Internationalizing Education for the Health Professions

By Cathy Yarbrough
About the Author

Cathy Yarbrough has written about health, medicine, and biomedical research for more than 25 years. She resides in San Diego, California.

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Preface

Healthcare is constantly changing in response to an increasingly interconnected population. Economies, cultures, and social factors cross national boundaries with increasing frequency, regularly impacting the health of individuals and communities in profound ways. Those training healthcare professionals recognize that the populations their students will serve may encompass a wide array of cultures and nationalities, even if the student remains in a single location.

Recognizing this, NAFSA’s Office of Academic Programs launched the Colloquium on Internationalizing Education for the Health Professions as part of its suite of activities geared toward helping professional programs adapt to an increasingly interconnected world.

Faculty, staff, and administrators from health-related programs and organizations met in San Diego, California, to discuss best practices for teaching global competence as part of their existing health-care training curriculum. Experts in the field guided attendees through strategies and techniques to help them incorporate the teaching of global competencies into their programs. Participants discussed common challenges and ethical dilemmas that they faced in designing responsible international and intercultural programming.

Central to the discussions were the changing roles of healthcare workers in public health, medicine, nursing, and other fields. Healthcare workers must provide services to increasingly diverse communities. These communities are composed of patients (and their families) from various ethnic backgrounds, wide-ranging socioeconomic levels, and who often speak multiple languages. In addition, health challenges cross national and regional boundaries with increasing frequency, making what were once distance health challenges of local importance. In order to successfully practice, healthcare workers must be equipped to navigate these complexities.

Faculty training healthcare workers must provide students with the tools and experiences necessary to practice in these complex environments. In order to do so, faculty must first identify what competencies are necessary and then help students develop these competencies in ethical and effective ways. Partnerships among faculty, programs, organizations, and communities are crucial to accomplish these goals.

Multiple organizations are working to define what “global competencies” students need in the context of various healthcare fields in order to practice effectively in diverse and globally interconnected communities. For example, the Association of Schools and Programs of Public Health (ASPPH) and the Association of American Medical Colleges (AAMC) worked together to produce a report on Cultural Competence Education for Students in Medicine and Public Health.

Faculty seeking to offer experience with different communities around the world need to carefully plan these experiences in close collaboration with these communities so that they “do no harm.” Such partnerships can and should provide powerful opportunities for students to learn how sociocultural factors can impact the delivery of healthcare services. They can also provide tremendous benefit to host communities if they are delivered in true partnership with them.

NAFSA is committed to supporting faculty and leaders within professional schools in developing these crucial partnerships. A similar colloquium is planned for the NAFSA 2015 Annual Conference in Boston, Massachusetts.

Stay tuned to learn more about how to participate in additional opportunities for discussion, networking, and exploring what makes these educational partnerships successful.
Healthcare is simultaneously a local and a global practice. Diseases and challenges do not respect national boundaries, crossing them with increasing frequency. At the same time, local cultural contexts and resources influence the provision of healthcare services.

The 2014 NAFSA Colloquium on Internationalizing Education for the Health Professions was dedicated to discussion of 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. NAFSA brought together leaders in the field of global and public health with participants from around the world to discuss how universities could incorporate these competencies into education and training programs for health professionals.
Framing the Future of Public Health

“We’re completely rethinking education in public health,” said Donna J. Petersen, ScD, MHS, CPH, in her keynote presentation about the national task force on “Framing the Future: The Second 100 Years of Education for Public Health,” at the colloquium.

Petersen, senior associate vice president and dean at the University of South Florida College of Public Health in Tampa, chairs the task force, which the Association of Schools and Programs of Public Health (ASPPH) convened in 2011 to reconsider the role of public health education 100 years after the 1915 Welch-Rose Report and to create a new vision for public health education for the next 100 years. The Welch-Rose Report, sponsored by the Rockefeller Foundation, provided the rationale and blueprint for the establishment of schools of public health to develop health officers with the knowledge to apply clinical skills to community health challenges. Public health officers were needed to staff state and local health departments.

