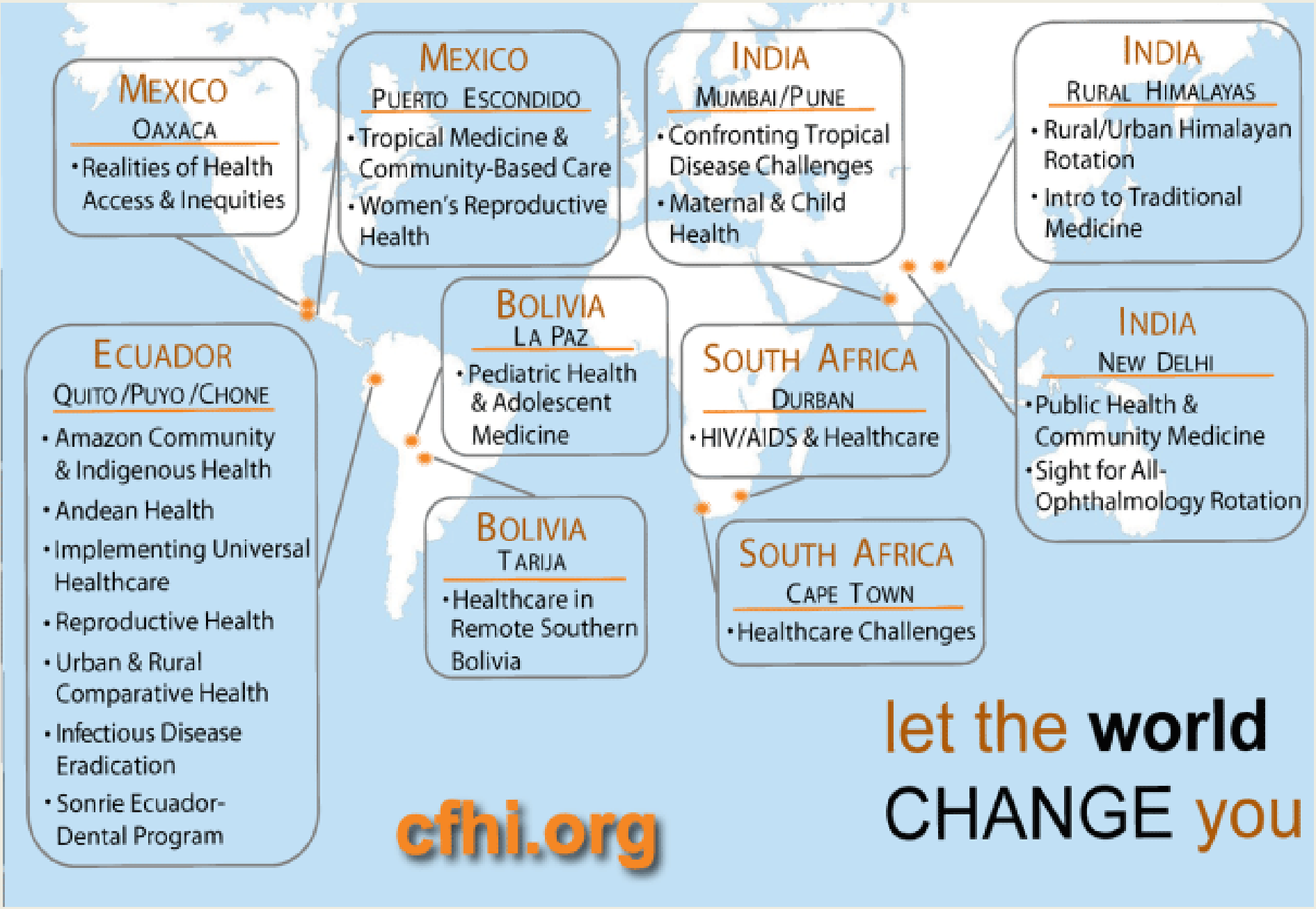
Global Health Education: Connecting Ethics, Program Structure, and Competencies



Jessica Evert MD
Executive Director, Child Family Health International
Associate Professor, UCSF Department of Family and Community Medicine
Affiliate Faculty, UCSF Global Health Sciences



Argentina • Bolivia • Ecuador • India • Mexico • South Africa• Uganda• Ghana• Philippines• Tanzania

“I am trying to establish a long-term and impactful relationship between the [my school’s] student body and the villages and small towns of South Africa. [My school’s] students, who have a reputation for being extremely medically-driven, would be very interested in serving the communities medically, whether it is through patient advocacy, disease/illness awareness, or being able to directly participate in minor surgeries and procedures.”

