awareness of the suffering of others from preventable diseases, malnutrition and conflict, and more pressure by a concerned public to take action.⁴ There is also the understanding that the health of the developed world is affected by previously exotic illnesses such as malaria, tuberculosis and leprosy.⁵ Existing and impending pandemics such as HIV/AIDS and pandemic influenza are now seen as real threats to global security and economies.⁶

As interest in global health has grown, medical schools and schools of public health have begun to introduce curricula around these issues.⁷ Such trends are encouraging, but in many ways this movement has proceeded without adequate discussion of the ethics of such work. Reviews of education addressing global health in Canada, the United States and Europe have revealed little discussion regarding ethics training, despite it being listed as part of a core set of topics.⁸ Only a few specialized programs are in existence and are not targeted towards students from developed countries.⁹ Without appropriate training students are unprepared to face ethical dilemmas in global health and

risk causing harm to patients, research subjects and communities. Teachers and institutions have a responsibility to provide training in ethics as an essential precursor to global health work. This paper develops a framework to assist students in exploring these issues, building on the unique role of a trainee and the existing discourse on ethical issues.

STUDENTS AND GLOBAL HEALTH

Global health experiences are different in many respects from clinical or research work within typical developed world settings. It is important to examine these differences and how they may alter the ethical analysis of a situation. This will assist in creating a framework for students to use in global health experiences.

The same characteristics that drive global health work also create ethical dilemmas: vulnerable populations whose health is threatened, groups who are marginalized or oppressed in their local or global society, who have little control over their political or social future, and who exist in extreme poverty.¹⁰ Such conditions create enormous disparities between developed world health professionals and the developing world patient.¹¹ Due to this power imbalance, patients are more vulnerable to exploitation by clinicians and researchers.¹² Patients may fear to question the authority of a physician, seek a second opinion or refuse an invasive procedure due to a lack of options or a lack of knowledge about alternatives.

Global health work often requires a different lens of analysis, relying more heavily on a deterministic approach to health due to the major influence of socioeconomic status and other upstream factors, and the primary role of public health initiatives.¹³ This is not generally the focus of developed world

³ M.L. Rekart et al. International Health: Five Reasons why Canadians Should Get Involved. *Can J Public Health* 2003; 94: 258–259.

⁴ P. Jha, B. Stirling & A.S. Slutsky. Weapons of Mass Salvation: Canada's Role in Improving the Health of the Global Poor. *CMAJ* 2004; 94: 258–259.

⁵ K.C. Kain et al. Imported Malaria: Prospective Analysis of Problems in Diagnosis and Management. *Clin Infect Dis* 1998; 27: 142–149; A.K. Boggild et al. Leprosy in Toronto: An Analysis of 184 Imported Cases. *CMAJ* 2004; 170: 55–59; T.K. Marras et al. Tuberculosis among Tibetan Refugee Claimants in Toronto: 1998 to 2000. *Chest* 2003; 124: 915–921.

⁶ J. Gow. The HIV/AIDS Epidemic in Africa: Implications for U.S. Policy. *Health Aff* 2002; 21: 57–69; G. Rezza. Avian Influenza: A Human Pandemic Threat? *J Epidemiol Community Health* 2004; 58: 807–808.

⁷ C. Bateman et al. Bringing Global Issues to Medical Training. *Lancet* 2001; 358: 1539–1542.

⁸ J.E. Heck & R. Pust. A National Consensus on the Essential International-Health Curriculum for Medical Schools. *Acad Med* 1993; 68: 596–597.

⁹ C. Haq et al. New World Views: Preparing Physicians in Training for Global Health Work. *Int Fam Med* 2000; 32: 566–572; R. Rivera et al. Many Worlds, One Ethic: Design and Development of a Global Research Ethics Training Curriculum. *Developing World Bioeth* 2005; 5: 169–175.

¹⁰ S.R. Benatar. Avoiding Exploitation in Clinical Research. *Camb Q Healthc Ethics* 2000; 9: 562–565.

¹¹ P. Jha et al. Improving the Health of the Global Poor. *Science* 2002; 295: 2036–2039; S.R. Benatar, A.S. Daar & P.A. Singer. Global Health Ethics: The Rationale for Mutual Caring. *Int Aff* 2003; 79: 107–138.

¹² Benatar, *op. cit.* note 10; T. Edejer. North-South Research Partnerships: The Ethics of Carrying out Research in Developing Countries. *BMJ* 1999; 319: 438–441.

¹³ G. Verma et al. Critical Reflection on Evidence, Ethics and Effectiveness in the Management of Tuberculosis: Public Health and Global Perspectives. *BMC Med Ethics* 2004; 5: 5.

medical training. The human and physical resources available may be quite different from those in the teaching hospitals where students receive most of their education. Cultural differences may also create the need for a different patient-physician relationship and a different ethics framework.

Why is a framework specific to students required? Students have an educational mandate in addition to service; hence there can be conflicting priorities when pursuing a learning experience at the patient's expense. Language barriers may necessitate the involvement of a translator, using local resources and possibly impeding the regular delivery of care. Students often have little previous experience in global health. They may have limited exposure to other cultures, languages and working in resource-poor locations. Students are also still developing the concept of 'professionalism' and what this role entails.¹⁴

Understanding the ethics of global health work can be key to grasping the underlying social justice issues within global health.¹⁵ Ethics deals with the 'right thing to do', what the basis is for right and wrong, and provides some reasons for norms of behavior. This requires a detailed analysis of the situation, motives and an understanding of other people's positions. The framework illustrated below and the additional principles proposed will assist in this process and with answering the questions raised by these experiences.

FOUNDATIONS OF GLOBAL HEALTH ETHICS

Having explored the characteristics of global health work it is helpful to examine what will form the basis for an ethical framework. Students must go

¹⁴ H.M. Swick et al. Teaching Professionalism in Undergraduate Medical Education. *JAMA* 1999; 282: 830–832; ABIM Foundation. Medical Professionalism in the New Millennium: A Physician Charter. *Ann Intern Med* 2002; 136: 243–246; J. Coulehan et al. The Best Lack All Convictions: Biomedical Ethics, Professionalism, and Social Responsibility. *Camb Q Healthc Ethics* 2003; 12: 21–38; J. Shaw. Professionalism 101. *Update: The GHEC Newsletter* 2005; 1: Online. Available at: http://www.globalhealth-ec.org/GHEC/Resources/Newsletter/Vol1Issue1/Fea_Pro101.htm [Accessed 1 July 2007].

¹⁵ J.C. Thomas. Teaching Ethics in Schools of Public Health. *Public Health Rep* 2003; 118: 279–286.

beyond classical principles of ethics and into what Benatar calls a 'global state of mind'.¹⁶ He argues that ethics can be a mechanism for reframing the global health agenda, as well as the duties of wealthy nations and citizens within a universal social contract. Such an analysis draws on current ethical discourse within public health, human rights and theories of working with vulnerable populations.

Global health is intimately linked to public health work. Public health deals with population level interventions, examining upstream causes of poor health and primary prevention strategies such as vaccination campaigns, injury prevention and food security. Several ethical frameworks have been suggested to guide public health practitioners that are relevant for global health work. Roberts emphasizes the need for a communitarian approach to health interventions, where constructing a 'good society' should be a stated goal.¹⁷ Childress et al. expand on this by suggesting five principles to judge public health interventions: effectiveness, proportionality, necessity, least infringement and public justification.¹⁸ Finally, Kass suggests six major questions in the ethical analysis of public health interventions, including examining goals, questioning effectiveness, assessing burdens and who bears them, and judging fairness in implementation.¹⁹ Global health ethics, by its connection to the similar goals and mechanisms of public health should draw on these conceptualizations.

Global health also draws on the philosophy of health and human rights, which is based on the inherent value of each person and the claims one has on the local and global community. Global health is concerned with fulfilling these claims and seeking a world where all enjoy a certain standard of health and healthcare. Specific issues that have come to the forefront recently have been access to treatment for people living with HIV/AIDS, the imprisonment and torture of refugees and prisoners of war, and the right to healthcare in the face of the privatization of

¹⁶ Benatar et al., *op. cit.* note 11.

¹⁷ M.J. Roberts & M.R. Reich. Ethical Analysis in Public Health. *Lancet* 2002; 359: 1055–1059.

¹⁸ J.F. Childress et al. Public Health Ethics: Mapping the Terrain. *J Law Med Ethics* 2002; 30: 170–178.

¹⁹ N.E. Kass. An Ethics Framework for Public Health. *Am J Public Health* 2001; 91: 1776–1782.

social services in many countries around the world.²⁰ While the direct protection of social, political and economic human rights may not be seen as the responsibility of many health professionals, the understanding of these issues in the global health context is important in both clinical work and research.²¹ It helps connect law, ethics, healthcare and the role of the physician in speaking out when rights violations occur. This philosophy is deeply rooted in a sense of social justice similarly to public health work.²² Farmer frames violations of human rights as products of 'structural violence', or historically given processes and forces that constrain agency.²³ The discourse of human rights is critical of constraints on the development of these capabilities, such as those imposed by international financial institutions, the 'modern slavery' of debt in the developing world²⁴ and intellectual property laws that limit access to pharmaceuticals.²⁵ Students should not take a narrow view of rights but rather look at their obligations and seek answers to who should do what for whom.²⁶

It is also useful to consider recent discussions of the ethics of working with vulnerable groups in developed countries, such as refugees, immigrants, Aboriginal populations and the inner city poor. While all patients are at risk of exploitation, these groups are especially vulnerable due to poverty and social and cultural factors. Leaning outlines several guidelines for research involving immigrants and refugees. These include the importance of obtaining appropriate consent from participants who may misunderstand the voluntary nature of the research, protecting them from any harm or discrimination

²⁰ J. Mann et al., eds. 1999. *Health and Human Rights*. New York, NY: Routledge; S. Gruskin et al. 2005. *Perspectives on Health and Human Rights*. New York, NY: Taylor & Francis Group.

²¹ C. Beyrer & N.E. Kass. Human Rights, Politics, and Reviews of Research Ethics. *Lancet* 2002; 360: 246–251.

²² Childress et al., *op. cit.* note 18.

²³ P. Farmer. 2003. *Pathologies of Power: Health, Human Rights and the New War on the Poor*. Berkeley: University of California Press.

²⁴ Benatar et al., *op. cit.* note 11.

²⁵ S.R. Benatar. South Africa's Transition in a Globalising World: HIV/AIDS as a Window and a Mirror. *Int Aff* 2001; 77: 347–375; J.C. Cohen & P. Illingworth. The Dilemma of Intellectual Property Rights for Pharmaceuticals: The Tension between Ensuring Access of the Poor to Medicines and Committing to International Agreements. *Developing World Bioethic* 2003; 3: 27–48.

²⁶ O. O'Neill. Public Health or Clinical Ethics: Thinking beyond Borders. *Ethics Int Aff* 2002; 16: 35–45.

and ensuring the research actually serves the needs of the studied community.²⁷ These themes are repeated in discussions of working with the homeless where establishing trust is an even more crucial issue.²⁸ Within many societies, clinical and research work can represent a continuation of racist, imperial or colonial relationships. A great deal can be learned from frameworks for working with Aboriginal communities, who often represent the 'developing world within the developed world'.²⁹ Students should also be aware that their writing may be used to provide the intellectual arguments for systematic human rights violations.³⁰

These fields form the basis to move forward in exploring global health ethics and formulating principles for students to use in clinical and research work.

GLOBAL HEALTH ETHICAL DILEMMAS IN CLINICAL MEDICINE

Clinical settings can introduce students to ethical dilemmas that they are ill prepared to deal with. Exploring several examples will assist with constructing the proposed global health ethical framework.

The physician-patient relationship is centered on trust. However, power imbalances may challenge true patient autonomy and can exist to a greater extent within global health settings. This is twofold, as students may be trusted simply due to their assumed membership in the medical community (e.g. wearing a lab coat and carrying a stethoscope can indicate a professional status) as well as due to their developed world background.³¹ Obtaining informed consent for procedures and diagnostic

²⁷ J. Leaning. Ethics of Research in Refugee Populations. *Lancet* 2001; 357: 1432–1433.

²⁸ S.W. Hwang. Homelessness and Health. *CMAJ* 2005; 164: 229–233; T.L. Zakrison, P.A. Hamel & S.W. Hwang. Homeless People's Trust and Interactions with Police and Paramedics. *J Urban Health* 2004; 81: 596–605.

²⁹ K. Ten Fingers. Rejecting, Revitalizing, and Reclaiming: First Nations Work to Set the Direction of Research and Policy Development. *Can J Public Health* 2005; 96: S60–S64.

³⁰ Beyrer & Kass, *op. cit.* note 21.

³¹ B. Maina-Ahlberg, E. Nordberg & G. Tomson. North-South Health Research Collaboration: Challenges in Institutional Interaction. *Soc Sci Med* 1997; 44: 1229–1238.

tests can be hampered by ignorance of the language and the difficulty in explaining complex tasks or their ramifications.³² Testing for certain diseases, such as HIV, when no treatment may be available or affordable, is another major ethical challenge.³³ Students must work with local practitioners and community members to understand what the standard of care is, and how to approach these issues. Trainees may be given opportunities to function at a level well above their current skill level; for example, in assisting with complex surgery.

In their clinical work, students may want to recommend certain things to patients that are not culturally appropriate or which would be problematic to suggest, such as condoms or birth control. Conversely, students may observe traditional or local health practices that they perceive to be harmful. Due to the role families play in treatment decisions, there is often a lack of confidentiality as measured by Western standards. This can also be affected by the physical organization of many clinics and hospitals in developing countries, where consultations can occur in open settings. Finally, students should always be aware of using already scant resources, such as a clinician's time, in fulfilling their educational objectives.

As in other settings, students must balance their learning needs with the right of the patient to appropriate care. In global health work this can be a serious issue, with vulnerable patients, a lack of oversight, and a low likelihood of negative ramifications for students who abuse their position. Students must reflect on what they are doing and refrain from certain actions, even if they could proceed without much risk to themselves. Although in some situations every 'extra set of hands' can be useful, students must be aware of their current skill level and limitations. This is difficult, as students are naturally challenging the limits of their abilities. Wear offers a different paradigm for students, shifting from mere 'cultural competence' in clinical work to 'insurgent multiculturalism'.³⁴ This philosophy challenges stu-

dents to ask tough questions about the roots of inequality and racism and involves examining power structures. The framework developed below provides some concrete steps students can take.

GLOBAL HEALTH ETHICAL DILEMMAS IN RESEARCH

In addition to clinical work, students may act as research assistants in global health settings or carry out their own studies. The basic requirements for ethical research include value, validity, fair subject selection, favorable risk to benefit ratio, independent review, informed consent, and respect for enrolled participants.³⁵ However, students should be aware of the additional requirements of research in developing countries, such as the benchmarks established by Emanuel et al.,³⁶ and especially focus on how the research addresses inequality and who will ultimately benefit from the work. This also entails asking whether the research is truly necessary, or if the implementation of existing knowledge would be a better use of resources.³⁷

Global health research can be 'equity-linked' if it is focused on addressing social inequality and closing the '10/90 gap' (over 90% of global research dollars are spent on health problems that affect only 10% of the world).³⁸ However, there is a risk that research can reinforce disparities rather than diminish them. An example is a drug trial that tests a medication in patients who will ultimately be unable to afford the drug. Ironically, much of the research done in developing countries is ultimately published in journals that are not accessible to host country researchers, let alone the general public.

³⁵ E.J. Emanuel, D. Wendler & C. Grady. What Makes Clinical Research Ethical? *JAMA* 2000; 283: 2701–2711.

³⁶ E.J. Emanuel et al. What Makes Clinical Research in Developing Countries Ethical? The Benchmarks of Ethical Research. *J Infect Dis* 2004; 189: 930–937.

³⁷ S.R. Benatar. Moral Imagination: The Missing Component in Global Health. *PLoS Medicine* 2005; 2: e400.

³⁸ P. Ostlin, G. Sen & A. George. Paying Attention to Gender and Poverty in Health Research: Content and Process Issues. *Bull World Health Organ* 2004; 82: 740–745; Z.A. Bhutta. Ethics in International Health Research: A Perspective from the Developing World. *Bull World Health Organ* 2002; 80: 114–120; V. Neufeld et al. The Rich-Poor Gap in Global Health Research: Challenges for Canada. *CMAJ* 2001; 164: 1158–1159.

³² C. Ijsselmuiden & R. Faden. 1999. Research and Informed Consent in Africa – Another Look. In *Health and Human Rights*. J. Mann et al., eds. New York, NY: Routledge: 363–372.

³³ Benatar, *op. cit.* note 25.

³⁴ D. Wear. Insurgent Multiculturalism: Rethinking How and Why We Teach Culture in Medical Education. *Acad Med* 2003; 78: 549–554.

Open-access journals, or journals that provide access to the developing world without fee, are a more ethical choice. Overall, students involved in research must ensure that their work serves the health, social, political and economic goals of the community.³⁹ This 'responsive research' is highlighted in the drive for an AIDS vaccine where the communities who contribute to these global public goods are being guaranteed access.⁴⁰

Research is also equity-linked when the benefits and burdens of the project are shared by all partners.⁴¹ Unfortunately, usually the developed world partner conceives the project and acts as coordinator,⁴² while the developing world researcher is seen as the trainee with nothing to contribute.⁴³ This form of neo-colonialism can extend to a disregard for the ethics review boards of developing countries⁴⁴ and is part of a broader problem of a lack of representation by researchers from developing countries on editorial boards and as journal or grant reviewers.⁴⁵ Students should be cognizant of this issue and work to be part of the solution.⁴⁶ Funding bodies, both public and private, may also practice such 'ethical imperialism',⁴⁷ and students should be

critical of all funding sources. This includes exploring the motives behind the funding and what the donors receive in return, for example, positive publicity for the pharmaceutical industry or governmental agencies. As with other areas of medical research, there is a 'publish or perish' attitude in global health. Edejer argues instead that success should be judged not merely on publication or even the acquiring of new knowledge, but rather on how well the priorities of the Southern community are met, the sustainability of the work and the investment in local research capacity.⁴⁸ Ultimately the goal should be to move from a semi-colonial relationship to true partnership, with the knowledge created being held communally.⁴⁹

In relation to research subjects, as with clinical work, obtaining informed consent is especially of concern. While cultural differences may require obtaining the permission of other parties, such as village councils or the head of the family, this cannot take the place of individual consent. In some settings, signing documents is associated with distrust and oral consent may be more appropriate.⁵⁰ Benatar uses a story to illustrate the imbalance between the trial subject and the researcher from a developed country. 'Ntombi' is a young, pregnant woman living in poverty in South Africa who is approached to be tested for HIV, and possibly enrolled in a study of a drug for the prevention of vertical transmission of HIV. A number of questions go through her mind: Who are these people and what are their intentions? What will happen to her and her baby if she is HIV positive? Can she rely on the researchers for answers, or should she consult her local leaders who she respects?⁵¹ Often enrollment in a clinical trial is the only means of access to treatment and hence becomes a matter of life and death, thus contributing to a coercive environment.

A related debate that students should be aware of is the concept of standard of care. Guidelines have

³⁹ Council for International Organizations of Medical Sciences (CIOMS). 2002. *International Ethical Guidelines for Biomedical Research Involving Human Subjects*. Geneva: CIOMS; M. Warren. HIV Research and Access to Treatment. *Science* 2006; 311: 175–176; S. Basu, J. Andrews & D. Smith-Rohrberg. Populations Who Test Drugs should Benefit from Them. *Nature* 2006; 440: 605.

⁴⁰ S. Berkley. Thorny Issues in the Ethics of AIDS Vaccine Trials. *Lancet* 2003; 362: 992.

⁴¹ S.R. Benatar. Distributive Justice and Clinical Trials in the Third World. *Theor Med* 2001; 22: 169–176.

⁴² Maina-Ahlberg et al., *op. cit.* note 31; J.B. Eastwood et al. Medical Collaborations between Developed and Developing Countries. *Q J Med* 2001; 94: 637–641.

⁴³ B. Chilisa. Educational Research within Postcolonial Africa: A Critique of HIV/AIDS Research in Botswana. *Int J Qual Studies Edu* 2005; 18: 659–684.

⁴⁴ P. Wilmhurst. Scientific Imperialism. *BMJ* 1997; 314: 840; Bhutta, *op. cit.* note 38; Gambia Government/Medical Research Council Joint Ethical Committee. Ethical Issues Facing Medical Research in Developing Countries. *Lancet* 1998; 351: 286–287.

⁴⁵ R. Horton. Medical Journals: Evidence of Bias against the Diseases of Poverty. *Lancet* 2003; 361: 712–713; Ostlin et al., *op. cit.* note 38.

⁴⁶ A. Langer et al. Why is Research from Developing Countries Underrepresented in International Health Literature, and What can be Done about It? *Bull World Health Organ* 2004; 82: 802–803.

⁴⁷ M. Angell. Ethical imperialism? Ethics in International Collaborative Clinical Research. *NEJM* 1988; 319: 1081–1083; Gambia Government/Medical Research Council Joint Ethical Committee, *op. cit.* note 44.

⁴⁸ Edejer, *op. cit.* note 12.

⁴⁹ A. Costello & A. Zumla. Moving to Research Partnerships in Developing Countries. *BMJ* 2000; 321: 827–829; Chilisa, *op. cit.* note 43.

⁵⁰ A.A. Hyder & S.A. Wali. Informed Consent and Collaborative Research: Perspectives from the Developing World. *Developing World Bioeth* 2006; 6: 33–40.

⁵¹ Benatar, *op. cit.* note 41; S.R. Benatar. Reflections and Recommendations on Research Ethics in Developing Countries. *Soc Sci Med* 2002; 54: 1131–1141.

consistently held that research should compare the experimental arm against the best current treatment. This has been challenged by trials that have used placebo, on the basis that this was what was available to the people in the community and should make the results more applicable.⁵² Others have labeled this a new and insidious form of exploitation,⁵³ arguing against such a 'double standard'.⁵⁴ Benatar, Childress and others⁵⁵ have called for a more complex approach, wherein the political, economic and social conditions in which the research takes place are taken into account. Hyder and Dawson take this further by suggesting researchers should consider the overall health system of the country.⁵⁶ Students must be wary of 'ethical relativism', or changing their ethical values or priorities simply due to the situation, or to accommodate lesser values, such as efficiency or cost-effectiveness.⁵⁷

PRINCIPLES FOR GLOBAL HEALTH ETHICS FOR STUDENTS

Having reviewed the characteristics of global health work, the foundations of ethical theory and examples of clinical and research dilemmas, it is possible to develop a framework for students. In teaching ethics, medical schools in developed countries have focused on the four principles of justice, beneficence, nonmaleficence and autonomy. However, global health introduces students to situations that have different challenges and involve individuals from different cultures, with different concepts of

health. The four classic principles have their origins in Western philosophies and do not represent the summation of a global moral language. What constitutes 'justice' is different in different societies, as it deals with expected duties, rights and the process of decision making. 'Beneficence' and 'nonmaleficence' should be interpreted in light of a different cultural context from the student, and where different perspectives and roles (e.g. family member, citizen) are assumed. Finally, 'autonomy' relates to rationale decision making and a lack of interference in this process. Global health introduces students to situations where autonomy is defined differently depending on cultural differences in rationality and resource limitations relating to interference.⁵⁸ Ethics teaching has also focused on the individual patient-physician relationship within the context of clinical decision making. A global health ethical framework needs to be applicable to work involving communities and populations, which is the level of many global health interventions.

Students may find the following four additional concepts useful in global health work. These values are not only applicable to students, but can be helpful to global health practice throughout one's career. While no global field of bioethics exists,⁵⁹ this may be a starting point for a broader and more applicable ethical framework.

Humility

Students must recognize their own limitations within the setting of global health work. Medical training in a developed world context does not translate to competence in all settings. Rather one should recognize that being in a different setting puts one at a disadvantage, especially in clinical medicine. 'Medical tourism' can undermine existing health care and cause great harm, especially in emergency situations or humanitarian disasters.⁶⁰ This recognition forms the basis of future learning and

⁵² B.A. Brody. Philosophical Reflections on Clinical Trials in Developing Countries. 2002; 197–205; H. Varmus & D. Satcher. Ethical Complexities of Conducting Research in Developing Countries. *NEJM* 1997; 337: 1003–1005; J. Killen et al. Ethics of Clinical Research in the Developing World. *Nature Reviews* 2002; 2: 210–215.

⁵³ M. Angell. The Ethics of Clinical Research in the Third World. *NEJM* 1997; 337: 847–849; Bhutta, *op. cit.* note 38.

⁵⁴ Editorial. One Standard, not Two: Declaration of Helsinki Amendment on the Ethics of Human Medical Research. *Lancet* 2003; 362: 1005; Editor. Dismantling the Helsinki Declaration. *CMAJ* 2003; 169: 997; J.A. Singh. Standards of Care in the Antiretroviral Rollout World. *Lancet* 2004; 364: 920–922.

⁵⁵ S.R. Benatar & P.A. Singer. A New Look at International Research Ethics. *BMJ* 2000; 321: 824–826; Childress et al., *op. cit.* note 18.

⁵⁶ A.A. Hyder & L. Dawson. Defining Standard of Care in the Developing World: The Intersection of International Research Ethics and Health Systems Analysis. *Developing World Bioeth* 2005; 5: 142–152.

⁵⁷ Angell, *op. cit.* note 53.

⁵⁸ T. Takala. What is Wrong with Global Bioethics? On the Limitations of the Four Principles Approach. *Camb Q Healthc Ethics* 2001; 10: 72–77.

⁵⁹ S. Holm & B. Williams-Jones. Global Bioethics – Myth or Reality? *BMC Med Ethics* 2006; 7: 10.

⁶⁰ R.A. Bishop & J.A. Litch. Medical Tourism can do Harm. *BMJ* 2000; 320: 1017; Editorial. Emergency Medical Aid is Not for Amateurs. *Lancet* 1996; 348: 23.

being open to education from all sources. It is also important in forming research questions, where humility is necessary in seeking direction from the host community as to their needs, their experience with disease and their perspective on the etiology and solutions.⁶¹ This principle is connected to beneficence, but is more specific to students in a different setting than where they have been trained. As Benatar et al. note, humility involves one's general attitude to one's place in the world and whether one feels subject to the same moral constraints as others. Unfortunately, the world is characterized by actions that reflect a value system where some lives are considered infinitely more valuable than others.⁶² In global health settings, humility is crucial and helps undermine neo-colonial trends that often permeate relationships between the North and South.

Introspection

A rigorous examination of one's motives is challenging but ultimately of great importance. A desire merely to explore an exotic part of the world is obviously not sufficient and contributes to wasting limited resources for global health work. Students should consider honestly whether the expense of transporting them to the research site is truly money well spent, as opposed to creating an opportunity for students and researchers in the developing world. It is also important to be very aware of one's own privilege, whether based on class, ethnicity, gender or education, and understand how this affects one's motives. Such an 'anti-discriminatory' analysis has been developed within fields such as social work and equity studies and offers a great deal to global health practitioners. Students are led to understand the basis for their privilege, how to identify multiple forms of oppression and how to create a worldview that considers issues such as colonialism, imperialism and systemic social inequality.⁶³ A set of questions for students is suggested as an aid in this process of reflection (see Figure 1). This introspection is related to the ques-

⁶¹ Chilisa, *op. cit.* note 43.

⁶² Benatar et al., *op. cit.* note 11.

⁶³ N. Razack. Anti-discriminatory Practice: Pedagogical Struggles and Challenges. *Br J Soc Work* 1999; 29: 231–250.

1. Why do you hope to do this work?
2. What are your objectives, both personal and structural, short and long-term?
3. What are the benefits and who will receive them, and what are the costs, and who will bear them?
4. In the context of very limited resources for global health needs, is your elective justified? What exists close-by?
5. What do you need to do to prepare for your elective, both practical and personal?
6. Where are the weaknesses in your plan, specifically?
7. Is the work feasible, cost-effective, necessary, focused, and justified?
8. Will it work to undermine disparity, or actually contribute to it? Will there be a net benefit to the community?
9. What do you hope to bring back to your community, and whom will you share it with?
10. Is your work sustainable, and if not, will this leave a negative impact?

Figure 1. Questions for Students Prior to Global Health Work.

tions posed in public health ethics.⁶⁴ In clinical medicine, these questions will assist the student in beginning to understand the reality of their patients and the difference in values that may exist in vulnerable populations. Within research, such a questioning of motives is becoming ever more important. Will the research actually address the gap between knowledge and practice, the 'know-do gap', or is it just for the sake of publishing? Overall, it is essential to understand how the developing world is subjugated by the developed world, historically and today, and how poverty can be reinforced through one's day-to-day actions.⁶⁵

Solidarity

Solidarity is a powerful value to bring to global health work, and 'without it, we ignore distant indignities, violations of human rights, inequities, deprivation of freedom, undemocratic regimes and damage to the environment.'⁶⁶ Students should work to ensure that their goals and values are aligned with those of the community in which they hope to work, in both clinical and research settings.

⁶⁴ Kass, *op. cit.* note 19.

⁶⁵ Benatar, *op. cit.* note 37.

⁶⁶ S.R. Benatar, A.S. Daar & P.A. Singer. Global Health Challenges: The Need for an Expanded Discourse on Bioethics. *PLoS Medicine* 2005; 2: e143.

This active process includes developing a sensitivity to the suffering of others and working to prevent their marginalization.⁶⁷ This can be difficult when different parties have conflicting views of health.⁶⁸ Unfortunately, indigenous views of health are often seen as a ‘barrier’ to a research project rather than an opportunity to see a problem from the viewpoint of those studied.⁶⁹ Establishing on-going relationships and exchanges between the developed and developing world can counter such marginalization. As the People’s Health Movement urges, true solidarity exists when citizens of the community are mobilized, when capacity building of local organizations and strengthened links within civil society occurs, and when attempts are made to bridge power imbalances between the wealthy and the poor.⁷⁰ This is especially necessary in research, which should embody a partnership between equals. Importantly, students should recognize challenges that exist to solidarity, such as economic disparity that grows due to unfair trade policies, the privatization of social services and the burden of debt repayment. Within clinical work, different cultures provide different ideas of solidarity that students can learn from and incorporate into their own belief system. The concept of a global commons and the production of global health goods is another way of conceptualizing solidarity in global health.⁷¹ It is based on the belief that the health of all people is connected and interdependent. Fundamentally, a sense of solidarity can counter social discrimination that creates multiple barriers to good health.⁷²

Social justice

Ultimately global health work should be concerned with diminishing the gross inequity seen in the world.⁷³ This is to go beyond the classic ethical inter-

pretation of ‘justice’ in relation to the allocation of healthcare resources. Similar to public health work⁷⁴ and the discourse within health and human rights,⁷⁵ students who hope to work towards a just society must go further ‘upstream’ from what they see and consider the underlying causes of ill health. Within clinical work in developing countries, it is important to understand power relationships and the networks that exist in society. Western medicine often reinforces myopia around these issues, labeling such an analysis as being ‘politically biased’. There is usually little critical examination of society or communities and the patient is seen in isolation. As students have little contact with policy change, their training can emphasize a learned helplessness around social justice.⁷⁶ However, students should not make the same mistake in global health work, where taking action on broader issues is essential. Many initiatives are concerned with societal level change, especially in health promotion interventions. Strengthening and rebuilding health systems and the provision of basic necessities are often crucial.⁷⁷ Within research, students should consider equity and why funding is structured the way it is, examining the broad forces of globalization and what prevents progress on issues such as debt cancellation and funding for neglected diseases. Community consultation must be taken seriously, with research being directed at creating solutions that will actually benefit the studied population.⁷⁸ Beyrer and Kass urge researchers to learn about the political and human rights conditions in the community, and consider the impact of the work on human rights violations, including those by the host country government.⁷⁹ Overall, as Farmer notes, this analysis must be historically deep and geographically broad, being based in a preferential option for the disadvantaged.⁸⁰

⁶⁷ Benatar et al., *op. cit.* note 11.

⁶⁸ J.P. Ruger. Health and Social Justice. *Lancet* 2004; 364: 1075–1080.

⁶⁹ L.T. Smith. 1999. *Decolonizing Methodologies: Research and Indigenous Peoples*. London: Zed Books.

⁷⁰ D. McCoy et al. Pushing the International Health Research Agenda towards Equity and Effectiveness. *Lancet* 2004; 364: 1630–1631.

⁷¹ Benatar et al., *op. cit.* note 11.

⁷² Ostlin et al., *op. cit.* note 38.

⁷³ P. Farmer. 2006. Challenging Orthodoxies in Health and Human Rights. Address to the 134th Annual Meeting and Exposition of the American Public Health Association. Boston, MA: 5 November. Avail-

able at: http://www.pih.org/inforesources/essays/APHA_2006_keynote-Paul_Farmer.pdf [Accessed 1 July 2007].

⁷⁴ Childress et al., *op. cit.* note 18.

⁷⁵ Gruskin et al., *op. cit.* note 20.

⁷⁶ Razack, *op. cit.* note 63; Coulehan et al., *op. cit.* note 14.

⁷⁷ J.Y. Kim & P. Farmer. AIDS in 2006 – Moving toward One World, One Hope? *NEJM* 2006; 355: 645–647.

⁷⁸ N. Dickert & J. Sugarman. Ethical Goals of Community Consultation in Research. *Am J Public Health* 2005; 95: 1123–1127.

⁷⁹ Beyrer & Kass, *op. cit.* note 21.

⁸⁰ Farmer, *op. cit.* note 23.

CONCLUSION

Students are increasingly involved in global health. These situations have unique ethical dimensions that most medical students from the developed world are not appropriately trained to address. Medical schools and other institutions that send students on such experiences have a responsibility to prepare students before they go. Not only can this potentially prevent students from causing harm, it can greatly enhance the student experience and foster improved relationships between North and South. With training in ethical analysis, such experiences can also be integrated into a broader understanding of work with marginalized communities at home.

A framework has been suggested here based on four key principles: humility, introspection, solidarity and social justice. More work needs to be done to address larger questions about development and ethics and what it means to be a citizen in an increasingly interdependent world, including a renewed idea of solidarity and a deeper insight into complex systems. Further consideration must be given to the connection between the problems of the developing world, the inner city poor and Aboriginal populations. Students can contribute to the production of global public goods for health,⁸¹ and prevent global health research from becoming a microcosm of larger inequities.⁸² Finally, Edejer succinctly pro-

⁸¹ Benatar, *op. cit.* note 25.

⁸² K. Shapiro & S.R. Benatar. HIV Prevention Research and Global Inequality: Steps towards Improved Standards of Care. *J Med Ethics* 2005; 31: 39–47.

poses three ‘guideposts’ for all global health work, both clinical and research: think action, think local, think long term.⁸³

CASE RESOLUTION

Lara decides she needs to learn more about global health work before making a decision about the project in South Africa. She realizes how little she knows about the history, people, culture and unique political problems of the country. She finds the expatriate community in Canada to be a great resource. In her research around HIV/AIDS, she learns a great deal about the struggle for treatment, both in the North and South. She decides to postpone taking part in this project for at least one year, and chooses to spend her summer working with local groups working with HIV/AIDS patients and helping with a research project focused on prevention. Next year, with this experience under her belt, and with the more advanced clinical skills of a senior medical student, she may try to pursue the opportunity in South Africa.

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⁸³ Edejer, *op. cit.* note 12.



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DEVELOPING AN ETHICAL FRAMEWORK FOR SHORT-TERM INTERNATIONAL DENTAL AND MEDICAL ACTIVITIES

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ABSTRACT

The popularity of volunteering to provide charity health care in third-world countries has increased dramatically in recent years. While there are advantages to both those being helped and to volunteers, there are also ethical issues that need to be addressed. A framework for analyzing the ethical impact of such service is presented which continues 27 principles that should be addressed.

In an interview, Peter Singer, moral philosopher and Professor of Bioethics at Princeton, observed, “More often there is a compromise between ethics and expediency.” To avoid this compromise when considering or undertaking engagement in short-term international medical and dental activities, it is prudent to develop and operationalize an ethical framework—both on a program and an individual level. It is recognized that embarking on clinical volunteerism without first considering alternative or supplemental activities that may have a greater benefit on community health is potentially harmful (Wilson et al, 2012). Similarly, embarking on such activities without considering the ethical framework guiding the activity represents the compromising haste alluded to by Singer. The utility of short-term medical and dental activities has been increasingly scrutinized (Seymour, 2012). By developing an ethical framework and consciousness for these activities, participants and programs have the potential to evolve from engaging in short-term “band-aids” toward structuring programs that prioritize sustainability, local health systems integration, and facilitation of alignment with the goals of global health (Mouradian, 2006; Seymour, 2012; Vaduganathan 2014).

THE RISE AND IMPACTS OF SHORT-TERM INTERNATIONAL DENTAL AND MEDICAL ACTIVITIES

Interest in global health is on the rise among healthcare professionals and trainees, driven by the globalization of multiple sectors (Crump & Sugarman, 2008). Short-term participation, in particular, has grown in popularity. In 1978 only 6% of medical students participated in health-related activities abroad, with recent data showing 32% participating in global health education and service activities during medical school (AAMC, 1978; 2013). A 2009 survey similarly showed that half of all dental schools offer international volunteer opportunities to their students (Cohen & Valachovic, 2012).

The nature of short-term global health experiences abroad varies in length, purpose, and participants. Trips may range in length from two days to four weeks (Maki, 2008). Teams are often multidisciplinary and activities during such trips may include research,



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service, education, and public health projects (Crump & Sugarman, 2010). This heterogeneity of short-term experiences presents challenges in distinguishing between voluntourism (combined volunteering and tourism) and “responsible engagement in global health” (Seymour, 2013; Snyder, 2011). What is increasingly clear, however, is that poorly planned short-term international medical and dental activities that do not consider ethical implications run the risk of falling under the former designation, with numerous unintended consequences. For example, there is a growing recognition that the provision of service by visitors from high-income countries often competes with and further weakens existing host community health systems (Seymour, 2013). International activities that are short-term and sporadic are often accused of being a band-aid approach that do not attend to underlying causes of ill health (Mouradian, 2006).

Despite these concerns, the motivations and benefits attributed to visiting participants of short-term international experiences are well documented in literature. These include improved clinical knowledge and skills, enhanced global perspective, fostering of international career intentions, increased dedication to underserved care domestically, and an increased appreciation of public health (Dowell & Merrylees, 2009; Drain et al, 2007; McBride et al, 2010). Institutions also benefit from experiences in healthcare provision abroad by competing for desired candidates, drawing needed funding, and building interna-

tional reach and prestige (Dowell & Merrylees, 2009).

For hosting institutions and communities, however, the benefits of short-term trips are far less clearly defined. While their receptiveness to such trips can link them to future aid, knowledge exchange, and resources (Crump & Sugarman 2008; Dowell & Merrylees 2009; McBride et al, 2010), receiving communities also bear numerous potential harms. Local patients may be at risk of being treated by inexperienced, foreign trainees; the magnitude of potential harm is further increased by language and cultural barriers (Crump & Sugarman 2008). At the same time, host institutions use great time and resources to accommodate short-term volunteers, faculty and trainees, orient them, and provide logistic support (Dowell & Merrylees 2009). A lack of resources limits the ability of these institutions to evaluate and inform their decisions to host such endeavors (Provenzano et al, 2010).