Since the publication of the Welch-Report, rapid, dramatic changes have been occurring worldwide in not only health and healthcare but also technology and higher education. Because of these changes, the nation’s schools of public health and the universities and colleges with bachelor’s degree programs in public health must adapt their curricula so that graduates will be equipped with the tools, values, and knowledge required to improve public health in the twenty-first century, said Petersen, who also chairs the ASPPH education committee.

Unlike their predecessors, future public health professionals must be knowledgeable about the health and healthcare of communities and countries outside their geographical borders. “Because of the globalization of the world’s economy, we are all citizens of the world,” said Petersen. “As a result, health is global, and thus global competency is essential for all public health professionals.”

A global approach to public health has been repeatedly emphasized in the task force’s deliberations about the basic competencies of future recipients of undergraduate, MPH, and DrPH degrees.

For example, the task force’s report on the bachelor’s degree in public health recommends that the curriculum for these programs, most of which are offered at colleges and universities without schools of public health, cover the core values, concepts, and functions of public health across the globe as well as the fundamental characteristics and organizational structures of the differing healthcare systems of the United States and other countries. The task force’s report, titled Critical Component Elements of the Undergraduate Degree, is posted on the ASPPH website.

The task force’s discussions on the MPH Degree of the 21st Century recommends that the curriculum for this degree cover global health perspectives and content as well as globalization and sustainable development and their relationship to population health, said Petersen. A global approach to public health also is built into the DrPH degree core competency model, she said. For example, recipients of the most advanced degree in public health must thoroughly understand the impact of local, national, and global trends and interdependencies on health systems, as well as the various factors that influence complex health situations and future population health outcomes. Human rights frameworks and the principles that underpin ethical practices also should be included in DrPH degree programs, according to the task force.

Not surprisingly, the task force’s recommendations for the undergraduate and graduate degree programs call attention to the value of international learning experiences. “Experiential, immersive learning is crucial for students,” said Petersen. “Working as members of teams in other environments challenges students’ thinking about themselves and their home environment.”

“There is a huge demand for the type of skills provided in public health training programs,” she said. (Please see table, “Career Trajectories in Public Health, 2014” on page 6.)

The expert panel’s reports and recommendations will be packaged into a dynamic, interactive website set to launch in early 2015.
Career Trajectories in Public Health, 2014

- Governmental public health
- Hospitals and healthcare delivery settings
- Insurance companies and health plans
- Pharmaceutical companies
- Private and public research institutions
- Voluntary organizations, NGOs
- Other public sector agencies (schools, corrections, social service, planning agencies)
- Nonprofits, foundations, think tanks
- Professional associations

Credit: Donna J. Petersen; used with permission

REFERENCES


The Making of the Globalized Health Professional

“We throw around a lot of terms without defining them,” Jessica Evert, MD, said during the opening comments of her colloquium presentation titled, “The Making of the Globalized Health Professional: Competencies for Internationally Based Experiential Learning.”

One of those terms is global health. Evert, who is executive director of Child Family Health International (CFHI) and member of the clinical faculty at the University of California-San Francisco, Department of Family and Community Medicine, asked the attendees at the colloquium to consider and comment about the following two different definitions of global health:

- “A field of study, research, and practice that places a priority of achieving equity in health for all people. Global health involves multiple disciplines within and beyond the health sciences, is a synthesis of population-base prevention with individual level clinical care, promotes interdisciplinary collaboration, and emphasizes transnational health issues and determinants.”

- “A concept fabricated by developed countries to explain what is regular practice in developing nations.”
  —Physician based in sub-Saharan Africa who spoke at the 2008 CUGH conference that led to the Lancet paper cited in the definition above.

Both definitions are valid, according to the comments of several attendees. Attendees noted that the second definition highlights the need for public health professionals and students to recognize that the United States and other high-income countries “do not have all the answers,” and that experiential learning programs in low- and middle-income countries provide students with opportunities to learn different approaches to solving common challenges. Among health professionals, there is a growing interest in reverse innovation, the application of technologies and approaches developed in low- and middle-income areas to the United States and other high-income nations, Evert said.