-Email from undergraduate (bachelor’s) student

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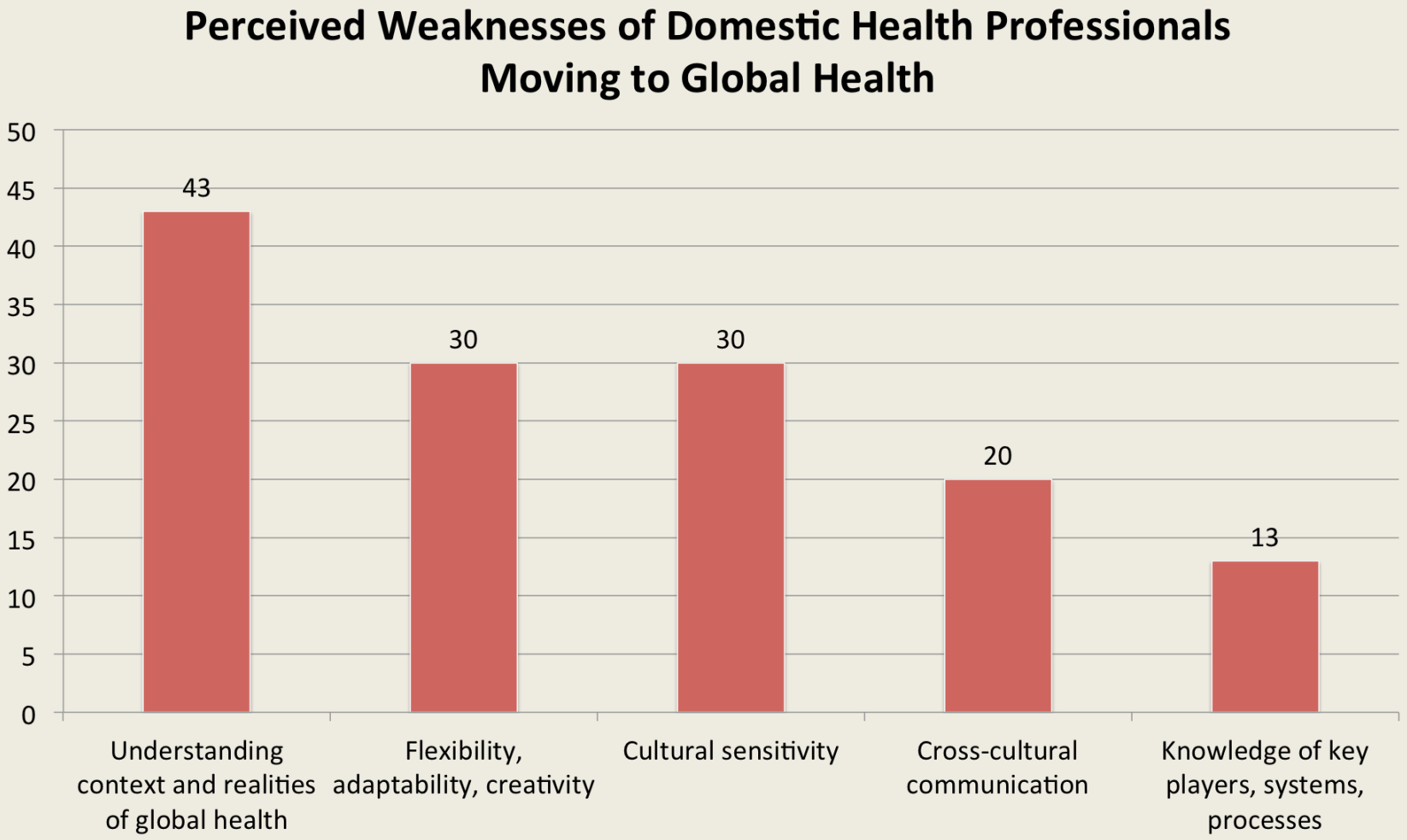
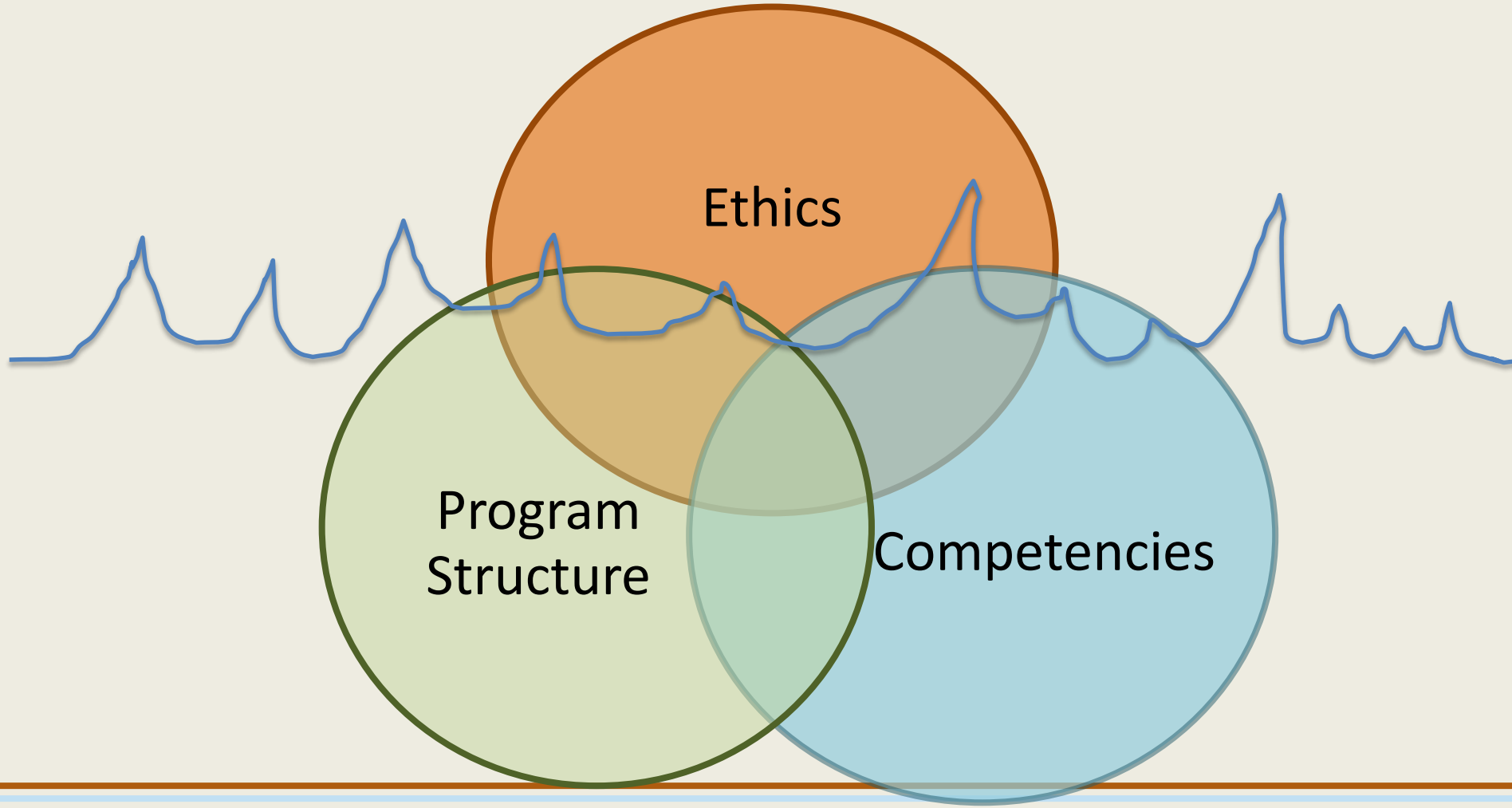
Perceived Weaknesses: Opportunities for International Education



Rudy, S. The Global Local Divide: Impact On Career Paths And Employment Opportunities. CUGH. Boston MA, 2015.