These tensions, coupled with increasing interest in global health participation by dental and medical professionals, highlight the need for comprehensive ethical approaches to short-term experiences abroad (Crump & Sugarman, 2008; Machin, 2008; McBride et al, 2010; Sherraden et al, 2008). The World Dental Federation (FDI) Guidelines for Dental Volunteers provide directives to mitigate risks and set best-practice standards for dental volunteering worldwide. These

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The motivations and benefits attributed to visiting participants of short-term international experiences are well documented in literature.

guidelines include the recommendation that volunteers join a project that is integrated into the host community and recognized by host government, as well as one that conforms to legal requirements for the practice of dentistry (FDI 2005). These guidelines are commensurate with the ethical tenets of prioritizing sustainability, common good, and respect for persons. A 2011 American Dental Association (ADA) resolution, issued in response to concerns about untrained students performing dental procedures abroad, called on both dental and pre-dental students taking part in international volunteer activities to adhere to the ADA *Principles of Ethics and Code of Professional Conduct* and to only perform procedures for which the volunteer has received proper education and training (ADA, 2011).

Ethical Analysis of Short-Term Medical and Dental Activities

The first, critical step in developing an ethical framework for short-term medical and dental activities requires a broader understanding of ethical analysis. Ethical analysis generally evaluates four central components (Jennings, 2010):

- Character and intentions of the agent: what virtues and vices does the agent exemplify?
- Inherent properties of an action: what rights and duties does the action fulfill or violate?
- Consequences (most often understood as causal effects) of an action: what benefits or harms are brought by the action?
- Context in which the action takes place: does the action support or undermine the system or context which makes the action possible or meaningful in the first place?

By applying these questions to international short-term medical and dental work in a generic sense we begin

to foster a dialogue about the ideals, tensions, realities, and consequences of such activities. Using this analytical framework to consider each short-term project or international engagement effort lays the foundation of inquiry necessary for developing an ethical framework.

Ethical Principles to Consider When Developing an Ethical Framework

The ethical principles that may apply to short-term international service activities are many. The accompanying table represents an array of principles, ranging from foundational bioethical tenets to those specific to international activities and the power dynamics therein. While the traditional bioethical principles of justice, beneficence, nonmaleficence, and autonomy do apply, they are often interpreted or valued differently in a global setting (Pinto & Upshur, 2013). Foundational bioethical principles alone are insufficient to provide a comprehensive ethical evaluation of the potential pitfalls of short-term international activities. Thus, a more robust framework is necessary, preferably one that challenges and prevents the usual shortcomings of such activities from being manifested.

Literature has described six domains of ethics for international global health activities and programs, including social ethics, professional ethics, clinical ethics, business ethics, organizational ethics, and decision ethics (Evert et al, 2014; Porter, 2004). Four ethical commitments and considerations suggested by Wilson and others (2012) for short-term international service activities include: (1) *service* that is in the best interest and addresses the needs of each patient; (2) *sustainability* through training of

the trainer models, use of locally available medications and astute outcomes assessments; (3) *professionalism* that ensures that community and existing health systems are not left worse off by short-term efforts and that ethical patient care standards practiced in visitor's home country are upheld when visiting an international, underserved community; and (4) *safety* that includes appropriate approvals from local health organizations to be involved in patient care, pre-travel medical clearance, and in-country security measures. Others have suggested the centrality of collaboration between often disparate, parallel short-term international activities and with local partners as being an ethical imperative (Loh et al, 2012). An ethical framework for global health aimed at students suggests the importance of tenets of humility, introspection, solidarity, and social justice (Pinto & Upshur, 2009), while other frameworks include distributive justice, respect for persons, and sustainability (Evert et al, 2014).

Crump, Sugarman and the Working Group on Ethical Guidelines for Global Health Training (WEIGHT) proposed guidelines for establishing trips; preparing for visits; ensuring open communication before, during and after the trip; monitoring impact; and soliciting feedback (Crump & Sugarman, 2010). These and other ethical guidelines inform program structure, impact measurements, and operations of short-term global activities. Ethical guidelines and frameworks that fail to penetrate the execution of programs from planning to delivery stages may actually be more harmful as they can serve as a deceptive veil for ethically unsound activities.

The next step, considering the principles described, is to identify a process by which an ethical framework can be created for each unique short-term healthcare activities abroad. This process should ideally occur at the individual, organizational, or project

level and be consistent between levels. An ethical framework is as important as the project framework in permitting program leaders and stakeholders to reflect on their activities and goals through an ethical lens and to outline ethical priorities and integration of tenets into projects or programs. However, it is often a choice of which principles will be prioritized in program development and operations, as it is difficult to prioritize all ethical principles simultaneously. In addition, certain ethical principles can potentially conflict with one another. For example, focusing on the principle of need and addressing needs of patients or a community in an immediate, time-limited sense, may be in conflict with prioritizing sustainability if perpetuation of the intervention is not possible, or in conflict with professionalism if addressing the immediate need requires someone to act beyond his or her level of training. In the table below we list and define key ethical principles that might be included in the development of short-term international service activities' ethical frameworks. Programmatic ethics governs clinical care selection, design, implementation, and follow-up, ensuring that activities are ethically sound before, during, and after the trip, while individual (participant) ethics govern thought, communication, and behavior before, during, and after the short-term activity. Relationship ethics governs the partnerships that are an ideal component of any international effort between high-income country entities and those in low and middle income countries.

Similarly, an ethical framework is useful in program evaluation. Programs and individual participants alike should consider the ethical guidelines upon trip completion, critically assessing the principles that were upheld and those that were challenging to accomplish.

Open conversations about potential improvements should be a part of the discussion. Where possible, the host community or institutions therein should be included in reflection and evaluation process.

Avoiding Harms of Band-Aids: Compulsory Ethical Principles for Short-Term International Activities

In order to avoid the pitfalls often associated with short-term international medical and dental service activities, we suggest that six ethical principles be compulsory for any framework applied to short-term international activities. These are sustainability, transparency, humility, professionalism, collaboration, and nonmaleficence. By embracing these tenets, projects will have to be thoughtful to collaborate with local health systems, as well as other short-term visiting teams (Vaduganathan, 2014). Ensuring professionalism and not doing harm, either on individual patient or community-levels, will require projects to contemplate potential harms and distractions from health systems strengthening. Prioritizing transparency requires a degree of humility that translates into efforts being clear with regard to their reach, capacity, and limitations both with patients and with community-based stakeholders. Finally, by emphasizing sustainability over tempting transient quick-fix efforts, projects can begin to integrate long-term impacts into short-term programmatic operations.

Discussion

Developing an ethical framework is essential for any short-term medical or dental activity abroad. The use of such frameworks allows participants,

Foundational bioethical principles alone are insufficient to provide a comprehensive ethical evaluation of the potential pitfalls of short-term international activities.

program leaders, and institutions to determine if the nature of the activities, their impact, and their sustainability are optimal. A realization that this is not the case may dissuade further participation short-term activities or encourage pursuit of alternative models of engagement in the global health arena.

We have presented ethical principles that can be incorporated into a framework for the selection of, preparation for, and implementation of international short-term medical and dental activities. We believe that by examining ethical considerations repeatedly from project conception to execution and evaluation, all stakeholders are more likely to benefit. In addition, viewing the short-term activity through a variety of perspectives, including those of locally-based native health providers, host community members who are pulled from their usual duties to support visitors, as well as that of the visiting volunteer can, lead to valuable insights (White & Evert, 2012).

Due to the diverse nature of short-term medical and dental international activities, the application of ethical principles to develop a framework will not result in a uniform framework for all projects. The universality lies in the need and responsibility to develop a framework. Effective implementation of ethically sound short-term international activities will increase the likelihood of critical assessment of impacts. It may also lead to a decision to not take part in short-term international volunteer efforts in favor of other activities that contribute to global health, such as advocacy, fundraising, and research, to name a few. Using ethical frameworks, with a prioritization of transparency, humility, sustainability, professionalism, collaboration, and nonmaleficence will be a crucial piece of the next generation of short-term medical and dental international activities.

While the imposition of an ethical framework may make it more difficult for ad hoc, organic, short-term global health experiences to develop, it is important to note that many of the tenets described here call for greater involvement of local stakeholders and critical examination of the work being conducted. Indeed, applying any ethical framework to a stand-alone, “one-off” trips will likely result in a clear message that participation in such experiences may not necessarily be impactful, nor in line with accepted ethical tenets. Greater advocacy work, arising from this framework and in line with the guidance of other organizations, will encourage a generation of interested young health-care professionals and trainees to critically assess any short-term volunteer work they might take on abroad. ■

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ETHICAL TENETS FOR DEVELOPING AN ETHICAL FRAMEWORK IN SHORT-TERM INTERNATIONAL DENTAL AND MEDICAL ACTIVITIES

	<i>Principle Definition</i>	<i>Guiding Questions</i>
Solidarity	Alignment of goals and values of yourself with the community you are working in and with (Pinto & Upshur, 2009)	How are my goals and values aligned with the goals and values of the community I am working with?
Humility	Unpretentious openness, honest self disclosure, avoidance of arrogance, and modulations of self-interest (Coulehan, 2011)	What are my limitations to impacting the host community? How can I delegate or turn over power to those traditionally less powerful?
Introspection	Looking inward, honest self-reflection (Pinto & Upshur, 2009)	What contributions have I made? What potential harms/costs has my activities had?
Authenticity	The degree to which one is true to one's self	How transparent are my motivations? How authentic am I being in what I am claiming to do and what I am actually doing? How do my actions abroad compare to how I act at home?
Veracity	The duty to tell the truth	How honest have I been with those around me?
Openness	Being open to people, ideas, and criticism (Gill, 1999)	How open am I to people who are different from me? How am I listening to my hosts? How am I accepting divergent views from my own?
Social Justice	View that everyone deserves equal economic, political, and social rights and opportunities. Recognizing the historically deep and geographically broad understanding of gross inequities, power imbalances, and other underlying causes of ill health	What broad determinants of health exist? How is disempowerment bred and sustained? How is my project contributing to equity?
Principle of Double Effect	An action that is good in itself has two effects: an intended and otherwise not reasonably attainable good effect, and an unintended yet foreseen evil effect (Ashley & O'Rourke, 1997)	What problem does this program hope to address? What other unintended effects might it have?
Distributive Justice	Basic good should be distributed so that the least advantaged members of society are benefited	How can our program ensure resources reach those in most need of them?
Principle of Need	Each person is guaranteed the primary social goods that are necessary to meet the basic needs in the society in which one lives, assuming there are sufficient social and economic resources in the society to maintain the guaranteed minimums	What basic needs can this population not meet because of lack of resources, how can we address these? How is the guaranteed minimums in the community abroad different than your reference community?
Equality	Regardless of their inputs, all group members should be given an equal share of a societal benefit	How are the benefits of the project distributed among the population? How is this project tied to addressing inequalities?
Sustainability	Behaving in a way that can be continued or sustained. The ability to continue a project or effort long-term is valued over other efforts that may have a more immediate, but finite, impact	How will the impacts of this project be maintained? What lasting effect is the project having after short-term visitors and volunteers left?

ETHICAL TENETS FOR DEVELOPING AN ETHICAL FRAMEWORK IN SHORT-TERM INTERNATIONAL DENTAL AND MEDICAL ACTIVITIES CONT.

	<i>Principle Definition</i>	<i>Guiding Questions</i>
Respect for Persons	The duty to honor others, their rights and their responsibilities. Showing respect for persons implies we do not treat them as a mere means to our ends	How are people in this project treated: as means or ends? How are local health practitioners, professional standards being respected?
Liberty	Each person has an equal right to the most extensive scheme of equal basic liberties compatible with a similar scheme of liberties for all	What basic rights are absent for this group and how can our project work to resolve this?
Common Good	Having the social systems, institutions, and environments on which we all depend work in a manner that benefits all people (Velasquez et al, 1992)	How does this project contribute to the community and systems created to serve the entire community?
Beneficence	All forms of activities intended to promote the good of others	How are the welfare of the host community and patients prioritized?
Nonmaleficence	Avoiding harm to others	What are the potential harms caused by our project? Do we have the proper skills to carry it out? How will we recognize and mitigate harms?
Informed Consent	The right and responsibility of every competent individual to advance his or her own welfare. The right and responsibility are exercised by freely and voluntarily consenting or refusing after being given the most information available from which to base a decision	How can people related to this work be fully aware of what their participation means? How can patients consent to care in an informed fashion in the context of short-term activities?
Human Dignity	The intrinsic worth inherent to every human	How can this work respect the worth being of every individual? How about the dignity of native healthcare workers? Community leaders?
Stewardship	The responsible planning and management of resources	How can this work best be planned and organized? How can resources be maximized?
Subsidiarity	Requires that those in positions of authority recognize that individuals have a right to participate in decisions that affect them	How can the voice of the people this work involves best be accounted for? How can the power be decentralized to those at the most fundamental levels of the community?
Conflict of Interest	When an individual or organization is involved in multiple interests, one of which could possibly corrupt the motivation for an act in another	What prior connections could affect his work? How could my [the project's] allegiance to one entity or goal corrupt another of my [the project's] interests?
Transparency	Acting in such a way that it is easy for others to see what your actions are and the motivations for your actions	How am I ensuring my motivations and activities are transparent to the host community?
Altruism	Living for the sake of others actions are right if they are more favorable for others rather than for the agent (Comte, 1852)	Are my actions beneficial only to the host community at my own expense?

	Principle Definition	Guiding Questions
Mutual Altruism	Altruistic activities are bilaterally beneficial and represent enlightened self-interest (Mendonca, 2001)	Are my actions beneficial to both the host community and myself? If so, how are we both benefiting? How am I acknowledging this self-interest?
Professional Ethics Professionalism	A group of ethical tenets laid out by professional bodies; generally includes acting consistent with professional ideals and stature required by a professional skills set	Are the tasks assigned to volunteers commiserate with their professional level and formal training? Am I providing a standard of care that is similar to that I would expect for myself or provide in my home context?
Collaboration	A cooperative approach to working together and problem-solving; common values include joint decision-making, open communication, respect among group members (Stevens and Bhardwaj, unpublished)	Are all the important stakeholders acting in partnership and able to provide their input into joint activities for the betterment of the receiving community? Are these partnerships fair and equal, free of coercion?

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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

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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-term 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 complements 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 companions 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.

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Beyond Medical “Missions” to Impact-Driven Short-Term Experiences in Global Health (STEGHs): Ethical Principles to Optimize Community Benefit and Learner Experience

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Abstract

Increasing demand for global health education in medical training has driven the growth of educational programs predicated on a model of short-term medical service abroad. Almost two-thirds of matriculating medical students expect to participate in a global health experience during medical school, continuing into residency and early careers. Despite positive intent, such short-term experiences in global health (STEGHs) may exacerbate global health inequities and even cause harm. Growing out of the “medical missions” tradition, contemporary participation continues

to evolve. Ethical concerns and other disciplinary approaches, such as public health and anthropology, can be incorporated to increase effectiveness and sustainability, and to shift the culture of STEGHs from focusing on trainees and their home institutions to also considering benefits in host communities and nurturing partnerships. The authors propose four core principles to guide ethical development of educational STEGHs: (1) skills building in cross-cultural effectiveness and cultural humility, (2) bidirectional participatory relationships, (3) local capacity building, and (4) long-term sustainability.

Application of these principles highlights the need for assessment of STEGHs: data collection that allows transparent comparisons, standards of quality, bidirectionality of agreements, defined curricula, and ethics that meet both host and sending countries’ standards and needs. To capture the enormous potential of STEGHs, a paradigm shift in the culture of STEGHs is needed to ensure that these experiences balance training level, personal competencies, medical and cross-cultural ethics, and educational objectives to minimize harm and maximize benefits for all involved.

Growing interest in global health has promoted the expanding phenomenon of short-term experiences in global health (STEGHs). Historically undertaken by licensed professionals, trainees are increasingly involved. Trainee participation in STEGHs can drastically vary in scope, but considered elements include short duration abroad (1–30 days),¹ nature of activities undertaken (e.g., clinical care, education, research, public health efforts),² and philosophy of the facilitating organizations.

Almost two-thirds of matriculating medical students expect to participate in a STEGH during medical school.^{3,4} This has driven a proliferation of programs in the form of alternative spring breaks, service trips, and medical

electives.⁵ STEGH participants often have multiple objectives ranging among education, training, social responsibility, medical service, and/or tourism.⁶ Of note, STEGHs have been shown to provide significant educational gains that are foundational for preparing globally engaged health care workers from higher-income countries (HICs).⁷ Common educational objectives for HIC trainees include exposure to diseases uncommon in HIC settings, increased clinical acumen, development of professional networks, fulfilling a social responsibility, and providing care to the underserved.⁸ However, STEGHs focused solely on clinical service, and participant learning may constrain the broader aim of international development, elimination of health disparities, and public health, particularly if the experiences are not associated with a capacity-building agenda.^{1,9,10}

In the absence of clear definitions, standards, impact data, and appropriate conduct, STEGHs may represent a suboptimal use of time and resources,¹ harm the host community,¹¹ and even perpetuate global health inequities.¹²

Present literature pertaining to STEGHs by practitioners and learners from HICs is primarily descriptive¹ and is limited to case studies, reflections, ethical discussions, and descriptions of curricula. In this Perspective, we propose recommendations for the ethical implementation of STEGHs especially relevant for those involving trainees; however, many concepts are generalizable for all STEGHs. These principles require shifting from a primary focus on trainees’ experience, to preventing harm and effectively addressing the agenda of host communities, who, through this model, become participatory partners. These principles provide an overarching framework for a needed paradigm shift on which practical “how-to” guides can be based.¹³

The “Medical Missions” Tradition and Contemporary Global Health Experiences

Medical missions historically accompanied missionary work and colonization efforts. Dr. David Livingstone, the well-known 19th-century medical missionary, primarily aimed to spread Christianity but also performed obstetrical procedures

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and surgeries.¹⁴ Medical missionary work often garnered local goodwill and allowed proselytizing, thereby facilitating colonial governments' management and exploitation of their territories.¹⁵ Similarly, Dr. Norman Bethune's surgical missions during the Spanish Civil War and World War II in China were inspired by political ideology (i.e., avowal of communism).¹⁶

In turn, travel and colonization gave rise to the field of tropical medicine. In the late 19th century, Albert Dock Hospital established the London School of Hygiene and Tropical Medicine, which provided care for ill travelers returning from abroad.¹⁷ One predecessor of contemporary STEGHs could be the school's first epidemiological research expedition in the Roman Campagna in 1900, which documented that mosquitoes were required for the transmission of malaria.¹⁷

A move beyond faith-based medical missionary traditions began with the secular, population-based approach exemplified by the International Committee for the Red Cross and Red Crescent. Created in 1863, the organization provided care without regard to affiliation and formed the basis for modern humanitarian assistance.¹⁸ *Medecins Sans Frontieres* (Doctors without Borders) follows this model as well.¹⁹

Global health work was transformed in the mid-20th century with the founding of the World Health Organization (WHO), in addition to advances in hygiene and the development of antibiotics and vaccines. Large-scale international development programs were created around these interventions, undertaken by national governments in cooperation with organizations like the WHO, nongovernmental firms, and universities.²⁰ With a shifting focus from patient care to population-based efforts, the role of physicians became less about clinical acumen and more about public health, capacity building, and program administration.

Medical missions gained prominence in the late 1970s and 1980s, owing to the ease of modern air travel and growing awareness of health challenges in low- and middle-income countries (LMICs). By the late 1990s, the advent of the Internet facilitated the growth

and visibility of numerous community groups and nonprofit organizations offering STEGHs, leading to discussions around their educational and ethical considerations.¹³ Modern-day "medical missions" can be either faith based or secular in their underlying ideologies.

STEGH Ethical Principles: Focusing on Community Benefit

Accredited and extracurricular opportunities for STEGH participation have arisen in response to the widespread interest within undergraduate, medical, and postgraduate training programs.³ Many of these STEGHs operate under flawed assumptions that such programs are relatively innocuous and meet specific community needs. However, this is not always true. For example, local partners desiring preventive health promotion activities may not be well served by STEGHs that focus on providing reactive approaches to diseases. Suboptimally conducted STEGHs may also lead to inappropriate volunteer medical care (including unregulated provision of medications, equipment, and surgeries).^{1,21,22} If not integrated with broader plans for health and development, STEGHs can potentially undermine long-term community health outcomes by shifting responsibility from local governments to STEGH providers, which in turn may lead to some patients waiting for subsequent STEGHs to receive care while their conditions worsen.⁵ Likewise, narrow focus on clinical learning objectives for trainees may be a missed opportunity for the development of unique, broad-based, interprofessional global health competencies.²³ Finally, without standardization and guidelines, STEGHs can harm local community health systems and social capital by sidelining local health professionals or working in a disjointed fashion, which may cultivate negative sentiment toward visitors, further limiting impact.

We have identified four principles that highlight key ethical areas in STEGH planning and execution to mitigate harms and optimize benefits for host communities: (1) emphasis on cross-cultural effectiveness skills and cultural humility, (2) bidirectional participatory relationships, (3) local capacity building, and (4) long-term sustainability (see List 1).

Principle 1: Skills building in cross-cultural effectiveness and cultural humility are critical components of successful STEGHs

Health care providers and students receive limited education regarding cultural beliefs and health practices.^{1,24,25} Health professions educators may assume that cultural competency can be taught as a technical skill and focus on "static culture traits."^{26,27} However, anthropologists teach an "explanatory models" approach,²⁶ cultural humility,²⁸ and communication skills that may be more effective when not only cultural but also language, economic, and power differentials exist between local communities and STEGH participants. The Listen, Explain, Acknowledge, Recommend, Negotiate (LEARN) framework²⁹ is a medical anthropology model that has been used successfully in interprofessional training in cultural competency.³⁰ Predeparture training for STEGHs involving role-play and discussion can use cross-cultural effectiveness resources such as the *Worlds Apart* film series.³¹

Without significant understanding and preparation of cultural diversity and cross-cultural communication methods, STEGHs are more likely to cause harm and less likely to contribute meaningfully to learner and community development. Didactic sessions about cultural beliefs and ethnographic techniques can improve learner skills in cross-cultural effectiveness and cultural humility, allowing them to recognize and value local partners' knowledge and advice over preconceptions and hubris.

The underlying principle of any STEGH is that participation is a privilege, not a right. Complementing cultural humility, the principles of humility, nonmaleficence, and professionalism demand that STEGH stakeholders guard against trainees providing suboptimal or inadequately supervised clinical care under the guise of appropriate training opportunities or unsubstantiated community health gains.^{1,32-34} Students and trainees can be allowed to learn, deliver, and participate in clinical care, but only under supervision and with necessary redundancies, such as those that exist in their home training environments. Each trainee's abilities and degree of independence should be

List 1

Summary Guidelines for Implementing Short-Term Experience in Global Health (STEGH) Principles**Principle 1: Skills building in cross-cultural effectiveness and cultural humility are critical components of successful STEGHs**

- Understand that (HIC) health care professions medical education is limited in fully preparing one for work abroad; predeparture training and other extracurricular professional development is necessary preparation
- Promote “explanatory models” and communication skills (e.g., Listen, Explain, Acknowledge, Recommend, Negotiate [LEARN] framework²⁹)
- If locally allowed, HIC trainees may provide supervised services within scope of training and ability as assessed in the local LMIC setting
- Recognize that trainee independence is often decreased because of language and cultural discordance, lack of familiarity with formularies, resource level, and local standards of care
- Recognize that ethics and professionalism should travel across borders

Principle 2: STEGHs must foster bidirectional participatory relationships

- Adopt paradigm focusing on local capacity building and participatory program priority setting between HIC and LMIC stakeholders
- Determine scope of STEGHs through bipartisan collaboration and community engagement rather than unilateral “aid”
- Engage other disciplines (e.g., anthropology, public health) to help develop bidirectional relationships between local community and visiting institution
- Support reverse innovation and reciprocity of opportunities
- Focus on community development rather than solely learner skills or visiting institution prestige

Principle 3: STEGHs should be part of longitudinal engagement that promotes sustainable local capacity building and health systems strengthening

- Optimize resources to address locally identified needs
- Avoid operating STEGHs as short-term “fixes” to long-term complex problems
- Create new funding models to increase participation, access, and exchange and to minimize power imbalances and inequities
- Focus on creating long-term capacity in public health, primary health care, and health systems

Principle 4: STEGHs must be embedded within established, community-led efforts focused on sustainable development and measurable community health gains

- Understand the roles of poverty and inequality, public health infrastructure, and human resources for health in promotion of long-term population health
- Understand that downstream clinical efforts may serve to delay morbidity or mortality rather than reduce them, and give consideration to a more upstream, root-cause focus
- Understand the limitations of repeated and/or isolated short-term efforts
- Ensure development and monitoring of appropriate outcome indicators
- Employ long-term planning to address development goals

Abbreviations: HIC indicates high-income countries; LMIC, low- and middle-income countries.

reassessed once in LMIC host settings, rather than assuming that levels of independence in novel LMIC settings mirror those afforded in familiar HIC training environments. Because of language and cultural discordance between STEGH participants and host communities, as well as novel formularies, standards of care, and treatment algorithms, it is often appropriate that trainees have less independence and scope of practice when

abroad. In other words, simply crossing international borders should not degrade professional and ethical standards and often requires trainees to take a step back in their scope of independent activities.

Principle 2: STEGHs must foster bidirectional participatory relationships

STEGHs have sometimes been referred to as “medical voluntourism,”³⁵ which may exacerbate economic and power differentials between provider and host

communities.³³ Short-term voluntourists and recipients can be characterized, respectively, as “people who travel easily and people who do not.”³⁶ The latter also often lack access to health care, food, and economic and political power and may feel unable to say no to charity in any form offered. Programs that do not actively combat this inequality gap will not sustainably address the long-term needs of those they aim to help. It is the responsibility of those who travel from more developed settings to ascertain the needs of those they desire to help, without preconceived notions of their own, and to partner with these communities to create mutually beneficial programs, such as the Medical Education Partnership Initiative (MEPI).³⁷

Health professionals traveling abroad may bring needed skills or equipment to LMICs, but unidirectional STEGHs run the risk of creating dependency by providing short-sighted fixes to long-term, complex problems.³⁵ Furthermore, physicians may not always be able to tackle these problems alone; multidisciplinary teams including public health experts, development practitioners, engineers, anthropologists, and others are often necessary.

For certain surgical specialties (e.g., cataract, cleft palate/lip, oral, and obstetric fistula repair surgery), providing downstream services by STEGH volunteers commonly removes pressure on local governments to provide and respond to health needs with long-term solutions, thereby “masking deeper ills of social, political and economic inequities.”²⁴ They also may create new and unforeseen issues (e.g., infections due to lack of appropriate follow-up) and perpetuate the illusion that foreigners are better able to address local needs.⁶ Longer-term solutions engage local providers in identifying areas to augment training capacity and developing plans to address these priorities, eventually phasing out external support within a defined timeline in favor of locally developed resources.³⁸ Successful examples include the Himalayan Cataract Project, which pairs local ophthalmologists with visiting experts to provide cataract procedures in rural areas of the world,^{39,40} and partnerships through MEPI.³⁷

Participatory bidirectional relationships also encourage “reverse innovation”—the adaptation of health care and innovative

successes developed in LMIC settings to HIC contexts.⁴¹ For example, community health and outreach programs in Africa and India have provided models for community health workers in New York City.⁴² In this manner, bilateral collaboration rather than unilateral aid can be ethical and instructive for all.⁴³ For trainees participating in STEGHs, those undertaken in the context of bidirectional institution-level relationships allow for modeling of ideal longitudinal global engagement.

Principle 3: STEGHs should be part of longitudinal engagement that promotes sustainable local capacity building and health systems strengthening

The shortage of human resources for health (HRH) is one of global health's biggest challenges.⁴⁴ STEGHs often focus on supporting the participants' interests and skills sets and their desire to help those in need. Too rarely do STEGHs prioritize the congruence between local LMIC community priorities and training interests with the abilities of visiting HIC participants. STEGHs must incorporate local needs/strengths and promote capacity building; good examples include the Himalayan Cataract Project referenced above, and MEPI "communities of practice."⁴⁵

STEGH participants are often self-funded. Together with the donation of financial and in-kind resources, they often represent a potential revenue source for local communities that could be used in building local capacity. This may not constitute cost-effective global health investment compared with high-impact, low-cost interventions, such as vaccines and water purification. However, research has shown that participants who spend thousands of dollars on STEGHs are unlikely to donate that amount instead.⁴⁶ Given this dynamic, the use of funds related to STEGHs to support larger projects targeted at host community impacts should be carefully explored. Channeling funds for STEGHs through institutional program fees, with visiting participants paying a sliding scale fee based on their own finances, may enable more people to participate while minimizing the power imbalances arising from a sense of entitlement and one-way charity. Participants' fees could partly allay the travel costs of host community members to the STEGH-sending country as well, resulting in true cross-cultural exchange.

Capacity development includes strengthening of long-term comprehensive primary health care in communities abroad, requiring that STEGH participants understand structural and social determinants of inequitable conditions.³⁵ Consequently, creation of effective capacity-building plans requires training and/or a familiarity with principles of international development, social determinants of health, and public health systems. A broader understanding of community health would optimize engagement with health systems development efforts. Although inclusion of capacity development in STEGHs may significantly alter learner expectations—from direct delivery of medical/surgical care to one of partnership, mutual education, and sustainability—such STEGHs hold the most promise for impact in the host community. This approach may prove ultimately more fulfilling for the returning learner, who might also apply such approaches at home.⁴²

Principle 4: STEGHs must be embedded within established, community-led efforts focused on sustainable development and measurable community health gains

Many populations in LMICs and subpopulations in HICs suffer from poor health and lack of access to health care, arising commonly from poverty, inadequate infrastructure, and HRH shortages.^{47,48} These provide a commonly seen impetus for STEGHs: to provide health care for people who otherwise would have limited or no access. Yet, long-term solutions for these communities need to involve local infrastructure and human resource development to avoid dependence on a repetitive and often disjointed cycle of STEGHs.

Downstream clinical efforts serve to delay morbidity or mortality rather than prevent the underlying condition.²⁴ Population health measures including education or awareness campaigns, or public health programs for vaccination or sanitation, might reduce the need for short-term outsiders filling in for local HRH. Global health organizations that have had success improving local population health and health care delivery often commit to long-term community engagement.

Traditional "medical missions" (both secular and faith based) reflect a certain paternalism by using HIC

health care standards as a benchmark for health in LMIC contexts. This tradition has the risk of prioritizing the needs of the sending institution over local realities and approaches. For instance, institutions may use their resources toward enabling the participant experiences and technical skills rather than focusing on long-term population health or HRH capacity building in communities abroad. This problematic approach is also evident in the mind-set that any LMIC can suffice to provide STEGH opportunities to learners. The locations for possible STEGH partnerships must be seen as more than an undifferentiated mass of "underdeveloped" communities with poor health. Participatory programs that emphasize increasingly common development principles of strengths-based approaches with local control may provide new models and paradigms for STEGHs to empower locals while avoiding the pitfalls of "philanthropic colonialism."⁴⁹

Monitoring STEGH sustainability and effectiveness requires the use of appropriate indicators, which must incorporate a longitudinal perspective. For example, if success is measured using process indicators (e.g., number of patients seen, successful surgeries, or prescriptions dispensed), service-focused STEGHs could be considered highly effective. However, if assessed in terms of health outcomes (e.g., change in disease occurrence or improved access to consistent medical services), STEGH effectiveness is less clear-cut, highlighting the need for a more longitudinal planning focus.²⁴

With appropriate indicators and principles, STEGH stakeholders can then identify program limitations and ensure program sustainability and impact. Some academic institutions have faculty members living and working abroad; this can augment local bandwidth for supervision of HIC trainees and STEGH impact assessment. Community-based organizations providing STEGHs can also invest in local capacity building in conjunction with STEGH operations.⁵⁰ Focusing on sustainability also supports efforts to address the rise of chronic disease in LMICs.⁵¹ STEGH preparation should reinforce training participants on the epidemiologic shift and an expanded definition of "tropical medicine" beyond infectious disease.⁵²

Applying STEGH principles: Focusing on community benefit

Applying these principles toward obtaining maximum benefit within host communities requires deployment of appropriate strategies across the entire spectrum of STEGH planning. These key strategies include assessment, data collection and dissemination, standards of quality, bidirectionality of agreements, formal curriculum definition, and ethical considerations.

Assessment. Existing professional groups should assess objectives, structure, monitoring and evaluation, cultural issues, and ethical concerns of STEGHs as they relate to medical education, as well as community impacts (both positive and negative). The American Public Health Association, American Academy of Family Physicians Global Health Workshop, Consortium of Universities for Global Health, and Network Toward Unity for Health are forums for this discussion. However, there is a need for increased focus on robust applications, which could include the use of assessment data to accredit STEGHs, develop uniform program standards (e.g., with respect to preparing trainees), and facilitate a paradigm shift that focuses on promoting participatory research and programming that prioritize elevating the voice and input of LMIC-based stakeholders.

Data. Professional organizations must take the lead in vetting STEGHs and providing this information to their members and the public. Internet searches reveal diverse STEGH opportunities, with no evidence on whether they conform to norms of practice. Although some organizations have created directories of STEGH programs, these are rudimentary and often lack sufficient information about program quality. This information gap also highlights the need for objective data on effective STEGH models that positively influence community health outcomes. Pouring resources into programs without transparency and quality improvement is not encouraged in any system. Effective deployment of online databases could allow the global health community to evaluate the ethics and sustainability of STEGHs. The first step to developing any such database would be for constituent stakeholders to

identify best practices for which data can be collected and analyzed against defined metrics, supported by medical education and global health funders.

Standards. STEGH practices should conform at minimum to defined quality standards established by regulators in the origin HIC, and must not be promoted as an opportunity to advance trainees' procedural skills or function clinically with reduced supervision. Local mentors of clinical activities during STEGHs should be compensated or otherwise recognized for their contributions to participants' education. Refinement of standards informed by data and assessment processes will act as a benchmark on which STEGHs can be measured. Programs that fail to meet expectations should not be supported by any stakeholder to continue without targeted improvements toward adherence with defined principles.

Bidirectionality. Identifying all stakeholders in STEGH opportunities is critical to avoid exacerbating existing inequalities within and between communities abroad, and between the host LMIC and sending HIC. Relevant models can be found in the community-based/community-driven⁵³ and community engagement⁵⁴ development literature. There should be explicit expectations by all parties through a memorandum of understanding, which should also include a timeline for sustainability, clarity of financial obligations and resource allocation, and mechanisms for conflict resolution.

Curriculum. Organizations and institutions sending trainees on STEGHs should define formal global health curricula, including competencies, predeparture training, on-site orientation, and cross-cultural effectiveness/cultural humility education for participants, along with robust postreturn evaluation and debriefing mechanisms.³⁷ Where possible, STEGHs should be embedded into broader international development efforts; this focus necessitates faculty development on community-based education principles.⁵⁵

Ethics. At all times, STEGHs should respect local laws, and focus as identified by local community partners, and should remember that broader ethical principles extend beyond international boundaries.

Conclusions: STEGHs Moving Forward

Growing interest in STEGHs should be channeled into interventions and programs demonstrated to be useful in improving global health and educating about complex determinants of health. To accomplish this improvement, the discourse around program implementation should refocus on STEGHs' impact on host communities, as well as the limitations of short-term trainee activities and necessity of longitudinal institution-level engagement. STEGHs must address, rather than perpetuate, underlying power imbalances, ethical pitfalls, resource differentials, and inequities that the global health movement seeks to eliminate. These principles must be consistently applied to capture the enormous potential of STEGHs to nurture globally engaged health professionals and institutional partnerships necessary to achieve global health targets and reduce health disparities locally and globally.

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Documenting Your Experience

A guide for undergraduate researchers and interns on using photography and video

Introduction

All global health practitioners have a responsibility to protect and promote the human rights of all people. Maintaining the dignity of the people and communities with whom you'll be working this summer will be a crucial part of your learning experience. This includes the specific project on which you'll be working and the way you document and tell others about your experience. One common way previous interns have documented their experiences is through photography. As Unite for Sight notes on their webpage, "Ethics and Photography in Developing Countries,"

Those who take photos while participating abroad have an ethical responsibility to preserve the dignity of their subjects and provide a faithful, comprehensive visual depiction of their surroundings so as to avoid causing public misperceptions. Visual images are a cogent way to convey an experience to an audience and to evoke strong public emotions, as people often formulate their opinions, judgments, and behaviors in response to visual stimuli. In this way, the photographer wields substantial control over public perception. Photographers' decisions about how to depict their subjects can entirely alter viewers' perceptions.¹

This information is intended to help you think through how and when you should document your summer experience through photographs or videos, how to take photographs, how you should share them, and how you should present visual images of your experience in order to honestly and ethically present the struggles as well as the achievements of the communities in which you'll be working.

Ethical Considerations

This summer, many of you will be encountering a very different quality of life than you are accustomed to in the United States (although poverty certainly exists in the U.S., many of us do not see it on the same scale of severity as may be apparent in parts of the developing world). While this may be the first time you'll see this level of poverty first-hand, it's very likely you've seen photos of poor children presented by a non-profit organization seeking donations. While these images may be effective at soliciting donations (although that is being questioned more and more), they neglect to demonstrate the resilience and strengths of the people in the communities depicted. In the same way, participation in a film can have lasting and often unintended consequences for the participants. What parts of a person's life will be revealed? How might those revelations affect that person's standing in their community? Video depictions of your experience can convey important information about challenging situations in developing communities, but how those videos are contextualized and presented is critical to providing a balanced impression of those communities.

Case Study in Ethical Photography: Perspectives of Poverty

Used with permission from <http://www.uniteforsight.org/global-health-university/photography-ethics>

A "Perspectives of Poverty" project was recently implemented by Duncan McNichol of Engineers Without Borders Canada. Duncan photographed Edward Kabzela of Chagunda Village, Malawi. In the photo on the left, Edward was asked to look and act as poor as possible, while in the photo on the right, Edward was asked to dress as rich as possible. The two images convey completely different stories, and elicit entirely different emotions in the viewer. The photo on the left does not reflect Edward's success, portraying him instead as a hopeless, dirty, hungry, and impoverished beggar. However, this is



¹ <http://www.uniteforsight.org/global-health-university/photography-ethics>

not an accurate portrayal of Edward. In reality, he is very successful as an area mechanic and grower of tobacco, and he works for a basket-weaving business. He is also thinking of investing in a truck to start a transportation business. Edward explained, “NGOs come to the village here to take pictures of people. At church, at the market, on the road, at meetings. Only people who are dressed poorly.” These images are unfair to the local population and have “become a marketable commodity. They are blown up and displayed at fund-raisers by NGOs, donors, and U.N. agencies; they help organizations to stay in business. The more graphic they are, the more money they help to raise.” Even *Time Magazine* recently published an issue that included a photo essay of an African mother dying in childbirth in Sierra Leone. This photo essay aroused an outcry. Though the intentions of the editors may have been to motivate wealthy donors and nations to take action to improve maternal health care in developing countries, dehumanizing photos should not be used. As Rasna Warah notes in the essay, “While these images might shock Westerners into digging deeper into their pockets, they have the unintended effect of disgusting the very people they are supposed to help. Moreover, they reflect double standards.”² It is not often that similarly graphic pictures of individuals in developed countries are displayed in the media.