Like global health, competency-based education is a term that is “thrown around a lot,” she said. Competency-based education characterizes educational achievement based on whether the student can demonstrate that he or she has progressed toward or mastered the required competencies of knowledge, skills, and judgment. The curriculum of a competency-based degree program arranges educational experiences and coursework around the desired outcomes. “Competency-based education also places an emphasis on abilities of learners rather than just the knowledge that they have,” she added.

In the training of health professionals, the term ‘competency’ has been defined as the “habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community being served.”

Evert and colleagues at CFHI provide community-based global health education programs in seven low- and middle-income countries for students in other health professions. These programs allow students to learn firsthand that individual and population health is not determined solely by the provision of clinical medical care, said Evert, who referred to a 2007 New England Journal of Medicine paper reporting that U.S. patients’ behavior, genetics, and social circumstances were the major contributors to premature death of adults.

More than 800 students in medicine, public health, social sciences, and the other health professions thus far have participated in 25 CFHI interdisciplinary experiential global health education programs. CFHI recently analyzed 400 students’ responses to its questionnaire about their experiences during the 5-year period ending in 2011. (Please see CFHI’s chart titled, “Students responses to questionnaire about their experiential global health programs.”)

“Two of the most significant impacts were ‘greater capacity for cultural understanding in the healthcare field’ and ‘broader view of health and healthcare,’” said Evert, adding that these are the outcomes that should be achieved in experiential programs.

Programs that allow students to gain experience in providing health services to patients in other countries create many legal and ethical challenges, Evert added. “Students should be primarily learners, not health professionals,” she said. Program providers and faculty must ensure that students are not placed as the primary providers of healthcare in clinics and other healthcare facilities whose culture, language, health systems, formularies, and resources differ drastically from their usual training environments. Prior to participating in experiential global health educational programs, students must understand that they have an ethical obligation not to practice outside of their scope of training. These boundaries and the primary role of students as learners are consistent with both undergraduate and health professions standards for international education in health-related settings.\(^3\)\(^4\)

“The roles of pre-clinical learners should include observation and reflection in clinical settings,” said Evert. “Programs that give students a false sense of accomplishment during several weeks abroad do not serve them in understanding the exceedingly complex picture of global health and wellness.”

Evert has created a list of questions to guide institutions in evaluating international educational opportunities for students:

Ethical Challenges of Global Health Experiential Programs

Global health learning experiences can challenge and inspire medical, nursing, public health, and dental students from resource-rich countries such as the United States. However, these programs, which typically occur in low-resource environments, can be ethically challenging for students, their home universities and colleges, as well as the institutions that host the students’ training programs.

For example, while observing patient care at a community clinic in a low-resource area, medical students may be asked or expected to perform procedures that they are not yet allowed to conduct at their home institutions.

“We must teach students that they have the right to say, ‘No, thank you,’ without feeling guilty,” said colloquium speaker Jessica Evert, MD. Students must understand their boundaries and their ethical obligation not to practice outside of their scope of training, she added.

Students who perform beyond their training can inadvertently do more harm than good.1 While planning a global health education program for a student, the home university or college or sponsoring organization should clearly define the individual’s level of training and limitations with the host institution. Systems must be in place so that everyone knows what the students can and cannot do, said colloquium moderator Timothy Brewer, MD, MPH, who helped develop standards for predeparture training programs for medical students in global health education programs. During predeparture training, students should learn how to recognize their limitations and ask for assistance.2

The ethical risks of experiential learning programs in resource-poor countries prompted a group of international leaders in health and ethics to establish the Working Group on Ethics Guidelines for Global Health Training (WEIGHT).3

Competencies for Global Health Interprofessional Training

Jody K. Olsen, PhD, director of the Center for Global Education Initiatives at the University of Maryland-Baltimore (UMB), likes to tell stories to illustrate the value of interprofessional education (IPE) in training students interested in global health.

During her colloquium presentation, “Competencies for Global Health Interprofessional Training & Implementation Example,” Olsen recalled a World Health Organization (WHO) Safe Motherhood maternal health project in Malawi, where one in seven women dies during childbirth. The summer 2012 project involved 12 students from UMB’s schools of dentistry, law, medicine, nursing, pharmacy, and social work, who visited 12 clinics in Chikwawa district.