The Sweet Spot of Impactful Programming



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-Email from undergraduate (bachelor's) student

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

Melissa K. Melby, PhD, MPhil, MA, Lawrence C. Loh, MD, MPH, Jessica Evert, MD, Christopher Prater, MD, Henry Lin, MD, and Omar A. Khan, MD, MHS

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.

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] framework[29])
- 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

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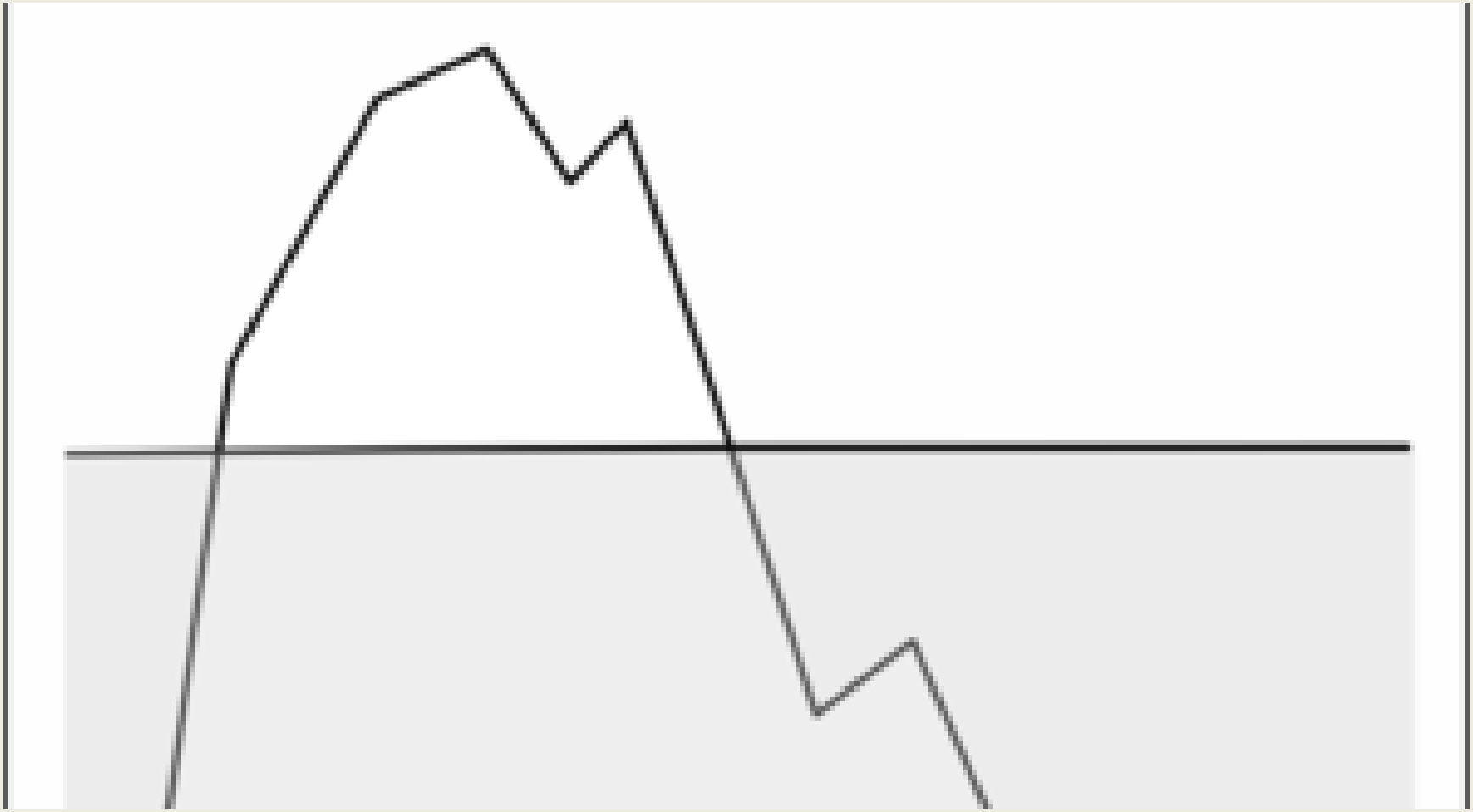
Iceberg Model of Culture



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

Approaching partnership from with the question “What can we learn from you?” rather than “How can we help you?”