Case Study in Ethical Filmmaking: Good Fortune

Used with permission from <http://www.uniteforsight.org/global-health-university/filmmaking>

The film *Good Fortune* demonstrates multiple voices to represent a community and portray their reality. *Good Fortune* is a film about development projects, and focuses on community members instead of emphasizing policy makers and the people giving out aid. The film follows two Kenyans, Silva, a midwife and community leader who lives in Kibera, Nairobi’s largest slum, and Jackson, a farmer in the rural swamp area. Both of their lives have been affected by outsiders’ projects. Silva’s home and job are being threatened by the United Nations HABITAT program, which hopes to improve upon the “deplorable living conditions” in the slum by demolishing sections of it and replacing the houses with cement, block-styled apartments. As the UN-HABITAT’s project director explains, “it is absolutely unacceptable that Kibera exists.” Though there are aspects that could be improved upon in the slum, such as the lack of indoor plumbing or electricity, many of the people who actually live there are happy. Silva explains, “since I came from home, I have seen a big difference in my income, so I am happy to stay in Kibera. There’s a lot of trash, but life is good.” She also mentions how if she is evicted from the slum, she will not be able to find other affordable housing, so she’d “prefer it if those people just let us stay in the slum.”

Jackson is a farmer whose land and livelihood are being threatened by the plans of Dominion Farms Limited, a farming company that plans on flooding the land to create rice paddies. Dominion Farms hopes that the farm will help alleviate poverty by providing food, jobs, and stimulating the local economy. Though this may be a well-intentioned idea, Jackson explains, “I am not poor, I have resources... and that resource is being taken away by a developer.” By including Silva’s and Jackson’s stories, as well as the perspectives of U.N. officials and the CEO of Dominion Farms Limited, *Good Fortune* effectively illustrates some of the complex and divergent opinions about aid work. The movie also acknowledges that not everyone in the communities was against the aid work. The myriad voices represented more accurately reflect the realities and complexities of aid work than a one-sided film would have done.

Ethical Documentation of Your Summer Experience

The Harvard Global Health Institute encourages you to document your experience. However, think critically about how you do so, and what images and videos you are capturing. You will be operating alongside intelligent, competent people working diligently with their communities to promote good health and well-being, and who are generous enough to host you. Many organizations and travelers photograph only the poorest, most down-trodden in a community in order to solicit pity, often in pursuit of donations. Termed “poverty porn,” these images cultivate a culture of paternalism, reinforcing the idea that those in the developing world are incapable of helping themselves. In addition, they often invade the subjects’ privacy by publicizing photos without consent, and violate human rights standards by robbing people of their dignity and autonomy. In the same way, filmmakers sometimes neglect to adequately explain to those being filmed the purpose of the recording, the intended audience, and how the participant will be portrayed. Often there is a power or social status differential that is exploited in order to capture a more “compelling”—but less authentic—story. Those compelling stories can be manipulative and degrading to the subjects. Even if the intent is good (to raise awareness of an issue or raise funds for a cause), the ethical missteps are serious.

² <http://bit.ly/KJnfL5>

In order to document your experience in the most ethical and honest way possible, adhere to the following standards (via Unite for Sight):

Before Photographing

- Always get the subject's consent first, especially if you want to do a close-up.
- Examine your motives for shooting a particular frame. Do you want to inspire hope and understanding, or maybe even expose wrongdoing and neglect? It is not acceptable to use the photographs simply to harness pity. People who donate out of guilt tend to see subjects as pitiful objects, which is dehumanizing and disrespectful.
- You should not bribe subjects to feign despair, anger, or other emotions, or seek to influence the "slant" of your photos in any way.
- Think about what you want to portray in your photo. Balance the reality of poverty with the hope and empowerment present in a community. Never portray your subjects as useless or inadequate.

While Photographing

- Sometimes, it works well to photograph subjects from behind so that only their activities, and not their faces, can be seen. For example, your photo may show the face of the doctor who is performing an eye exam, but not the patient's face. This not only prevents the patient from getting distracted, but also protects his or her privacy.
- Be humble, considerate and respectful, especially during private moments of grief. Try to take the picture from afar without being intrusive.
- Try not to be an aloof stranger; build a relationship of mutual understanding with your subject.

After Photographing

- When possible, use captions to provide context to a photograph; avoid broad generalizations (an individual's experience may not be representative of a community's, nation's, or region's experience as a whole).
- Photos should be used to raise public awareness, not to exploit public sympathy.
- Edit photos minimally in a way that avoids misrepresentation.
- Ensure that your photos document what you believe is the real situation of your subjects.

Filming

Many (if not all) of the standards above apply to video as well. In addition:

- Inform the subject(s) of the intent of the video.
- Do not take video in situations that may violate a patient's privacy in a health care setting.
- Portray multiple voices and perspectives, or acknowledge that they exist.

Images are powerful tools to convey information, and so photographers and videographers should use their skills responsibly. As you document your summer experience, think about how you should represent your temporary community to your permanent one effectively and ethically.

For more information and additional resources, please see:

<http://www.uniteforsight.org/global-health-university/photography-ethics> and
<http://www.uniteforsight.org/global-health-university/filmmaking>

Thanks to Unite for Sight for much of the information included here.

Global Health Training

Ethics and Best Practice Guidelines for Training Experiences in Global Health

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Abstract. Academic global health programs are growing rapidly in scale and number. Students of many disciplines increasingly desire global health content in their curricula. Global health curricula often include field experiences that involve crossing international and socio-cultural borders. Although global health training experiences offer potential benefits to trainees and to sending institutions, these experiences are sometimes problematic and raise ethical challenges. The Working Group on Ethics Guidelines for Global Health Training (WEIGHT) developed a set of guidelines for institutions, trainees, and sponsors of field-based global health training on ethics and best practices in this setting. Because only limited data have been collected within the context of existing global health training, the guidelines were informed by the published literature and the experience of WEIGHT members. The Working Group on Ethics Guidelines for Global Health Training encourages efforts to develop and implement a means of assessing the potential benefits and harms of global health training programs.

PREFACE

Educational institutions, foundations, and governmental and non-governmental organizations have shown a growing interest in applying their technical expertise, energy, talent, research capability, and resources to addressing global health challenges and disparities.¹⁻⁴ Students increasingly request global health content in curricula and often wish to experience global health challenges firsthand.⁵⁻⁷ Accordingly, global health educational programs frequently include field experiences that often involve crossing international borders and during which trainees often encounter ethical challenges related to cultural and professional differences.⁸

Health science students participating in global health field experiences have been shown to be more likely to care for the poor and ethnic minorities, to change focus from sub-specialty training to primary care medicine, to report improved diagnostic skills, and to express increased interest in volunteerism, humanitarianism, and public health.⁹⁻¹⁴ For these and other trainees, such experiences may form the foundations for a career focused on or oriented toward global health or may help them to decide against such a career.¹⁵ By offering short-term global health field experiences, sending institutions may strengthen their position to recruit trainees interested in

global health and to benefit from the appeal of such programs to funders and philanthropists.

Because global health is inherently interdisciplinary and multidisciplinary,¹⁶ students from a growing range of disciplines directly and indirectly related to health seek training in short-term experiences. Students also represent a range of levels and experience and may include undergraduate students, graduate students, and faculty wishing to expand their work into the global health arena. Bi-directional exchange programs offer trainees the opportunity to experience health issues in each other's environments. Experiences may vary in duration from as short as a few days to as long as 12 months and may vary considerably in quality.¹⁷ The goals of training experiences also vary; some can be viewed as training opportunities for the primary benefit of the trainee, whereas others claim to provide some form of service to the host or may involve research.^{18,19} However, little is known about the benefits and unintended consequences of global health training experiences to host institutions and host trainees and, if a component of service is anticipated, whether benefit is realized and at what cost.²⁰⁻²² Global health training that benefits the trainee at the cost of the host is clearly unacceptable; mutual and reciprocal benefit, geared to achieving the program goals of all parties and aiming for equity, should be the goal.¹ Exploitation of one partner for the benefit of another must be avoided.

Although global health training experiences offer potential benefits to trainees and to sending institutions and appear to be growing rapidly in scale, these experiences are sometimes problematic and raise ethical challenges.^{1,18,23-25} Such challenges include substantial burdens on the host in the resource-constrained setting; negative impact on patients, the community, and local trainees; unbalanced relationships among institutions and trainees; and concerns related to sustainability^{26,27} and optimal resource utilization. Although considerable attention has been given to ethical issues surrounding research conducted across international borders²⁸ and under circumstances

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SUMMARY POINTS

- Academic global health programs are growing rapidly in scale and number.
- Global health curricula often include field experiences that involve crossing international and socio-cultural borders.
- Although global health training experiences offer potential benefits to trainees and to sending institutions, these experiences are sometimes problematic and raise ethical challenges.
- The Working Group on Ethics Guidelines for Global Health Training (WEIGHT) developed a set of guidelines for institutions, trainees, and sponsors of field-based global health training on ethics and best practices in this setting.
- The WEIGHT guidelines address the need for structured programs between partners; the importance of a comprehensive accounting for costs associated with programs; the goal of mutual and reciprocal benefit; the value of long-term partnerships for mitigating some adverse consequences of short-term experiences; characteristics of suitable trainees; the need to have adequate mentorship and supervision for trainees; preparation of trainees; trainee attitudes and behavior; trainee safety; and characteristics of programs that merit support by sponsors.
- To refine the guidelines, WEIGHT encourages work aimed at developing and implementing means of assessing the potential benefits and harms to institutions, personnel, trainees, patients and the community in host countries of global health training programs.

of unequal wealth or power, much less attention has been given to the ethical issues associated with education and service initiatives of global health programs and no formal ethical guidelines are available for global health training experiences. To develop ethics and best practice guidelines, we formed the Working Group on Ethics Guidelines for Global Health Training (WEIGHT). The WEIGHT members were selected by JAC and JS through a process of consultation with leaders in global health and ethics. The goal was to select members with experience and expertise with global health training and ethics from a range of perspectives and geographic locations. Of 13 initial membership invitations, 10 (77%) accepted. Those who declined were replaced by persons with similar expertise and experience to create a balanced membership.

GUIDELINE DEVELOPMENT PROCESS

The international, peer-reviewed literature was searched for publications relevant to ethics of global health training and a paper was published raising ethical concerns for global health training programs.¹ Reflecting the nascent nature of ethics research and scholarship in the area of global health training, published literature on the topic represented case reports, case series, and expert opinion. Following the formation of WEIGHT, the literature review was updated and an annotated bibliography was sent to members. The WEIGHT met in person in March 2010 in London to draft a preliminary set of ethics and good practice guidelines through group discussion around ethical issues that have arisen for individuals and institutions that send or receive trainees in global health. The guidelines were developed through a moderated workshop format. All members were given the opportunity to raise and discuss dissenting views for each recommendation. Agreement was reached by consensus. The primary goal of the guidelines is to facilitate the structuring of an ethically responsible global health training program and to discourage the implementation and perpetuation of

imbalanced and inequitable global health training experiences and programs.

SCOPE OF THE GUIDELINES

The guidelines are structured to address the multiple stakeholders involved with global health training experiences. The main stakeholders are host institutions, including program directors, mentors, other faculty, and support staff based at the receiving institution; trainees both foreign and local; sending institutions, including program directors, mentors, administrators, and managers; patients and the community at the host site; sending countries, including committees or councils responsible for medical and research ethics, and other health professional education; and sponsors of global health training. The guidelines are designed to apply to multiple levels of trainees, including undergraduates, graduate and medical students, post-graduate students, and others such as faculty or other professionals seeking to apply or expand their skills in the global health arena. Although the guidelines are predominantly focused on ethical issues for programs sending trainees from wealthier to less wealthy settings, many of the principals also apply to bi-directional trainee exchanges. The guidelines encompass the multiple disciplines and multiple activities that take place under the umbrella of global health including in the clinical, public health, research, and education arenas. Although these guidelines were developed in response to the global health activities of educational institutions, the principles are applicable and adaptable to informal programs and individual global health efforts. They also apply to programs of varying duration, while recognizing that duration can affect the nature of issues encountered. Although the guidelines can apply to exchange programs locally and internationally, they are not intended to address ethics issues encountered during long-term (> 1 year) global health service or by experts providing technical assistance. The WEIGHT recognizes that the evidence available to inform the guideline development process was limited and expects that the proposed approach to global health training will be refined in the future as new data are accumulated.

GUIDELINES

Sending and host institutions. Well-structured programs seem to be the optimal means of ensuring optimal training programs in global health. Developing and maintaining well-structured programs generally involves a sustained series of communications and seems to have a common set of attributes as listed below, and may include clear delineation of roles and responsibilities of all parties, budgets, duration of attachments, participation in and distribution of written reports, and other products. We recommend that sending and host institutions should do the following:

1. Develop well-structured programs so that host and sender as well as other stakeholders derive mutual, equitable benefit including:
 - a. Discuss expectations and responsibilities of both host and sending institutions and agree on terms before program implementation; the terms may be outlined within a memorandum of understanding. Revisit the expectations and responsibilities on a periodic basis;

- b. Consider local needs and priorities regarding the optimal structure of programs;
 - c. Recognize the true cost to all institutions (e.g., costs of orientation, insurance, translation, supervision and mentoring, transportation, lodging, health care, administration) and ensure that they are appropriately reimbursed;
 - d. Aspire to maintain long-term partnerships so that short-term experiences may be nested within them; and
 - e. Promote transparency regarding the motivations for establishing and maintaining programs (e.g., to meet an educational mission, to establish a relationship that might be used to support research, to meet student need) and identifying and addressing any conflicts of interests and conflicts of obligations (e.g., to local patients, communities, or local trainees compared with the global health trainees) that may result from such a program.
2. Clarify goals, expectations, and responsibilities through explicit agreements and periodic review by
 - a. Senders and hosts;
 - b. Trainees and mentors; and
 - c. Sponsors and recipients.
 3. Develop, implement, regularly update, and improve formal training for trainees and mentors, both local and foreign regarding material that includes:
 - a. Norms of professionalism (local and sending);
 - b. Standards of practice (local and sending);
 - c. Cultural competence, e.g., behavior (local and sending) and dealing effectively with cultural differences;
 - d. Dealing appropriately with conflicts (i.e., professionalism, culture, scientific and clinical differences of approach);
 - e. Language capability;
 - f. Personal safety; and
 - g. Implications of differential access to resources for foreign and local trainees.
 4. Encourage non-threatening communication to resolve ethical conflicts as they arise in real-time and identify a mechanism to involve the host and sending institutions when issues are not readily resolved.
 5. Clarify the trainees' level of training and experience for the host institution so that appropriate activities are assigned and patient care and community well-being is not compromised.
 6. Select trainees who are adaptable, motivated to address global health issues, sensitive to local priorities, willing to listen and learn, whose abilities and experience matches the expectations of the position, and who will be good representatives of their home institution and country.
 7. Promote safety of trainees to the extent possible (e.g., vaccinations, personal behaviors, medications, physical barriers, security awareness, road safety, sexual harassment, psychological support, insurance and knowledge of relevant local laws).
 8. Monitor costs and benefits to host institutions, local trainees, patients, communities, and sponsoring institutions to assure equity.
 9. Establish effective supervision and mentorship of trainees by the host and sending institution, including the selection of appropriate mentors and supervisors and facilitating communication among them.
 10. Establish methods to solicit feedback from the trainees both during and on completion of the program, including

exit interviews, and track the participants post-training to evaluate the impact of the experience.

Trainees. Trainees themselves play an important role in the quality of global health experiences. It is essential that trainees understand their responsibility in this regard, not only to ensure their personal experience is a good one, but that their actions and behaviors can have far-reaching and important implications. To help meet such responsibilities, we recommend that trainees should do the following:

1. Recognize that the primary purpose of the experience is global health learning and appropriately supervised service. The duration of the training experience should be tailored so that the burden to the host is minimized.
2. Communicate with their local mentor through official channels regarding goals and expectations for the experience before the training, and maintain communication with mentors throughout the experience.
3. Learn appropriate language skills relevant to the host's locale as well as socio-cultural, political, and historical aspects of the host community.
4. Seek to acquire knowledge and learn new skills with appropriate training and supervision, but be cognizant and respectful of their current capability and level of training.
5. Participate in the process of communicating to patients and the community about their level of training and experience so that appropriate activities are assigned and patient care and community well-being is not compromised.
6. Recognize and respect divergent diagnostic and treatment paradigms.
7. Demonstrate cultural competency (e.g., personal dress, patient privacy, culturally appropriate and inappropriate gestures, gender issues, traditional beliefs about health, truth telling, social media) and engage in appropriate discussions about different perspectives and approaches
8. Take measures to ensure personal safety and health.
9. Meet licensing standards, visa policies, research ethics review, training on privacy and security of patient information, and other host and sending country requirements.
10. Follow accepted international guidelines regarding the donation of medications, technology, and supplies.^{29,30}
11. If research is planned as part of the training experience, develop the research plan early and in consultation with mentors, focus on research themes of interest and relevance to the host, understand and follow all research procedures of the host and sending institution, obtain ethics committee approval for the research before initiation of research, and receive appropriate training in research ethics.
12. Follow international standards for authorship of publications emanating from the global health experiences and discuss these issues and plans for presentations early in collaborations.
13. When requested, be willing to share feedback on the training experience and follow-up information on career progression.
14. When seeking global health training outside of a well-structured program, potential trainees should follow the guidelines for institutions (above) so as to maximize the benefits and minimize potential harms of such training experiences.

Sponsors. Sponsors of global health training programs understandably desire high quality experiences for trainees as well as minimizing any potential adverse consequences related to programs they support. By requiring recipients to be involved with high quality global health training programs as a condition of receiving funds, sponsors can play an important role in creating and maintaining such programs. Where practicable, we recommend that sponsors should do the following:

1. Promote the implementation of these guidelines.
2. Consider local needs and priorities, reciprocity, and sustainability of programs.
3. Ensure that the true costs are recognized and supported (e.g., costs of orientation, insurance, translation, supervision and mentoring, transportation, lodging, health care, administration, monitoring and evaluation).
4. Execute explicit agreements with recipients, with periodic review, to help clarify goals, expectations, and responsibilities.
5. Aim to select trainees who are adaptable, motivated to address global health issues, sensitive to local priorities, willing to listen and learn, whose abilities and experience match the expectation of the position, and who will be a good representative of their home institution and country.
6. Promote safety of trainees to the extent possible (e.g., vaccinations, personal behaviors, medications, physical barriers, security awareness, road safety, sexual harassment, psychological support, insurance, and knowledge of relevant local laws).
7. Encourage effective supervision and mentorship by the host and sending institution.
8. Require that sponsored programs comply with licensing standards, visa policies, research ethics review, training on privacy and security of patient information, and other host and sending country requirements.
9. Encourage the collection and evaluation of data on the impact of the training experiences.

CONCLUSIONS

Global health training programs are associated with a range of ethical issues for all stakeholders. These ethics and best practice guidelines set out a range of measures designed to minimize the pitfalls of such programs. It is hoped that these guidelines will be used to reassess and improve existing programs, be applied in the design of new programs, and, where necessary, promote the discontinuation of programs or activities that cannot meet basic practices described in these guidelines.

Although these guidelines are based on a range of published data and the unpublished experience of WEIGHT members in consultation with stakeholders, they have limitations. The principal limitation is the lack of available systematic data collected within the context of existing global health training programs reflecting the scope of programs and challenges experienced by partners. WEIGHT encourages work aimed at developing and implementing means of assessing the potential benefits and harms to institutions, personnel, trainees, patients, and the community in host countries of global health training programs. Data from such assessments would inform and support future refinement of these guidelines. Although efforts were made to ensure that WEIGHT represented a

range of perspectives and geographic locations, membership could be further expanded to include other groups such as trainees.

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THE FORUM ON EDUCATION ABROAD

Guidelines for Undergraduate Health-Related Programs Abroad

Updated March 2013

There is a growing interest in global health among college students in the U.S. Some are interested because of a passion to “help people”; others see pursuing a health related activity as a way to gain experiences that will help them be successful when applying to medical school, or another health profession. With the increase in interest in global health, has come an increase in organizations trying to serve these students, and give them experiential learning opportunities in health settings. The concern that has been raised by many focuses on the safety and ethical nature of the types of experiences these students are having when abroad. These standards have been created to support sending institutions and hosts that serve students who are involved in experiential learning in health-related settings outside the United States.

These guidelines should be used to augment The Forum’s *Standards of Good Practice for Education Abroad*.

These guidelines are designed for a wide range of program types including: academic, for-credit, direct enrollment, hybrid, center-based, field research and non-credit bearing internship and volunteer programs. They are applicable to: semester, year-long, summer, and short-term programs; and programs organized by domestic and international universities, and education abroad providers.

These guidelines are specific to programs serving students registered at a U.S. undergraduate institution and participating in volunteer, experiential, observation, internship, or other learning activity in a clinic, hospital or community health setting. Such experiences provide an excellent learning opportunity for students but also present unique challenges not typically encountered in other education abroad programs. While any experiential-based learning activity can involve interfacing with individuals or communities, public health or patient-care activities involve interactions that affect health and well-being, and therefore have the potential of putting individuals, community’s and the students health at risk.

Additionally, students who travel abroad for health related programs will frequently find themselves in under-resourced communities. This is particularly true for students who have an interest in public health and healthcare, because they have a strong desire to serve others. While there may be some validity to this assumption, there are also some serious challenges faced by both students and programs when students confuse service with learning. When students go abroad and participate in service-learning programs (e.g. volunteer, internship etc.) in under-resourced communities where there may be health workforce shortages and overburdened health professionals, students may be viewed as being there to help fill the human resources needs in a healthcare or public health settings. This can put students, patients and communities at risk. If health professionals in other countries are not fully aware of the students’ present level of education, they may assume students are prepared to provide services for which they have not yet been trained. Additionally, students from resource-rich countries, like the United States, may have an

inflated opinion of their own skills and talents. When given the opportunity to participate in direct patient-care, these untrained students may not recognize the risk they pose to themselves and to patients.

1. **Purpose:** All programs (including sending institutions, hosts, and experiential settings) that arrange and provide experiential opportunities for students in hospitals, other clinical settings, or community/public health settings should provide appropriate and relevant learning and observation experiences for the students. By doing so, they will ensure the safety of the patients and communities with whom the student interacts.
2. **Program Planning and Development:** Programs serving undergraduate students should assure experiences that take into consideration the needs of the community and patients in coordination with the students learning needs. Therefore, all programs should:
 - a. Respect the public health and health care needs of the community when developing learning opportunities for students.
 - b. Match student capacity including knowledge, skills, and competencies with the capacity necessary for the experiences they are engaged in so patient and community well-being are not compromised.
 - c. Ensure students receive training that articulates and limits their patient-interaction to the same level of patient/community interaction that they would have in a volunteer position in the United States.
 - d. Ensure that students understand and comply with all applicable licensing policies, visa policies, research ethics, data privacy and security and any other health policy related to their experiential position.
 - e. Ensure all experiential sites are legitimate and adhere to international, national and local laws with regard to providing patient and community care (e.g. patient privacy training, immunizations, etc).
 - f. Ensure students meet language competency or that language services are available for students in all settings. Programs should consider compensating translators when they are required to assist in student interactions.
 - g. Ensure pre-departure training, onsite orientation and reentry assessment and feedback are available for all students. These should address ethics and impart an understanding of the student's responsibility for their actions while abroad.
3. **Student Learning and Development:** Programs should identify appropriate student learning and development outcomes specific to the experience:
 - a. Ensure learning and development outcomes are appropriate for undergraduate students.
 - b. Ensure learning outcomes focus broadly on professionalism, standards of practice, ethics, cultural competency, language proficiency, community health, patient safety and personal safety.
4. **Academic Framework:** Programs should clearly articulate the academic requirements of students prior to placing them in an experiential setting.
 - a. Ensure undergraduate students have adequate academic education that matches expectations in the experiential setting, including but not limited to medical language skills.

- b. When students are involved in research, assure all projects are reviewed by the appropriate oversight body for every entity involved.
5. **Clinical or Community Health Experiences:** Experiential opportunities should be offered in collaboration with established, licensed health care and public health organizations located in the host communities. Prior to students participating in an experience, host programs should negotiate and come to agreement with the experiential institutions to ensure student learning and safety objectives will be met. Through negotiation, host programs and experiential institutions will:
- a. Establish that the primary purpose of the experience is learning about health care and public health and provide an opportunity for students to learn through observation, as well as relevant and appropriate activities that do not exceed the student's education and training level.
 - b. Clearly distinguish between the learning role and the service role of students and ensure any student service is within their scope of training and education.
 - c. Ensure that the sending institution, the host and the experiential setting staff understand student's current capability and level of education, and provide a learning experience that is relevant.
 - d. Ensure that students are educated to understand the local culture that influences the healthcare and public health of the community and that students are prepared to function professionally and interact appropriately with local practitioners and community members.
 - e. Engage with existing healthcare and public health organizations and avoid ignoring, displacing, disregarding or circumventing those organizations and professionals by providing experiences outside of those systems.
 - f. Negotiate and clearly articulate supervision responsibilities by all involved organizations. Ensure the safety of the student and those whom the student interacts with and that the student remains in the observer and learner role.
 - g. Provide support for clear and efficient communication between the host, experiential setting and the student.
 - h. Ensure students have a safe place to report activities they are asked to perform that are out of scope of their education, training, knowledge and skills.
 - i. Ensure that any research results, project reports audio/visual products are submitted to and reviewed by the local institutions prior to submission for publication. Provide credit and acknowledgement for local authors and contributors.
6. **Prepare for the Learning Abroad Environment:** Both sending institution and host ensure that students are appropriately prepared for their learning abroad experience in a public health or patient care setting and that students are aware of and can articulate appropriate and inappropriate activities.
- a. Sending institutions and hosts provide orientation information that puts health in a social-cultural context and provides sufficient comparative information about health systems, health status, and public health allowing students to adjust their perceptions and expectations prior to participating in experiential settings.
 - b. Hosts and experiential settings provide ongoing orientation and teaching of relevant and appropriate skills to ensure the health and well-being of both students and those they are interacting with.

- c. Sending institutions and hosts clearly articulate that the experience is intended as an observation and learning experience only.
 - d. Students are made aware of their obligation to act appropriately and not engage in activities beyond their education level.
7. **Student Selection and Code of Conduct:** Programs provide a fair and transparent policy for student selection and conduct.
- a. Programs clearly articulate the expected knowledge and competencies needed to be successful in the experiential setting. These will include language, cultural, interpersonal, and academic knowledge.
 - b. Students are selected based on the expected knowledge and competencies required for the program.
 - c. Programs have clearly articulated code of conduct that is provided in writing to students.
 - d. Students agree to abide by the code of conduct while participating in the program.
8. **Organizational and Program Resources:** Programs and experiential settings have adequate financial, human and facility resources to provide health services and a learning environment for students.
- a. Programs are sufficiently staffed to train and oversee the students while in an experiential setting.
 - b. Students are made aware of the limits of an organization's resources and to be respectful of the resources they are using in the interest of meeting their educational objectives.
9. **Health, Safety, and Security:** Sending institutions will articulate clear expectations for hosts and their partnering experiential sites regarding health, safety and security of the students. Sending institutions will explain that if expectations are not met, partnerships may be dissolved and students removed from the site. Sending institutions should:
- a. Select host partners and experiential settings with comprehensive health, safety, security and risk management policies to protect students, patients and the community's health and well-being.
 - b. Provide students with information about infectious diseases endemic to the host community and any potential health risks that students might be exposed to during their program.
 - c. Arrange for students to have appropriate supervision at the experiential site and compensate supervisors or other persons supporting students in a mutually-agreed upon fashion.
 - d. Include in pre-departure and/or on-site orientation information about safety protocols when working in patient-care settings and training on what to do in the case of an incident of exposure.
 - e. Clearly articulate policies to protect the health and safety of students in patient care or community health settings in the event of an outbreak or other health risks.
 - f. Ensure that students are made aware that they are responsible for recognizing their own limitations, educate and empower them to decline when asked to perform activities outside their scope of training to protect themselves, the patients and the community.

- g. Have policies in place to address students who work outside their scope of practice and clearly articulate those policies to students during orientation.
10. **Ethics and Integrity:**
- a. Sending institutions or organizations have an ethical obligation to ensure that supervisors/host sites understand the level of education and qualifications (or lack thereof) of the student, as well as the appropriate nature, scope and limitations of the student's activities.
 - b. Sending institutions and organizations should recognize the implicit power differential that exists in educational partnerships that involve partners with disparate levels of resources and influence.
 - c. Sending institutions and organizations should recognize the risk of paternalism, exploitation, and neocolonial behavior on behalf of institutions from resource-rich environments when engaging with partners in low-resource settings.
 - d. Sending institutions or organizations as well as host institutions and local supervisors should be familiar with and utilize relevant ethical guidelines and best practices.
 - e. Human dignity and patient autonomy should be prioritized such that educational agendas of the student or the sending organization should not be prioritized over patient safety, autonomy, dignity and the provision of health services.
 - f. If culturally acceptable, host sites and onsite supervisors should make patients aware of the student's learner status and ask patient permission for student presence during and involvement in clinical encounters.
 - g. Meet World Health Organization quality and process standards for donation of equipment, pharmaceuticals, and other medical supplies.

<https://forumea.org/resources/standards-of-good-practice/standards-guidelines/undergraduate-health-related-programs-abroad/>

WHAT TO LOOK FOR IN GLOBAL SERVICE LEARNING

6 STANDARDS OF PRACTICE TO GUIDE YOUR DECISIONS

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1 ORGANIZATIONAL ALIGNMENT

Do the sending, intermediary, and host community entities really share the same mission, commitment and capacity to collaborate? Or is one using another to achieve different goals? Do the people involved have the proper credentials to deliver what they promise? Or are they working in an uncoordinated and complex space without proven competencies?

WHAT TO LOOK FOR

- ✓ Aligned missions, equitable relations, critical thinking, and dialogue among stakeholders
- ✓ Evidence of long term commitment to collaborative practices and common goals
- ✓ Professionals with related academic preparation and professional experience in international education and community development

WHAT TO AVOID

- ✗ Organizations that are aimlessly jumping on a trend of internationalization without partners
- ✗ Conflicting academic, commercial, cultural, or community visions, values, and methods
- ✗ Amateurs with an abundance of enthusiasm and a shortage of pertinent qualifications

WHY IT MATTERS ●

Aligned sponsoring, intermediary, and community organizations produce more defined reciprocal public benefits and less vague mutual private benefits that advance the overall aims of global education and community development.

2 SUSTAINABLE MANAGEMENT

Are the organizations ethically managing their legal, financial, administrative, and human resource functions in compliance with formal requirements and best practices? Or are they taking advantage of unregulated spaces to operate informally? Is there openness and in-depth transparency or reluctance and superficial sharing?

WHAT TO LOOK FOR

- ✓ Civic licences to operate and written partnership agreements with communities and stakeholders
- ✓ Proactive disclosure and explanation of financial statements and access to substantive information
- ✓ Staffing policies and manuals, codes of conduct, fair remuneration, and professional development

WHAT TO AVOID

- ✗ Organizations that are operating without any public status or established local partnerships
- ✗ Simplistic and one-time financial reporting that boasts of low overhead and imprecise high impact
- ✗ Exploitation of people in uneven power relationships with less access to resources

WHY IT MATTERS ●

Sustainable and ethically operated sponsoring, intermediary, and community organizations have a long-term, accountable presence that engages local authorities, extends public networks, develops local capacity, and supports collective initiatives.

3 RESPONSIBLE MARKETING

How are words, images, and symbols used to promote engagement and outcomes? Respectfully, realistically, accurately, and consensually? Or do they perpetuate stereotypes, reinforce clichés, provoke pity, glorify individuals, exaggerate claims, or misuse cultural icons? Does content analysis lead to clear and mission-relevant messaging? Or to faulty assumptions and slacktivism?

WHAT TO LOOK FOR

- ✓ Text that uncovers assumptions about power, privilege, outcomes, and personal agency
- ✓ Images that are genuine, balanced, and dignified that provide context and perspective
- ✓ Modest and qualified use of short and long-term claims reflective of both success and limitations

WHAT TO AVOID

- ✗ Text that presents short and easy solutions and predicts grand outcomes and amplified impact
- ✗ Images that gratuitously use or idealize children and vulnerable populations without consent
- ✗ Symbols or unverifiable statistics that over-simplify complex issues and wicked problems

WHY IT MATTERS ●

Responsible marketing materials inform and inspire local and global engagement rooted in reality not illusion, and invite multi-faceted collective participation not one dimensional individual solutions.

WHAT TO LOOK FOR IN GLOBAL SERVICE LEARNING

6 STANDARDS OF PRACTICE TO GUIDE YOUR DECISIONS

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4

INTEGRATED IMPLEMENTATION



Is the program and/or project identified, designed, prepared, and implemented within a shared theory of change and operationalized in a logic model? Or is it segregated solely by function and convenience based on assumed roles? Are there common strategies, resources, and decisions? Or unrelated independent activities?

WHAT TO LOOK FOR

- ✓ Shared processes, roles, responsibilities, and solutions across organizations
- ✓ Comprehensive pre/during/post experience materials and itineraries for all parties
- ✓ Connection between systemic local and global issues; interdependence not independence

WHAT TO AVOID

- ✗ Northern organizations assuming substance, Southern ones relegated to logistics
- ✗ One-sided attention to broadening the participants, but not communities, service learning experience
- ✗ Adventure-destination and consumer-oriented international travel that appropriates cultures

WHY IT MATTERS ●

Integrated design and implementation reduces neo-colonial tendencies while challenging and raising the capacity of all entities to demonstrate true partnership and a more equitable distribution of responsibilities, risks, and rewards.

5

PROTECTION OF PEOPLE & PLANET



What safeguards are in place to protect children, vulnerable populations, and the environment from harm? Is the need for them articulated and reflected in policies, procedures and training? Or are boundaries and obligations forgotten in the excitement of travel and absence of regulation?

WHAT TO LOOK FOR

- ✓ Protocols for contact with children and vulnerable populations that protect privacy, prevent interference, exploitation or abuse
- ✓ Codes of conduct for photography that honor cultural norms and require respectful use of images by individuals and organizations
- ✓ Health, safety, and conservation practices for visits to urban, rural, natural, wildlife and heritage sites
- ✓ Carbon offset mechanisms for air travel

WHAT TO AVOID

- ✗ Unrestricted access, contact, and voyeurism of children and vulnerable populations
- ✗ Unbounded photography of people as objects, posting of images without consent, and use of images in marketing materials without recognition
- ✗ Lack of evidence of due diligence, health and safety risk mitigation, and carbon offset strategies

WHY IT MATTERS ●

The rights of children and vulnerable populations merit respect and legal and moral obligations exist to protect all people and our planet from harm.

6

REALISTIC EVALUATION



How are inputs, activities, outcomes, and indicators chosen to be monitored, evaluated and shared effectively? Is reliable and valid quantitative and qualitative data collected? Or are reports mostly anecdotal and episodic? What metrics are employed and who benefits from analysis? Or do feedback loops appear self-serving?

WHAT TO LOOK FOR

- ✓ Data collected by a variety of means over time from a sufficient number and scope of consenting sources
- ✓ Recognition of the complexity of evaluation and the limitations of findings – for example, deadweight, displacement, and drop-off effects
- ✓ Credibility gained from failure reporting, external evaluators and on-going research efforts

WHAT TO AVOID

- ✗ Findings derived from unreliable or invalid data
- ✗ Organizations that invest a little in evaluation and a lot in promoting simplistic results as impact
- ✗ Resistance to external critique or performance analysis

WHY IT MATTERS ●

Realistic evaluation measures allow organizations to incrementally improve their efficacy and efficiency in a credible and constructive context.

Fair Trade Learning: A Rubric Guiding Careful and Conscientious Partnership (1 of 4)

Indicator	Ideal	Level 3	Level 2	Level 1
Common Purposes	Agreement upon long-term mutuality of goals and aspirations	Agreement upon overlap of goals and aspirations	Clarity from multiple stakeholders regarding how service* supports community and participant interests	Existing connection facilitates immersive exchange; service is added to “make a difference”
Host Community Program Leadership	Community members have clear teaching, leadership roles; Community-driven research initiatives are co-owned, including fair authorship rights to any co-generated publications	Content and activities of program, from educational through development intervention, are owned by the community through diverse input by community members	Multiple community members have remunerated speaking and leading roles	Key dynamic community member facilitates access
Host Community Program Participation	Community age-peers of participants have financially embedded opportunities to <i>participate</i> (where applicable, in an accredited way) in programming	Community age-peers of participants are continuously invited for exchange, participation, and structured interaction	Deliberate spaces of free interaction exist within the program, and participants are made aware of opportunities to connect with local community members	Program is largely a bubble of visiting students; interactions with community tend to be highly structured, often as guest speakers

Fair Trade Learning: A Rubric Guiding Careful and Conscientious Partnership (2 of 4)

Indicator	Ideal	Level 3	Level 2	Level 1
Theory of Change	Reasons for partnership – in terms of community and student outcomes – are understood and embraced by multiple and diverse stakeholders	In addition to clear student development rationale, the program is infused with and guided by a clear understanding of its approach to community outcomes	Clear efforts are made to systematically grow students' intercultural skills, empathy, and global civic understandings and commitments through best practices in experiential learning	Service is not tied to consideration of its implicit theory of development, community partnership, or social change
Recruitment & Publications	Recruitment materials serve educative function; Shaping expectations for ethical engagement	Writers, photographers, web developers, etc., understand and express responsible social mission via materials	Recruitment materials portray diverse scenes and interactions	Recruitment materials reproduce stereotypical and simplistic portrayals of community members
Communication	University / NGO** and community members know whom to communicate with about what; communication is continuous throughout year	Communication occurs throughout year between institution and community, but increasingly dense network includes individuals unaware of one another	Communication among two individuals is steady; they hold relationship	Communication occurs with key leader; Increases and decreases dramatically near once-annual programming

Fair Trade Learning: A Rubric Guiding Careful and Conscientious Partnership (3 of 4)

Indicator	Ideal	Level 3	Level 2	Level 1
Learning Integration	Text and carefully facilitated discussion on responsible engagement, cross-cultural cooperation, and growth in global community are facilitated learning themes before, during, and after immersion	Participants are introduced to several materials specific to the community, culture, as well as service and development ideals and critiques, and encouraged to consider global citizenship or social responsibility	The idea of integrating reflection is present, but unsystematic “roses and thorns” or other “top of the head reasoning” is predominate	Formal programming focuses on service; conversations are organic
Local Sourcing, Environmental Impacts, & Economic Structure	Economic and environmental impacts of experience are understood and discussed openly between sending institution and multiple community stakeholders; Impact is deliberately spread among multiple community stakeholders	Decisions about housing, transportation, and meals reflect shared commitment to community change, sustainability, and/or development model	Key local leader owns most of the decisions relating to sourcing; makes effort to distribute resources among community-owned businesses and institutions	Decisions about housing, transportation, and meals are not tied to consideration of community or environmental impact

Fair Trade Learning: A Rubric Guiding Careful and Conscientious Partnership (4 of 4)

Indicator	Ideal	Level 3	Level 2	Level 1
Clarity of Commitment and Evaluation of Partnership Success	Clarity of ongoing commitment or clear reason for alternative***; Mutual agreement on reasons and process for end of partnership	Partners have clear understanding of ongoing relationship and common definition of partnership success	Commitments are understood in relational terms and open-ended	Commitments are specific to individual program contracts, which reflect economic exchange and obligations
Transparency	Specific economic model, commitment, amount, and impact is publically accessible and regularly discussed among partners	NGO and/ or university shares full budget with one another and with interested community members, as well as with any other stakeholders who request access	NGO and/or university makes broad form of budget available, such as through 990 disclosure	Economic model, financial exchange amounts, and impacts are not accessible
Partnership not Program	Time horizon and commitments always stretch beyond single experience*** or individuals; Relationships are generative rather than merely exchange-oriented	Clear expectation of ongoing exchange of resources and people among multiple stakeholders in hosting community and in sending institution	Partners communicate about expectation of an ongoing programming relationship	Time horizon is program-specific, as are contracts, commitments, and relationships

Global Health Educational Engagement—A Tale of Two Models

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Abstract

Global health learning experiences for medical students sit at the intersection of capacity building, ethics, and education. As interest in global health programs during medical school continues to rise, Northwestern University Alliance for International Development, a student-led and -run organization at Northwestern University Feinberg School of Medicine, has provided students with the opportunity to engage in two contrasting models of global health educational engagement.