“The students had to work together as equals,” she said, “and trade technical responsibilities throughout each project.” As a result, they witnessed firsthand how each of the professions contributed to identifying gaps in healthcare among the villagers and how each added to the other students’ observations.

“For example the students were amazed at the importance of the dental student in the team. Simply by observing the gums of children with whom the students were playing, the dental student identified potential nutritional deficiencies such as a lack of vitamin A,” said Olsen.

“The students also learned the value of observation and touch over machines,” she added. For example, before traveling to Malawi, the nursing student had never observed a health practitioner’s initiating an intravenous (IV) infusion by counting drips. In the United States, health professionals depend on infusion pump technology to begin IVs.

The summer 2012 study was one of four 6-week projects that UMB sponsored over four summers in Malawi. Each project was led by Olsen and other UMB faculty representing the six UMB schools and focused on a different topic. The topics were healthcare for orphans and vulnerable children, healthcare for children with fevers, a community-based health needs assessment, as well as safe motherhood.

To learn about health needs and healthcare availability, the students and faculty members met with village chiefs, health center directors, and heads of households.

During their last week in Malawi, the students collaborated on a report describing the project and the results. “Because their individual writing responsibilities did not necessarily correspond to their professional background, the students had to share across disciplines as they wrote,” said Olsen. Each project report encompassed not only data that the students had collected on the health needs of individuals and their families but also information about community support, culture, policy, human rights, and the national legal structures under which the Malawi healthcare system operated. In each report, the students also added their individual perspectives about working as a member of an IPE team.

Inspired by the students’ positive experiences, Olsen and her UMB colleagues organized a roundtable discussion at the university to identify best methods for integrating IPE skills into the curricula of didactic and experiential global health education studies. “We have to prepare students to function in their specific professions as well as interprofessionally,” she said. “We need to identify competencies that enable students early on to work together, hear each other, and learn how the other professions approach problems.”

UMB subsequently invited 42 nationally recognized experts in IPE and global health competencies to participate in a larger roundtable discussion on key IPE global health competences and incorporating them into well-designed global health education programs that would prepare students for collaborating across disciplines in global health. The experts worked together in six small groups during the October 2013 roundtable discussion.

The day-long meeting, “Global Health Interprofessional Council Roundtable,” will be summarized in a paper coauthored by Olsen and scheduled for publication in the December 2014 edition of the Journal of Law, Medicine & Ethics.
In her presentation at the colloquium, Olsen reported that the roundtable participants recommended IPE competencies focusing on:

- Teamwork;
- Understanding and valuing professional differences and contributions;
- Communication that reflects and supports personal and professional differences; and
- Cultural awareness among team members and between teams and their in-country counterparts in global health practice.

Olsen distributed a handout to colloquium attendees that listed the competencies for students that were recommended during the roundtable discussions at UMB. The participants agreed that students in interprofessional global health teams should be able to:

- Develop a shared vision of the project or assignment;
- Empower all group members and place importance on team, rather than individual, success;
- Engage other team members in shared decision-making;
- Understand process of group development (forming, norming, storming and performing);
- Understand that the cultural background of team members affects team formation and dynamics;
- Apply concepts of transdisciplinary collaboration to teamwork;
- Use conflict management skills to manage disagreement within the team;
- Use basic negotiation techniques when appropriate to develop and work toward shared goals;
- Identify specific global health issues that require or could benefit from an interprofessional approach;
- Subordinate personal interests to the goals of the team, needs of the in-country partner and requirements of the partnership;
- Understand how individual characteristics and expectations influence team dynamics; and
- Reflect on the influence of professional cultures or “tribes” on training and jargon and minimize barriers to team development.

During the roundtable discussion, the experts identified the following consensus goals for integrating IPE into curricula of schools of medicine, nursing, dentistry, social work, and law.

- Review existing global health curricula with interprofessional lens;
- Remain open to different ideas for building team skills;
- Model interprofessional skills and behaviors by demonstrating team-based problem solving; and
- Examine various team-building methods available and incorporate those with demonstrated effectiveness.