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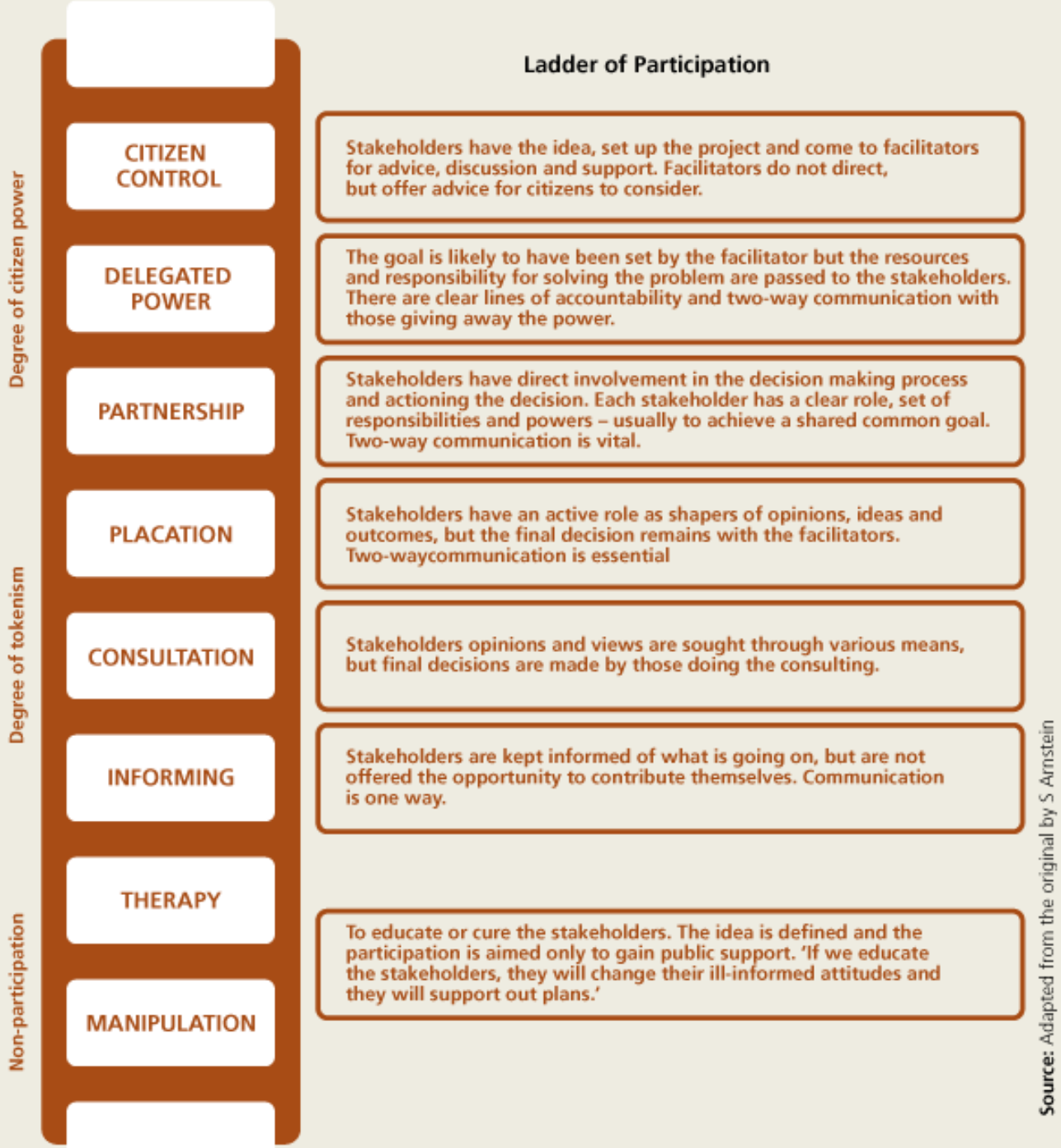
Ladder of Participation
Degree of citizen power
Degree of tokenism
Non-participation
CITIZEN CONTROL
Stakeholders have the idea, set up the project and come to facilitators for advice, discussion and support. Facilitators do not direct, but offer advice for citizens to consider.
DELEGATED POWER
The goal is likely to have been set by the facilitator but the resources and responsibility for solving the problem are passed to the stakeholders. There are clear lines of accountability and two-way communication with those giving away the power.
PARTNERSHIP
Stakeholders have direct involvement in the decision making process and actioning the decision. Each stakeholder has a clear role, set of responsibilities and powers – usually to achieve a shared common goal. Two-way communication is vital.
PLACATION
Stakeholders have an active role as shapers of opinions, ideas and outcomes, but the final decision remains with the facilitators. Two-waycommunication is essential
CONSULTATION
Stakeholders opinions and views are sought through various means, but final decisions are made by those doing the consulting.
INFORMING
Stakeholders are kept informed of what is going on, but are not offered the opportunity to contribute themselves. Communication is one way.
THERAPY
To educate or cure the stakeholders. The idea is defined and the participation is aimed only to gain public support. 'If we educate the stakeholders, they will change their ill-informed attitudes and they will support out plans.'
MANIPULATION
Source: Adapted from the original by S Arnstein

Go

NO RELIEF

In India, a Quest to Ease the Pain of the Dying

By DONALD G. McNEIL Jr.
Published: September 11, 2007

TRIVANDRUM, India — It was a neighbor scr
ago that set Dr. M. R. Rajagopal on the path to
"father of palliative care."

Enlarge This Image

Ruth Fremson/The New York Times

A palliative care team in Kerala, India, tending to a tongue cancer patient.

"He was dying
tumors on his f
Rajagopal recal
if I could help,
just a medical s

Today, the sam
same cancer wo
die the same wa
where Dr. Rajagopal runs his Palli
the capital. Although opium was c
British India and the country still
legal morphine industry than any
Indians benefit. They end up like
poor — spending their last days w
death would hurry

No Relief

The first article in this series told how millions of the world's poorest patients cannot get opium-based medicine to relieve pain.

Journal of Pain & Palliative Care Pharmacotherapy. 2012;26:278–279.

ISSN: 1536-0288 print / 1536-0539 online
DOI: 10.3109/15360288.2012.708392

NARRATIVE ON PAIN SUFFERING AND RELIEF
Edited by M.R. Rajagopal

When Two Worlds Meet

Lyndsey M. Brahm

ABSTRACT

The author is one of four American premedical students traveled to India to spend a month with Palliu
(palliumindia.org) to learn about palliative care at Trivandrum Institute of Palliative Sciences, in the sout
state of Kerala. Th
room sessions an
not just what palli
that all health car
of the suffering in

Medical Director

Country Coordinator

Local Coordinator

Preceptors

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


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Global Health Educational Engagement—A Tale of Two Models

Jasmine Rassiwala, Muthiah Vaduganathan, MD, MPH, Mania Kupershtok, Frank M. Castillo, MD, MA, and Jessica Evert, MD

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.

	Brigade Model	Integrated Model
Duration of clinical team	Short-term (usually 1-2 weeks)	Long-term presence in community; based on national health system model/planning
Relationship with existing health system	Outside of it; often in parallel or tangent	Imbedded in local health systems- public, NGO, private, academic
Source of Medications	Often brought from outside by brigade teams	Essential medications (WHO) plus local formularies
Who's teaching you	Physicians/others from outside the community	Physicians/nurses/community members native to the community; committed to long-term, continual engagement
Patient volume/patient follow-up	High/Low	Medium/High
Accommodations	With westerners; dorms/apartments/hotels	With local families

Rassiwala J et al. Global Health Educational Engagement: A Tale of Two Models. Acad Med, online; 2013.

	Brigade Model	Integrated Model
Competencies/Objectives Achieved	1. Western style of presenting/precepting 2. High volume of patients/limited ability to address advanced problems 3. Running a program that is controlled by the "Global North" 4. Western 'standard of care'	1. Health systems Community Health 2. Disease processes over time 3. Levels of referral and care capacity 4. Cultural influences to health and health care practice 5. Community context outside clinical setting. 6. Public Health 7. Partnering with local communities and respecting local expertise 8. Local 'standards of care' and clinical approaches

Rassiwala J et al. Global Health Educational Engagement: A Tale of Two Models. Acad Med, online; 2013.