Eleven students, accompanied by two Northwestern physicians, participated in a one-week trip to Matagalpa, Nicaragua,

in December 2010. This model allowed learning within a familiar Western framework, facilitated high-volume care, and focused on hands-on experiences. This approach aimed to provide basic medical services to the local population.

In July 2011, 10 other Feinberg students participated in a four-week program in Puerto Escondido, Mexico, which was coordinated by Child Family Health International, a nonprofit organization that partners with native health care providers. A longer duration, homestays, and daily language classes hallmarked this experience. An intermediary, third-party organization served to bridge

the cultural and ethical gap between visiting medical students and the local population. This program focused on providing a holistic cultural experience for rotating students.

Establishing comprehensive global health curricula requires finding a balance between providing medical students with a fulfilling educational experience and honoring the integrity of populations that are medically underserved. This article provides a rich comparison between two global health educational models and aims to inform future efforts to standardize global health education curricula.

Editor's Note: A commentary by J. Scott appears on page 1596–1597.

Young medical trainees across the United States have demonstrated a high level of interest in global health opportunities for many decades.^{1–3} In

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fact, participation in global health at the medical school level has increased more than threefold from 1984 to 2010.⁴ Infrastructure that assists students and residents in their pursuit of global health training has concurrently flourished in recent years, irrespective of medical specialty.^{4–8} Global health education may offer unique advantages during the formative years of medical training including the following: understanding the dynamics of the doctor–patient relationship, incorporating cultural sensitivity into patient encounters, recognizing the socioeconomic barriers to effective patient care, and introducing students to potential careers in underserved areas.⁹ Indeed, data suggest that the benefits of even brief exposure to global health through an international visit may persist years after the initial experience.¹⁰ Students who have completed an international rotation in a developing country have reported increased confidence in clinical skills, a greater understanding of the cost burden of disease, less reliance on technology, and a larger appreciation of the barriers to communication between the physician and patient.³ The ultimate goal of such educational efforts is to inspire and nurture, at an early stage, a vested

interest in global health and in the care of medically underserved populations.¹¹

Although the benefits of international medical rotations have been demonstrated in various settings, the optimal model of global health education has yet to be established, especially for medical students. The authors of a recent review of global health programs found that these programs lack standardization and that information on their structure is elusive.¹² This issue has garnered significant interest in domestic and international arenas. In 1991, the Global Health Education Consortium, a pan-American nonprofit organization, first formally recognized the unmet need to standardize policies related to international medical education across different medical schools.¹³ Since then, multiple other organizations have spearheaded efforts to create standardized curricula for medical students in the United States and abroad.

To date, the studies exploring the development of global health curricula for medical students have entailed small, isolated experiences. Further, they have not offered a comparison of different models. International training

experiences are highly variable: They range from months-long trips focused on exposing participants to international sites to weeklong immersion trips; some involve an intermediary coordinating organization, while others do not.^{13,14} Recent data suggest that although one-week service-learning trips may benefit students, they may also raise concerns regarding the value of global health engagement, particularly about the effects these student placements have on host communities.^{15,16} Thus, further program evaluation comparing multiple models of global health educational delivery is warranted.

Northwestern University Alliance for International Development (NU-AID) is a student-led and student-run organization at the Feinberg School of Medicine that is dedicated to promoting public and global health. For the last 12 years, NU-AID has coordinated short-term trips to various regions of the world in order both to provide direct medical assistance in areas that are medically underserved and to offer global learning opportunities for medical students. Because of a recent expansion of the medical school's internal global health program, NU-AID leaders have transitioned international trip structures from the short-term service trips towards longer-term, more sustainable projects. Thus, NU-AID and participating students had the unique experience of approaching global health education from two varying angles: Model 1, in which medical students accompanied U.S. doctors to temporary clinic sites to provide high-volume care; and Model 2, in which medical students worked directly with local physicians and with a nonprofit organization committed to long-term care for patients and educational agendas for visiting students. Although many in the global health field have met short-term service trips and medication distribution between nonaligned institutions with skepticism,¹⁷ in this article we explore the optimal educational delivery strategy for students, rather than the provision of care itself. Major themes that we address include the value of immersion experiences, the ethics involved with medical student participation, the relative costs and durations of stays, and the role of an intermediary organization.

Model One—Matagalpa, Nicaragua, December 2010

Matagalpa is a small city in northern Nicaragua with only 3 physicians per 10,000 people.¹⁵ The approximately 145 health centers and/or clinics in Matagalpa, along with the 3 physicians, bring the health care center or provider-to-patient ratio to approximately 1:850 persons.¹⁵ Matagalpa was one of the areas devastated by Hurricane Mitch and its aftermath in 1999. After the hurricane, local nonprofit organizations solicited external medical care providers.

This call for assistance was the major driver in the initial interaction between NU-AID and this international site. In 2010, NU-AID recruited 1 family medicine physician, 1 cardiologist, and 11 medical students to deliver care to this medically underserved population. Specific learning objectives for the students included developing concrete clinical skills when working with patients in community health clinics in an international setting and learning tropical medicine in a “Western” framework under the instruction of U.S. physicians. For the purposes of this article, we define “Western” countries broadly as “non-lower- or middle-income countries that are situated in the Western hemisphere, primarily the United States and Canada.” NU-AID partnered with Fundación por los Derechos y Equidad Ciudadana A.C. (Foundation for Citizens' Rights and Equality), which is a nongovernmental organization committed to indigent health care.¹⁸ This organization subsequently connected the NU-AID team with another organization called Casa de la Mujer (“Woman's House”). Casa de la Mujer is a local Nicaraguan organization dedicated to the medical care of domestic abuse victims.¹⁹ It fosters female empowerment by providing business classes and job training opportunities to local women. In Nicaragua, Casa de la Mujer assisted the NU-AID team with organizing local clinic sites, transporting supplies, and recruiting patients.

The 13-member NU-AID team visited four total sites over the course of one week. The first clinic was at Casa de la Mujer's main health site, located in the central town square. Normally, health “promoters” (i.e., nurses, social workers), rather than physicians, staffed the clinic. The second clinic site was at a distant

coffee plantation where the local workers have routine access to only a nurse. The third site was in a nearby neighborhood within the home of local community members. For the fourth site, the team traveled to a remote coffee processing center where the workers were frequently without electricity and medical care. At each site, 10 medical students (of the total 11) were divided into five pairs, each composed of one upperclassman (a third- or fourth-year student) and one underclassman (a first- or second-year student). The remaining student assisted with patient flow to enhance the overall efficiency of the clinic sites. At all four clinical sites, students were able to speak directly with patients. On a rotating basis, one student pair established a pharmacy and dispensed medications (all provided by NU-AID) according to patient needs; the senior member of the student pair supervised the pharmacy. Throughout the week, senior students were responsible for teaching junior students how to elicit a pertinent history, conduct a physical exam, posit an assessment, and formulate an appropriate treatment plan. After doing so, each student pair presented their patient case to one attending physician, and together the team revisited the patient. Patients received counseling on basic public health behaviors (e.g., condom use, hand sanitation), as well as necessary medications, with detailed instructions. The team served nearly 700 patients over the course of their one-week visit.

Although we described a visit that occurred in December 2010, a NU-AID team established (with the assistance of Casa de la Mujer) the four clinic sites biannually between 1999 and 2010. The clinics were neither staffed nor functional between these trips.

Model Two—Oaxaca, Mexico, July 2011

Puerto Escondido is a small coastal town in the state of Oaxaca in southern Mexico. The city is composed of two general populations: (1) a stable, long-standing indigenous population; and (2) a high-volume, tourist population. In the summer of 2011, NU-AID collaborated with Child Family Health International (CFHI), a nonprofit organization,²⁰ to send 10 medical students on a pilot trip to Puerto Escondido.

CFHI, operating in six countries, provides global health education programs for U.S. medical students. CFHI immerses students into local cultures by organizing homestays for them and integrating them into various public and nongovernmental safety-net systems with local providers.²¹ Because CFHI has been running programs for 20 years, it has cultivated and maintained long-standing relationships with homestay families, local coordinators, and medical directors. In addition, CFHI has policies, procedures, and risk management approaches aimed at ensuring patient and student safety.

Specific learning objectives for the summer 2011 trip to Puerto Escondido included broadening participant understanding of the social determinants of health, engendering a larger sense of cultural competency, and cultivating a deeper interest in service and in the primary-care-oriented fields. To enhance student education regarding national and local health infrastructure, local CFHI staff members gave weekly lectures on topics ranging from national health policy to endemic diseases.

The four-week trip was divided into two 2-week blocks. During the first block students rotated in local primary health care clinics, and during the second, students joined brigades (small groups of community members) to learn about public health measures within the community. During the first two clinical weeks, Northwestern students were assigned to pairs by two parameters: (1) medical school year (i.e., a first-year medical student with a fourth-year medical student) and (2) Spanish fluency (i.e., a fluent speaker with a nonfluent speaker). Each student pair was assigned to one of five clinics along the coast of Puerto Escondido. Each of these *centros de salud* (health centers) was staffed by at least one local physician and nurse who cared for approximately 15 to 35 patients each day. The second two-week block was further divided: one week was dedicated to maternal and reproductive health, and the second to vector-borne diseases such as Chagas, dengue, and malaria. To learn about maternal and reproductive health, the students met midwives and attended classes on reproductive health. At the end of the week, they delivered a public health presentation regarding contraception and perinatal care to a group of 30

women from the community. To learn about vector-borne diseases, the 10 students joined a local brigade member from the Ministry of Health and visited local cemeteries and fields, identifying risk factors for disease transmission. At the conclusion of this week, the students delivered a second public health presentation regarding the transmission, symptoms, and treatments of tropical disease.

Approach to Program Evaluation

NU-AID released information advertising each trip approximately six months prior to departure. Interested students completed applications, in which they expressed their prior and current interest in pursuing global health outreach work. The NU-AID executive board selected approximately 10 students biannually for these trips. U.S. physicians recruited by the NU-AID team under Model 1 participated on a strictly voluntary basis. Trip costs approximated U.S. \$400 (Model 1) or U.S. \$800 (Model 2) per student per week. Predeparture fundraising and institutional support helped to fund student participation in these global health experiences. Predeparture curricula included team-building activities, language assessment, an overview of the program and local region, and informal discussion of ethical/cultural issues of global health student experiences. Clinical and nonclinical mentors (i.e., Northwestern physicians and Mexican health brigade members) were available during the course of each trip to help medical students navigate ethical, cultural, and social situations. Within one month of returning to the United States, the students who had traveled on the trips, along with medical school program staff, participated in an unrecorded, two- to three-hour, group-based discussion forum. All global health participants attended these mandatory sessions, which NU-AID leaders moderated. Students did not receive any incentive for attending.

Some of the major themes that the students returning from Mexico and the students returning from Nicaragua discussed included constructive educational structures, volume of patients, extent of on-site learning, degree of “immersion,” the social and ethical issues of global health educational endeavors, and suggestions for future programs.

Below, we attempt to summarize the major findings from these program evaluation meetings, primarily from the perspective of the medical student. Although NU-AID has been involved in planning short-term global health experiences for the last 12 years (1999–2011), this article reflects only the experiences of the students who visited Nicaragua in December 2010 and Mexico in July 2011.

A Rich Comparison

Model 1’s team structure, consisting of both physicians and students from the United States, allowed for a more cohesive team dynamic. U.S. physicians were able to maintain the familiar Western university teaching framework (i.e., obtain a history, develop presentation skills, posit an assessment, and formulate a plan) that was reportedly easier for students to follow. Model 1 allowed for a higher volume of supervised hands-on care compared with Model 2; that is, Model 1 students saw approximately 70 (versus 25) patients per week—which greatly helped to refine their physical exam and history-taking skills. Through collaboration with a local Nicaraguan partner, Model 1 students engaged in semi-independent clinical care, a potentially important difference between these two models. (As explained, Casa de la Mujer, though a locally based organization, did not independently provide health care to surrounding communities but, rather, built a framework through which the NU-AID medical team was able to do so.)

Provision of medical care in Nicaragua was challenging. The U.S. team was forced to navigate a number of endemic barriers including (1) financial—patients often delayed medical examination because of the perceived high cost of care; (2) sociocultural—major medical conditions such as diabetes, hypertension, and dengue were considered the “norm” and part of daily life; (3) geographic—the access to health care for most local residents was regionally restricted and limited by the lack of established public transportation systems; and (4) structural—national investment in medical resources is minimal. Though possibly compromising continuity of care,¹⁵ importing short-term, single-visit U.S. physicians provided resources

for those who otherwise faced great challenges in obtaining medical attention.

On the other hand, collaborating with an intermediary organization, such as CFHI, as was done in Model 2, facilitated a more holistic understanding of medicine and of the overarching local health care system as it exists without external actors. Homestays, language studies, and collaboration with local physicians nurtured an immersive experience that provided students with a deeper understanding of the health status and cultural nuances of the local community. The clinical role of the student, however, was less active, as local physicians and nurses—rather than student pairs—tended to patients. Although students assumed observer roles, they were able to learn more formally about the local and national insurance systems and about the ongoing public health agenda in Mexico through scheduled didactic sessions organized by CFHI.

Through CFHI, students were able to engage in community health, an aspect lost in the first model because of consuming clinical demands. This public health work fostered communication and presentation skills as well as an aspect of cultural sensitivity. Students completed the program with a thorough understanding of the health infrastructure in Puerto Escondido, which students on trips of shorter duration may not gain.

Table 1 summarizes the major characteristics of the two global health models. Both Puerto Escondido and Matagalpa are burdened by a high incidence of vector-borne infectious diseases^{22–24} and of maternal mortality¹⁵ that physicians in the United States rarely witness. During these relatively brief global health trips, medical students in both models were afforded a learning opportunity that transcended the traditional classroom setting. Both experiences encouraged students to integrate clinical medicine and public health at international sites. To optimize learning for all students, NU-AID enlisted a vertical learning structure for both models. In this structure, first- and second-year medical students were paired with more clinically experienced third- and fourth-year students. Each member of each pair directly participated in clinical care, deriving patient histories and refining

Table 1

Comparative Description of Two Models of Global Health Programs Experienced by Medical Students at Northwestern University, Feinberg School of Medicine*

Characteristic	Model 1	Model 2
Site	Matagalpa, Nicaragua	Puerto Escondido, Mexico
Date	December 2010	July 2011
Duration of trip	1 week	4 weeks
Population	~110,000	~20,000
Relative access to medical resources	Minimal	Moderate
Primary site of training	4 team-established temporary clinics	7 locally established clinics
Accompanying staff	2 U.S. physicians	Local physicians/staff
Coordinating organizations	FUNDECI and Casa de la Mujer (Woman's House)	CFHI
Average number of patients seen per student per week	~70	~25
Financial cost per student per week	~U.S. \$400	~U.S. \$800
Teaching mode	"Western" model, service-learning	Holistic model, immersion experience
Supplies and donations	Medications	Mosquito nets
Public health interventions	Minimal	High

*This comparison focuses on the major differences identified between the two global health models as determined by consensus during posttrip reflection sessions. "Minimal," "moderate," and "high" represent the students' consensus of the measure. FUNDECI indicates Fundación por los Derechos y Equidad Ciudadana A.C. (or, in English, Foundation for Citizens' Rights and Equality); CFHI, Child Family Health International.

physical exam skills, and the senior student offered constructive feedback to his or her more junior colleague at each step of the examination process.

Both modalities also included debriefing sessions at which students were able to discuss their experiences in the international clinics. These sessions served as an outlet for students to identify the challenges in working in international health and to further brainstorm solutions to these barriers.

There are important differences between these global health program models in the relative financial costs to the students and to the institution. Model 1 requires dedicated institutional faculty to be away from academic duties for the trip duration (in this case, a voluntary decision). Model 2 may represent a less resource-intensive approach for academic institutions to be able to provide their learners with international medical experiences. Model 2 allows institutions to ensure safety, orientation, partner site coordination, and faculty involvement all without committing huge internal resources. This represents an excellent opportunity for smaller institutions

that may lack the experience, staff, and resources to run independent global health programs. However, in Model 2, the intermediary program (CFHI) required a program tuition. Thus, without an external funding source, the burden of the expense shifts to the learners who are then responsible for their own trip expenses and for the organizational fees that fund their classes abroad and their homestays, and which contribute to overall program quality. These fees are integral to the program model as they are reinvested in the community through the compensation given to local preceptors for their work as educators, through capacity-building efforts (support for degrees, training, and other professional development), and through concurrent, locally driven community health projects.²⁵ Model 2 reflected a tuition-based approach similar to educational institutions and offered reciprocity to the local site through, as mentioned, financial compensation of local preceptors and others—rather than through externally provided health care services.

The inherent barriers (primarily language and cultural) that make international

health work difficult may also decrease the learning of U.S. students in international settings. The two models took different approaches to manage the obstacles to effective learning. The first model allowed for educational delivery in the context of a known and familiar framework; that is, U.S. physicians applied and reinforced educational practices common in their home institutions but with a tropical medicine focus. The familiar practices helped students anchor their understanding and expand their knowledge base despite the new context. The high volume of patients also provided more hands-on experience through which students could solidify their clinical skills. Because patient care followed a Western structure in Model 1, students were able to apply skills learned in Nicaragua to clinical settings at their home institution. Model 2 reflected a mode of global health care delivery that is recognized as more sustainable.¹⁶ This model directly targeted barriers to education and student learning by providing an “immersion”-based solution. Homestays and daily language classes helped students relate directly with patients and the greater community, strengthening the patient–provider bond. Further, trips of longer durations appear to help students assimilate to a new culture and learn to adapt their medical knowledge to better suit a resource-limited setting. This approach provides students an opportunity to see “global health” through the eyes of the local community as it exists without Western intervention. In addition, it empowers local providers to educate foreigners about their own reality. Following the immersion at health care sites, CFHI organized structured didactics with local medical directors to bridge gaps between local realities and student perceptions. After experiencing Model 2, medical students reported returning to the United States with a more holistic understanding of the impact of cultural issues on medical care delivery.

Medical Students and Ethics

Although the purpose of this article is to highlight the strengths of two different global health education models in terms of medical student learning, these educational programs fit into a larger system of global health care delivery, and this article touches on larger issues of ethics. During the posttrip debriefing

discussions, medical students frequently commented on the lack of training in the ethics of international health education. Though consensus reports recognize ethics as an integral part of global education programs,²⁶ few practical, real-world approaches have been attempted to address this issue.²⁷ This deficit is consistent with others’ experiences.²⁸

Indeed, each model prioritizes unique global health ethical concepts. Model 1 emphasizes health equity as a central tenet in global health. In that model, U.S. personnel address the immediate health care needs of community members, filling an apparent void. This model facilitates high-volume care and directly addresses several identified barriers to health care delivery, including access to quality care; however, this model precludes reliable follow-up and makes continuity of care challenging for the local population. Larger systemic approaches are likely required to ameliorate structural issues, such as poverty and maldistribution of resources. One hope of the weeklong, intensive experience was to inspire young physicians-in-training to become a part of this larger systemic approach and to help establish more equitable and sustainable health care in medically underserved regions.

However, this model carries concerns about sustainability, unintended malfeasance, and, potentially, lack of humility.²⁹ Very temporary interventions, such as the one in Nicaragua, that do not concurrently build capacity through training local professionals or collaborating with an established local health care system, are in their very nature unsustainable. In addition, there is an inference that health care issues can be addressed adequately through sporadic short-term interventions, which is contrary to existing health care systems and chronic disease care models.²⁸ Furthermore, Model 1 risks malfeasance in the possibility that patients may experience side effects from medications they take that are from the United States. Patients may not be able to access appropriate follow-up care as a result of the short-term efforts, or the use of a foreign medication may hamper follow-up care with local health care providers. Finally, this approach challenges humility by positioning students as primary caregivers and U.S. physicians as empo-

wered providers, rather than empowering local providers through support, education, and collaboration.^{30,31} This imbalance has led medical students in the past to question the services provided during one-week international health trips and to identify a need for community partnership.¹⁵

The CFHI model²⁵ aims to support local practitioners by making them the experts of their own health care environment. In doing so, this empowerment alters the prevalent power dynamic present when Westerners insert themselves into medically underserved communities abroad. CFHI uses an asset-based engagement approach that reflects similar development models³² to provide educational opportunities that reflect the strengths and agenda of the host community. In this way, CFHI’s model aspires to embody humility, sustainability, and justice.³³ However, there are challenges to this model too, as it assumes local health care personnel or systems are operating with an eye to health equity or social justice. In addition, Model 2 preferentially addresses the goals of the community over those of the visiting students who more commonly observe other health care providers, rather than actively engage in medical care themselves.

The Working Group on Ethics Guidelines for Global Health Training³⁴ suggests that best practice is to “consider the local needs and priorities regarding optimal program structure.” It appears that Model 1 and Model 2 have interpreted local needs in different fashions: Model 1 with an eye to immediate alleviation of disease, and Model 2 with a goal of nurturing a better understanding of local health infrastructure. These contrasting models exemplify needs-based versus asset-based community development. In the former, a need (lack of medical care) was identified and immediately addressed by U.S. physicians and medical students. In contrast, in the latter, students immersed in the local health care context capitalized on existing assets—the local health infrastructure and local expertise. Subsequently, the students in Model 2 further built on these by providing integrated community health education.^{33,35} The primary tenets of the asset-based model are to leverage the preexisting skills of local populations, to use intermediary organizations, and to

provide a supportive network for future sustainable growth. This latter model, however, is fairly resource-intensive and requires long-term investment of social and financial capital. The Asset-Based Community Development Institute, based at Northwestern University, has been developed to focus specifically on this sustainable model.^{35,36}

Striking a Balance

Global health learning experiences for medical students sit at the intersection of capacity building, ethics, and education. Western students and their sponsoring institutions may erroneously focus on the attainment of clinical skills over that of cultural competency or anthropological understanding. From early in their medical training, Western medical students receive relatively few tools to deal successfully with potential ethical dilemmas. Many of these students have had minimal prior international experience, yet often when they visit a medically underserved community in another country, they are allotted a higher degree of freedom than they usually receive within their structured, regulation-based institutional environment. At the patient level, local populations face vulnerabilities related to their social, economic, and health status as well as to their overall lack of situational control. Ethical standards suggest that medical students should be in a learning—rather than a service—role during international placements because their lack of supervision and experience, especially in performing clinical tasks, raises concerns.^{15,34,37} However, students are often regarded as fully educated health practitioners in an international setting, or they are less carefully supervised than when they rotate through domestic clinical placements.³⁸ Models that place students in a service or provider role may increase the students’ access to patients and pathology but also may violate ethical commitments to the community.

Thus, intermediary organizations may be integral to bridging the gap between U.S. medical students and local communities (Figure 1). These third-party organizations can serve to ameliorate the large power imbalances, cultural differences, and language barriers that exist between these two players. In addition, these organizations can mediate between the agendas of local

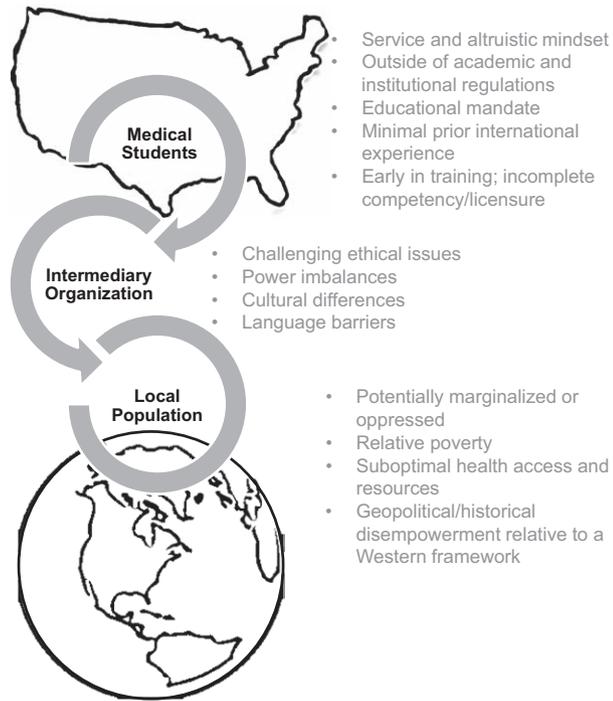


Figure 1 Bridging the gap. A schematic illustration of the unique elements that influence international educational models from the perspective of the medical student and the local population. Intermediary organizations may serve an integral role in bridging the gap between these two potentially disparate entities.

communities and Western institutions. They may also play a role in safeguarding the interests of the host communities and ensuring appropriate compensation for local personnel who have helped to facilitate the global health education experiences for students. Importantly, long-standing affiliations between these third-party organizations and local populations are required to ensure that the relationships remain mutually beneficial and continue to serve the community.

Future Directions

A number of key areas need to be addressed in the future evaluation process of these global health experiences. Literature-based resources may help administrative organizations such as NU-AID better structure reflection sessions so as to facilitate semiquantitative data output, increase student participation, and foster reproducible methodologies. Using more established program evaluation strategies, we hope to continue to collect data about international trips and perhaps to track students longitudinally to evaluate whether they pursue global health careers. Future initiatives must focus on bolstering medical student knowledge of ethical

issues and cultural competency during predeparture sessions prior to students actually engaging in global health outreach work. Recently developed ethical curricula can be integrated into a more traditional pretrip preparatory guide.³⁹ As programs’ relationships with the local community build, longer-term patient follow-up may be plausible—just as assessing patient experiences and gathering local feedback after the medical student encounters may be. NU-AID plans to continue to partner with CFHI in upcoming years on the basis of the general consensus of participants of prior trips and the internal global health program at Northwestern. On the basis of positive feedback from Model 1 participants, future iterations of the month-long program in Oaxaca will attempt to incorporate higher-volume, more hands-on involvement and patient care within the established local framework.

Conclusions

Establishing comprehensive global health curricula requires finding a balance between providing medical students with a fulfilling educational experience and honoring the integrity of the local community members. An intermediary, third-party organization may serve to bridge the cultural and ethical

gap between visiting medical students and local populations. More comparative data evaluating the influence of these global health programs on medical student trajectories will help inform future efforts to standardize global health education curricula.

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VIEWPOINT

Service Learning as a Framework for Competency-Based Local/Global Health Education



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INTRODUCTION

Service learning is a field that can provide the foundation for emphasizing the relevancy and realities of local/global health. Service learning is now widely accepted as a form of experiential education in which students “engage in activities that address human and community needs together with structured opportunities intentionally designed to promote student learning and development.”¹

Service-learning courses are not just regular courses with community service for homework; rather, they are courses that unite service and classroom and include a rigorous pedagogy to maximize student development, as well as community priorities. As a result of these carefully drawn distinctions, service learning has survived throughout the years as a formal construct that allows for academic foundations, community engagement, and assessment. With the recent expansion in global health competency sets, including those with interprofessional applications, service learning becomes an increasingly relevant construct for competency-based global health education.¹ Service learning is a construct that optimizes the relevance and effect of local global health education and community engagement.

Global service learning (GSL) is a specialty within this field. GSL focuses on service learning in international settings, as well as cross-cultural engagement wherever it occurs. Like global health, GSL is not geographically specific or only applicable internationally. It builds on lessons and practices from domestic service learning, but borrows from both international education and international development literature to develop a distinctive set of values and principles. According to Hartman and Kiely,² GSL stands apart in 5 key ways:

1. It is committed to student intercultural competence development.
2. It has a focus on structural analysis tied to consideration of power, privilege, and hegemonic assumptions.
3. It takes place within a global marketization of volunteerism.
4. It is typically immersive.
5. It engages the critical global civic and moral imagination.

GSL has several definitions, including “a community-driven service experience that employs structured, critically reflective practice to better understand global citizenship, self, culture, positionality, socio-economic, political and environmental issues, relations of power, and social responsibility in global contexts... It is a learning methodology *and* a community development philosophy. It cultivates a way of being in that it encourages an ongoing, critically reflective disposition.”² Although service learning of all types usually includes students receiving academic credit, many contemporary thought leaders do not consider this essential. Further exploration of the topic suggests it is “experiential educational programs in which students are immersed in another community and culture, providing meaningful service in partnership with a host community. Global experiences are not defined by geographic boundaries but are inclusive of experiences in which participants are immersed completely in another community and culture.”³ Whether local or international, immersive experiences provide opportunities for students to nurture global health competencies. Service learning and GSL are constructs to optimize the formality and intention of educational programs in global health.

CONNECTING LOCAL AND GLOBAL

A goal of local/global health education is to educate young people who are rooted in a given locality to have an eye toward global challenges and to see the local opportunities to address and engage in them. In an interconnected world, where decisions about resources in one locale can affect the lives of people in distant communities and where distant events and forces can have a profound effect on local endeavors, it is important to connect global themes with local action. In the sphere of international education, a new term *study away* is taking hold and broadening the traditional notion of study abroad.⁴ Study away is “a concept and educational strategy that integrates study abroad programs with domestic programs. Diverse cultures within a local, regional, or national community should be recognized for providing learning opportunities and experiences that can also be transformative.” An outcome of international study abroad is openness to diversity, suggesting that study away, which immerses students in a diverse community (one distinct from the one most familiar to them), is essential to nurture such student outcomes.⁵

Drawing on the concept of global citizenship, the connection is reinforced between the local applicability of student development that has happened during international experiences and vice versa. Global citizenship includes “recognizing an ethical imperative or willingness to reduce one’s ecological impact and support a sustainable footprint that may have no immediate personal value but ultimately benefits others around the world.”⁶ This is the local/global connection that helps to train a generation of global citizens who will one day harmonize across nation-state and cultural bounds to address challenges that face the entire human family. When combined with theoretical foundations and critical thinking activities, the experience of being the “other” in a global setting can challenge assumptions about oneself and others, foster cultural humility, and enhance self-knowledge.⁷ Reflection on the experience provides the learner with an opportunity for “assessing the grounds (justification) of one’s beliefs.”⁸

To meet the requirements of service learning as pedagogy, programs must have specific characteristics (Table 1). As service learning becomes increasingly common within graduate and health professions’ education, curriculum, and accreditation, understanding these requirements when working under the auspices of service learning is essential.⁹

Table 1. Required Components of Global Service-Learning Initiatives

Community-driven service
Intercultural learning and exchange
Consideration of global citizenship
Continuous and diverse forms of critically reflective practice
Deliberate and demonstrable learning
Ongoing attention to power and privilege throughout programming and coursework.
Safe programs ²

SYNERGY BETWEEN GSL AND COMPETENCY-BASED GLOBAL HEALTH EDUCATION

Although it is common to have a fieldwork or other experiential component within global health education programs, broadly known as short-term experiences in global health (STEGH), there is lack of uniformity or use of consistent or well-designed pedagogies within the field.¹⁰ Experiential learning theory (ELT) defines learning as “the process whereby knowledge is created through the transformation of experience. Knowledge results from the combination of grasping and transforming experience.”¹¹ It is proposed that such learning occurs in a cycle of action/reflection and experience/abstraction. Global health educational programs occurring locally and internationally have maximum affect when they are intentional about this cycle and frameworks to encourage it. Service learning creates an intentional structure where the cycle plays out for the learner.

The requirement that service learning include “deliberate and demonstrable learning” aligns with increasing reliance on competency-based education. Competency-based education is a focus of health professions and global health training.¹² Recently, levels of proficiency that apply to trainees in all disciplines relevant to global health have been suggested as follows:

- Level 1: Global citizen level,
- Level 2: Exploratory level,
- Level 3: Basic operational level, and
- Level 4: Advanced level.

Service-learning frameworks are particularly relevant to structure the exploratory level of proficiency, which is competence “required of students who are at an exploratory stage considering future professional pursuits in global health or preparing for a global health field experience working with

individuals from diverse cultures and/or socioeconomic groups.”¹² However, service-learning resources and approaches enrich STEGH or professional pursuits at any level of global health proficiency. Global health competencies are, in turn, a tool to direct this pedagogical requirement of service learning. Wilson et al.¹² reviewed 30 competency sets and derived 11 domains and ≥ 30 competencies that apply to the various levels of global health professional proficiency that apply regardless of trainee or professionals specific discipline.

Recognition and utilization of appropriate competency aims and learner development in the design of local/global health programming is essential. Appropriate competencies are linked to optimal learner development, ethical integrity, and patient/learner setting. ELT and emerging GSL outcomes research have revealed ways in which global health competencies are nurtured by local programming. Similarly, there is a growing appreciation that local career trajectories are built on international service-learning education. Examples of competencies developed by GSL that can be applied locally or internationally include cultural awareness, enhanced civic engagement,¹³ self-efficacy, and a globalized perspective.¹⁴ Benefits of international experiences include changed values, increased consciousness of social justice and global health issues, significantly improved communication skills, confidence, and increased dedication to underserved and multicultural populations domestically.¹⁵

Competency-based education is not without critiques. Several key challenges of competency-based education include a failure to adequately recognize the localization that proficiency requires, the lack of inclusion of perspectives from communities most affected by health disparities in the creation of competencies, inadequate assessment mechanisms and the failure to appreciate acquired versus participatory competencies. Acquired competencies are those that are generally not context specific, whereas participatory competencies are very dependent on context, culture, power and relationship dynamics, and so on. Service learning and GSL have long grappled with similar challenges. The pedagogy of service learning and tools that have originated in this thought community are salient for optimal local/global health education.

OUTPUTS AND ASSESSMENT IN GSL

GSL has been suggested as one of the most effective ways to facilitate the development of intercultural

competence, and “global citizenship.”¹⁶ *Intercultural competence* is defined as the ability to communicate effectively and appropriately with people of other cultures.¹⁷ The nature of local/global health emphasizes the relevance of this skill domestically as culturally diverse populations experience health disparities and hurdles to optimal wellness and thriving. Global citizenship is a concept common to service-learning circles.¹⁸ Global citizenship connotes that when an individual is interacting with persons who are different in characteristics such as faith, ethnicity, and sex, the interaction is done in a fashion that acknowledges that regardless of how different 2 individuals are, they are members of the same community and equally worthy of respect and acknowledgment simply because of their status as citizens.¹⁹ The goal of global citizenship “is to extend that courtesy of equal recognition throughout the human community.”¹⁴ The concept of global citizenship, although it has connotations of internationalism, is rather more naturally applied locally, where 2 individuals are actually a part of the same local community and geography.

GSL, similar to the blossoming field of global health, fills an important niche in the changing role of the university in global society, as institutions of higher education partner in helping to solve some of the world’s most pressing societal challenges.²⁰ This increased attention has led to rapid growth within the field of GSL, which is now accompanied by an increasing demand for accountability and demonstration of positive community affect and learning outcomes. Despite this continued momentum across colleges and universities, systematic research²¹ and scholarly knowledge within the field²² continues to evolve.

Ideally, assessment of effective programming assumes a 3-pronged approach—examining outcomes for the institutions involved, communities where service learning takes place, and the individual trainee. Although community and institutional effects often have primary importance within the field of global health, we suggest means for measuring the effectiveness of global health education with regard to student development based on service learning. Although no assessment scale has reached a place of dominance to be considered a singular standard, several scales have been widely used within GSL to assess overall competence and learner progress. Most of these scales are self-report inventories that use pre- and postimmersion experience to measure relevant benchmarks.

Table 2. Global Service-Learning Assessment Tools

Domain of Trainee	Assessment Tool
Development	
Intercultural sensitivity	Intercultural Development Inventory ²³
Global civic engagement	Global Engagement Survey ²⁴
Global perspectives	Global Perspectives Inventory ²⁵

To adequately measure and be able to further develop their programs for local/global health education, institutions must evaluate and develop intercultural sensitivity, global civic engagement, and global perspective of students (Table 2). Intercultural sensitivity accounts for the student’s ability to tolerate and interact with other cultures. Global civic engagement measures the desire of students to participate with and contribute to the well-being of people worldwide. Finally, global perspective measures a student’s ability to take into account many diverse perspectives when thinking and making decisions about the world. Each of these 3 domains of student development assesses different aspects of educational and service programming by integrating the cognitive and interactive portions of a student’s worldview. Therefore, students’ motivations, expectancies, intercultural sensitivity, global civic engagement, and global perspective constitute the foundation of formidable programming.

INTERCULTURAL SENSITIVITY

Intercultural sensitivity (also referred to as cultural sensitivity or cultural humility) has long been considered an essential component of the ability to work and learn in a setting that is foreign to the learner (whether domestic or international). Individuals must demonstrate the ability to adapt and accept concepts and actions that are different than their own, and when highly advanced, adjust their own actions to demonstrate a relevant ability to relate. Cultural difference is difficult because it challenges individuals to reconsider their own ethnocentric views of the world and to treat each intercultural experience with an open mind and as a unique concept.²⁶ However, students tolerant of culturally and ethnically diverse peoples more often can understand and engage in intercultural relationships, demonstrating an ability to navigate cultural transitions.

This line of reasoning is captured in the Developmental Model of Intercultural Sensitivity (DMIS), which assesses an individual’s perspective

of development.²⁷ Understanding these stages is crucial to constructing an applicable competency-based educational roadmap. The DMIS is based on Bennett’s definition of *subjective culture*, defined as, “the learned and shared patterns of beliefs, behaviors, and values of groups of interacting people.”²⁷ This definition is contrasted with the term *objective culture*, “behavior that has become routinized into a particular form” (ie, art, food, music, etc.).²⁶ The DMIS is a research-based model that includes an intercultural development inventory (IDI). The IDI assesses the individual’s intercultural developmental level. The DMIS focuses on 6 development stages to determine the range an individual falls under regarding intercultural sensitivity, ranging on a continuum from the 3 ethnocentric worldviews (denial, defense, minimization) through the 3 “ethnorelative” levels (acceptance, adaptation, integration). Consisting of a 50-item measure of Bennett’s DMIS, the test reports are scored in comparison and range of a large data set that lends the benefit of comparison both pre/post (for individual development markers) as well as comparison to a large data set (allowing for group benchmarking). Now one of the most widely used and time-tested instruments for assessing intercultural development and competence, it often is acquired and administered at low cost, which includes a written report on findings.

GLOBAL CIVIC ENGAGEMENT

As a concept, global citizenship emphasizes an individual’s responsibility for issues and concerns of the broader global community—someone who identifies with being part of an emerging world community and whose actions contribute to building this community’s values and practices. Global citizenship is not received at birth, but rather develops over time with involvement in the surrounding world, something offered through educational abroad programs.²⁸ The enactment and development of this concept often is considered “global civic engagement.” *Global civic engagement* is defined as “the demonstration of action and/or predisposition toward recognizing local, state, national, and global community issues and responding through actions such as volunteerism, political activism, and community participation.”²⁹ Within categories of global citizenship, global civic engagement is unique because it involves a choice of action from the participant as demonstrated when applying for, and coming back from, international education or global health programs.³⁰

Global civic engagement is critical in constructing a global education as the idea of a nurtured citizen among students must come from engaging in the world all around, transforming this active role into a duty.⁶ Students recognize the importance of learning experiences involving other nations, and people different than them domestically, because they help create a comprehensive global framework from which the students can better interpret global issues and concerns.³¹ The factors of volunteerism, political activism, and community participation are pertinent because of their influence on decisions to undertake global health, as well as their influence on the lifestyles of those who return from such a program.²⁹ Ultimately, these opportunities allow students to participate while learning the importance of participation, helping fulfill the purpose of global civic engagement.³² Most assessment tools have yet to account for global citizenship and global civic engagement. However, a recently developed instrument, the Global Engagement Survey (GES), measures intercultural competence, critical thinking, civic engagement, and social responsibility among students following a global experience. Unlike tools that measure separate characteristics (eg, open-mindedness, flexibility), the GES builds on decades of intercultural development research as well as social responsibility scales recently introduced by theories of democratic education adopted by the American Association of Colleges and Universities.