Olsen said that another outcome of UMB’s studies in Malawi was the establishment of grants to support short-term IPE global health projects based on faculty members’ ongoing international research studies. The 10 funded projects in 2014-15, which were selected through peer competition, support the travel and related expenses of 10 faculty members and 35 students on short-term global health studies in Nigeria, Kenya, Gambia, Malawi, Rwanda, Hong Kong, Israel, Philippines, and Brazil. The students in each project represent at least two different campus schools.

UMB is one of the first universities to fund such a program, which will be evaluated by pre- and post-surveys of the faculty members and students, Olsen said.

References

University of Maryland-Baltimore Global Health Interprofessional Council: http://www.global.umaryland.edu/ghic


In her second colloquium presentation, Evert described a Northwestern University study comparing the experiences of medical students who participated in two different models of global health education.1 The models are referred to as “brigade” and “integrated.”

Participating in the “brigade” model were 11 Northwestern medical students who set up a temporary clinic to provide basic medical services, based on the Western standard of care, in Matagalpa, Nicaragua. During the 1-week program, two Northwestern physicians accompanied and supervised the students. Although the students gained hands-on experience with many patients, they did not have the time and resources to help diagnose or treat advanced health problems. In addition, the students’ interactions with local healthcare practitioners were minimal, and both the students and physicians lived separately from the local community.

In the “integrated” model, the students were integrated into the existing health system in Mexico, said Evert. CFHI coordinated the 4-week program for 10 rotating Northwestern medical students at a local community clinic in Puerto Escondido. Instead of gaining hands-on experience with patients, the students observed and learned about local standards of care and clinical approaches. During their interactions with patients, students deferred to the clinic’s healthcare practitioners. They also lived with local families.

According to postprogram evaluations, students benefited more from the “integrated” model because they were able to observe disease processes over time and learn about levels of referral and care capacity as well as cultural influences on health and healthcare practices. “Unlike their counterparts in the ‘brigade’ model, the students in the ‘integrated’ model had the opportunity to learn about the importance of partnering with local communities and respecting the expertise of local healthcare practitioners,” she said.

In addition to highlighting the medical students’ experiences with the “brigade” and “integrated” models, Evert pointed out that every global health education program for students must be carefully structured with clear learning objectives, goals, and competencies. “The way that a program is structured will affect what the student will achieve,” she said.

Evert called attention to the global healthcare competencies identified by Michael Peluso, et al.2 These competencies, which are global and local, are a useful framework for understanding the goals of global health experiential learning programs, she said. Her presentation was titled, “The Making of the Globalized Health Professional: Integrating Competencies into Community-Based Partnerships.”

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"Today's meeting was a very powerful educational experience," said Brewer in his closing comments.

Following the colloquium, Brewer offered several key points related to the meeting's theme, global health competencies in the training of future health professionals:

- **The field of global health education is maturing.** Global health education is no longer an ad hoc activity but a discipline with a critical mass of academic programs and experts and an intellectual and logistic infrastructure.

- Although a substantial overlap exists, **global health and public health are distinct entities.** For example, global health involves lawyers who address human rights and legal access to healthcare as well as engineers who develop better ways to design sanitation facilities in low-resource settings.

- Health professionals who work well in Los Angeles may not function effectively in Lagos, Nigeria, where the cultural context and resources available are likely to be very different. Thus, **global health competencies, which form the foundation of educational programs, must be contextual, specific to the location where the students will practice.**

- **Experiential training programs in low-resource countries for students in the health professions from high-resource countries such as the United States must be structured.** In the past, many students were on their own, participating in elective programs with unclear educational objectives or without supervision. "That's not acceptable in the twenty-first century," said Brewer, because of increased concerns about the potential harm to patients that can occur when students practice beyond their training and are unsupervised.

- In addition, students and universities/colleges in high-income countries should not be perceived as taking advantage of their training partners in the low-resource communities that host their students. **Experiential training programs must benefit partners financially, educationally, or otherwise.**

- Global health is an outgrowth of international health, which targets health problems, such as Leishmaniasis, unique to low-resource areas of the world. In contrast, global health is transnational and requires partnerships between institutions in high- and low-resource countries to reduce or solve shared health problems, such as chronic shortages of healthcare practitioners. "We can learn from each other," Brewer said.
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