What do we mean by *impactful*?

What do we mean by *impactful*?

- Increased prestige of clinic/clinician

"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 foreign student.'"

Kung T, Richardson E, Mabud T. Host community perspectives on trainees participating in short-term experiences in global health. Medical Education, pending publication.

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What do we mean by *impactful*?

- Serving as global citizen

"As a global citizen of the world, if I am able to educate a student from any other nation, and he feels a little softer about places that are not as economically well off, then from that perspective of course it is beneficial, because we are benefiting some students living in affluent nations to have a balanced view of life."

Kung T, Richardson E, Mabud T. Host community perspectives on trainees participating in short-term experiences in global health. Medical Education, pending publication.

CFHi
child family health international

What do we mean by *impactful*?

- Broadened world views of local community members
- Resource enhancement
- Improved local networks and leadership development

Kung T, Richardson E, Mabud T. Host community perspectives on trainees participating in short-term experiences in global health. Medical Education, pending publication.

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What do we mean by *impactful*?

- Perceived hesitancy and apathy of trainees

"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 rapport is not good."

Kung T, Richardson E, Mabud T. Host community perspectives on trainees participating in short-term experiences in global health. Medical Education, pending publication.

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What do we mean by *impactful*?

- Unfulfilled promises
- Cultural insensitivity
- Lack of equal opportunity

Kung T, Richardson E, Mabud T. Host community perspectives on trainees participating in short-term experiences in global health. Medical Education, pending publication.

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Perceptions of a short-term medical programme in the Dominican Republic: Voices of care recipients

Matthew DeCamp[a], Samuel Enumah[b], Daniel O'Neill[c] & Jeremy Sugarman[a]

[a] Berman Institute of Bioethics and Division of General Internal Medicine, Johns Hopkins University, Baltimore, MD, USA

[b] School of Medicine, Johns Hopkins University, Baltimore, MD, USA

[c] Department of Family Medicine, University of Connecticut School of Medicine, Farmington, CT, USA

Published online: 11 Mar 2014.

Table 1. Major themes and subthemes.

Major theme	Subthemes
Misidentification	Of the interviewer
	Of MMI
Access to care	Less costly
	Health care workers
	Medicines
	Transport
	Surgical services
Identified needs	Specialty services (paediatrics, gynaecology)
	Education
	Vision
Social determinants of health	Poverty
	Environmental concerns
Faith	Personal spiritual growth
	MMI as 'God's plan'
	General spiritual statement
Language	No miscommunication
	Occasional miscommunication
Student involvement	Benefits community
	Benefits student
	Future non-specific benefits
Improving the organisation	Stay longer
	Come more frequently
	Work more with locals
	Target communities
	No improvement suggestions
Respect	No subthemes

Everything that they [MMI] offers us is [metaphorical] bread that will last us a long time..... It will not cause things to get worse. And this is good for us and the community because we are a poor community. In reality, I cannot read. Only a few people can read and write. Most do not understand what they [MMI] are saying. But, the service is phenomenal.

[I feel] very good because when you [mistaking the interviewer for an MMI volunteer] are practising on me you are studying. You need to practise because medicine is 50% theory and 50% practise.

They [students] give us competent and intelligent services, and we are very pleased with them because it is a great service.

It [student involvement] is good because now they know.... they help the campaign [referencing this participant's previously expressed view of the political campaign to increase access to health care in the community].

The positive assessment of student involvement cannot be separated from MMI's commitment to adequate supervision. As one participant reported:

When a student does not understand something, he is able to ask another doctor in order to do the right thing. For that reason, I feel good.

DeCamp M, Enumah S, O'Neill D, Sugarman J. Perceptions of a short-term medical programme in the Dominican Republic: Voices of care recipients. Global public health 2014;9(4):411-425.

"I am trying to establish a long-term and impactful relationship between the [my school's] student body and the villages and small towns of South Africa. [My school's] students, who have a reputation for being extremely medically-driven, would be very interested in serving the communities medically, whether it is through patient advocacy, disease/illness awareness, or being able to directly participate in minor surgeries and procedures."

-Email from undergraduate (bachelor's) student

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New 'Doctors Without Licenses' Program Provides Incompetent Medical Care To Refugees

NEWS IN BRIEF · Doctors · Healthcare · News · ISSUE 50·08 · Feb 25, 2014

l Health Workforce Alliance
t the Alliance
ers & partners
try responses
ledge centre
a centre
l Forums

Models and tools for health workforce planning and projections. Human Resources for Health Observer

Members document

Authors:
WHO

Publication details

Number of pages: 19
Publication date: 2010
Languages: English
ISBN: 9789241599016

Downloads

— English

The formulation of national human resources for health (HRH) policies and strategies requires an evidence-based planning to rationalize decisions. A range of tools and resources

"We recently did not offer a student admission who had great test scores, grades, extracurricular activities, and was someone we would have other accepted because she couldn't see the ethical issues with what she had done when she was on an international volunteer trip as a pre-med and she had done stuff that the admission committee had major concerns about."

-Medical School Admissions Dean

GASP

The Working Group on Global Activities by Students at Pre-Health Levels

Child Family Health International

Subject: ADA House Resolution 31H-2010

We are writing to share with you the American Dental Association's recently-adopted policy addressing students' participation in dental outreach programs. The policy statement was first proposed by the American Student Dental Association and the Pennsylvania Dental Association last fall. The 2010 House of Delegates supported the concept and adopted Resolution 31H-2010: Participation in Dental Outreach Programs:

> **Resolved**, that it be policy of the American Dental Association (ADA) that students in U.S. dental schools and pre-dental programs who participate in a dental outreach program (e.g., international service trips, domestic service trips, volunteerism in underserved areas, etc.) be strongly encouraged:
>
> - To adhere to the ASDA Student Code of Ethics and the ADA *Principles of Ethics and Code of Professional Conduct*;
> - To be directly supervised by dentists licensed to practice or teach in the United States;
> - To perform only procedures for which the volunteer has received proper education and training.

The dedication of the growing number of volunteers who work in some of the world's most deprived communities is fully supported by the American Dental Association. However, we

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 student 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.