GLOBAL PERSPECTIVES

Global perspective is a third factor that completes a holistic view of learned development. Global perspective is crucial as it incorporates several different aspects of one's view regarding global contexts, cultures, and situations. A well-developed global perspective alters how students think rather than solely the knowledge they accumulate, thus study-abroad programs attribute to their comprehensive development. Although the term is still evolving, *global perspective* can be defined as "the capacity for a person to think with complexity taking into account multiple perspectives, to form a unique sense of self that is value-based and authentic, and to relate to others with respect and openness, especially with those who are not like him or her . . . [with a] sense of people, nation, and world beyond themselves."³³

A global perspective integrates both internal and external aspects of one's current global orientation beyond mere cognitive effects.³⁴ The 3 major

domains of global perspective include the cognitive, intrapersonal, and interpersonal categories. Cognitive knowing refers to how one processes culture and uses these instances to evaluate what is important, whereas cognitive knowledge focuses on what one knows about various cultures and their effects in greater context. Intrapersonal affect includes the relativizing of one's own culture, acceptance of different beliefs, and general confidence in foreign settings.³⁵ The interpersonal domains include skills in developing meaningful relationships, interdependence with others, collaboration, and effective leadership. This concept is crucial in global education as global perspective demands awareness and comprehension of the world (like the environment or population growth) as well as global events, international relationships, and a relative placement of one's own culture and context.³⁶

In order to measure changes in global perspective, the Global Perspectives Inventory (GPI), was developed to measure how students think, view their own cultural heritage, and relate to people from other cultures, backgrounds, and values. The GPI uses 6 global perspective-taking scales: cognitive knowing, cognitive knowledge, intrapersonal identity, intrapersonal affect (acceptance of cultural perspectives different from one's own), interpersonal social responsibility, and interpersonal social interactions. The GPI is designed to focus on connections between global student learning and inter- and intrapersonal development through experiences in the cocurricular, curricular, and community immersion. It is also web-based, easily administered, affordable, has the ability to add questions to the delivery platform (so the test can be administered as part of wrap-up evaluations), and offers a significant database for benchmarking both international and US-based experiences of crossing-cultures.

SERVICE-LEARNING TOOLS AND RESOURCES FOR LOCAL/GLOBAL EDUCATION AND ENGAGEMENT

Standards of Good Practice. The Forum on Education Abroad, an organization that is designated as the Standards Development Organization (SDO) for study abroad by the US Department of Justice and Federal Trade Commission, has created the Standards of Good Practice.³⁷ These standards are additionally useful for service learning and other domestic local/global education programs. The standards are organized into 9 domains:

1. Mission and goals
2. Student learning and development
3. Academic framework
4. Student selection
5. Preparation and advising
6. Student code of conduct and disciplinary actions
7. Policies and procedures
8. Organizational and program resources, health, safety, and security
9. Risk management and ethics

The standards are backed up by online toolkits, as well as queries for programs and institutions to review their adherence. Local/global health experiential learning program development and administration has responsibilities and accountabilities that mirror those of international education. These Standards of Good Practice are a useful resource to examine the integrity and completeness of local/global health education programs.

SERVICE-LEARNING EXERCISES

Personal Identity Pie. The personal identity pie³⁸ activity allows learners to consider their self-concept of identity, as well as how the local/global community that is distinct from their own frame of reference will perceive them. Students are asked to draw a circle on a piece of paper. They are instructed to divide the circle in as many pieces (even or uneven sizes) as they need to answer the question “what are the pieces of my identity?” Once completed, students share their pies with their peers and have a group discussion of each of their identities—the similarities and differences. They are then asked to draw another circle and divide it in as many pieces as they need to in order to answer the question “how will my host/partner community see my identity?” They each create a pie (often very different than the one reflecting their self-concept) of how the community where their service learning takes place will perceive them. Students then discuss these pies as a group.

Training for a Global State of Mind. Jane Philpott proposed a salient motivations exercise in her seminal article *Training for a Global State of Mind*.³⁹ In this exercise, learners are asked to consider their motivations for wanting to “help” or engage in service-oriented activities. They are instructed to classify their motivations into “motivations I suppress,” “motivations I can tolerate,” and “motivations to which I aspire.” They then share motivations by category. Motivations they wish to express often are those that are self-centered, such as “getting to

travel,” “receiving awards and recognition,” and “adding to my resume.” Motivations that they tolerate often are less abashedly self-centered, such as “learning a new language,” or “learning about a new culture.” Whereas those to which they aspire tend to be idealistic, such as “making the world a better place,” and “addressing health disparities.” This can lead to an extended discussion about motivations and ensuring that one is in touch with a variety of motivators and/or outcomes of service learning.

Unpacking the Invisible Knapsack. Local/global health immersion often begins best by students understanding their own identity as a social and economic actor in a global system. The classic article, *Unpacking the Invisible Knapsack*,⁴⁰ helps identify some of the daily effects of privilege in our lives. Originally designed as a way to shed light on race and social advantage, the article defines privilege as “an invisible package of unearned assets that I can count on cashing in each day.” This exercise, which is built on the physical embodiment of a “privilege walk,” through a series of questions can serve as a guideline for creating customized questions for global health programming.

CRITICAL REFLECTION MODELS

On the path to becoming active, global citizens, most students must travel a continuum of identity development that allows them to adopt a growing awareness of their social location and ability to create positive change as a result of this location. Critical reflection is a key tool used in service learning to elicit this transformation. Contrasting to noncritical reflection, which may be considered akin to journaling or basic recall of events, critical reflection examines larger systems, agency, and implications for the future behavior or perspectives of the learner.⁴¹ In their discussion of active citizen development, experts note that a successful educational immersion will move students from not being aware of their roles in social issues (*member*) to a well-intentioned, but not well-educated actor (*volunteer*). From here, sustained immersion and service can lead to the ability to see systemic social inequalities, asking “why” questions, and exploring causality (*conscientious citizen*) and then finally, to becoming involved in continued service, advocacy, and activism to address these causes (*active citizen*). However, all of these stages are not reached by simply experiencing a local/global health immersion. Rather, one must critically reflect in self and context in order to gain understanding and carry out informed action. The following exercises offer short, time-tested methods

for students to better understand their own identity and the critical they are experiencing.

DEAL Model. The DEAL (Describe, Examine, and Articulate Learning) Model for critical reflection has learners describe the experience objectively, examine it per 3 categories (personal growth, civic learning, academic enhancement), and articulate learning. Articulating learning has structured prompts: “I learned that ...”; “I learned this when ...”; “This learning matters because ...”; and “In light of this I will ...”.⁴²

Rolfe’s Framework. Rolfe’s framework, which has become popularly known as “The ‘What?’ ‘So What?’ ‘Now What?’” framework, can provide a simple, but reliable method of intentional reflection during discussions and activities. Rolfe’s approach is based on work by Terry Borton⁴³ that outlined stages of student development: sensing (what), transforming (so what), and acting (now what). In using this framework, students learn first to “step outside their own experience and question it” and then to “step outside their *way of* experiencing and question that.” Using this framework can guide students as they step into a new health immersion experience and question their ways of thinking and acting.⁴⁴

SOAP Format. For trainees in clinical provider fields familiar with the use of Subjective-Objective-Assessment-Plan (SOAP) notes for patient documentation, Louise Aronson’s adaptation of the SOAP note to facilitate critical reflection is useful.⁴⁵ Using this model, learners discuss the subjective (what happened, how it happened, why they believe it happened), then seek objective data (including peer/other perspectives, scholarly work, expert consultation), followed by assessment (drawing parallels, a larger perspective, identifying learning issues), and finally a plan (using SMART goals for how the prior sections will inform future behavior/perspective).

Fair Trade Learning. Service learning must be “grounded in a network, or web, of authentic, democratic, reciprocal partnerships and ... as a way to incorporate mutuality and reciprocity, resulting in more appropriate, inclusive, and

sustainable development.”⁴⁶ However, educational partnerships for local/global health education come in many forms and iterations, with varying levels of success. Although program outcomes begin with good intentions and have documented contributions, critics have also acknowledged issues of power, positionality, and neocolonialism.⁴⁷⁻⁴⁹ However, until recently, there has been no mechanism to ensure that these programs are designed and conducted ethically.^{50,51} As a result, practitioners and professionals of international education, volunteer tourism, non-government organizations, and community development collaborated to develop the first iteration of Fair Trade Learning (FTL) principles.

FTL⁵² is a framework that informs partnerships and practices that facilitate service learning. This framework prioritizes reciprocity in relationships through cooperative, cross-cultural participation in learning, service, and civil society efforts. As global health programs and partnerships require participants and institutions to examine their potential effects on vulnerable communities, the FTL rubric helps to advance just global partnerships. It foregrounds the goals of economic equity, equal partnership, mutual learning, cooperative and positive social change, transparency, and sustainability.

CONCLUSION

Service learning and global service learning are vibrant communities of thought and practice that provide important theoretical and practical frameworks for local/global health education. At its heart, local/global health is aimed at addressing health disparities both domestically and internationally. Educational programs that aim to develop the competency of learners to engage in local/global health are well served by drawing on the decades of research and pedagogy established in the service-learning field. Only through conscious and intentional programming can learner outcomes be ethically appropriate, safely imparted, and optimally constructive.

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TWELVE TIPS

Twelve tips for teaching reflection at all levels of medical education

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Abstract

Background: Review of studies published in medical education journals over the last decade reveals a diversity of pedagogical approaches and educational goals related to teaching reflection.

Aim: The following tips outline an approach to the design, implementation, and evaluation of reflection in medical education.

Method: The method is based on the available literature and the author's experience. They are organized in the sequence that an educator might use in developing a reflective activity.

Results: The 12 tips provide guidance from conceptualization and structure of the reflective exercise to implementation and feedback and assessment. The final tip relates to the development of the faculty member's own reflective ability.

Conclusion: With a better understanding of the conceptual frameworks underlying critical reflection and greater advance planning, medical educators will be able to create exercises and longitudinal curricula that not only enable greater learning from the experience being reflected upon but also develop reflective skills for life-long learning.

Introduction

In recent years, professional organizations and accrediting bodies have called for the inclusion of reflection at all levels of medical education (ACGME 1999; ABIM Foundation, ACP-ASIM Foundation, European Federation of Internal Medicine 2002; Frank 2009; GMC 2009). These calls come in response to a growing literature in medical education suggesting that reflection improves learning and performance in essential competencies. Specifically, reflective learning can improve professionalism and clinical reasoning, and reflective practice can contribute to continuous practice improvement and better management of complex health systems and patients (Mann et al. 2007; Sandars 2009). This work builds on an extensive and decades-old literature on the benefits of reflection in higher education and life-long learning, but offers only partial guidance for medical educators in deciding how best to teach and develop reflective skill in their learners.

Review of studies published in medical education journals over the last decade reveals a diversity of pedagogical approaches and educational goals. The following tips outline an approach to the design, implementation, and evaluation of reflection in medical education based on the available literature and author experience. The tips are ordered in a sequence an educator might use in planning a reflective activity and are applicable to learners in undergraduate, graduate, and continuing education settings.

Tip 1

Define reflection

Because reflection is a familiar concept in everyday life, medical educators must distinguish the common usage of the term from the particular skill set associated with important educational outcomes. Colloquially, to reflect means to look back and consider something. While such thoughtfulness can result in insight and learning, it does not automatically lead to the high level analysis, questioning, and reframing required for transformative learning. *Critical reflection*, by contrast, has been described by Mezirow as follows:

... the process of becoming critically aware of how and why our presuppositions have come to constrain the way we perceive, understand, and feel about our world; of reformulating these assumptions to permit a more inclusive, discriminating, permeable and integrative perspective; and of making decisions or otherwise acting on these new understandings. More inclusive, discriminating, permeable and integrative perspectives are superior perspectives that adults choose if they can because they are motivated to better understand the meaning of their experience (Mezirow 1990).

Simply put, critical reflection is the process of analyzing, questioning, and reframing an experience in order to make

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an assessment of it for the purposes of learning (reflective learning) and/or to improve practice (reflective practice). If we take the example of a medical mistake, a superficial, educationally ineffective reflection will consist of a description of the events or a description accompanied by reasons such as the team/clinic was busy and other people failed in their responsibilities. A more useful and deeper reflection would include consideration of how and why decisions were made, underlying beliefs and values of both individuals and institutions, assumptions about roles, abilities and responsibilities, personal behavioral triggers, and similar past experiences (“when pressed for time, I...”), contributing hospital/clinic circumstances and policies, other perspectives on the events (frank discussion with team members, consultation of the literature or other people who might provide alternative insights and interpretations), explicit notation of lessons learned and creation of a specific, timely, and measurable plan for personal and/or system change to avoid future similar errors. Effective reflection, then, requires time, effort and a willingness to question actions, underlying beliefs and values and to solicit different viewpoints. This “triple loop” approach moves beyond merely seeking an alternate plan for future similar experiences (single loop) or identifying reasons for the outcome (double loop) to also questioning underlying conceptual frameworks and systems of power (Argyris & Schön 1974; Carr & Kemmis 1986).

Tip 2

Decide on learning goals for the reflective exercise

Reflection should not feel like busy work or an add-on activity. By providing rigorous learning objectives synergistic with those in other parts of the course, clerkship, or continuing education program, the educator signals an expectation that the goal of the reflective exercise is meaningful learning and practice improvement. The benefits of this approach are twofold since in addition to improved immediate outcomes, a more positive learning experience from reflection is associated with greater effort in future reflection (Sobral 2005). This is crucial since reflection is part of an experiential learning cycle in which experience leads to reflection which leads to reconceptualization which informs subsequent experience which is followed by further reflection, and so forth (Kolb 1984).

In selecting learning goals, educators should answer the following questions: Are there key competencies, attitudes, content areas, or skills in need of greater attention or assessment? How can the exercise be used to help learners integrate (1) new learning with existing knowledge; (2) affective with cognitive experience; and/or (3) past with present or present with future practice? Will reflective learning or reflective skill building be an explicit focus of the exercise? Is one of the goals to identify learning or practice needs and strategies to address them? The literature suggests that reflection may be most effective as a learning strategy and that it is more useful in resolving complex rather than simple clinical challenges (Mamede & Schmidt 2005;

Mann et al. 2007). Prompts can take any number of forms but are most useful if they ask the learner to choose a “disorienting dilemma,” i.e. a situation that cannot be resolved using previous problem solving strategies (Mezirow 2000). Such dilemmas generally arise from experiences which triggered questions or concerns, such as: (1) a situation where they did not have the necessary knowledge or skills; (2) a situation that went well but they are not entirely sure why; (3) a complex, surprising, or clinically uncertain situation; or (4) a situation in which they felt personally or professionally challenged (Schön 1983).

Tip 3

Choose an appropriate instructional method for the reflection

In designing a reflective exercise, educators must consider whether the assignment will take place “in class” or at home and whether the exercise will be oral, written, or completed using new media such as audio recording, blogs, or digital storytelling (Sandars 2009). Most of the medical literature on reflection discusses written exercises with a range of applications from critical incident reports to storytelling (Branch et al. 1993; DasGupta & Charon 2004; Wald 2009). With the exception of a single study of oral *versus* written reflections, there are no data for the superiority or inferiority of any approach (Baernstein & Fryer-Edwards 2003). Certainly, oral reflection is most suitable to what Schön called reflection-in-action and what Eva and Regehr call self-monitoring, reflection that occurs during a surprising or troubling experience (Schön 1983; Eva & Regehr 2008). In medical education, most reflection is reflection-on-action which occurs after the event. For this type of reflection, written exercises and perhaps some of the new digitally recorded media offer multiple advantages. Creation of an artifact shows commitment to learning and ownership of experience. It promotes critical thinking and offers more opportunities for feedback, including feedback from different sources. A trainee critically reflecting through development of an artifact on a patient care experience might receive feedback on medical knowledge and learning goals from a preceptor and feedback on professionalism and reflective skill from a mentor. Finally, artifacts allow for the longitudinal integration of learning, creation of a record for use in ongoing self-assessment, mentored reflection, evaluation of progress within and across multiple domains, and inclusion in a portfolio or maintenance of certification program. Reflection artifacts can be produced in class or as homework. In class reflection will be shorter but assures timely compliance and can sometimes be explicitly linked to other educational activities. Assignments completed outside of formal sessions offer the advantages of allowing learners more time to choose an appropriate experience upon which to reflect and opportunities to look things up and seek the feedback necessary to help them reframe their experience. Educators should consider their learning objectives when deciding which instructional methods to use for a given reflection exercise.

Tip 4

Decide whether you will use a structured or unstructured approach and create a prompt

Absent guidance and education about reflection, a majority of learners produce reflections which are largely anecdotes devoid of learning (Wong et al. 1995; Niemi 1997). This may in part be why learners – and some educators – object to reflection. In response to these findings, educators have used structured approaches to help learners reflect in deeper and more educationally meaningful ways (Johns 1994; Wald et al. 2009). Although structure and guidance leading to deeper learning can be offered by an educator as part of feedback on an unstructured reflection (“what reasoning did you use to come to that conclusion?” “It seems you’ve made some significant assumptions here”), given the low placement of most novice reflectors on the continuum of non-reflection to critical reflection, the more efficient approach is to provide both upfront guidance and feedback. This can be done by using a structured prompt which makes explicit the components of critical reflection: discussion of processes and assumptions as well as actions and thoughts; consideration of the role of associated emotions and relevant past experiences; solicitation of feedback and review of relevant literature where appropriate; explicit notation of lessons learned; and creation of a plan to improve future behavior and outcomes. Arguments against structured reflections include concerns that structure limits and distorts the very response the exercise is designed to elicit and that it risks encouraging mindless “recipe following” rather than insightful analysis (Boud & Walker 1998; Branch & Paranjape 2002). One potential strategy to mitigate these concerns is to start with a free write approach and follow that with a structured analysis.

Tip 5

Make a plan for dealing with ethical and emotional concerns

Reflection is not therapy. Educators should make this clear at the outset of the exercise so as to avoid inappropriate disclosures. Even with this caveat, however, readers of reflections sometimes will come across concerning revelations. These typically consist of psychological distress on the part of the writer or depictions of unprofessional, illegal, or troublesome statements or actions by the writer or others. Educators must plan in advance for how they will handle such material. In deciding on an approach, it is crucial to remember that a reflection presents just one view of a situation and as such may be misleading or inaccurate. Equally, it would be irresponsible to disregard comments which suggest the possibility of illegality or danger to the learner, patients, or others.

If the reflections will be shared without the learners’ presence, a good initial approach is to contact the author of the disturbing content to gather more information. If the sharing will take place in a group, the educator should decide in advance how she/he will deal with worrisome revelations

to ensure not only that appropriate action is taken but also the safety and privacy of the writer and those mentioned in the reflection and role modeling of a professional response, even if that response is acknowledgment of concern and referral to qualified help. The best way of dealing with such situations is to develop programmatic or institutional guidelines so individual educators do not have to decide on next steps under trying circumstances and manage the situation without organizational support. Some key considerations in designing guidelines include:

- In cases of reflector distress: Is the reflector of danger to self or others or merely in need of support? If in need of support, is the educator for the reflection exercise qualified to provide that support and if not, who is?
- In cases of inappropriate behavior: Is this a legal issue or a professional one? If the latter, is this a learning opportunity or an occasion for referral to a disciplinary body (or both)?
- If accusations have been made, implicitly or explicitly, who will determine the facts of the situation and how?

Tip 6

Create a mechanism to follow up on learners’ plan

Reflection is iterative. The goal is to learn from experience, but in order to ascertain whether what was learned was useful, it needs to be applied (Kolb 1984). Either in the reflection itself, perhaps with the help of a structured prompt, or in the feedback, the learner should be encouraged to make a plan to address learning gaps or test out behavioral hypotheses generated by their analysis. Ideally, the reflector will state explicitly the relevance of the topic to their practice beyond the individual described experience. If not, educators and/or peers can help them see the larger issue in the feedback session. For example, if a clinician writes about an encounter with a patient who has left her practice as a result of the experience described in the reflection, she should be encouraged to identify the issues relevant to her own behavior or the care of other patients which can be extrapolated from that experience. For trainees, if the reflection – or the initial reflective session – is structured early enough in a course or clerkship, learners can reflect on how the plan worked at follow up sessions or discuss the outcome of the plan in small group. This increases the utility of the reflection and the learners’ accountability. Similarly, continuing education and recertification programs could encourage deeper reflection by offering additional credits for evidence of application of reflective learning to clinical practice.

Tip 7

Create a conducive learning environment

To succeed, reflective exercises require the establishment of positive learning climate through the use of an authentic context and creation of a safe and supportive environment for reflection. The authenticity of the exercise depends on how

well it is tied into the larger educational program and the individual learners' needs at the time of the exercise. Good learning objectives are necessary but not sufficient to link reflection to the learners' current activities. For example, reflecting on surgical skills would be appropriate partway through a surgical rotation but less useful at the conclusion of the rotation on the eve of pen-and-paper test of surgical knowledge. In addition to establishing relevance, educators can increase authenticity by modeling reflection and encouraging other faculty to incorporate reflection into their practice and teaching. This latter will help create a supportive environment for reflective learning. Other critical environmental elements include providing enough time for the reflective activity, insistence upon respectful and supportive treatment of others in group discussions of reflection, explicitly acknowledging hindsight bias and the inclination to present an expected rather than an authentic persona, and making clear at the outset who will have access to the reflection and for what purposes, who will provide feedback, and whether assessment will be formative or summative.

Tip 8

Teach learners about reflection before asking them to do it

The conflation of reflection and critical reflection has led to the misperception that educators can ask learners to reflect without teaching them how to do so first. Before initiating a reflective exercise, educators need to define reflection (or preferably, critical reflection, as discussed above) for their learners, provide them with evidence of the educational and practice-related benefits of reflection, and outline the components of good critical reflections, such as (1) linking past, present, and future experience; (2) integrating cognitive and emotional experience; (3) considering the experience from multiple perspectives; (4) reframing; (5) stating the lessons learned; and (6) planning for future learning or behavior. It is also useful to have learners analyze one or more reflections so they better understand what each component means in practice. These components should be the same as those that will be used to assess the reflections.

Tip 9

Provide feedback and follow-up

Evaluation of reflection is essential since it motivates learning and shows that the educators and organization/institution value the exercise. Feedback can be individual, group, faculty, or peer and any feedback is better than none. The literature shows that shared reflection is better than individual and self-assessment is often inaccurate (Branch & Paranjape 2002; Eva & Regehr 2008). In reflection, others often see things the reflector cannot see. When done well, feedback provides multiple perspectives on the experience, supports integration of affective and cognitive experience, discourages uncritical acceptance of experience and guides what Eva and Regehr have called "self-directed assessment seeking." This can be

accomplished by identifying the reflector's key concerns, pointing out where assumptions were made, offering alternate interpretations or data, and by asking for clarification of reasoning, omissions, and conclusions.

The nature of the feedback merits note as well since reflective exercises often serve two purposes: addressing the relevant learning objectives and developing reflective skill. Educators should provide feedback not just on the content of a reflection but on the learner's reflective skill as well. Often, it will be possible to comment on many different aspects of the reflection. The goal should not be comprehensive feedback but feedback which is challenging rather than overwhelming, aligned with the learning objectives, and educationally useful. Aim for 2–3 key teaching points, one of which addresses the learner's reflective skill. In the process feedback, note the elements of reflection the learner has incorporated effectively and offer one more they might include or improve on their next reflection.

Tip 10

Assess the reflection

Assessment can be linked to or distinct from feedback. The goal of the feedback is deeper learning. The goal of assessment may include learning but also involves evaluation of the learners' abilities in the topic areas of the reflection and/or in reflection itself. Assessment can be done in narrative by stating judgments about the learners' abilities or engagement with the exercise or by using validated and reliable scoring rubrics (Learman et al. 2008; Wald et al. 2009). These methods can be combined to provide learners with a score indicating their level of reflective skill and also narrative noting the adequacy of the reflection in addressing the assigned topic, what was done well, and suggested next steps.

Educators must decide whether assessment will be formative, with the exclusive goal of developing learners' abilities, or summative and used for grading purposes in courses or clerkships, advancement in a training program or certification process, or award of continuing medical education (CME) credit. Some have argued that the goal of reflection is to nurture a skill the trainee or practitioner can apply throughout their career so its assessment should always be low stakes and formative. Others believe an exclusively formative approach encourages focus on complex topics and professional vulnerabilities without fear of negative evaluations. But such arguments confuse evaluation of reflective skill with evaluation of the reflector. Extensive data demonstrate that evaluation drives learning. Monitoring and enforcing compliance with codes of professionalism and other complex, value-laden skills and behaviors vital to medical competence are part of the core missions of professional schools, training programs, and certifying organizations. Assessment signals that the topic or skill being assessed matters and should be part of a clinician's continuous professional development. This is not to say that every reflective exercise requires summative assessment but rather that periodic summative assessment should be considered as part of any program aimed at cultivating reflective skill.

Tip 11

Make this exercise part of a larger curriculum to encourage reflection

Reflection is a skill which requires development and can be applied broadly in medical education. For trainees, the best approach to developing reflective skills may be a longitudinal integrated curriculum with different mileposts in terms of both reflective skills and application contexts as the learner moves through their professional program. At the student level, for example, one potential trajectory might begin with understanding the components of critical reflection, move to demonstrating the ability to apply those components to learning strategies and/or clinically relevant skills which can be practiced in the preclinical years such as leadership or teamwork, then apply critical reflection to clinical practice and clinical reasoning, and finally critically reflect on their development over the course of the training period. An alternative approach which also would work at the residency level, would be competency-based, aligning reflective skill building with competency assessment, and increasing reflection expectations while moving through competency mileposts, using the reflections to identify knowledge and skill gaps, integrate learning across rotations, and plan for future practice. In continuing education, exposure to reflective exercises may be single or episodic making integration into a larger curriculum difficult except *via* recertification processes or longitudinal CME activities. Moreover, since reflection is a relatively new phenomenon in medicine, educators need to consider how a single exercise might serve a diverse learner group with a broad array of reflective skills.

Tip 12

Reflect on the process of teaching reflection

Practice the skills you are teaching. This is faculty development and continuous educational practice improvement and should take place prior to, during, and after teaching reflection. If you select a structured approach, use the structure yourself. Identify someone from whom to seek feedback. If you will take a structured approach to feedback, have that person use your format to comment on your reflection. If you will assess your learners' reflections, have your own reflection assessed in the same manner. Your reflection should produce insights about yourself as a reflector, learner, and educator as well as about the challenges of the exercise you have designed. You can then re-examine your reflective exercise and modify it to more effectively avoid the potential pitfalls described by Boud and Walker, including: recipe following, reflection without learning, mismatch between the exercise and its learning context, intellectualizing, inappropriate disclosure, uncritical acceptance of experience, and raising issues beyond the educator's expertise (Boud & Walker 1998). Apply what you have learned to your next reflective teaching session.

Conclusion

In trying to incorporate reflection in their teaching, many educators have implemented exercises which elicit anecdotes rather than the sort of analysis, questioning, and reframing of experience likely to produce meaningful educational outcomes. With a better understanding of the conceptual frameworks underlying critical reflection and greater advance planning, medical educators will be able to create exercises and longitudinal curricula that not only enable greater learning from the experience being reflected upon but also develop reflective skills for life-long learning.

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Competencies for Global Learning

Heather MacCleoud
April 6, 2017

NAFSA International Education Professional Competencies™

COMPETENCY ICEBERG

SKILLS
KNOWLEDGE

ATTITUDES
VALUES
SELF CONCEPT
TRAITS
MOTIVES

Image courtesy of Graham Williams
www.CultureSense360.com

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NAFSA International Education Professional Competencies™

OVERVIEW OF MAJOR CATEGORIES

COMPREHENSIVE INTERNATIONALIZATION

- Advocacy for Comprehensive Internationalization
- Internationalization of the Curriculum
- Internationalization of Instructional Practice and Assessment
- Strategic Internationalization

EDUCATION ABROAD

- Competency for Comprehensive Internationalization
- Leadership and Management of International Learning and Studies
- Funding and Resource
- Study Abroad
- Quality Control and Risk Management
- Student Health and Safety

INTERNATIONAL ENROLLMENT MANAGEMENT

- Competency for Comprehensive Internationalization
- Leadership and Management of International Learning and Studies
- Quality Control and Risk Management
- Planning for International Enrollment Management
- Strategic Internationalization and Student Services
- Student Health and Safety

INTERNATIONAL STUDENT AND SCHOLAR SERVICES

- Competency for Comprehensive Internationalization
- Crisis Management
- Study Abroad
- Student Health and Safety
- Student Services and Support Services Programming

CROSS-CUTTING COMPETENCIES

- Advocacy
- Communication with Stakeholders Across Campus and Community
- Financial Stewardship
- Human Resources
- Information Technology
- Intercultural Communications
- Leadership
- Strategic Planning

Intercultural & Global Competence

How do you define culture?




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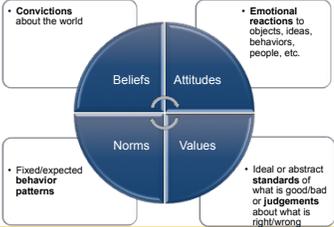
Cultural Awareness



<ul style="list-style-type: none"> Ethnicity Nationality Language Religion Race Political Affiliation 	<ul style="list-style-type: none"> Personality Interests Learning Modalities Life Experiences Gender Identity Socio-economic Background
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Characteristics of Culture

- Convictions about the world
- Emotional reactions to objects, ideas, behaviors, people, etc.
- Fixed/expected behavior patterns
- Ideal or abstract standards of what is good/bad or judgements about what is right/wrong

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Overview




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Key Considerations

Cultural & Global Learning

- Developmental
- Transformative
- Takes Time
- Requires a Safe Environment




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Explicit Culture

- Behaviors
- Attitudes
- Beliefs

Implicit Culture

- Values

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What is the purpose of culture?




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Global Competencies

- Self-Awareness
- Perspective Taking
- Understanding Cultural Diversity
- Personal and Social Responsibility
- Understanding Global Systems
- Applying Knowledge to Contemporary Global Contexts




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Resources

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NAFSA: Association of International Educators is the world's largest nonprofit association dedicated to international education and exchange, working to advance policies and practices that ensure a more interconnected, peaceful world today and for generations to come.



Current Perspectives Cultural and Global Learning

Please circle the number that best represents your current level of understanding.

1. The best way to meet people from another cultural group is through international travel.

Disagree 1 2 3 4 5 6 7 8 9 10 Agree

2. The terms “international” and “global” are essentially the same.

Disagree 1 2 3 4 5 6 7 8 9 10 Agree

3. While people differ culturally in many ways, deep down we are all basically the same.

Disagree 1 2 3 4 5 6 7 8 9 10 Agree

4. Global issues are important, but it is easy not to think about them on a daily basis.

Disagree 1 2 3 4 5 6 7 8 9 10 Agree

5. It is easy to identify another person’s culture by the way he/she looks, talks, or acts.

Disagree 1 2 3 4 5 6 7 8 9 10 Agree

Write a short-answer response to each of these reflection prompts.

6. Think about a cultural group other than your own that you know something about. Describe five attributes you would use to describe that cultural group.

7. List and describe three characteristics that might define a “global citizen.”

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Adapted from the My Cultural Awareness Profile (myCAP[®]) Self-Reflection & Discussion Tool
www.nafsa.org/myCAP



Action Plan

Step 1. What is your personal learning goal?	
Step 2. What specific action(s) will you take?	
Step 3. How will you engage in cultural-contextual thinking?	
Step. 4 Practical Plans for Future Learning	
Step 5. Documentation of Cultural & Global Learning	



“Culture Bump” Exercise

<p>What was your “culture bump”¹? (Describe your experience)</p>	
<p>Define the situation</p> <ul style="list-style-type: none"> • List the behaviors of the other person • List your own behaviors • List your own feelings 	
<p>What were YOUR values?</p> <ul style="list-style-type: none"> • List behaviors expected in <u>your</u> own culture • What were the underlying values in <u>your</u> own culture that prompted that behavior expectation? 	
<p>What were THEIR values?</p> <ul style="list-style-type: none"> • List behaviors expected in <u>their</u> culture • What were the underlying values in <u>their</u> culture that prompted that behavior expectation? 	
<p>What have you learned?</p>	

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¹ “Culture Bump” an individual in a strange or uncomfortable situation interacting with persons of a different culture.
Adapted from Carol Archer www.CultureBump.com



Resources & Networking

NAFSA Networks

Teaching, Learning, Scholarship Knowledge Community

Community of practice which hosts an Intercultural Communication & Training (ICT) network filled with resources and networking opportunities: www.nafsa.org/tls

Healthcare Institutions Institutional Interest Group (IIG)

Community of practice which brings together NAFSA members who work with or in the academic healthcare and medical community for the purpose of better understanding the key issues confronting that community: network.nafsa.org

NAFSA Resources

My Cultural Awareness Profile (myCAP[®]) Suite of Resources

The My Cultural Awareness Profile (myCAP[®]) Suite of Resources is part of a series of professional development opportunities and materials provided by NAFSA to promote cultural and global learning in education. These resources were designed to support faculty members in colleges and departments of education in preparing teachers for twenty-first century classrooms: www.nafsa.org/mycap

NAFSA International Education Professional Competencies[™]

The NAFSA International Education Professional Competencies[™] is the most comprehensive listing of the necessary competencies for success in the field of international education. These competencies form the basic building blocks of the international education profession. This inventory is intended to define the professional knowledge, skills, and abilities expected of international education professionals working in the United States, regardless of their area of specialization or role within the field. From adviser to manager to policy maker, the International Education Professional Competencies offer everyone working in international education a direction for professional success.

www.nafsa.org/competencies

See also: [Hiring Manager Questions: In Alignment with the NAFSA International Education Professional Competencies[™]](#)



NAFSA Learning and Training

Global Learning Colloquia

Global Learning Colloquia at the NAFSA Annual Conference & Expo are opportunities for faculty members, academic leaders, and international educators to explore global learning in disciplinary and cross-disciplinary contexts. Expert facilitators lead participants in discussion of strategies and techniques for creating, implementing, and assessing curricular and co-curricular experiences that help students develop the knowledge and skills they need to engage with the wider world.

Colloquia are designed to help participants define student learning outcomes, design pathways that produce these outcomes across the curriculum, and develop practices to bring global perspectives into the classroom.

www.nafsa.org/colloquia

Architecture for Global Learning Series

Architecture for Global Learning is a professional enrichment series designed for faculty, scholars, administrators, and other international educators seeking to develop and enhance global learning initiatives at their institutions.

Core Education Program Workshop: Intercultural Communication in Practice

This on-site workshop provides the theoretical foundations of intercultural communication and walks participants through how to put it into practice. This workshop can be offered at any time through our On-Site Workshop program.

www.nafsa.org/workshops

E-Learning Seminars:

- **Improve Your Intercultural Training Through Transformative Learning**
- **Cross-Cultural Dynamics in Crisis Management**
- **Student Learning Abroad: What Our Students Are Learning, What They're Not, and What We Can Do About It**

www.nafsa.org/elearningseminars

E-Learning Express Course:

Developing Proficiency in Intercultural Communication

- Part 1: Foundations of Intercultural Communication
- Part 2: Communicating Across Cultures
- Part 3: Culture and Identity
- Part 4: Intercultural Adjustment and Adaptation

www.nafsa.org/elearningexpress

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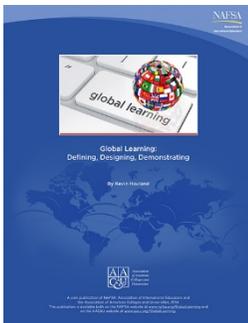
Publications

www.nafsa.org/publications



Internationalizing Education for the Health Professions

This e-Publication explores challenges and opportunities related to internationalizing education for the health professions. It is based on NAFSA's 2014 Colloquium on Internationalizing Education for the Health Professions, which explored the unique "global competencies" healthcare professionals need in order to successfully practice in diverse environments and to provide effective local care in a global system.



Global Learning: Defining, Designing, Demonstrating

The publication aims to provide a definition and rationale for the term global learning, as well as related student learning outcomes in an effort to help campus practitioners work together more effectively. Additionally, it discusses designing educational experiences through which students gain competence and meet those outcomes and the importance of demonstrating how experiences help students become global learners. It follows a 3-D (defining, designing, and demonstrating) approach, and briefly describes the multidimensional maps that could emerge at colleges and universities for global learning.



Curriculum Integration of Education Abroad

Much of the increased interest in curriculum integration (CI) of study abroad is a result of faculty and international education professionals responding to mandates to internationalize the campus and the undergraduate student learning experience. This e-Pub describes concepts and key issues that the reader can use to determine the best way for implementation at a particular institution.

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Risk Assessment and Crisis Management

Resources for professionals who establish emergency communication protocols to be shared with faculty, staff, and students; prepare health and safety instructional materials for emergency situations; respond to international emergencies according to institutional protocols; develop policies and procedures for health and safety, risk reduction, and crisis management.

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Title 	Description 	Document Date 
Regulatory Compliance for Education Abroad Risk Management: A NAFSA and URMIA Seminar	Through a framework of case studies, participants will discuss incidents and investigations stemming from obligations under the U.S. law and regulations.	Jan 19, 2017
Prioritizing Fire Safety for Education Abroad Programs	There is much attention paid to health and safety on education abroad programs, however not much that specifically applies to fire safety abroad. Even modern European cities, which are often the most popular study abroad destinations, often have fire safety	Dec 07, 2016
Zika Resources for Education Abroad	The recent Zika outbreak in Central America and the Caribbean has received significant media coverage, but to date, the impact of the disease on study abroad programs has been minimal. NAFSA encourages its members to develop comprehensive crisis management plans	Jun 16, 2016
Gender Discrimination (Title IX) and the Violence Against Women Act	This resource is designed to help education abroad professionals with identifying the regulatory implications and student health and safety steps when a student studies abroad. The expansion and increased attention to enforcement of Title IX and the Violence Against Women Act require strong responses when students confront gender discrimination and sexual violence abroad.	Mar 14, 2016
Risk Disclosure in Education Abroad	Deciding what practices are appropriate for risk disclosures and waiver documentation is the education abroad professional's responsibility to insure a student's health and safety while embarking on an education abroad program.	Feb 26, 2016
Health, Safety, & Security: Resources for Monitoring Conditions Abroad	A compilation of internet resources offering information from various sources to help you make decisions about safety and security abroad.	Jan 12, 2016
Risk Management in Education Abroad	An underlying goal in all Education Abroad programming is to enhance the experience and mitigate risk. In this e-Learning Seminar series, expert presenters discuss the risk landscape in education abroad, safety and security issues abroad, requirements of the Clery Act, and concrete steps for dealing with crisis situations abroad.	Nov 30, 2015
Home Universities & Overseas Partners: Optimizing Communication Involving On-Site Student Issues	Determining the line between what you need to know and what you don't with regards to your students abroad can sometimes be tricky. Think about the reasons why you want to know, are they helping the student? Learn how to work with your third party program providers to develop guidelines and clearly communicate to them your expectations on reporting incidents.	Nov 17, 2015
The Clery Act and Education Abroad: Understanding Crime Reporting Requirements	The Clery Act requires universities to report on-campus crime, including crimes committed in education abroad locations. Learn about how U.S. federal regulations may affect your education abroad program and how you can take steps to ensure compliance.	Jan 29, 2015
Getting Out	"Getting Out", by Julie Anne Friend, Associate Director for International Safety and Security at Northwestern University and a Past Chair of the EA KC Health and Safety Subcommittee, looks closely at preparing for terrorism, political unrest, government collapse, and armed conflict in education abroad locations. The article was published in the 2010 NAFSA International Educator magazine's Health and Insurance Supplement.	Aug 18, 2014
Danger Ahead	"Danger Ahead," by Julie Anne Friend, Associate Director for International Safety and Security at Northwestern University and a Past Chair of the EA KC Health and Safety Subcommittee, looks closely at institutional risk tolerance and strategic risk assessment to ensure international programs	Aug 18, 2014

	and activities have emergency plans that match their worldwide presence. The article was published in the 2012 NAFSA International Educator magazine's Health and Insurance Supplement.	
Clarifying Clery: Collaborations Between Education Abroad, Risk Management, and Campus Safety Professionals	All U.S. universities that participate in federal financial aid programs are required to comply with the Clery Act, a law that compels institutions to report incidents of crime on or near campus. However, when asked about how their campus handles Clery Act compliance, many education abroad (EA) professionals will admit that they're unsure of their responsibilities and their institution's approach.	Jul 07, 2014
Enhancing Health and Safety in Education Abroad	In this Collegial Conversation, representatives from American Citizen Services , the Overseas Security Advisory Council , and NAFSA's Health and Safety Subcommittee discussed the array of services and resources that are available to help make your education abroad programs safer for you and your students.	Mar 11, 2014
Risk Management Survey Results - Fall 2012	This report is based on responses to a survey posted to SECUSS-L in the fall of 2012, which asked for institutional policies related to risk management practices and training needs.	Nov 06, 2013
Developing Your International Risk Management Action Plan	Learn from leaders in risk management and education abroad to create a plan for your campus and discuss specific operational, financial, and strategic aspects of managing off-campus risk.	Apr 26, 2013

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4/6/17

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International Medical/Evacuation Insurance Lingo for Dummies (need-to-know language and concepts when you are sending students/faculty/staff to LMIC settings)

This is not a comprehensive list, nor is it in legal-speak, but its some helpful terms and 'food for thought' to consider when vetting international medical/evacuation insurance and when assisting your students/faculty in the event of a medical condition or other incident. This is plain language explanation and any accuracy or lack thereof is the fault of its humble author. If you wish to contact said author, please email jevert@cfhi.org.

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Duty of Care: When developing international programs, organizers should be mindful of the "Duty of Care," meaning the obligation to anticipate, care about, and attempt to minimize sources of risk or danger to program participants (and some would argue patients, community members, others). Duty of care requires that risk is minimized and program operations are structured in such a way to educate, prepare students/faculty for, and pre-empt overly risky behavior and activities. If organizations/institutions do not demonstrate they have fulfilled the Duty of Care, they are vulnerable to being accused of negligence.

Guarantee of Payment (GOP): A letter issued by the insurance company to the hospital or clinic in the international setting to guarantee payment to the hospital/clinic up to a certain maximum. In many countries, hospitals will require this guarantee before they will treat the patient (unless its truly an emergency). This letter is generated by the insurance company who provides your emergency/travel insurance and sent directly to the hospital (or delivered to hospital by your local staff). It's best to get this letter to the hospital as soon as possible to avoid students/faculty from being asked to pay a deposit up front or delaying care. When evaluating an insurance policy, be sure to be familiar with what the maximum amount of guarantee of payment is. Some hospitals will ask up to \$25,000 in guarantee depending on the complexity of the medical issues.

Cash Guarantee: Cash guarantee/cash deposit is required by some hospitals abroad in order to treat patients. The hospital will require a certain amount of cash be deposited in their account or given to them in person in order to treat an international student/faculty member/traveler. Generally cash guarantees are on the order of several hundred to \$1500, however, they can be ask high as \$10,000. It is important to understand what the cash guarantee maximum is of your insurance policy to make sure it is adequate in these situations. In addition, being familiar with hospitals' policies in this regard in the locations you work in is useful. However, it is common for these amounts to vary based on hospital leadership, time of day, and medical issue of the patient. Making sure the insurance company is sending cash in a way that gets it to the hospital as soon as possible is important, as the insurance company may not be as familiar as you or your local staff on how money can be quickly transferred or mobilized in the local LMIC community.

4/6/17

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Certification of Medical Necessity: This is a form that comes from the insurance company (usually) and has to be completed by a doctor in the local hospital/clinic to certify that hospitalization or other treatments are necessary. The “treating physician” is a local doctor at the hospital in the LMIC community who will communicate with the insurance company about the clinical status of the student/faculty/staff person/patient. This form will usually be necessary in order for any payments to be made after the guarantee of payment or cash guarantee is sent (these should be sent right away and usually do not require paperwork for the local physician, but may require such certification as well).

Exclusions: Exclusions of coverage are not uncommon in any insurance policy, travel/medical/evacuation is no different. One of the more common causes of student injury/sickness is drugs/alcohol and/or mental health. It is not uncommon that issues stemming from drugs/alcohol/mental health may be excluded from coverage. Sometimes these are excluded unless they require inpatient hospitalization. Make sure to look into the exclusions in this regard and consider contingency planning, education, etc to address issues stemming from any excluded illness/conditions. Other exclusions that are common: pregnancy/pregnancy-related conditions, age (ie. travelers over age 75), self-inflicted injuries, injuries from natural disaster, injuries from adventure sports, ‘pre-existing conditions,’

Claims Process: Generally bills generated by a hospital admission will/should be paid up front by the insurance company. In order to make this happen, it will be necessary to submit an invoice (or have hospital submit an invoice) while the student/faculty/staff are still hospitalized. It’s not uncommon to have multiple sources of invoices (often the hospital, doctor, pharmacy, ancillary services all bill separately). There is a chance that if the patient is discharged before invoices are paid, bills will have to be paid upfront by the student/staff/faculty (the hospital often demands full payment before a patient is released upon discharge), and then enter into a claims process. During the claims process, items paid by student/faculty/staff are submitted for reimbursement to the insurance company. This can take 6-8 weeks for processing (make sure all receipts are saved). Also, it is not uncommon for the student/faculty/staff to have to purchase medications up front from a pharmacy in order to have them administered at the hospital/clinic. In this event, it is good to advocate for these to be paid back to the student/faculty/staff by insurance before discharge from the hospital, otherwise they will have to go through a claims process if they are discharged before these are reimbursed. Often bills from outpatient services/clinics are paid up front by the student/faculty/staff and then submitted via a claims process to facilitate reimbursement. This process varies by insurer and is something to be clear about in advance of international travel.

Reading an insurance policy ; know your maximums? Generally you want to evaluate the maximums paid by an insurance policy when comparing policies. A few maximums to be aware of----

Accident/Sickness Medical: The maximum paid for medical treatments

4/6/17

Jessica Evert MD
Executive Director, CFHI
www.cfhi.org

Medical Evacuation: The maximum paid to fly/drive someone to another location to seek more advanced/safer treatment

Repatriation of Remains: The maximum paid to transport an expired person by to country of origin

Political Evacuation: The max amount paid to evacuate due to a political condition

Natural Disaster Evacuation: The max paid to evacuate due to a natural disaster

Cash Guarantee: Max amount of cash that will be transferred in advance of treatment

Guarantee of Payment: The max amount that will be cited in a guarantee of payment

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Assessing Intercultural Capacities, Civic Engagement, and Critical Thinking: The Global Engagement Survey

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Introduction

Universities, nongovernmental organizations, scholars, and activists are calling for global citizenship development. Arguably the most beautiful among these calls suggest global citizenship as a pioneering route to an as-yet-unimagined tomorrow (Falk, 2000); a future where our contingent understandings of human rights are embraced in a manner that is respectful of cultural differences and consistent with common human dignity (Appiah, 2006; Donnelly, 2003). Such an embrace requires intercultural competence, civic skills, and an ongoing commitment to critical thinking. How might we know when students have achieved this sort of complex global learning?

In recent years, several major associations and scholars have offered responses to the twin challenges of better understanding and assessing global citizenship. The chapter that follows considers conceptual framing before detailing several assessment efforts. It then proceeds by demonstrating the strengths and shortcomings of existing evaluations before sharing a novel, conceptually-integrated and theoretically-grounded approach to global citizenship assessment, the global engagement survey (GES). The GES is particularly useful in respect to assessing specific program interventions, such as study abroad or glocal, cross-cultural service-learning. The intent of this chapter is to clarify the conceptual basis for considering global learning in the manner advanced in the GES, and to demonstrate the discrete fields of research that informed its development.

Conceptual Framing and Previous Research

The desire for a systematic and integrated approach to measurement of growth in global citizenship led the authors to consider major US professional associations' framing of civic, intercultural, and global learning. The leading national association concerned with the undergraduate liberal education experience, the Association of American Colleges and Universities (AAC&U), has for several years focused specifically on social responsibility and integrative liberal learning in global context. AAC&U integrates key components of intercultural competence and civic development through its global learning rubric, where it suggests:

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Through global learning, students should 1) become informed, open-minded, and responsible people who are attentive to diversity across the spectrum of differences, 2) seek to understand how their actions affect both *local and global communities*, and 3) address the world's most pressing and enduring issues collaboratively and equitably (2014, p. 1, emphasis ours).

This integration of intercultural competence or attention to diversity with a focus on individual actions and attention to pressing issues, along with the development of critical thinking, is also featured throughout *A Crucible Moment: College Learning and Democracy's Future* (National Task Force on Civic Learning and Democratic Engagement, 2012), a document prepared at the request of the US Department of Education. The leading US association advocating that universities serve public, civic purposes, Campus Compact, responded to *A Crucible Moment* with a policy brief calling for higher education institutions to, among other things, “advance a contemporary, comprehensive framework for civic learning that embraces *U.S. and global interdependencies*” (Campus Compact, 2012, p. 8, emphasis ours). Meanwhile, AAC&U cooperated with NAFSA to develop *Global Learning: Defining, Designing, Demonstrating*, a publication that again emphasizes that 21st Century graduates must integrate local and global civic knowledge and engagement, intercultural knowledge and competence, as well as ethical reasoning and action (Hovland, 2014). Here and elsewhere (Hartman & Kiely, 2014; Sobania, 2015; Whitehead, 2015), it is clear that US theorists and administrators are also integrating the local aspects of global citizenship and learning that are highlighted throughout this volume.

Several research studies have worked to assess outcomes related to global learning and internationally engaged global citizenship development (Bowman, Brandenberger, Mick, & Toms Smedley, 2010; Lough, 2010; Lough, McBride, & Sherraden, 2009; Morais & Ogden, 2011; Niehaus & Cain, 2012), while others have made the conceptual argument that local civic engagement may facilitate cross-cultural experience (Holsapple, 2012; Jacoby, 2009; Whitehead, 2015), or even explicitly provide local opportunity for global civic learning (Alonso Garcia & Longo, 2013; Battistoni, Longo, & Jayanandhan, 2009; Hartman & Kiely, 2014; Longo & Saltmarsh, 2010; Sobania, 2015). Yet, existing research has been limited because it has neglected to consider all components of global citizenship at once or failed to identify the full range of potential program and population factors that may influence outcomes.

International Education and Intercultural Competence

Limitations in existing research developed in large part because the components of intercultural and civic learning have only recently been integrated to the extent called for above. For example,

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Bennett (1993, 2012), as well as Braskamp, Braskamp, and Engberg (2014) have worked for several decades to better understand intercultural learning and the development of global perspectives. That work, however, has primarily drawn from the international education and intercultural communications literatures, pointing the research instruments toward intercultural learning to a greater extent than toward civic learning. Even when there has been some consideration of civic learning, the programs examined have not systematically targeted civic learning.

Bennett's Intercultural Development Inventory (IDI), a 50-item scale, is central to the creation of the Developmental Model of Intercultural Sensitivity (DMIS), which itself suggests a progression of orientations toward cultural difference. In use in various contexts around the world since 1998, the IDI has been determined to be a statistically valid and reliable psychometric instrument for deepening understanding of an individual's intercultural competence (Bennett, 2012). The IDI is also known to contribute understanding of immersion-readiness as well as change, which remains a useful contribution to assessing global learning.

Braskamp's Global Perspectives Inventory (GPI) also measures intercultural sensitivity, as well as several other related outcomes. The GPI positions student development across three domains, cognitive (How do I know?), intrapersonal (Who am I?), and interpersonal (How do I relate?). The intrapersonal and interpersonal scales both have potential implications for civic learning measurement, with items such as "I can explain my personal values to people who are different from me" (intrapersonal) and "I work for the rights of others" (interpersonal). Reporting on employing the GPI with approximately 500 students enrolled in semester-length study abroad programs, Chickering and Braskamp (2009) indicate students demonstrate growth in the expected direction across constructs, yet with considerable variation among constructs. The social responsibility construct (a sub-construct of interpersonal), for example, showed the smallest gain and, at less than .10, was not considered a meaningful gain despite statistical significance across all constructs.

Chickering and Braskamp (2009) did note that some programs demonstrated significantly different (and much more positive) gains in the social responsibility scale. But, due to the nature of their research, they were unable to report on the characteristics of those particular programs. Both Bennett and Braskamp's scales have been statistically validated and are available for university assessment on a fee-for-use basis (Hammer, Bennett, & Wiseman, 2003; Braskamp, Braskamp, & Engberg, 2014). An additional commonality is that they are both entirely self-report measures, prompting respondents to express degrees of agreement or disagreement with statements frequently infused with social desirability. A comprehensive review of decades of research and programming that employs the IDI and GPI led to a collection of essays relating to

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international education. The edited volume and the essays within it lead to the conclusion that, “Most students learn to learn effectively abroad only when an educator intervenes, strategically and intentionally” (Vande Berg, Paige, and Hemming Lou, 2012, p. 19).

Despite their extensive use in study abroad and international education circles, both Bennett’s intercultural learning and Braskamp’s global perspective are consistent with an understanding of global citizenship learning that is inclusive of domestic and international understanding. Whether in domestic or international contexts, Bennett writes, “More successful intercultural communication similarly involves being able to see a culturally different person as equally complex to one’s self (person-centered) and being able to take a culturally different perspective.” (2004, p. 73). While Braskamp avers, “A global perspective includes both a domestic focus on multicultural education and diversity and an internationalization focus that includes global trends and relationships among nations” (2015, p. 5).

The Bennett and Braskamp scales, in other words, are conceptually consistent with glocal learning aspirations. Yet within higher education they have not been employed to compare global learning across a wide variety of program types, instead focusing predominantly on study abroad.

Civic Learning through Global Service-Learning and Community Engagement

Other research has grown out of the integration of service-learning/community engagement (SLCE) and study abroad. Studies in this vein have drawn on and benefitted from the SLCE civic learning literature (Eyler & Giles, 1999; Clayton, Bringle, & Hatcher, 2013). Bowman et al. (2010), for example, considered the effects of short-term, immersive service-learning experiences on nearly 500 students’ orientations toward equality, justice, and social responsibility. The immersive learning experiences in question took place in the United States (the “home country” in this case) and abroad, and ranged from two days through eight weeks in respect to the length of immersion. Coursework and targeted reflection before, during, and after the immersive experience focused upon common learning goals. Typical course objectives included, for example:

Course 1: To reflect upon and analyze the social, political, economic, religious and cultural forces operative in the Appalachia region through class presentations, discussions, and readings.

Course 2: To examine the social forces contributing to migrant work patterns and injustice, and reflect upon means to improve conditions (p. 21 – 22).

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354 students participating in the one-credit immersive courses during the academic year, along with 115 students enrolled in three-credit immersive programming during the summer, completed pre- and post- tests with seven scales measuring values and attitudes relevant to “the recognition and denunciation of social inequality and the importance placed on helping others” (Bowman et al., 2010, p. 24). Five of the scales employed (situational attributions for poverty, openness to diversity, responsibility for improving society, social dominance orientation, and self-generating view of helping) demonstrated Cronbach Alpha measures above the typically accepted .7 standard, while two were somewhat lower (empowerment view of helping = .63, belief in a just world = .66).

The researchers found that, in contrast to previous research in the service-learning community, short-term (two- to seven-day) immersive learning experiences can positively impact college student learning and development, in respect to equality and social responsibility orientations. The authors concluded that systematic learning objectives, course structure, and academic rigor were key in leading to the positive outcomes associated with short-term immersion. However, students in the eight-week, three credit courses did exhibit desired changes in respect to belief in a just world and social dominance orientation measures, while the students in the shorter programs did not (Bowman et al., 2010).

Hartman (2008, 2014) undertook a similar study, though the scales he employed were more derivative of conventional measures of civic engagement and efficacy. Drawing on Myers-Lipton (1998) and Reeb, Katsuyama, Sammon, & Yoder (1998), Hartman constructed a Global Awareness and Efficacy Scale and a Global Civic Engagement Scale. Pre- and post- tests were administered with students enrolled in the following three scenarios: (1) a typical English Composition course on campus, (2) a set of short-term global service-learning (GSL) courses lacking a focused global citizenship development curriculum, and (3) a set of short-term GSL courses with a focused global citizenship development curriculum. Results indicated that both scales exhibited Cronbach Alpha scores above .8. Additionally, while both groups of global service-learning students exhibited higher awareness, efficacy, and engagement scores than the on-campus students during the pre-test, the only group to show statistically significant gains from pre- to post- was the GSL group with a focused global citizenship development curriculum (Hartman, 2008, 2014).

Hartman’s findings are consistent with Bowman, et al., in that they suggest the importance of focused learning objectives and facilitated content delivery as fundamental to supporting student growth in indicators related to global civic learning; drawing on years of study with the IDI and GPI, Vande Berg, Paige, and Hemming Lou (2012) found the same for intercultural learning. The Bowman et al. and Hartman studies are also susceptible to similar critiques: each study

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examines only one institution, each study relies entirely on student self-report, and neither study delves particularly deeply into the intercultural learning and communication capacities that are central to a robust understanding of global citizenship.

The studies reviewed thus far have a strong orientation toward either intercultural learning or civic learning, but not both. Other studies have plunged more deliberately into the complexity of understanding global civic learning holistically, but either have not been attentive to specified global learning outcomes or have been conducted in ways that are not readily scalable. In a study of more than 2,000 students participating in diverse alternative break programs domestically and internationally, Niehaus (2012) found that participation in these short-term, immersive programs is positively correlated with intentions or plans to volunteer, engage in advocacy, or study or travel abroad, or student intentionality in respect to major or career plans. Niehaus found several program factors were significant in predicting growth in the areas listed above, including whether students were emotionally challenged and able to connect their experience to larger social issues, the frequency with which students wrote in journals, the amount students learned from interactions with community members and other students during immersion, and the comprehensiveness of the reorientation program following immersion.

Niehaus's data also suggested an international program location was significantly related to the likelihood of students expressing interest in future study or travel abroad. While Niehaus's study is very interesting because it suggests co-curricular programming (despite most alternative breaks not receiving credit) may play a strong role in advancing student thinking in respect to service, advocacy, travel, and career path, it did not focus tightly on global learning as understood by AAC&U and the other major associations mentioned above. It is important to note that the organization with which Niehaus worked rather extensively as part of the survey, BreakAway, is highly systematic in terms of encouraging campus partners to pursue specific learning outcomes, even if non-credit bearing.

A few qualitative studies are worth mentioning here because of their importance in the trajectories of global service-learning and global studies theoretical development in the United States. Kiely (2004, 2005) produced seminal work in the field of GSL, helping educators and students better understand the processes involved in high-dissonance, contextual border crossing. Kiely's theory of transformational learning through GSL highlights the challenge of employing pre- / post- tests to better understand specific interventions. His respondents demonstrate that high dissonance border crossing and the reflective processes to understand it, involve a great deal of personalizing, processing, and connecting over time that transcends the boundaries of any given program (Kiely, 2005). Further, Kiely's research since these seminal works has indicated that, while some outcomes track to specified learning outcomes in a manner consistent with

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analytic and logical reflective traditions, the critical reflection tradition may lead students to outcomes that involve critique of hegemonic discourse and patterns of behavior. This critique, following from high dissonance, immersive learning, then leads students to experiment with new forms of being, thinking, and doing to create new kinds of communities and community memberships more consistent with common human dignity. This second kind of critically reflective, anti-hegemonic outcome seems more challenging for evaluators examining program effects immediately following immersive learning experiences (Kiely, 2015).

Representing the globally-engaged programming that grew out of Providence College's Feinstein Institute for Public and Community service, Longo & Saltmarsh (2011) and Alonso Garcia and Longo (2013) made a theoretically-grounded case for global citizenship programming, locally, in the context of an increasingly interdependent world. The case for the value of such glocal programming was rooted in conceptually consistent argument and some student interviews following engagement across difference in the City of Providence, Rhode Island. Following those early publications, many theorists and practitioners, including the editors of this volume, have made the conceptual case for glocal programming (Hartman & Kiely, 2014; Sobania, 2015; Whitehead, 2015), yet these arguments to date have been made largely independent of confirmatory empirical evidence. As mentioned above, both Bowman et al. (2010) and Niehaus (2012) included domestic and international service-learning in their studies, and Bennett and Braskamp agree that movement on intercultural competence or global perspectives is as relevant domestically as it is internationally, but existing studies have not integrated systematic evaluation of all components of global learning with students exposed to both domestic (glocal) and international global learning programs.

Open Source Scales Integrating Civic and Intercultural Learning Outcomes

Two studies are exceptions, however, for their choice to be non-proprietary and for their embrace of scales that speak to intercultural and civic learning. Bennett and Braskamp, as mentioned above, have employed a fee-for-service structure to determine what institutions and student populations they will include in their dataset. This not only creates a bias toward better-funded institutions and their populations in terms of presence in the dataset; it also generates a situation where predominately first-generation-serving and predominantly minority-serving institutions, which for historic reasons tend to have smaller budgets and less endowment per student, struggle to find accessible opportunities for comparative evaluation (Lough & Toms, 2014). Furthermore, without releasing the full data set, there has been an opportunity missed to mine the causation-related factors contributing the greatest change across institutions.

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Morais and Ogden (2010), alternatively, intentionally developed an open-access scale for use across institutions. Their scale, which includes intercultural competence, self-awareness, social responsibility, and civic engagement, is theoretically grounded and empirically validated. They have conducted multiple exploratory and confirmatory factor analyses, as well as expert face validity trials. Their scale also drew heavily on insights gleaned from Bennett, Braskamp, and other prominent researchers in international education. Morais and Ogden tested their scale iteratively with a total of more than 500 students. The students were enrolled in either short-term abroad experiences tied to a course on the home campus (embedded programs) or in courses covering similar academic content without an education abroad component.

Because many of the scales developed demonstrated high construct validity, and due to their commitment to open access, their global citizenship scale played a strong role in informing the development of the global engagement survey described below. Their social responsibility dimension, however, was unclear. Additionally, their dataset included education abroad students, but did not explicitly include students exposed to glocal programming, service-learning, or civic engagement.

As Morais and Ogden were sharpening tools for understanding global citizenship development among students, Lough, McBride, and Sherraden (2009) were completing research on international volunteer program outcomes. The researchers looked at a 90-item survey delivered to 983 respondents who applied for or worked with short, nonprofessional (3.8 weeks) or long-term, professional (46.2 weeks) international volunteer placements. The majority of volunteers were 25 or younger, but volunteer service was typically not associated with university-sanctioned, accredited service-learning. Following factor analysis of the 983 matched pre- and post- surveys, the researchers shared eleven scales with Cronbach Alphas above .70. Those scales included international contacts, open mindedness, internationally-related life plans, international understanding, intercultural relations, global identity, civic activism, community engagement, media attentiveness, financial contributions, and social skills. Lough, McBride, and Sherraden's (2009) work was also instrumental in the development of the global engagement survey, because the scale is non-proprietary and measures several targeted outcomes that hang together well. However, the research is once again based entirely on self-report data, only examines international volunteering as the programmatic intervention, and is limited to analysis of two programs. As exhibited in Table 1 below, significant research operates on the edges of glocal and international engagement that is plausibly supportive of robust global learning, but existing research comes from limiting perspectives or locations. Table 1: Key Articles Examining Development of Intercultural Competence, Global Civic Engagement in Students, Volunteers

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Table 1: Key Articles Examining Development of Intercultural Competence, Global Civic Engagement in Students, Volunteers

Author(s)	Measure / Theoretical Contribution	Population and Intervention	Outcome(s) Measured	
Bennett, 1993, 2012	Developmental Model of Intercultural Sensitivity (DMIS)	College students exposed to study abroad; also employed in corporate and other settings	Intercultural competence	Developed out of international education literature with limited focus on civic engagement.
Braskamp, Braskamp, & Engberg, 2014	Global Perspectives Inventory (GPI)	Primarily college students, primarily study abroad programming	Global learning, development—cognitive (knowing and knowledge), intrapersonal (identity and affect), and interpersonal (social interactions and social responsibility).	Developed out of international education literature with limited focus on civic engagement.
Bowman et al., 2010	Various relating to attitudes on equality, justice, social responsibility	Comparison of college students exposed to 2-7 day global service-learning (GSL) programs with college students exposed to 8-10 GSL week programs	Student orientations to equality, justice, and social responsibility	Limited to single institution; no focus on intercultural competence
Hartman, 2014	Global Civic Engagement, Awareness, and Efficacy	College students exposed to GSL with structured curriculum compared with GSL students lacking structured curriculum	Global Civic Engagement	Limited to single institution; no focus on intercultural competence

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Kiely, 2004, 2005	A Transformative Learning Model for Service-Learning	Community college students who participated in a GSL program in Nicaragua	Transformational process in global service-learning	Data limited to single institution, program, and site; global citizenship & intercultural competence not explicit areas of focus
Longo & Saltmarsh, 2011; Alonso Garcia & Longo, 2013	Reframing International Service-Learning into Global Service-Learning	Undergraduate students in a global studies major with a sustained civic engagement focus	Conceptual argument with some supporting student interview data / co-writing, suggesting value in local forms of global engagement	Data limited to one program; largely conceptual argument
Lough, McBride, & Sherraden, 2012	International Volunteering Impacts Survey (IVIS)	International volunteers who participated in placements between 2 and 52 weeks in length	International contacts, open-mindedness, international understanding, intercultural competence, civic activism, community engagement	Data limited to two volunteer programs; not all constructs were fully validated
Morais & Ogden (2011)	Global Citizenship Scale	College students participating in study abroad programming	Social responsibility, global competence (including intercultural competence), and global civic engagement	Social responsibility was an unclear dimension in the scale development
Niehaus, 2012; Niehaus & Crain, 2012	National Survey of Alternative Breaks	US College students participating in alternative spring breaks	Student choices regarding major, career plans, intentions to volunteer, engage in advocacy, study abroad or travel abroad	Data limited to alternative breaks; global citizenship & intercultural competence not explicit areas of focus

Review of the studies in Table 1 illuminates several strong approaches to evaluating outcomes in this area. Yet the diversity of studies also emphasizes the extraordinary variation in populations and interventions employed to advance the capacious ideal: components of global learning for global citizenship. A review of the above and additional studies (Hartman, 2015; Sherraden, Lough, & McBride, 2008; Whitley, 2014) led the researchers to develop a considerable catalogue of global learning intervention program factors, as summarized in Table 2.

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Table 2: Program Factors Identified as part of the Global Engagement Survey

Category	Potentially moderating factors identified within category
Student Population	Highly selective - not selective; Socioeconomic diversity; Racial / ethnic diversity; Gender diversity; Level? (1st year - graduate student); Declared major / undeclared
Course	Required / elective; Service-learning required / elective; Length of course; Course before, during, or after immersion / cross-cultural experience? Throughout?; Number of Credits; No Course: Co-Curricular
Community Engagement	No community engagement; Structured presentations from local leaders / speakers; Visit local sites of historic, cultural importance; Direct service activities (tutoring, providing physical service); Cooperative problem solving with community partners (developing programs or research together); Cooperation with community partners on advocacy and change projects intended to outlast program
Community Relationships & Context	Extent of faculty member relationship with community /organization; Match / mismatch between students' general level of SES and community SES; Experience mostly in US, outside US, combination; US students leaving or non-US students arriving?
Language Immersion	No immersion; Students are engaged in community; Dominant language English; Dominant language not English (NE); <i>All following are sub-categories of NE</i> : students not required to have local language skills; students are required to have rudimentary local language training; students are required to have introductory local language skills to participate; students are required to have intermediate local language skills to participate; students are required to have advanced local language skills to participate
Housing during Immersion	No immersion; Homestays with host community housing; Student housing with host community peers; Independent stays in apartments or other housing that is within the host community

The factors enumerated in Table 2 were identified as having potentially moderating impacts on high impact global learning programming, including domestic and international versions of GSL, conventional study abroad programming, local engagement across cultures, and domestic programming for visiting international students. These potentially moderating impacts include accommodations (e.g. homestay or other) and extent of language immersion or lack thereof (Vandeberg, Paige, & Hemming Lough, 2012), extent and type of community engagement (Moely, Furco, & Reed, 2008), the required or elective nature of the course or program (Lassahn,

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2015), as well as whether it was credit-bearing or co-curricular (Eyler & Giles, 1999), along with demographic and socioeconomic similarity and difference among visiting students and host community members (York, 2013; Wilsey, Friedrichs, Gabrich, & Chung, 2014). These program factors were collected when program administrators completed an online form detailing the components of each program by responding to questions such as:

Please indicate the best description of student-community language relationships for this program:

-
- Students are engaged in the community and the dominant language is English

 - The dominant language is not English. Students are not required to have local language skills

 - The dominant language is not English. Students are required to have introductory local language skills to participate

 - The dominant language is not English. Students are required to have intermediate local language skills to participate

 - The dominant language is not English. Students are required to have advanced local language skills to participate

From domestic cross-cultural service to intentional on-campus interactions with international students and conventional study abroad, outcomes of interest are often similar if not the same. The uncertainty in respect to the sameness or dissimilarity of outcomes among these interventions is indeed one of the central reasons for more research in this area. If developmental student learning can be supported through a number of coordinated, targeted interventions spread over students' four-year university experiences, research that employs the same outcome measures across a variety of interventions will be helpful in chronologically ordering student experiences, as well as in making choices about scarce institutional resources and appropriate methods for encouraging student learning.

The Global Engagement Survey

Based on the AAC&U framing and previous research discussed above, the authors integrated the strengths in existing scales and focused efforts around an understanding of global learning predicated upon three primary outcome areas: (1) intercultural competence, (2) global citizenship, and (3) critical thinking. Further, the researchers responded to critiques that most of the above measures are exclusive self-report by adding clarifying questions that are responsive to respondents' assertions on the likert scale items. The following scale, which focuses on self-awareness as a component of intercultural competence, demonstrates how particular closed-item responses lead to relevant follow-up questions, in an effort to surface qualitative data that may serve as conformational or negating data in relation to self-report. The follow-up questions that

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appear depend upon students initial responses, with SD indicating strongly disagree and SA indicating strongly agree. On this scale and others, sometimes disagreeing with assertions regarding ease of performance in intercultural situations may be a signifier of experience, while it is possible that students who agree that they can perform well interculturally have very little experience in such situations.

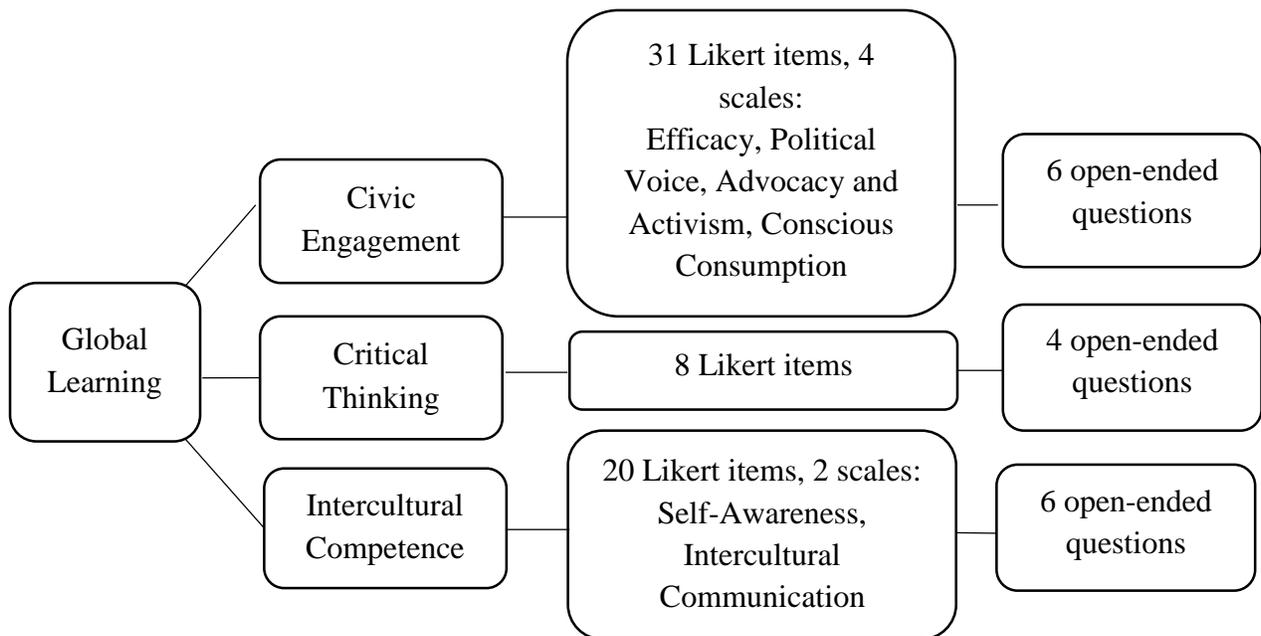
Intercultural Competence: Self-Awareness Scale

	I can easily resolve misunderstandings with people from other cultures.
	If SD or D - Can you briefly explain how you know that you are challenged to easily resolve misunderstandings with people from other cultures?
	If SA or A - Can you provide a brief example of a time you satisfactorily resolved a misunderstanding with a person from another culture?
	I adapt my behavior and mannerisms when I am interacting with people of other cultures.
	I often adapt my communication style to other people’s cultural background.
	I can easily adapt my actions in response to changing circumstances.
	My self-understanding is informed by many assumptions that are unique to my culture.
	I have a hard time working with people who are different from me.
	If SA or A, could you describe a point when you had a hard time working with someone who was different than you?
	If SD or D, can you describe when you have a hard time working with people who are different from you?
	I have a hard time understanding the feelings of people from other cultures well.
	If SA or A, could you describe a point at which you have had a hard time understanding different cultures well?
	If SD or D, Can you indicate how you have become aware that you have a hard time understanding the feelings of people from other cultures well?
	I work to develop and maintain relationships with people of backgrounds different from my own.
	I can easily resolve misunderstandings with people from other cultures.
	If SD or D - Can you briefly explain how you know that you are challenged to easily resolve misunderstandings with people from other cultures?
	If SA or A - Can you provide a brief example of a time you satisfactorily resolved a misunderstanding with a person from another culture?
	I adapt my behavior and mannerisms when I am interacting with people of other cultures.
	I often adapt my communication style to other people’s cultural background.
	I can easily adapt my actions in response to changing circumstances.
	My self-understanding is informed by many assumptions that are unique to my culture.
	I have a hard time working with people who are different from me.
	If SA or A, could you describe a point when you had a hard time working with someone who was different than you?
	If SD or D, can you describe when you have a hard time working with people who are different from you?

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Following revisions resulting from pilot year analysis, the survey now contains 59 closed-ended items across the three main outcome areas. The full survey is available for consideration at <http://globalsl.org/ges/>. All closed items in the survey use a 5-point scale with response options: 0=Strongly Agree, 2=Neither, 4=Strongly Disagree, presuming the presence of a latent continuous variable underlying respondents' attitudes and opinions. The survey also contains 16 open-ended questions and 15 items added to the baseline survey to assess the influence of moderating variables enumerated in Table 2, including demographic factors, past international and service experiences, and the length and intensity of the placement, among others. See Figure 1 for a visual overview of the survey structure.

Figure 1: The Global Engagement Survey



Conclusion: The Global Engagement Survey

As universities and activists make compelling arguments to glocalize global learning, assessing the efficacy of such learning is a looming challenge. Previous research can support assessment efforts, but existing studies tend to focus on only one component of global learning (e.g. intercultural competence), only one population (e.g. students at a single university), only one type of intervention (e.g. study abroad), and/or exclusively rely on self-report measures. The GES addresses these challenges by drawing upon the best scales in previous measures, integrating existing measures in a novel manner consistent with agreed-upon definitions of global learning, and adding open-ended clarifying questions to the established survey items. The

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addition of open-ended questions provides space not only for potentially confirmatory or negating utterances from respondents, but also creates the possibility that respondent reflections may capture unplanned, critically reflective insights tied to transformative learning (Kiely, 2015).

Additionally, the authors working with the GES have cooperated with funding agencies to ensure that primarily first-generation-serving and primarily minority-serving institutions have opportunities to participate in the survey, further diversifying the dataset. As the GES enters its third data-collecting iteration, and its most ambitious to date, it is clear that participating institutions range from Ivy League institutions through community colleges, and participating program interventions range from course-based international service-learning through study abroad without service-learning and community-engaged glocal learning efforts. As the researchers consistently examine these diverse populations and program types through the same, carefully structured global learning lens, they look forward to reporting upon relationships among specific populations, programs, and outcomes.

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Global Engagement Survey 2016

The **Global Engagement Survey (GES)** is a multi-institutional assessment tool that employs quantitative and qualitative methods to better understand relationships among program variables and student learning, specifically in respect to global learning goals identified by the Association of American Colleges and Universities (AAC&U, 2014). The GES is composed of seven scales to assess: intercultural competence, civic engagement, and critical reflection.

Scale	
Intercultural competence – Communication	ICC
Intercultural competence – Self-awareness	ICSA
Civic engagement – Efficacy	CEE
Civic engagement – Political Voice	CEPV
Civic engagement – Conscious consumption	CECC
Civic engagement – Values	CEV
Critical reflection	CR

Further articulation of the scales appears in the full report. Actual scales appear in Appendix of the report. The data consisted of: (1) participant background information, (2) program factors, and (3) responses to closed and open-ended questions. For the analyses that follow, only the sample of matched cases ($n=107$) was utilized to examine significant differences between the pre- and post-test surveys.

Findings: Quantitative Analysis

Participants: The participants were majority female (62%), born in the United States (68%), grew up in a suburban area (53%), and had not participated in volunteer service before (59%). The highest percentage of participants reported their race/ ethnicity as White (35%); however, the participants were more diverse than past years (with 15% Asian/ Pacific Islander, 18% other/ multiracial, and 10% Latino).

Demographic data and program factors: The analysis illustrates bivariate associations between learning outcomes and select demographic and program variables. As bivariate analyses, these associations do not control for any third variables that may mediate or moderate these relationships. Nonetheless, we report on these associations hoping to raise questions about potential programming options. As the GES population grows moving forward, we will include multivariate analyses in our analyses.

The following **demographic categories** were correlated with significant differences on participants' scores on at least one of the scales in the post-survey ($n=107$): gender, country of birth, prior volunteer experience, mother's education level, and father's education level (See report for further discussion).