Forum on Education Abroad, Standards for Undergraduate Health Related Programs, 2013.

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.

Crump J, Sugarman J, et al. Ethics and Best Practice Guidelines for Training Experiences in Global Health. Am J Trop Med Hyg. 83(6),2010.

Virtual Mentor

American Medical Association Journal of Ethics
March 2010, Volume 12, Number 3: 231-236.

MEDICAL NARRATIVE

Training for a Global State of Mind

Jane Philpott, MD

Universities and medical schools in high-income countries are scrambling to develop global health curricula for their undergraduate and postgraduate trainees in order to demonstrate their leading role in this burgeoning field. Missing from the topics of discourse is the matter of just why we are caught up in this global health education frenzy.

At a recent global health education meeting, someone stated that the ultimate goal of the global health programs that we facilitate for our trainees is to improve the health of the world's people. Yet I sense our motivations are not purely noble. If our

Motivations Exercise- have students divide motivations into those "I Aspire To," "I wish to suppress," "I can Tolerate."

Pearl #4: Frame the Conversation as an issue of patient safety

- Online workshop for students to learn about the risks related to participating in global volunteer experiences

- GAPS Website

GAPS Content

About the Workshop

- Benefits of a Global Experience
- Finding an Appropriate Global Health Experience
- Preparing to Learn
- Learning Ethically While Abroad
- Applying What You Learn When You Return
- Resources
- GAPS Oath

GAPS Oath

Oath of Global Ambassadors for Patient Safety

This certificate confirms that I have completed the University of Minnesota Health Careers Center's "Global Ambassadors for Patient Safety" workshop. I agree with and am committed to upholding the important standards it introduced regarding my responsibilities for patient safety and privacy while participating in a healthcare experience abroad.

I am currently an unlicensed pre-professional, and just as it is unethical for me to practice direct patient care within the United States, it is equally so in any country I am visiting. Regardless of intent, by engaging in any unlicensed medical practices, I would be disregarding patient boundaries and safety, and would be placing that patient at considerable risk.

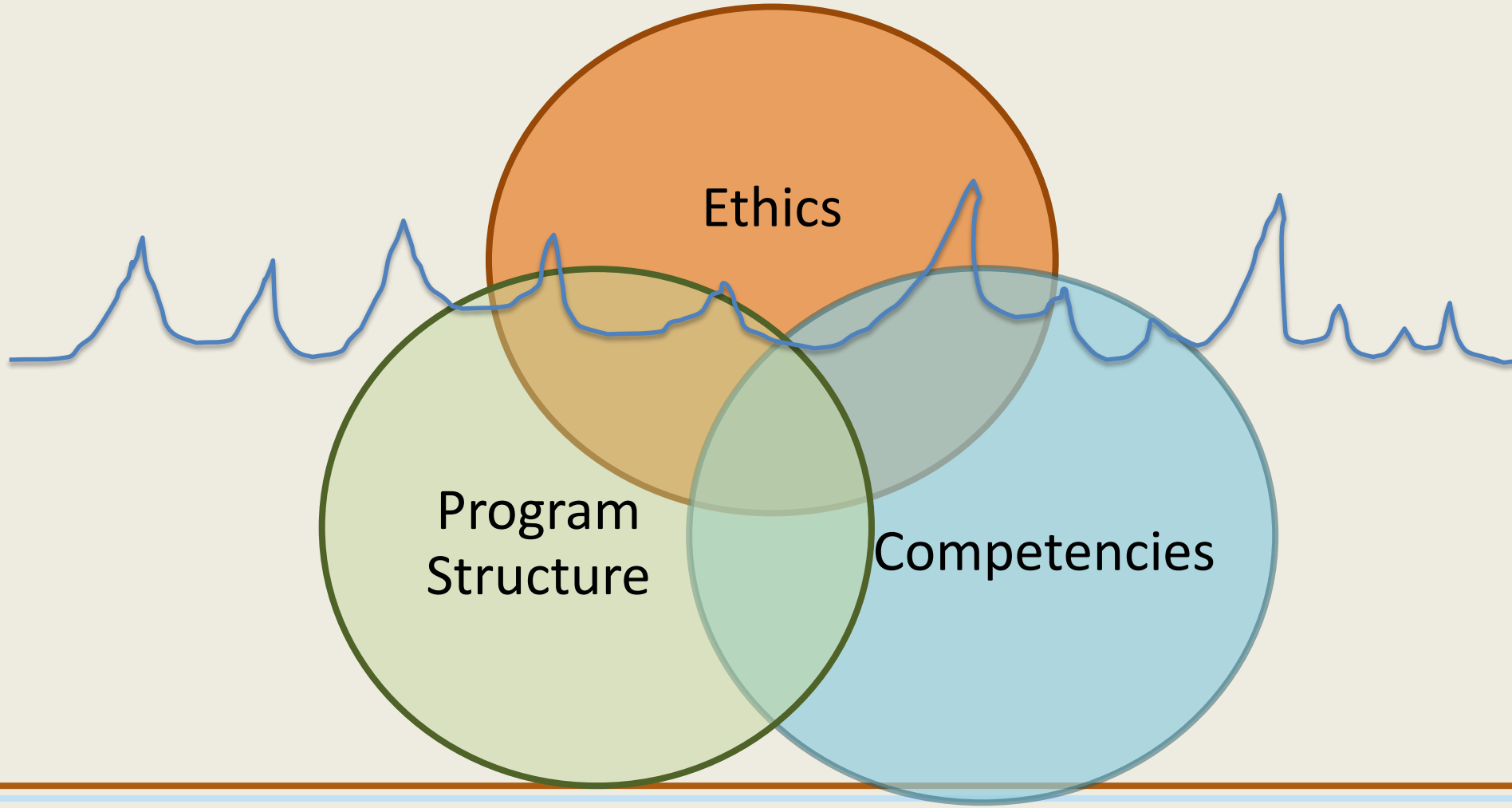
Signature Date

After taking a final quiz, students are given a certificate of completion.

"I am trying to establish a long-term and impactful relationship between the [my school's] student body and the villages and small towns of South Africa. [My school's] students, who have a reputation for being extremely medically-driven, would be very interested in serving the communities medically, whether it is through patient advocacy, disease/illness awareness, or being able to directly participate in minor surgeries and procedures."