The following **program factors** were correlated with significant effect on at least one of the scales in the post-survey: program leader relationship with the host community, program location, presence of program leader on the site with the students, program time horizon, and components of community engagement (service-learning or non-service-learning) (See report for further discussion).

Scales: For the total data set ($n=107$), there was significant change from pre- to post-survey for the following scales:

- ✓ Intercultural competence – communication
- ✓ Intercultural competence – self-awareness
- ✓ Civic engagement – efficacy
- ✓ Civic engagement – conscious consumption

Findings: Qualitative Analysis

While there were similar patterns across the whole data set, there were also quantitative and qualitative differences between institutions.

- One institution's students considered structural and systemic factors in their comments relating to cultural differences to a greater extent than was true for students from other campuses.
- At one institution, students included comments on politics and religion in their diversity comments to a much greater extent than was the case for other institutions or the total data set.
- Participants from one institution shared increased feelings of cynicism regarding political participation in a manner that was not paralleled on other campuses.
- When asked about adapting communication and behavior in different cultural settings, the participants from one institution described not only their program experiences, but also many examples about transitioning to the cultural context of their university.

In addition, the current political context in the U.S. surfaced throughout comments much more during this iteration of the GES than in the past.

Intercultural competence

When asked about **discomfort discussing diversity**, participant comments described: (1) a fear of offending someone, (2) acknowledgement of their limited or lack of knowledge or experiences, and (3) awareness about the social identifiers of the group with whom they were interacting. Across the total data set, the majority of respondents focused on the group composition and social identifiers of the group members when describing their discomfort discussing diversity. Students responded in ways that suggested the challenge with intercultural communication **often resided with the other person**, without considering their own role in the communication equation.

Students' responses described **difference** attributed to either: (1) individual background/ personality traits or (2) structural factors. Most commonly, students recognized less structural and historical context. Their responses tended to attribute cultural differences to individual background experiences or personality traits, arguably displaying an incomplete view of structural factors and global context. At some institutions, students were more likely to name and discuss structural, historical, and cultural determinants of difference.

Civic engagement

When asked about **ethical decisions when spending money**, participants across institutions described their efforts as: (1) charitable, (2) weighing needs vs. wants, or (3) connecting individual decisions to larger systems or structures. Across institutions, the pre-survey responses focused more heavily on charity and needs vs. wants; however, the post-survey responses reflected a shift to ideas about how individual spending decisions connect to larger systems or structures.

Many respondents reported increased civic engagement interests after the program experience, particularly increased likelihood of voting or in some cases no change because they already were civically involved. The majority of students in the total data set and at every individual institution reported increased likelihood to follow current events and vote after their summer experience. One interesting pattern that emerged across institutions was increased awareness about the **role of the U.S. in the world** and the link between current events/ voting and how the U.S. affects other countries.

When asked about how the program influenced their personal sense of their **ability to make a difference**, locally or globally, the majority of participants expressed an increased motivation or sense of possibility. One institution in particular seemed to expose students to contexts and coursework that highlighted the inadequacies of the political system for addressing problems, which appeared to spark **increasing cynicism or apathy among participants**. A number of students expressed an increased awareness about the **complexity inherent in making a change**. Among participants who reflected on their increased awareness of the complexity of change, they focused on **who drives change** and **connecting global and local** issues and efforts.

Critical reflection

Across institutions, the pre-survey responses described their process of learning about themselves as a cultural being as heavily influenced by their **coursework**. However, in the post-surveys, the majority of students described their **immersion experiences or opportunities for direct interaction** outside of the university as the factors contributing the most to their learning process.

Next Steps

The GES uniquely brings institutions and organizations into a common dataset in an effort to better understand the impact of specific program factors on broadly shared global learning goals. As a community of practice, globalSI is able support efforts to look across programs and consider possible differences stemming from variations in student population, institutional cultures, and specific programming choices and opportunities.

In order to **better inform program planning for globalSI partners and the field of global learning**, we plan to:

- ✓ Expand the GES during the 2017-2018 academic year
- ✓ Create additional opportunities to customize the GES for partners, and
- ✓ More explicitly cultivate peer-to-peer learning opportunities among GES participants.

Host community perspectives on trainees participating in short-term experiences in global health

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CONTEXT High-income country (HIC) trainees are undertaking global health experiences in low- and middle-income country (LMIC) host communities in increasing numbers. Although the benefits for HIC trainees are well described, the benefits and drawbacks for LMIC host communities are not well captured.

OBJECTIVES This study evaluated the perspectives of supervising physicians and local programme coordinators from LMIC host communities who engaged with HIC trainees in the context of the latter's short-term experiences in global health.

METHODS Thirty-five semi-structured interviews were conducted with LMIC host community collaborators with a US-based, non-profit global health education organisation. Interviews took place in La Paz, Bolivia and New Delhi, India. Interview transcripts were assessed for recurrent themes using thematic analysis.

RESULTS Benefits for hosts included improvements in job satisfaction, local prestige, global connectedness, local networks, leadership skills, resources and sense of efficacy within their communities. Host collaborators called for improvements in HIC trainee attitudes and behaviours, and asked that trainees not make promises they would not fulfil. Findings also provided evidence of a desire for parity between the opportunities afforded to US-based staff and those available to LMIC-based partners.

CONCLUSIONS This study provides important insights into the perspectives of LMIC host community members in the context of short-term experiences in global health for HIC trainees. We hope to inform the behaviour of HIC trainees and institutions with regard to international partnerships and global health activities.

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INTRODUCTION

Although medical students from high-income countries (HICs) have been participating in rotations in low- and middle-income countries (LMICs) for many decades, these international experiences have recently increased in popularity, as has the presence of global health curricula in medical schools.¹ Short-term experiences in global health (STEGHs) allow students to witness health care in unique cultural and geopolitical contexts.^{2,3} Students are generally supervised by local or HIC health care providers, and experience varying levels of independence in their clinical activities: depending on the global health programme, some students may be placed in foreign contexts strictly as observers, whereas others actively participate in, or independently provide, medical services.^{4,5}

An abundance of benefits to students visiting from HICs, referred to in this paper as ‘HIC trainees’, have been described. These include increases in skills and confidence, a better understanding of the social determinants of health, the ability to function optimally with limited resources, cultural sensitivity, novel disease familiarity, appreciation of the physician–patient relationship, and the desire to enter primary care and work with medically underserved populations.^{2,6–15} Whereas an abundance of research has focused on the benefits to HIC trainees, the benefits and drawbacks for LMIC host communities have not been well described.^{6,7} Some speculate that LMIC host communities benefit from the provision of health care or capacity building, particularly when trainees are placed as providers, educators or caregivers.⁸

However, many take issue with these alleged benefits and refer to the unlicensed nature of HIC trainees, the novelties of language, culture and resources within LMIC host communities, and the relatively short-term duration of HIC trainee international experiences. Direct improvements to community health resulting from HIC trainee clinical activities are not supported broadly in the literature.⁹ Others argue that HIC trainees may actually have adverse effects on host community members, contributing to negative self-images and feelings of dependence, objectification or unworthiness.^{10–12} For community benefits to be realised, it is likely that HIC trainee global health experiences should be nested within longitudinal partnerships between HIC organisations and LMIC communities, and should recognise the costs of hosting HIC trainees.^{5,13–15}

Power imbalances between globally mobile HIC trainees, their home institutions and LMIC host communities complicate global health immersion programmes, as do differences in objectives.^{16,17} Personal development appears to be the overarching motive for trainees interested in travelling to LMICs.^{18,19} Consequently, critics of these programmes decry them as representing ‘developmental tourism’ or ‘voluntourism’.^{20,21} Some suggest that the intent of the trainee is – like that of the tourist – short term, and that there is little sense of responsibility for continuity or follow-up.

To date there has been scant research into host community perceptions of HIC trainees in STEGHs through qualitative interviews.²² The majority of host perspective studies have focused on the impact of sending fully trained HIC medical providers to LMICs^{7,23} or have utilised surveys as their methodology.²⁴ This study aims to describe in depth the benefits and drawbacks of such programmes from the perspectives of those hosting and supervising HIC trainees. Importantly, we also aim to investigate host views on the long-term partnership within which individual trainee activities are nested. We capture here the perspectives of LMIC host community collaborators, including physician preceptors, social workers, non-governmental organisation (NGO) directors, home-stay families, and programme administrators.

METHODS
Study setting

We conducted semi-structured interviews with LMIC host community collaborators with the US-based non-profit NGO Child Family Health International (CFHI) in La Paz, Bolivia and New Delhi, India.²⁵ Child Family Health International facilitates year-round global health education programmes and sends 600–700 undergraduate, graduate and post-graduate HIC interprofessional trainees annually to nine countries. From 1995 to 2010, CFHI ran a medical donation programme in which medical supplies donated by HIC organisations were transported by HIC trainees to international programme sites.

We selected La Paz, Bolivia and New Delhi, India as study sites because CFHI has organised HIC trainee programmes in both locations for over 10 years, which allowed us to make inquiries about the host communities’ perceptions of the long-term partnership. The clear cultural differences between the two

countries are conducive to a more dynamic interview sample and add breadth to the research data.

In both sites, trainees rotate among various clinical settings (governmental hospitals, rural clinics and traditional medicine clinics). In India, trainees have additional opportunities to rotate in community-based health outreach efforts (local NGOs [e.g. needle exchange or domestic violence centres]). The programmes are generally 4 weeks in length, but can range from 2 to 16 weeks. When they undertake CFHI's pre-departure online module, students are made aware of their roles as 'learners' and are told not to practise beyond their level of training while overseas.

Data collection

Study participants were selected by the administrative coordinators or head physicians of the CFHI sites in Bolivia and India. Thirty-five of the selected study participants were available for interview (response rate unknown); 34% were LMIC host community physicians ($n = 12$), 26% were directors or social workers of local NGOs that offered opportunities for CFHI trainees ($n = 9$), 17% were programme administrators ($n = 6$), and 23% were home-stay family members ($n = 8$). All study participants had been born in their respective LMIC host community or had lived there for at least 20 years. Additionally, all participants had interacted with HIC trainees for 3–8 years. Women constituted 40% of the sample ($n = 14$). The programme site in India offered trainees additional opportunities to work with Indian NGOs and social workers, and consequently we were able to interview this additional cohort. Participant characteristics are displayed in Table 1.

Participants engaged in 45-minute, semi-structured, face-to-face interviews with a third-party interviewer, unaffiliated with CFHI. Interviews were conducted in the participant's office, home or hospital, according to the participant's preference. In Bolivia, interviews were conducted in Spanish, whereas in India, interviews were conducted in English. All participants in India were fluent in English. Interviews allowed for exploration of unanticipated statements and were tape-recorded to ensure accuracy and preserve organic speech flow. Data collection continued until data saturation. Interviewees were not compensated for their participation in the study. Institutional review board approval was granted by Stanford University.

Table 1 Low- and middle-income country host interviewee characteristics

Participant group	Bolivian, <i>n</i>	Indian, <i>n</i>
Physician preceptor	5	7
Local NGO director or social worker*	0	9
Programme administrator	2	4
Home-stay family member	5	3
Total	12	23

* Unlike the Bolivian programme site, the Indian site offered trainees additional opportunities to work with Indian NGOs and social workers; consequently, we interviewed this additional cohort
NGO = non-government organisation

Data analysis

We transcribed all interviews verbatim. To facilitate data analysis, we translated Spanish transcripts into English, and asked translators to listen to a sample of interviews and verify translations. We developed a grounded coding scheme based on previous studies of host perspectives of trainee impact in US service-learning placements.^{26,27} We applied codes manually to a line-by-line analysis of each transcript. We subsequently analysed using thematic analysis,²⁸ using the qualitative data analysis software NVivo Version 10.0 (QSR International Pty Ltd, Melbourne, Vic, Australia) to apply codes and compare data. Throughout the coding process, we noted emergent themes and identified relationships and contrasts between original themes.²⁹ After at least three rounds of coding, we applied multiple matrices to identify similarities, contrasts and interrelations among the perspectives of the four key populations across India and Bolivia.²⁹ Once analysis was completed, we sent our results to two participants in both countries to seek feedback and confirmation through member checking. These participants expressed satisfaction that the research accurately reflected their opinions.

RESULTS

Rise in local prestige

Nearly all physicians in both India and Bolivia (83%, $n = 10/12$) claimed that working with a US-based organisation and hosting HIC trainees

increased the prestige of their medical centre in the eyes of the community. Physicians reported that their patients were impressed that HIC trainees had travelled from far away to learn from the patient's local personal physician. An Indian physician stated:

'Most of our patients are appreciative, and some think, "My doctor has visitors from other countries. Okay, the doctor is so learned because he is teaching the foreign student."'

The presence of HIC trainees was perceived by patients to elevate the local physician's skills and the quality of care provided.

This effect appeared to be more pronounced for rural or small town-based providers and those serving predominantly low-income patients. A homeopathic medicine physician described the HIC trainees as a 'racial advertisement' for his clinic. A programme administrator reported that rural clinics hosting HIC trainees had grown in popularity since trainees had begun to arrive about 10 years earlier and attributed this growth to the 'name and fame' that accompanies the title of CFHI preceptor.

Local physicians told stories in humorous tones about patients who cherished the knowledge of HIC trainees, perceiving the trainees as possessing high qualifications beyond their actual level of training. One doctor described patients who brought in their old medical files for HIC trainees to look over, hoping they could recommend additional treatment or an astute diagnosis. The physicians unanimously agreed they did not find their patients' attention to the trainees frustrating. One physician noted:

'White skin is an advantage for us... we should use it.'

Physicians explained that local community members equated the trainees' visible foreignness (White or other race) with wealth, power and influence.

High-income country trainees bolstered the legitimacy of local NGOs serving socially marginalised populations. The director of an Indian transgender centre explained:

'Your visits help us because the community can see that other people are also supporting us. Maybe they see you, foreign students, and funding agencies, and then the community thinks we are doing good work.'

Host community collaborators regarded their HIC collaborators' willingness to work with them as representing recognition of their skills, and endorsement of their clinic, hospital or NGO.

Serving as global citizens

Global health immersion programmes transform local physicians' day-to-day clinical duties by requiring them to engage in the role of educator; they teach HIC trainees and broaden their perspectives of the world. Multiple physicians stated that their motivation for receiving HIC trainees was to fulfil their role as a 'global citizen' and that they were happy to have an influence beyond their country's geographic borders. A Bolivian physician said:

'This opportunity makes me feel important... I can build something more that is not only in my country, but outside my country.'

All physicians reported that the ability to teach HIC trainees from around the globe leads to greater job satisfaction.

Although the stay of HIC trainees is short, physicians were eager to use this opportunity to inspire civic engagement among HIC trainees. Physicians felt a sense of duty to teach HIC trainees from affluent nations about the difficulties of LMIC health care systems. One physician stated of US-based trainees:

'I believe they are leaving Disneyland.'

Host community physicians hoped that HIC trainees would draw from these experiences when making career decisions. Although 25% ($n = 3$) of physicians reported hoping that HIC trainees would come back to work in Bolivia or India after finishing training, the remaining 75% ($n = 9$) of physicians did not expect students to reappear. Rather, they expressed a desire for HIC trainees to return home with a dedication to public service and a better understanding of underserved populations in their own countries. Some Bolivian physicians hoped that HIC trainees would develop a deeper sensitivity towards Latino patients. One Bolivian physician said:

'I believe the American students come here to become world leaders. If you only know your place, you are going to be a local leader. But if you open yourself to the world, you're going to be a world leader.'

Physicians expressed gratitude for the opportunity to shape young HIC trainees.

Broadening world views

Although several LMIC physicians wished that their local Bolivian and Indian students had opportunities to work in HIC health care settings first hand, all felt these aspirations were unrealistic as a result of cost-related barriers and a lack of infrastructure. In light of this, some physicians saw hosting HIC trainees as an opportunity to expose their local students to foreign health care, albeit indirectly. This exposure led to a number of benefits to local students according to local physicians; realising the minimal differences in skill and ability between themselves and HIC trainees, LMIC students gained increased communication skills, self-confidence and maturity.

Both home-stay families and physicians stated that local youth developed enhanced English language skills and broadened perspectives with regard to future career opportunities through working with HIC trainees. A physician running a rural adolescent clinic noted that, through interactions with HIC trainees, local youth now 'expect to have the opportunity to travel to other countries and study'. In both India and Bolivia, home-stay families commented that HIC trainees motivate adolescent home-stay children to develop their proficiency in English in the hope of increasing their travel opportunities and professional potential.

Resource enhancement

All host physicians reported that outside donations and funds enabled them to provide better health care services. Some HIC trainees transported medical supplies donated by HIC organisations to international host clinics. Doctors highly valued these donations, which included items such as gloves, syringes, bandages and stethoscopes. Physicians perceived the quality of these HIC supplies as superior to those available in their own country and said that having these supplies elevated their confidence.

Improved local networks and leadership development

Medical directors – local physicians who lead medical initiatives for each CFHI programme – are responsible for developing long-term relationships with a network of community-based physician

educators. They reported that, in creating a cadre of local community-based preceptors, they were able to build a network of like-minded, public service-oriented colleagues. Programme administrators also reported benefiting from CFHI's local network, claiming to have gained increased leadership skills by managing relationships with the physicians and NGOs who precept HIC trainees.

Perceived hesitancy and apathy of trainees

In both Bolivia and India, 50% of physicians ($n = 6/12$) expressed exasperation that some HIC trainees were reluctant to touch patients in clinic. Physicians agreed that the HIC trainees stood at a distance and watched as if, in the words of one interviewee:

'...they want to sit in a glass cubicle and look at people.'

Referencing the historic caste system, one Indian doctor felt HIC trainees behaved as if his patients were 'untouchables'. Summarising the general sentiment, one physician stated:

'Some students have had a lot of fear about sickness. Then I didn't know why they are studying medicine.'

Many physicians (67%, $n = 8$) noted that some HIC trainees were not proactive and did not ask questions. An Indian physician said:

'Quite a lot of them have been, you know, not interested much... But something has to come from them. I cannot just go blabbering on and on and on. So if the student is not showing an initiative... then maybe we don't feel like teaching those students. Then the rapport is not good.'

Physicians were largely involved with CFHI because they loved teaching, and they recalled hurtful moments when students had appeared bored in the clinic.

All physicians and programme administrators across both countries commented that HIC trainees generally did not take the initiative to do community work beyond required rotations. In these situations, it became apparent to host communities that the students' intentions were to enjoy themselves instead of giving back. A programme administrator stated:

‘Students can do more, but don’t do more. That’s the sad part. Students want to have fun: rafting, trucking, going [to] the mall, partying late into the night. Students want to have fun. But it should not be fun only.’

This carefree behaviour contributed to the perception that trainees’ intent to undertake the programme abroad was based mainly on the wish to build their résumé and gain enjoyment.

Unfulfilled promises

Programme administrators and physicians recounted their disappointment at the lack of continuity in relationships with HIC trainees. A physician stated:

‘They just come and go. In their perspective, it’s just a programme they’re doing, and then they go back.’

Host communities in LMICs were hurt by the short-term mentality of some HIC trainees.

Programme administrators in both Bolivia and India stated that the worst thing an HIC trainee could do was to make unfulfillable promises. Many HIC trainees had promised physicians or NGOs that, upon returning home, they would fundraise, send supplies or return to India or Bolivia the following summer; the majority of HIC trainees had not yet carried out their commitments. Some host community members expressed resentment towards HIC trainees for whom they had helped set up research projects; the majority of these students did not remain in touch or provide collaborators with research results.

Lack of cultural sensitivity

A common frustration for host community collaborators was HIC trainees’ insensitive and, at times, ignorant behaviour. Trainees were cited as taking insensitive photographs and rejecting customary hospitality offerings of tea and food. Host community members noted that HIC trainees travelling together in large groups of classmates or friends tended to be particularly insular.

Lack of equal opportunity

An observation that came up in conversations with LMIC host community collaborators was the frequency of visits by US-based staff of CFHI. Host community collaborators recognised the importance

of face-to-face meetings to develop relationships, but believed it was possible for US staff to visit too often. After a certain point, host community members questioned the purpose of the frequent visits and sometimes tallied travel costs. A programme administrator stated:

‘[CFHI] is gathering the medical directors [and US staff] and flying them in for one night, during the peak holiday time. And paying for the hotel stays and food. . . I don’t think that, as a socially responsible organisation, we should do that.’

Host community members recognised the great expense of these trips and sometimes felt that such spending did not align with their mission.

Some LMIC host community collaborators expressed disappointment that they had not received recognition or promotions commensurate with those of US-based staff. Local programme administrators saw US employees promoted from the position of coordinator to that of director and wondered why they had not received similar acknowledgement, given their long tenures with CFHI. Additionally, some LMIC host community collaborators wished that they had opportunities to travel to the US or to visit CFHI sites in other countries. Although many acknowledged the positive impacts of working with HIC trainees and US-based staff on their careers and personal development, some felt CFHI did not provide professional development opportunities comparable with those offered to US-based staff.

DISCUSSION

Although global health continues to gain momentum both within the medical field and interprofessionally, there are gaps in LMIC perspectives.³⁰ Our study begins to address the lack of understanding about LMIC community perspectives in the context of hosting HIC trainees. Multiple benefits and several drawbacks of hosting HIC trainees were reported by LMIC-based supervising physicians (Table. 2). The other key host community stakeholders consistently reported benefiting in other ways: (i) programme administrators gained improved networking and leadership skills; (ii) local NGOs attained increased prestige and networking, and (iii) home-stay families developed enhanced proficiency in English and broadened world views.

In reflecting upon the benefits of HIC trainee visits, host community members did not mention

Table 2 Benefits and drawbacks of hosting high-income country (HIC) trainees as reported by host supervising physicians

Benefits

Increased prestige for local physicians and their practices
 Opportunities for leadership, networking, and developing global connectedness
 Increased job satisfaction
 Health resources and supplies brought by HIC trainees
 Opportunities for local students to interact with HIC trainees
 Increased motivation to pursue professional development opportunities commensurate to HIC-based staff

Drawbacks

Frustration associated with HIC trainee hesitancy and apathy
 Disappointment regarding short-term, transactional relationships between HIC trainees and hosts
 Disappointment in HIC trainee failure to fulfill commitments
 Frustration with lack of parity in professional development opportunities between HIC and host country staff

improved patient care or community health outcomes, although these are the benefits perceived by some HIC trainees and are often touted in recruitment for global health international programmes.^{31,32} Rather, locally practising physicians commonly cited the presence of HIC trainees as boosting their job satisfaction, global connectedness and prestige. Our findings reinforce the belief that the presence of HIC trainees improves the professional image of the host clinical site.^{24,33} This supports the notion that HIC trainees in the roles of learner, admirer and observer of local physicians support global health. Our results confirm the suggestion that a main motivation for teaching HIC trainees is to fulfil the supervising physician's role as a global citizen, indicating that benefits are perceived to extend beyond the individual HIC trainee.^{22,33,34} These results have implications for those establishing or continuing international programmes as the presence of HIC trainees can be seen to represent an endorsement of a particular clinic or provider. This may be a reason to ensure that HIC trainees are placed with quality health care providers within the community so that the locally defined, highest standard of care is endorsed by global partnerships. Further research exploring the intersections of race and international health-related programmes, as well as LMIC host preceptors' conceptualisations of 'global citizenship' are needed.

Our study is limited by several factors. Interviewees were recruited by local CFHI leadership, which potentially may have skewed the pool of respondents. However, recruitment was carried out by host community collaborators rather than by HIC-based CFHI employees as these individuals maintained the best networks of potential interviewees. The interviewer came from an HIC, which potentially may have altered the manner in which questions were asked or answered. As the majority of study participants are paid an honorarium by CFHI for teaching and hosting, interviewees may have feared that negative feedback might compromise their relationship with CFHI and present an economic risk. To minimise these concerns, participants were assured of their anonymity and of the interviewer's independence of CFHI. The distribution of participants (23 in India and 12 in Bolivia) was weighted towards Indian participants as the Indian site had a larger network of preceptors and an additional community health outreach component. Although we sought to confirm our findings with interview participants by member checking, we received feedback from only two participants. Furthermore, the generalisability of results may be limited as LMIC host community members are not homogeneous globally, and HIC trainee activities may take place in different philosophical contexts with NGOs other than CFHI.¹⁴

Our findings reveal conflicts that may result from activities that are considered to be best practice in global health.⁵ Physicians in both countries cited HIC trainees' reluctance to physically touch patients, which was interpreted as indicative of trainees' prejudice against 'unclean' or 'untouchable' patients, as well as trainees appearing 'bored'. Meanwhile, increasingly stringent standards originating in HICs are calling for the activities of pre-health students to involve observation only, and for all students to avoid practising beyond their level of training, or even to narrow their scope of practice when in novel international settings.^{5,35} Our results indicate a need for discussions between LMIC host community collaborators, HIC institutions and HIC trainees to detail how trainees can touch patients in a humanistic way without overstepping ethical or safety boundaries, while demonstrating active learning and engaged observation.

Host community collaborators were particularly sensitive to the making of unfulfilled promises by visiting HIC trainees. The short duration of STEGHs often transfers to a short-term mentality regarding commitments. Sending novice clinicians and trainees with short-term commitments, yet relatively

massive financial capital, raises concern that such programmes confer inappropriate amounts of influence to young travellers. Our results indicate that pre-departure training for HIC trainees should include the provision of information on the potential detrimental impact of making unfulfilled promises and lack of follow-through with host communities.³⁶

Host community programme leaders believe that organisational spending and professional developmental opportunities disproportionately benefit HIC-based staff. Although HIC-based universities and non-profit organisations often have obligations to conduct site visits for risk management, monitoring and evaluation, and other reasons, these trips can appear unnecessary and even frivolous in the eyes of LMIC partners, particularly when they are coupled with tourism. Our results reinforce the tenets of Fair Trade Learning with regard to reciprocity for international partners of HIC-based organisations.³⁷ Programme leaders from LMIC host communities want parity with US-based staff in terms of travel opportunities, professional development and promotion structure; this unique finding is important for continuing quality improvements towards equitable global health partnerships.

CONCLUSIONS

This study describes the perspectives of LMIC host community supervising physicians and local programme leadership in the context of STEGHs. Our results indicate numerous benefits to host community members, including improvements in job satisfaction, local prestige, global connectedness, local networks, leadership skills, resources and sense of efficacy within their communities. Host collaborators call for improvements in HIC trainee attitudes and behaviours and the avoidance of unfulfilled promises. Findings also provide cautionary tales to ensure parity of opportunities for US-based staff and LMIC-based partners. Overall, this study begins to capture LMIC host community perspectives about the placement of HIC trainees. Additional studies in diverse geographic settings and disciplines, and within differing global health partnership structures, are needed.

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Partnering with *Parteras*: Multi-Collaborator International Service-Learning Project Impacts on Traditional Birth Attendants in Mexico

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Medical students are increasingly seeking global health service-learning opportunities; however, the impact of these interventions is often not assessed. In this article, the authors describe a model for global health service-learning programs as well as a pilot tool for assessing program impacts on populations traditionally difficult to evaluate. Specifically, a group of medical students from the United States, in collaboration with local health officials and a global NGO, successfully implemented a training program for *parteras*, or traditional birth attendants, in Mexico. The training included educational objectives from the Ministry of Health. A pilot assessment tool was developed which included oral pretest and posttest self-reported knowledge and task-specific ability in 12 program-specific categories. The assessment was administered in an effort to determine educational impact: *parteras*, who were receptive to students as teachers, reported increased knowledge and skill in all topics except nutrition and postpartum care. The results of the assessment suggest that undergraduate medical students, when collaborating with a facilitating organization, community-based healthcare workers, and local ministries of health, can improve lay birth attendants' confidence in basic obstetric knowledge and skills through global service-learning. Moreover, creative assessments are required to understand impacts on difficult to access populations.

Keywords: service-learning, community engagement, capacity building, midwifery, global health education, infant/maternal health, intrapartum care

As more medical trainees have demonstrated interest in global health, new concerns have emerged around the ethics of global health travel and participation in international communities (Crump, Sugarman, & Working Group on Ethics Guidelines for Global Health, 2010; Friedman, Loh, Evert, 2015). While earlier global health experiences centered on short term, experiential "mission based" trips, global service-learning (GSL) has emerged as a new model for reciprocal learning and responsible engagement. According to Smith, Carpenter, and Fitzpatrick (2015), GSL includes "experiential educational programs in which students are immersed in another community and culture, providing meaningful service in

partnership with a host community” (p. 161). The benefits of immersive GSL are well documented and include the fostering of openness to diversity, cultural humility, and improved self-knowledge (Evanson & Züst, 2006; Haq et al., 2000; Lee, Walt, & Haines, 2004). As Kiely (2005) maintained, in order to be beneficial, GSL programs must include community-driven service, involve interaction with a global community, and rely heavily on reflection. Providing meaningful service, however, may be challenging for trainees entering new communities for the first time. Furthermore, measuring the impact of service is difficult in resource-limited, largely illiterate communities, where traditional assessment tools are inaccessible to those being evaluated or too cumbersome (Garcia, Morrison, & Savrin, 2012; Perosky et al., 2011).

The Northwestern University Alliance for International Development (NUAID) is a student-led global health organization at Northwestern’s Feinberg School of Medicine. Prior to 2011, NUAID had undertaken brigade-style global health activities, in which student teams, supervised by attending physicians from the U.S., provided single encounter, primary care services for patients (Rassiwalla, Vaduganathan, Kupershtok, Castillo, & Evert, 2013). In 2011, NUAID began collaborating with Northwestern’s Center for Global Health, which had engaged with the U.S.-based global health education organization Child Family Health International (CFHI) to facilitate integration of NUAID student learning into existing health systems and projects focusing on local capacity building. Since 2011, NUAID students have collaborated through CFHI with the Oaxacan Department of Public Health to facilitate annual training of *parteras*, or traditional birth attendants (TBAs), from the region. Local officials identified this project as a priority in order to enhance the capacity of *parteras* to recognize birth complications early and respond appropriately to intrapartum emergencies. In addition, the local public health officials considered the training an opportunity to build camaraderie among *parteras*, as well as to strengthen relationships between the local health system and the *parteras*, who are often isolated in rural villages.

Traditional birth attendants contribute significantly to health in many developing nations where access to medical facilities is oftentimes limited by distance, cost, and cultural barriers. A TBA is defined by the World Health Organization (WHO) (1992) as “a person who assists the mother during childbirth and who initially acquired her skills by delivering babies herself or through an apprenticeship to other TBAs” (p. 4). While some countries have made TBA practice illegal, groups like the WHO and UNICEF have recommended that TBAs be used to “bridge the gap until there is access to acceptable, professional, modern health care services for all women and children” (p. 2).

Several barriers, however, complicate the training of TBAs, including illiteracy, innumeracy, and divergent learning styles (Adegoke, Mani, Abubakar, & van den Broek, 2013; Jordan, 1989). Creative curricula have been developed by NGO workers, researchers, and clinicians utilizing pictorial representations, role-plays, simulators, and oral instruction with call and response to teach basic peripartum and neonatal care (Chabot & Eggens, 1986; Garcia et al., 2012; Gill et al., 2012; Perosky et al., 2011). The same challenges that limit education also make assessment of interventions difficult. Traditional written survey tools and knowledge assessments may not be accessible to illiterate TBAs, necessitating the use of more expensive and time-consuming measures like interviews, observed role-plays, and simulations with checklists (Garcia et al., 2012; Perosky et al., 2011). In one study in which TBAs and nurses were both taught bimanual massage for postpartum hemorrhage on a simulator, the only assessment tool utilized was a survey; thus, the illiterate midwives were not evaluated (Garcia et al., 2012).

This article describes a model global service-learning program: a partnership between medical students of varying levels of training and local leaders in midwifery and medicine, facilitated by a global non-governmental organization (i.e., Child and Family Health International). We highlight key features of global health education abroad and underscore capacity building as meaningful service-learning. Finally, we describe the pilot of a new assessment tool for evaluating the impacts of student-led training on illiterate health workers.

Materials and Methods

A group of 10 medical students from NUAID traveled to Oaxaca, Mexico, for a service-learning trip. The group included six first-year students and four third-year students, and comprised six women and four men. Three students planned to specialize in obstetrics and gynecology (OB-GYN), two in family medicine, two in general surgery, and three were undecided. Regarding language ability, one student was fluent in Spanish, four were proficient, and five were beginners. Students lived with host families in the local community and participated in daily language lessons based on ability level throughout the month.

During the first two weeks, students focused on improving their language and cultural capacities. They shadowed local physicians in outpatient family medicine clinics and the labor and delivery floor in the local hospital. Twice weekly, senior-level residents gave lectures on pertinent OB-GYN topics. Students also learned about efforts to reduce endemic diseases, including malaria and Chagas disease, by joining public health workers on risk-reduction home visits. Finally, students visited a local *partera* to learn about traditional birthing practices in the region.

During the third week, students worked in tandem with local government representatives and CFHI facilitators to design materials for co-facilitating a four-day *partera* training course. The curriculum centered on 12 principles outlined by the Mexican Ministry of Health (see Table 1). Students reviewed resources published by the American College of Obstetrics and Gynecology, the WHO, and the American College of Nurse Midwives to ensure that best practice recommendations were represented. Where possible, these recommendations were adapted for low-resource settings appropriate to the *parteras'* practice locations.

Table 1. Topics Outlined by the Mexican Ministry of Health for *Partera* Training

Topic	Subtopics
Risk Factors	Personal risk factors (substance use, STIs) Environmental risk factors Domestic violence
Anatomy and Physiology	Names and function of male/female reproductive parts Conception Reproductive cycle
Normal Pregnancy	Normal signs and symptoms of pregnancy by trimester Concerning signs and symptoms of pregnancy
Complicated Pregnancy	Symptoms and management of preeclampsia, hyperemesis gravidum, ectopic pregnancy/abortion, vaginal bleeding in pregnancy Management of risk factors for complications Know when to refer patient to hospital
Prenatal Care	Basic recommendations for prenatal appointments by trimester Proper history, exam, and tests for pregnant women Nutrition in pregnancy Lifestyle modifications in pregnancy
Normal Labor	Stages of labor and fetal movements History and exam of patient in labor Management of labor Delivery maneuvers
Complicated Labor	Preterm labor (Preterm) Premature rupture of membranes Prolonged labor

Topic	Subtopics
Neonatal Care	<ul style="list-style-type: none"> Immediate care of newborn Determining need for referral Alarm signs for the newborn
Postpartum Care	<ul style="list-style-type: none"> Delivery of the placenta Care in the postpartum period Management of postpartum hemorrhage Prevention and management of infection postpartum
Lactation	<ul style="list-style-type: none"> Benefits of breastfeeding Steps for successful breastfeeding Complications of breastfeeding
Contraception	<ul style="list-style-type: none"> Forms of birth control Use of emergency contraception Methods of permanent birth control
Nutrition	<ul style="list-style-type: none"> Basic food groups, vitamins, and minerals Foods to avoid in pregnancy Proper weight gain

Students worked closely with a local physician and a nurse representative from the Ministry of Health to ensure that the curriculum was designed and implemented effectively for the *parteras*. The physician and nurse had indicated beforehand that the *parteras* learned best through interactive teaching exercises. For this reason, activities such as call and response, role-play, simulation, and discussion comprised the focus of material delivery, with visual cues such as photos, models, and drawings supplementing the curriculum wherever possible.

Groups of two to three students led the development and implementation of material for each topic, with the majority of pairs consisting of an upper- and lower-level student, at least one of whom was a proficient Spanish speaker. A script (in English and Spanish) was created for each topic. All materials were reviewed with the doctor and nurse before they were delivered to the group as a whole.

In addition, students wanted to design a tool for assessing the impact of their curriculum on the *parteras* who participated in the training. However, a literature review revealed few available methods for efficiently or effectively assessing the impacts of training programs on largely illiterate populations. Available tools were time-consuming to implement (e.g., observed simulations, individually administered oral tests) and would have reduced the already limited time available for teaching. Students decided, therefore, to assess participants' confidence levels as a proxy for program impact. They developed individual confidence-related questions to be administered orally before and after each topic (see Table 2). A numeric scale from 1 to 5 (with 1 representing no confidence and 5 signifying a high degree of confidence) was used to rate the confidence questions. *Parteras* were given a packet in which to record their responses for each section, which was labeled with a representative symbol. In a section comprising three questions, three Likert scales (1-5) were available for marking responses with pens (provided). The physician and nurse responsible for overseeing the training reviewed the questions to ensure that they had been properly translated.

Table 2. Pretest and Posttest Questions by Learning Topic, Outlined by the Mexican Ministry of Health

Topic	Subtopics
Risk Factors	How able are you to explain the consequences of smoking/drinking during pregnancy? How able are you to identify common symptoms of STIs? How much do you know about identifying risk factors in the home?
Anatomy and Physiology	How much do you think you know about the reproductive organs? How able are you to explain a woman's menstruation and fertility to her?
Normal Pregnancy	How much do you know about when to send a woman to the hospital How able are you to recognize the normal and abnormal signs and symptoms of pregnancy?
Complicated Pregnancy	How able are you to recognize the symptoms of pregnancy complications? How able are you to identify when a woman needs to go to the hospital? How able are you to manage risk factors for complications in pregnancy?
Prenatal Care	How able are you to provide basic recommendations for prenatal care? How able are you to ask the right questions in a prenatal visit? How much do you know about what nutritional supplementation women need? How much do you know about the lifestyle modifications women should follow while pregnant?
Normal Labor	How able are you to determine where a woman is in the course of normal labor? How able are you to evaluate the fetus during normal labor? How able are you to manage maternal wellbeing during the course of labor?
Complicated Labor	How able are you to take care of a woman who comes to you in preterm labor? How able are you to take care of a woman who comes to you with premature rupture of membranes? How able are you to take care of a woman with prolonged labor?
Neonatal Care	How able are you to care for the newborn? How able are you to decide when a baby needs to go to the health center (Centro de Salud)? How able are you to explain alarm symptoms to the mother?
Postpartum Care	How able are you to remove the placenta? How able are you to care for the women after delivery? How able are you to manage excessive bleeding after delivery? How able are you to care for a woman with infection after delivery?
Lactation	How able are you to explain breastfeeding to a mother? How able are you to explain the complications of breastfeeding to a mother?
Contraception	How able are you to counsel a woman about contraception? How able are you to counsel men on vasectomies?
Nutrition	How able are you to recommend healthy foods to a pregnant mother? How able are you to identify foods to avoid in pregnancy?

During week four, the students co-facilitated the *partera* training program with the representative from the Mexican Ministry of Health. Each training day began at 9:00 a.m. following breakfast, included two 15-minute breaks, and ended between 2:00 and 3:00 p.m., at which time some students would remain to interact with the *parteras* during lunch. Two to four topics were covered each day. The students responsible for developing each content section led the topic, while other students assisted with facilitation as needed. The partnering physician and nurse orally administered the confidence surveys.

Each day following lunch, students met to debrief and prepare for the next day. Team leaders prompted students to reflect on their experiences working with lay health workers and implementing the curriculum. The team leader recorded these observations.

Survey data from the confidence surveys were entered into a Microsoft Excel spreadsheet by two participating students and reviewed by both for accuracy. In those cases where two responses were marked for the same question, an average of the points was entered. Data were analyzed using a paired t-test to compare means of the pretest and posttest questions for each category. Analyses were conducted using SAS software (version 9.2). Values of specific questions were calculated when a decrease in knowledge/ability was reported. Qualitative student observations recorded during team meetings were collated, serially reviewed, and abstracted for main themes.

Results

During the program, 32 *parteras* participated in the training and evaluation. Twenty-nine of the participants were female; three were male. This was the first training for some participants, while others had attended several facilitated trainings in the past. Participants traveled from across the state of Oaxaca to attend. While all could converse in Spanish, some were more comfortable using indigenous languages.

Orally Administered Surveys

When the local doctor and nurse delivered the oral surveys on the first day of the training, students observed that many of the *parteras* were not participating in the confidence assessment. When students asked *parteras* about their hesitancy, the *parteras* reported that they were not familiar with the word *confidence*. Furthermore, they did not understand the numeric scale; they were innumerate as well as illiterate. After consulting with the local physician and nurse, the decision was made to query *parteras* about their self-perceived ability and knowledge, asking questions beginning with “how able are you” or “how much do you know” in an effort to evaluate participant understanding. The scales were adjusted to include faces that correlated with each number; for instance, a smile indicated “very able/know well,” and a frown indicated “not at all able/do not know at all.” As a result of these revisions, the *parteras* were able to complete the orally administered survey without difficulty.

Data from the oral assessment are included in Table 3. Notably, participants showed statistically significant increases in their perceived knowledge/ability in five categories: normal pregnancy (4.39, 4.91 $p = 0.01$), anatomy (3.78, 4.46 $p = 0.007$), complicated pregnancy (4.59, 4.94 $p = 0.009$), prenatal care (4.2, 4.72 $p = 0.003$), and complicated delivery (4.2, 4.65 $p = 0.016$). Participants demonstrated a non-statistically significant decrease in their reported knowledge/ability in two categories: postpartum care (4.7, 4.6 $p = 0.8$) and nutrition (4.88, 4.65 $p = 0.07$).

Table 3. Participant Responses to Questions of Knowledge/Ability, Pooled by Topic, before and after Training Sessions

Education Topic	Pretest Average	Posttest Average	t-score	p-value	N
Risk Factors	4.06	4.54	-0.7	0.5	12
Normal Pregnancy	4.39	4.91	-2.75	0.01*	28
Anatomy	3.78	4.46	-2.96	0.0068*	25
Complicated Pregnancy	4.59	4.94	-2.79	0.009*	31
Prenatal Care	4.20	4.72	-3.28	0.0028*	29
Healthy Delivery	4.57	4.63	-0.66	0.52	31
Complicated Delivery	4.20	4.65	-2.59	0.016*	27
Neonatal Care	4.73	4.75	-0.27	0.79	31
Postpartum Care	4.70	4.66	0.25	0.8	32
Nutrition	4.88	4.65	1.89	0.07	29
Lactation	4.61	4.75	-0.78	0.44	30
Contraception	4.84	4.85	-1.81	0.083	26

Note. Questions were administered orally, with responses ranging from 1-5 marked on individual score sheets.

* $p < 0.05$

When a decrease was observed in a category, results were also broken down by question. In the postpartum care section, the responses to the questions “How able are you to manage excessive bleeding after delivery?” (4.85 vs. 4.7 $p = 0.19$) and “How able are you to care for a woman with infection after delivery?” (4.91 vs. 4.79 $p = 0.34$) were lower after the intervention; however, this difference was not significant. In the nutrition section, the responses to both “How able are you to recommend healthy foods to a pregnant mother?” (4.83 vs. 4.69, $p = 0.33$) and “How able are you to identify foods to avoid in pregnancy?” (4.93 vs. 4.54, $p = 0.039$) decreased, but only the latter was significant (see Table 4).

Table 4. Participant Responses by Question in Content Areas Demonstrating Decrease in Knowledge

	Pre-test Average	Post-test Average	t-score	p-value	N
Postpartum Care					
Q1	4.63	4.8	-0.89	0.38	30
Q2	4.59	4.67	0	1	30
Q3	4.85	4.7	1.37	0.19	19

Q4	4.91	4.79	1	0.34	14
					Nutrition
Q1	4.83	4.69	1	0.33	25
Q2	4.93	4.54	2.18	0.039*	27

* $p < 0.05$

Student Reflections

Four main themes emerged from student observations after serial review: *parteras*' knowledge base, learning style, clinical reasoning, and connection with students. Main ideas associated with each them are described in the following sections.

Knowledge base

Throughout the sessions, the breadth of the *parteras*' knowledge generally impressed the U.S. medical students. There were, however, a few key areas that stood out as needing improvement. First, the *parteras* struggled with identifying the names and functions of both male and female anatomy. In one activity, a large image of first male and then female genitalia was projected, and volunteers were asked to identify anatomic landmarks. Even with help from the audience, many could not complete the task. Similarly, *parteras* were unable to label parts of the reproductive cycle, fertilization, and contraception, or to answer basic questions about these topics during sessions.

Parteras also had little awareness of nutrition, including basic food groups and sources of nutrients. Students tried to find culturally relevant examples of foods comprising a complete diet; however, the *parteras* still could not apply the information to counseling a patient on well-balanced antenatal nutrition. Instead, they would share examples of soups and teas given to promote healing and recuperation according to local cultural practices.

Learning style

The Mexican doctor and nurse overseeing the training and CFHI's partners in Puerto Escondido informed students that the *parteras* learned more effectively through activities than formal presentations. This message was reinforced throughout the week. The *parteras* enthusiastically joined group activities, generating pictorial lists of risk factors or placing pictures of pregnancy symptoms on poster boards representing the three trimesters. During sessions on physical exam skills, the *parteras* learned best by doing; for example, during the session on determining fetal lie, many of the *parteras* began teaching each other the medical students' models, accurately assessing the fetal position (simulated by a doll under a sheet) and demonstrating external cephalic version maneuvers if the fetus was malpositioned.

Clinical reasoning

Students attempted a clinical reasoning exercise with the participants on postpartum hemorrhage (PPH). The exercise began with a description of the three main causes of PPH and the examinations necessary to determine the source of bleeding (i.e., palpating the uterus, examining the perineum, and checking the placenta to ensure it was removed completely). After a call and response-style review, the participants broke into small groups to evaluate a hypothetical patient who was bleeding after delivery. A brief description of the delivery was given, and the *parteras* were asked what to do next. Inevitably, the participants responded, "Take her to the hospital," rather than check for the source of bleeding. Even when walked through the steps again and shown pictures representing uterine atony, retained placenta, and perineal lacerations, the participants remained firm in their response. Through discussions with the

supervising physician and nurse we learned that the Mexican Ministry of Health has emphasized rapid referral for PPH and that most *parteras* are concerned about repercussions for delaying transport for any reason. We were therefore unable to determine if the *parteras* had difficulty with clinical reasoning, if our lesson was unclear, or if their responses were due to a prioritization of referral resulting from the government's recommendations for prompt hospital transfer.

Connection with students

The *parteras* appeared to enjoy working with the students. *Parteras* would seek out students on breaks and at lunch, excited to share experiences. One interesting connection came on the first day of training. The leaders began the session with an icebreaker in which participants passed string throughout the circle, creating a “web” within the group. Each person was invited to share a few lines about him or herself. While the medical students expected participants to be shy, they instead enthusiastically told stories about their communities and had to be prompted to move on to the next participant.

Some of the most joyous moments of the training occurred during breaks, when the students would lead line dances to re-energize the group. The *parteras* were grateful for these “exercise classes” and requested them each day. The *parteras* were similarly excited to teach the students and would frequently share an herbal remedy or a different obstetric method to broaden the students' knowledge. At the end of the training, many of the *parteras* shared their gratitude for the teaching. Some requested students' e-mail addresses so they could use a family member's e-mail account to stay in touch (few of the *parteras* had personal access to a computer).

Discussion

Participants in a four-day training program led by local physicians, public health officials, and visiting U.S. medical students, under the auspices of a longitudinally engaged global health partnership between an international education program provider in the U.S. and local stakeholders, demonstrated statistically significant improvements in self-reported knowledge of and ability to perform certain obstetric tasks in five of 12 topics outlined by the Mexican Ministry of Health. These results are notable partly because of their content but mostly because they exist at all: This pilot represented an innovative way of assessing the impact of training programs on illiterate and innumerate lay health workers, using limited time and resources.

Increasingly, medical students are seeking opportunities abroad to hone their diagnostic skills in low-resource settings, to observe cultural differences in administration of care, and to have sustainable impacts on communities with fewer resources than their own (Association of American Medical Colleges [AAMC], 2012; Rassiwala et al., 2013). Students who participate in clinical rotations may indeed fulfill the first two of these three goals but often miss the final one. Expanding medical student experiences abroad to include training programs for local community-based health workers, when done in concert with local health experts and facilitating organizations, may be an important step in improving student experience and building relationships with communities, while providing meaningful impacts. Our reflections further support the integration of U.S. medical student global health education and service into existing health systems' clinical and training efforts (AAMC, 2012).

Several conclusions could be drawn regarding those topics in which participant knowledge and ability decreased during training. First, trainings could have increased confusion, causing the *parteras'* understanding to become muddled. Participants may have overrated their knowledge of the topic prior to the lesson and, after learning more, become aware of their overestimation. Similarly, upon realizing the scope of a topic, participants may have felt less confidence in their mastery. We suspect the decreased post-intervention knowledge of postpartum care and nutrition was due to the latter two explanations. Regarding the postpartum period, particularly postpartum hemorrhage and infection, *parteras* have been taught to immediately refer any bleeding patient to a health center. Prompt referral is certainly appropriate, especially because many of the *parteras* live hours from established medical facilities, and

transport time may be substantial. Still, if *parteras* can make basic assessments and engage in cause-specific treatments while awaiting or during transport, mortality rates may be lowered. In relation to nutrition, *parteras* were unaware of the categorization of foods and many of the specific needs during pregnancy—in spite of being quite knowledgeable about traditional foods and taboos. It is possible that in being exposed to more information, the *parteras* realized that nutrition is a much broader topic than they originally thought.

Student observations suggest that *parteras* are both accepting of and enthusiastic about partnering with medical students as instructors and that they are willing to both teach and learn in a reciprocal model. Participants were dedicated to improving their skills throughout the session and were receptive to new information. Furthermore, *parteras* recognized the connections with students as longer lasting than one training period and tried to maintain global connections at the training's conclusion.

This program assessment was limited by several factors. First, in general, self-reported knowledge and ability are not necessarily reflections of true capacity. More extensive measures, such as those listed earlier, with role-plays and checklists, simulations, and interviewer-administered tools will be needed to draw firm conclusions. Self-confidence and self-assessment are recognized as important components of clinical mastery, connecting clinical knowledge with effective practice (Kukulu, Korukcu, Ozdemir, Bezci, & Calik, 2013). Self-confidence has been connected to improved academic performance and clinical competence in nurses, as well as leadership skills (Craven, Marsh, & Debus, 1991; Hay, Ashman, & van Kraayenoord, 1997; Sasat et al., 2002). Self-confidence has not been measured in lay health workers, so connections between self-perception of skills and actual practice have yet to be described; however, based on a review of the literature, it is reasonable to conclude that this is a proxy for improved clinical care.

The timeframe of the study also limited its generalizability. Data were collected only at two times, both during the training, and could not be extrapolated to draw conclusions about the *parteras* once they returned to their villages. For these reasons, we cannot draw conclusions from this data about how this intervention affected the health of the community. Finally, several difficulties arose with even the most basic assessment due to illiteracy and innumeracy. Any study conducted within this population will likely face similar barriers to capturing participants' perspectives, and we believe we have accurately captured *parteras'* experiences.

In spite of these challenges, this program assessment provided valuable insights into one form of global service-learning. As the outcomes suggest, medical students traveling abroad can provide valuable services through training programs for lay health care workers, and can assess the impact of these programs on participants who are both illiterate and innumerate. Partnering with local health officials and organizations to facilitate logistics and continuity in global relationships is crucial for ensuring that training reflects local recommendations and is sustained.

In summary, we believe training programs for lay health workers led by medical students, with oversight from local health professionals and facilitating organizations, are both welcome and impactful. Allowing students to lead meaningful global service-learning projects has the potential to create lasting ties among individuals, institutions, and international communities.

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Defining Community-Engaged Health Professional Education

A Step Toward Building the Evidence

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The Global Strategy for Health Workforce 2030 (WHO, 2016) outlines a set of milestones and strategies to expand and strengthen the health workforce that could better position countries to achieve universal health coverage and relevant sustainable development goals (SDGs). The Strategy underscores a need to counter the global shortage of health workers (expected to be 17 million by 2030) and ensure the workforce is appropriately trained to address the evolving health needs of the population. This training would ideally produce health professionals who are responsive to the population, socially accountable, both person- and population-centered, and supportive of empowered and engaged communities. Community-engaged health professional education is a mechanism for learning how to work in and with communities while obtaining the attributes just listed. **Developing socially accountable individuals and institutions within a health system is key to improving the health and well-being of present and future societies.**

Health professional schools with a commitment to social accountability are distinguished by their “obligation to direct their education, research, and service activities toward addressing the priority health concerns of communities, region, and /or nation they have a mandate to serve” (Boelen and Heck, 1995, p. 3). What has become evident is the lack of published literature analyzing learning taking place in and with communities that has a demonstrated value to that community.

The Innovation Collaborative on Learning through Community Engagement (the Collaborative) is a participant-driven group formed by members of the National Academies of Sciences, Engineering, and Medicine’s

Global Forum on Innovation in Health Professional Education. The Collaborative was catalyzed by a desire to generate and highlight the evidence behind community-engaged health professional education with the aim of sharing and disseminating best practice models. The authors, along with individual members of the Collaborative, recognize that the current lack of evidence is attributable to a number of factors, including disparate nomenclature for work related to community engagement and limited resources assigned to the evaluation of community-engaged activities, particularly in low-resource settings. In response to these challenges, the Collaborative members determined that an

important first step in building the evidence would be to establish a common definition for community-engaged health professional education. A critical element of this definition would be its relevance to all health professionals in all disciplines in all settings (or contexts).

In developing the definition, an initial search was conducted to compile existing explanations. Through a consultative and iterative process, Collaborative members ultimately chose to base the definition on one described by Strasser in 2010. By modifying the language to be relevant across professions, and highlighting the importance of community-engagement at the individual and institutional level, the members of the Collaborative and authors of this paper put forth the following definition of community-engaged health professional education:

Health professional education is community engaged when community-academic partnerships are sustained, and they focus on the collaborative design, delivery, and evaluation of programs in order to improve the health of the people and communities the programs serve. Programs and partnerships in community-engaged education are characterized by mutual benefit and reciprocal learning, and they result in graduates who are passionate about and uniquely qualified to improve health equity.

Elements of the Definition

The term *community* is an intangible entity that is not homogenous and is hard to define or measure (Rifkin, 1986). A community can include various geographic areas, clinical needs, socioeconomic statuses, cultural backgrounds, religious identities, ages, and more. Health professional schools with a social mission tend to focus on both medically underserved and/or disadvantaged communities. However, the Collaborative recognizes the importance of defining *community* based on the context, and therefore the proposed definition of community engagement can be applied to communities however they are defined.

Community-engaged health professional education involves learning activities that take place within and with the community. They require engagement of individuals (students, teachers, community members), institutions (from academia and from the community), and their leadership—all of whom come together to collaborate on the design, delivery, and evaluation of

their learning activities. Such activities should serve two purposes: (1) to educate the learner, and (2) to serve the community. While it may be difficult for one program to successfully implement every aspect of community engagement, the authors encourage the reader to view this definition as a vision from which institutions can embark on a journey toward community engagement, and therefore take a stepwise approach to gradually introduce and strengthen different elements of a program.

Sustainable Community-Academic Partnerships

An ideal and authentic community-academic partnership is interdependent, socially accountable, and sustainable. Community engagement in health professional education requires partnerships to be genuine and based on reciprocal learning and mutual benefit, recognizing the community as a teacher and students as part of a team of service providers. Community participation should ideally be nurtured both formally and informally. Formal policies within academia can facilitate leadership engagement and community representation at various levels of program management. Informal linkages between students and community members should also be encouraged to facilitate a shared understanding of the value each brings to the other. Personal relationships with community members would enable students to understand the effect of health on quality of life and the link between health and social determinants of health. In turn, student and academic activities that specifically address community-identified health needs within the community would lead the community to value the contribution of students and engender a relationship of trust and confidence. Successful community-academic partnerships are adequately resourced, have achievable goals, and are regularly evaluated and reported back to the community so program changes can be implemented that strengthen the learning and the value of the work by the community.

Collaborative Design, Delivery, and Evaluation

Collaborative Design and Establishing Priorities for Community-Engaged Activities

Community engagement means that the communities are active partners and that community and academic voices are valued equally. In a community-academic partnership, participants actively seek and

listen to all voices and acknowledge their necessary interdependence in achieving the goals set out in the partnership. Community representatives are involved at every stage of the process—during the design, implementation, and evaluation of educational activities. Another term for this is co-creation, and it occurs when communities have an active and equal role in decision making.

For students or academia to effectively engage in processes of co-creation, they must first have a deep understanding of the communities they serve. This can be achieved through community health assessments or asset mapping exercises, which identify community deficits, strengths, and resources. Understanding community health requires an appreciation of the effects of social determinants on individual and population health. The National Academies of Sciences, Engineering, and Medicine recently published a comprehensive framework for educating health professionals on the social determinants of health, which can serve as a resource for academic institutions in this process (NASEM, 2016). An important outcome of asset mapping and conducting a community health assessment is identifying mutually beneficial and desired priorities for learning and service activities.

Collaborative Delivery and Evaluation

Community-engaged health professional education requires more than just a community-oriented curriculum. It requires learning and service to be located in the community. With thoughtful pedagogy, the immersion of learning in and with communities, focused on areas of common interest and importance, is intended to be synergistic where students learn from community members while providing them a valued service in the community's environment.

Monitoring and evaluation of community-engaged education should incorporate three important elements. First, evaluation should assess the learning environment and the engagement of individuals within the program. For example, are the students, their teachers, and community members all contributing to and learning from the program? Second, evaluation should be conducted at the institutional level. Are community members adequately represented within academic leadership and/or are they active in managing education programs? Do the needs and resources from both the community and the academic institution inform the strategic plans? Are findings shared

and discussed between academia and community groups? Third, is there truly a shift in the broader systems? Are graduates being produced who are socially accountable and who choose to work in underserved communities? Are academic institutions improving community health and contributing to responsive health systems?

Building Evidence and Next Steps

Capturing and sharing the experiences of learners, teachers, community members, and educational institutions is important for program improvement and for identifying and replicating best practices. However, many academic institutions struggle with inadequate funds, limited expertise, overstretched staff, and lack of time to be able to evaluate their programs and publish their findings. As a result, the published literature is limited. If adequate resources are allocated and programs collect data systematically, program outcomes could be pooled and/or compared to facilitate the spread of effective models of community-engaged health professional education.

An important starting point in evaluation is defining a vision and objectives against which activities can be measured. The Collaborative hopes the definition and elements of community-engaged health professional education described in this paper will catalyze the generation or analysis of evidence. Building the evidence for community-engaged health professional education is an important step in meeting health workforce goals for 2030.

Notes

1. Zohray Talib and Bjorg Palsdottir are members of the Global Forum on Innovation in Health Professional Education of the National Academies of Sciences, Engineering, and Medicine. For more information about the forum, visit nationalacademies.org/ihpeglobalforum.
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REVIEW

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Short term global health experiences and local partnership models: a framework

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Abstract

Contemporary interest in short-term experiences in global health (STEGH) has led to important questions of ethics, responsibility, and potential harms to receiving communities. In addressing these issues, the role of local engagement through partnerships between external STEGH facilitating organization(s) and internal community organization(s) has been identified as crucial to mitigating potential pitfalls. This perspective piece offers a framework to categorize different models of local engagement in STEGH based on professional experiences and a review of the existing literature. This framework will encourage STEGH stakeholders to consider partnership models in the development and evaluation of new or existing programs.

The proposed framework examines the community context in which STEGH may occur, and considers three broad categories: number of visiting external groups conducting STEGH (single/multiple), number of host entities that interact with the STEGH (none/single/multiple), and frequency of STEGH (continuous/intermittent). These factors culminate in a specific model that provides a description of opportunities and challenges presented by each model. Considering different models, single visiting partners, working without a local partner on an intermittent (or even one-time) basis provided the greatest flexibility to the STEGH participants, but represented the least integration locally and subsequently the greatest potential harm for the receiving community. Other models, such as multiple visiting teams continuously working with a single local partner, provided an opportunity for centralization of efforts and local input, but required investment in consensus-building and streamlining of processes across different groups. We conclude that involving host partners in the design, implementation, and evaluation of STEGH requires more effort on the part of visiting STEGH groups and facilitators, but has the greatest potential benefit for meaningful, locally-relevant improvements from STEGH for the receiving community. There are four key themes that underpin the application of the framework:

1. Meaningful impact to host communities requires some form of local engagement and measurement
2. Single STEGH without local partner engagement is rarely ethically justified
3. Models should be tailored to the health and resource context in which the STEGH occurs
4. Sending institutions should employ a model that ultimately benefits local receiving communities first and STEGH participants second.

Accounting for these themes in program planning for STEGH will lead to more equitable outcomes for both receiving communities and their sending partners.

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Background

Short-term experiences in global health (STEGH) abroad are becoming increasingly popular among healthcare trainees and practitioners [1, 2]. A ever-growing contemporary number of organizations based in high-income countries (HICs) offer various STEGHs to low and middle-income settings (LMICs) which vary in length, from weeks to months, as well as purpose, be it educational, research, or community service. Taken together, STEGH attract large amounts of funding and mobilize thousands of volunteers and trainees each year [3].

Over the past 60 years, the implementation of the international development agenda has become a shared responsibility between governments, communities, the private sector, and civil society. Worldwide, non-governmental (NGO) and faith-based organizations (FBOs) contribute to a hundred billion dollar industry that plays a crucial role in development programming [4, 5]. In recent decades, academic institutions (such as medical schools and postgraduate medical education) have become increasingly involved in global health and development projects [6]. A variety of STEGHs thus occur within the present-day context of an unregulated amalgam of NGOs, faith-based organizations, and academic institutions.

Many STEGH rely on local organizations as hosts. Local partnership allows visiting groups to seek context-relevant community guidance with respect to their involvement. The literature increasingly identifies local partnership as an ethical principle around the conduct of STEGH, and outlines key considerations in such partnerships. Broadly, these call on STEGH institutions to:

- Avoid imposing additional resource burden on local partners
- Provide to local partners, funding commensurate to resources consumed
- Prepare written memoranda that outline the roles and responsibilities of each partner
- Ensure participation standards and expectations are clearly outlined by the local partner and community and
- Agree that shared responsibility sustainability, and capacity building must be the foundational basis of any engagement [7, 8].

Applying these ethical guidelines becomes more challenging when considering the variable nature of local contexts and partnerships involved in many of today's STEGH. Certain very remote LMIC communities, for example, may receive one STEGH a year, partnered with a single local organization. Other LMIC communities, perhaps more easily accessible to sending organizations

in HIC, might welcome multiple STEGH sending organizations annually.

This review examines different models of local partnerships employed by STEGH, and proposes a framework for categorization, outlining pros and cons of each model. Employing this framework is meant to allow sending and hosting organizations to consider their community context in assessing their current and desired partnership to support the conduct of impactful, locally-driven STEGHs.

Elements of a community-focused framework of local partner engagement models

The framework was developed by consensus among the authors and collaborators representing various organizations that conduct STEGH. This group consists of five men and one woman from the Global North encompassing a diverse background of experiences and training in public health and preventive medicine, academics, development studies, family medicine, internal medicine, and emergency medicine. All authors hold primary or adjunct academic appointments at institutions based in the United States or Canada. The primary rationale for inclusion of these panel members was related to their leadership roles in non-profit organizations based in the United States and Canada actively working on the issues surrounding STEGH. Of note, one panel member reported close collaborations with a faith-based organization (FBO), which added an additional lens. As an initial effort examining these issues, the panel did not include STEGH partners from host communities abroad, though the aim is to include representative members in ongoing discussions striving toward balanced and diverse perspectives.

A cursory literature search was conducted to identify sentinel articles that would stimulate initial conversations. This keyword search of PubMed, completed in January 2014, employed the terms “global health”, “short term” and “partnership”, with resulting articles reviewed by the group and initial agreement reached on what constituted a relevant publication. These articles, together with the experience of the authors, were subsequently used in an iterative discussion process. Nearly a dozen discussions occurred via teleconference for approximately 30–60 min in length, with a majority of authors present for all meetings and all authors attending a plurality of meetings. Following these discussions, consensus emerged on three key descriptive framework elements for categorizing local STEGH partnerships, which were:

1. **Visiting partners:** the number and nature of visiting organizations from abroad working in the host community;
2. **Host community partners:** the number and nature of local partners in the host community, and

3. **Frequency/continuity of short-term visits** by the visiting organizations to the host community.

Definitions for these themes follow below. Discussions following agreement on these definitions aimed to identify various models of partnership engagement based on these themes, as well as identifying broad principles for framework application.

Visiting partners

This framework category considers visiting partners as any STEGH sending organizations working outside their frame of reference; their participants broadly “visiting” the LMIC community who is receiving and hosting the STEGH. Primarily examining the relationship between visiting STEGH groups and the local host from the visitors’ perspectives, this category also considers the total number of groups visiting as well as the nature of their work. As an example, too few visiting partners working in conjunction with a local partner may be less intrusive, but might also limit the impacts and robustness of external resources available for health development. Conversely, receiving too many visiting partners may overwhelm a local institution that lacks adequate structure and compensation, thus creating the potential to impose unintended burdens on local resources [9].

Host community partners

This framework category considers the perspective of host community organizations that partner with STEGH sending organizations. Even before the widespread dissemination of ethical guidelines calling for local partner leadership, some STEGH groups would partner with host community organizations to achieve shared goals, such as development of local academic institutions, NGOs, and/or FBOs. Partnerships might occur with single or multiple host community-based institutions. Partnerships between visiting STEGH organizations and multiple host community partners may increase resources through pooling to support a variety of development and health activities, which in turn could generate more significant population health impacts. However, multiple partnerships also presents the challenge of maintaining collaboration across often diverse stakeholders, priorities, and motivations. In contrast, a bilateral STEGH – local partner partnership may seem more limiting, focusing on a sole local partner potentially permits STEGH groups to cultivate a deep relationship with narrowly-defined but mutually beneficial goals.

Frequency of visits

This framework category address the time commitment that a visiting partner makes to its host partner(s). Panel members differentiated between whether a visiting partner

has “boots on the ground” throughout the entire year on an intermittent or continuous basis. For definitional purposes, local staff hired by a foreign organization are considered members of the host community. Thus, a visiting partner that might employ local staff but only makes short visits once a year would be considered to be conducting intermittent visits. Continuous visits would be categorized if outside individuals are on the ground in the local community for a majority of time annually. It is important to note that this category aims to address only the continuity of presence of visiting partners, and does not ascribe comparisons with respect to valuing the work of visiting partners or local providers.

International partnerships require commitments of time, money, and resources. Early in the STEGH planning process, visiting partners must work with host partners to determine the scope of work, the available resources, and the community need they are addressing, and the impact that they hope to achieve. This will enable partners to consider either intermittent or continuous programming commensurate with their organizational strengths and weaknesses. These considerations should be constantly revisited as the partnership progresses.

Applying the framework

Table 1 outlines these primary elements and the resulting categorization that unfolds. Each category is described briefly below.

Single visiting partner, no local partner

STEGHs that are arranged by a single visiting organization without a local community partner are often colloquially termed “parachute” programs. Historically, many STEGH have occurred in this manner. Groups of providers from HICs would spontaneously head off on short-term relief missions, either via a personal contact in a host community abroad for whom they did not have a long-term relationship with, or at random. Following the 2010 earthquake in Haiti, for example, many groups of well-intentioned individuals travelled to the country of their own volition to volunteer and provide services to people displaced by the crisis. These undertakings often occurred parallel to one another and official efforts, and were largely panned as poorly prepared and contributing to the chaos in the acute aftermath of the natural disaster [10]. In less emergent situations, however, parachute STEGH continue to occur—with increasing attention being directed to their unintended effects and the need for greater local partnership [8, 9].

Single visiting partner, single local partner, and intermittent STEGH

Responding to concerns, many STEGH sending organizations are transitioning to a model by which their

Table 1 Framework for categorization of STEGH, by local partner engagement

Nature of visits		Intermittent STEGH	Continuous STEGH
Visiting partner	Host partner		
Single	None	Parachute	Multiple parachutes
Single	Single	Single host partner receives intermittent visit from single visiting partner	Single host partner receives continuous visits from single visiting partner
Single	Multiple	Multiple host partners receive intermittent visits from single visiting partner	Multiple host partners receive continuous visits from single visiting partner
Multiple	Single	Multiple visiting partners work intermittently with single host partner	Multiple visiting partners work continuously with single host partner
Multiple	Multiple	Multiple visiting partners link with multiple host partners for a stand-alone purpose	Multiple visiting partners continuously link with multiple host partners

programs are supported by a host partner on the ground; the most common resulting partnership thus occurs between a single visiting STEGH partner and a single host partner, with intermittent visits by the visiting organization. Such efforts are particularly common in the initial stages of a visiting partner's involvement in a community, and when the community in question is more remote or has only begun to recently receive STEGHs.

In planning STEGH, the visiting partner (often an academic institution or NGO) relies heavily on the host partner to provide logistic support as well as guidance specific to the community context, particularly in feedback around planned programs being brought forward by the visiting team. In between the intermittent STEGH visits, however, any work in sustaining initiatives until the next visit falls to the host partner, while the visiting partner may provide external resource support and remote technical assistance or knowledge.

This partnership model limits the scope of work that can be accomplished by the visiting partner on STEGH, with a typical focus on more service-focused care or narrowly-focused research/educational initiatives that can be accomplished while they are "on the ground."

Single visiting partner, single host partner, and continuous STEGH

For certain communities, the single visiting partner has a continuous presence on the ground, with staff and teams present in the community and in contact with the host partner at all times. This often takes place in the form of multiple STEGH, sent by the visiting partner, arriving in the community on a fixed schedule. Oftentimes, this model is adopted by particularly large and well-supported visiting partners with perhaps a longer-term interest in supporting health and development efforts in the community in question.

In an ideal application of this model, STEGH are part of a longer-term program undertaken between the visiting partner and the host partner. Each visiting STEGH, together with the host partner, provide an update and

hand-off to incoming STEGH groups immediately following them. The host partner continues to oversee logistics, but in ideal situations, standardization of team compositions and programming allows some mitigation of the resource burden to their organization. Conversely, other versions of this model may simply mirror the nature of intermittent STEGH by visiting groups; in this case, STEGH groups from the visiting partner come continuously one after another to provide longitudinal impacts. In this situation, the focus of the host partner remains to provide logistic support and essential insight into the community.

Implemented well, a continuous presence has the potential to multiple impacts by redirecting efforts towards a longer-term, sustainable model. Simple continuous STEGH mirroring an intermittent model, however, has the potential to greatly increase the burden of work for the host community institutions.

Multiple visiting partners, single host partner, intermittent STEGH

In more established STEGH receiving community settings this is an extremely common model. A typical example is a mission hospital in an LMIC community that receives a number of STEGH from multiple unique visiting partners on a sporadic and intermittent basis. Commonly, groups that might be received over a defined period of time could include students from an academic institution in a HIC; volunteer groups from an NGO on a service experience; and STEGH from visiting FBOs from HIC.

In the most basic variation of this model, each visiting partner effectively has a single partner – single host intermittent relationship with the host partner in question. For the most popular communities, this is a not uncommon situation, given that funding might come from multiple various partners to support a plethora of programs. Typically, as knowledge of a STEGH-hosting community increases, its ability to attract STEGH similarly increases, and many host partners may find themselves engaged with a number of visiting partnerships.

In practice, this leads to significant resource burden on the part of the host partner. STEGH may arrive at the same time and there are now potentially multiple different projects or competing demands for the host partner to navigate. The resulting context presents challenges for impactful outcomes, given the enormous potential for duplication of effort and redundancy. Adding to these concerns around this model of partnership is that the nature of work undertaken by each individual STEGH is still limited by their intermittent presence. Essentially, at worst, these are essentially multiple single-visiting partner STEGH that might have a narrow focus on downstream, episodic care, with similar intended impacts but a much more significant resource burden to the host partner and community.

Multiple visiting teams/organizations, single local partner, and continuous STEGH

As described in the previous section, the arrangement of STEGH by visiting partners independent of one another and on an intermittent basis with a single host partner results in limitations to STEGH outcomes, particularly around effectiveness and sustainability. With expanded, collaborative partnerships, however, disparate visiting partners could emulate a more continuous model, linking and pooling each of their intermittent STEGH into a continuous, coordinated presence. This continuous presence eases the burden of host partners, particularly around advising and logistics support, allowing them to take on a more strategic role in guiding STEGH and truly collaborative programs that could arise.

While these potential benefits are evident, bringing multiple visiting partners together in conducting continuous STEGH contains additional complexities from the corollary continuous single visiting partner – single host partner partnership. Obvious potential differences include ideology (e.g., between an academic institution and a faith-based organization), motivation (e.g., some visiting partners with a service focus versus others with an educational focus), and preparation (some partners may undergo extensive training while others might be poorly prepared.) Successful employment of this model relies heavily on extensive discussions towards consensus and privileging the leadership and direction of the host partner.

Single visiting partner, multiple host partners, and intermittent STEGH

This model involves a single foreign organization sending one team to a variety of local sites for STEGH or coordinating efforts with multiple local stakeholders within receiving communities. Most typically, the community settings where this might occur are with visiting partners with a very narrow or specialized programming focus, or

large with a diverse mandate and significant resources. For specialized visiting groups, their narrow focus allows them to quickly replicate their programs with local partner support. One good example is the mobilization of relief teams in situations of great need, such as humanitarian interventions. The intermittent nature of STEGH usually involves a relief team working in coordination with multiple host partners to deliver emergency/disaster mitigation measures.

For larger partners with a diverse mandate and significant resources, one could consider a visiting partner such as an academic institution with multiple departments that might conduct complimentary efforts in LMIC community. One department may establish a partnership with one host partner relevant to their mandate; another department might then be interested in establishing a STEGH program in the same community, but may partner with another host organization that is more in line with their mandate. The result brings the visiting partner together with multiple host partners, which provides broad opportunity for community impact through diverse STEGH, but also poses challenges around coordination and visiting partner messaging/branding, particularly if visiting partner internal communication processes are limited.

Single visiting partner, multiple host partners, continuous STEGH

A partnership model in which a single organization works continuously alongside multiple local partners actually often exits the STEGH realm, given the long-term commitment and dedication required. Groups that successfully coordinate multiple local stakeholders on a continuous basis can create meaningful community planning dialogue that leverages expertise, provided they remain committed to accurately representing potentially competing local needs.

This partnership model has the most potential to impact lasting changes in community context; in turn, many of the visiting partners that undertake such efforts are well resourced, well-staffed and well financed. Many of these visiting partners may have a brand or reputation that enables them to easily interact with leading stakeholders (e.g., local ministries of health) in accessing existing health systems. They may provide funding (particularly from STEGH participant fees or grant funding) to provide economic support for host partners and community programs. In turn, host partners provides strategic direction for programs and collaboration with impact assessments.

The challenges with this approach usually concern the competition for resources among the multiple hosting partners, particularly if there is a paucity other visiting partners in the community. The unintended impact of

the visiting partner might be to act as an external pressure on hosting partners to alter their mandate, operation, or scope to align more closely with the priorities of the visiting partner. This has implications in that the visiting partner's STEGH may end up not addressing actual community needs, but rather the needs that they are perceived to be visiting the community for. The principle of sustainability is thus even more important in a setting like this; the visiting partner may be able to bring STEGH to address immediate needs, but the focus should be on medium and long-term capacity building such that the many host partners are eventually able to transition into roles as the primary program or care provider.

Multiple visiting teams/organizations, multiple local partners, and intermittent or continuous

These specific models lie outside the realm of STEGH, but are relevant to the wider field of discussion around global health and development. In general, programs that mobilize multiple visiting teams to work with multiple local partners on an intermittent basis are rare and would likely fall into one of the other categories already described.

Broad principles in application

From the consensus discussions around various models described, the panel members identified four key principles to consider in the application of this partnership framework:

1. Meaningful impact to host communities requires some form of local engagement and measurement
2. Single STEGH without local partner engagement is rarely ethically justified
3. Models should be tailored to the health and resource context in which the STEGH occurs
4. Partners should employ a model that ultimately benefits local receiving communities first and STEGH participants second.

The second principle bears further explanation, in that literature increasingly highlights the potentially negative aspects of STEGH on host communities. These include lack of cultural competence, culture shock and insensitivity, the opportunity costs for local communities, and issues with continuity, particularly around funding and resources. Engaging partnerships has been proposed by several authors as a means to mitigate potential power imbalances and cultural clashes, establish longer-term resource transfers, and ensure relevance of STEGH work to community priorities [1, 3, 6].

Finally, measuring the impact of STEGH (as described in the first principle) is crucial [10]. Moving beyond

good intentions, the discipline of global health requires the use of evidence to quantify and qualify impacts [11]. While many impacts remain intangible, there is increasing inquiry into the impacts of trainees involved in STEGH revealing benefits that go beyond community health [12]. A variety of methodologies and approaches are relevant for STEGH including community-based participatory research (CBPR), implementation science, health impact assessment, and collaborative partnership evaluation tools [13-17].

Conclusions

This taxonomic framework examines the local perspective around visitor-host partner relationships and STEGH. Its applicability lies with many potential groups involved in the conduct of STEGH, including academics, potential volunteers, and organizations in LMICs partnered with STEGH visiting groups.

Beyond the simple descriptions provided by this categorization, it is recognized that STEGH work is multifaceted and that the efficacy of each model will decrease or increase based on the degree of locally relevant considerations. In addition, we recognize that many of these models may occur on a continuum; for example, an initial "parachute" STEGH may be a portal into the development of a meaningful local partnership that will ultimately have the same considerations as some of the other models described in the framework. It is also important to remember that any of these models can provide community benefit if the described challenges are carefully monitored and addressed. This could be resource support for host community organizations negotiating between intermittent STEGH, or careful consultation of host partners by visiting partners conducting multiple, continuous STEGH before implementing a common project addressing a locally-identified need. Regardless of the model adopted, however, an earlier identified key discussion theme reminds us that STEGH must aim to tailor interventions and programming to the needs of the local partner in the host community, and not the visitors' perceptions. As a first step, this review framework aims to present different models of partnership around STEGH to add to discussions about the importance of using local partner engagement to minimize community harms and optimize potential outcomes of STEGH being conducted in LMICs. Contemporary thinking, in applying various lenses of social justice, equity, and ethics, has encouraged a paradigm shift away from the model of the single visiting organization without a host partner. By focusing on community engagement and local partnerships, visiting partners are not only multiplying their potential impact, but are also designing programs that are informed by principles of ethics and social justice. The underlying intention is for STEGH-sending organizations to recognize their

roles as visiting partners in the communities they serve, and to use this framework to evaluate their work. Evaluating partnerships will also allow these groups to improve their STEGH in ensuring their responsible conduct and in achieving desired host community outcomes of improved health and wellbeing. There is great potential for STEGH to accomplish meaningful work, but this will almost certainly require successful partnerships with host organizations and communities.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

LCL and WC had the original conception of the idea, which all authors discussed and agreed to support, both in process and in review of the results. All authors were involved in the development of the framework and each author was responsible for providing content for a specific component. All authors were involved in revision and editing. LCL was responsible for the development of the final draft and all authors approved this draft for submission.

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