-Email from undergraduate (bachelor's) student

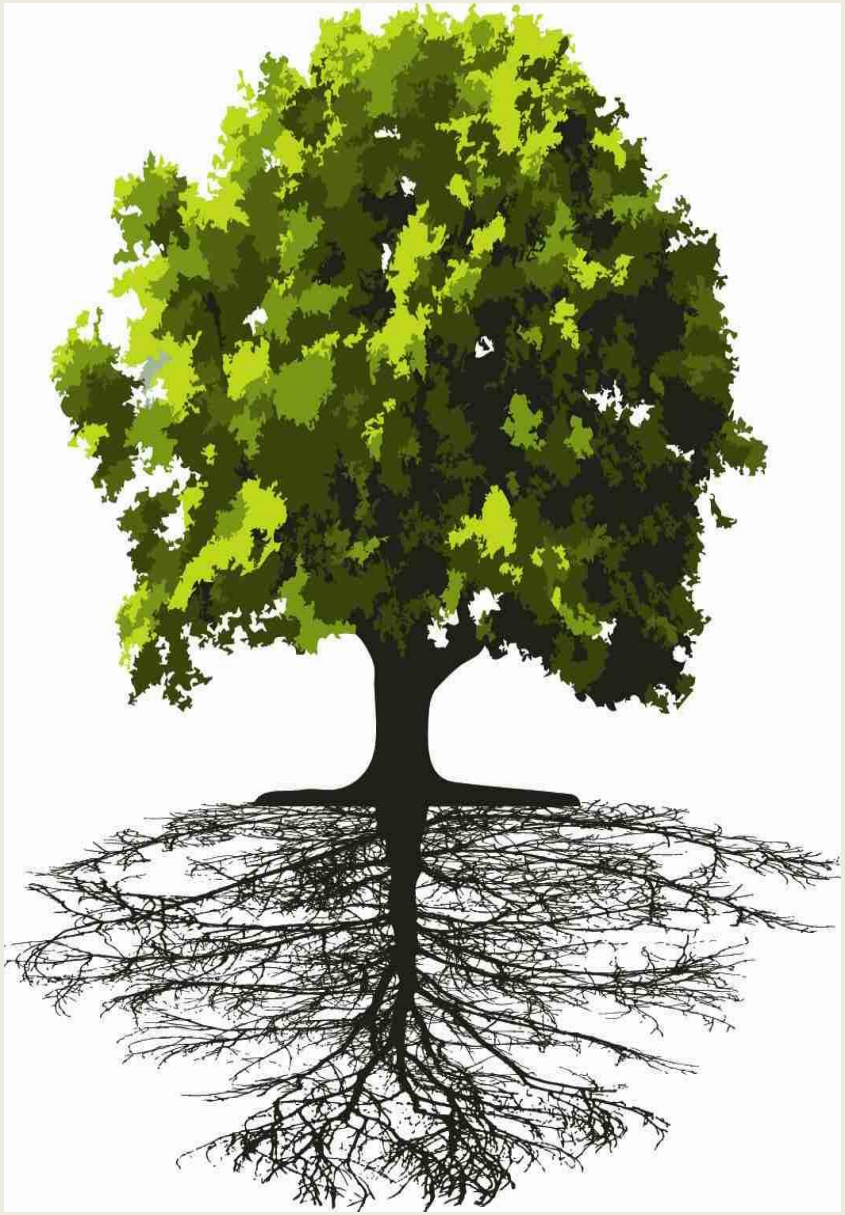
The Sweet Spot of Impactful Programming



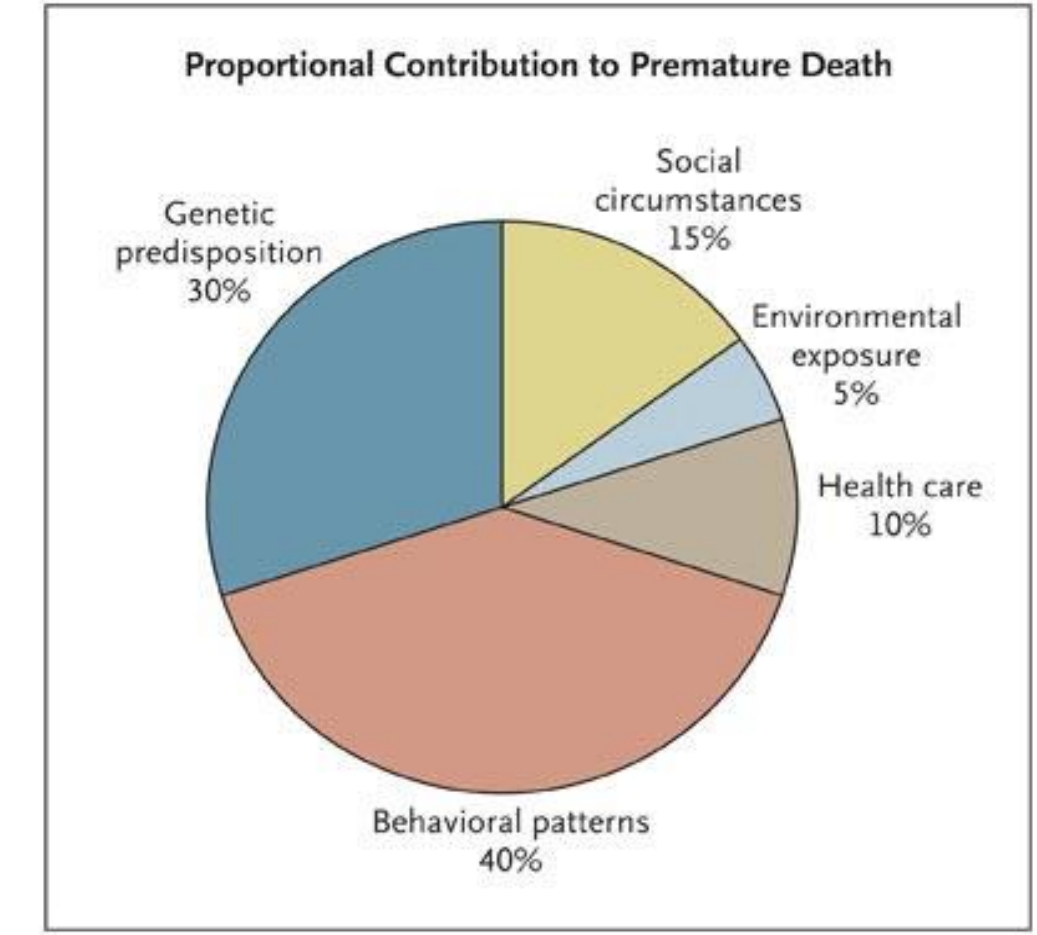
Ethics

Program Structure

Competencies



Determinants of Health and Their Contribution to Premature Death.



Schroeder SA. NEJM 2007;357:1221-1228

The NEW ENGLAND JOURNAL of MEDICINE

What is 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."

Koplan et al. Consortium of Universities for Global Health Executive Board: Towards a common definition of global health. Lancet. 2009; 1993-1995.

OR….

"a concept fabricated by developed countries to explain what is regular practice in developing nations."

Consortium of Universities in Global Health. 2008. Annual Report.

Annals of Global Health
VOL. 81, NO. 2, 2015

ISSN 2214-9996
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ORIGINAL RESEARCH

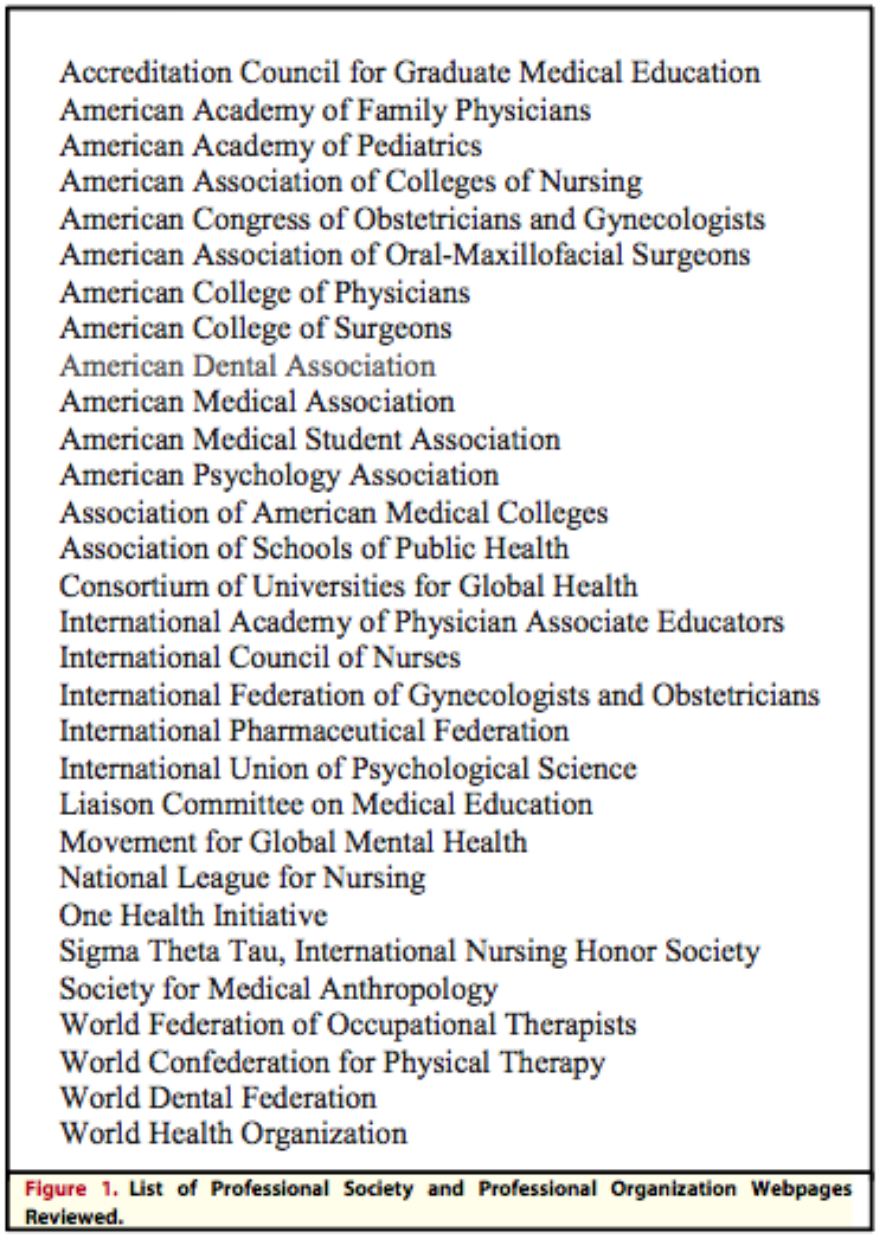
Identifying Interprofessional Global Health Competencies for 21st-Century Health Professionals

Kristen Jogerst, BS, Brian Callender, MD, Virginia Adams, RN, PhD, Jessica Evert, MD, Elise Fields, PharmD, Thomas Hall, MD, DrPH, Jody Olsen, PhD, MSW, Virginia Rowthorn, JD, Sharon Rudy, PhD, Jiabin Shen, M.Ed, Lisa Simon, DMD, Herica Torres, MSN, Anvar Velji, MD, Lynda L. Wilson, MSN, PhD

Hanover, NH; Chicago, IL; Washington, DC; San Francisco, Martinez, and Elk Grove, CA; Baltimore, MD; Birmingham, AL; Cambridge, MA; Albuquerque, NM

Abstract

BACKGROUND At the 2008 inaugural meeting of the Consortium of Universities for Global Health (CUGH), participants discussed the rapid expansion of global health programs and the lack of standardized competencies and curricula to guide these programs. In 2013, CUGH appointed a Global Health Competency Subcommittee and charged this subcommittee with identifying broad global health core competencies applicable across disciplines.



Accreditation Council for Graduate Medical Education
American Academy of Family Physicians
American Academy of Pediatrics
American Association of Colleges of Nursing
American Congress of Obstetricians and Gynecologists
American Association of Oral-Maxillofacial Surgeons
American College of Physicians
American College of Surgeons
American Dental Association
American Medical Association
American Medical Student Association
American Psychology Association
Association of American Medical Colleges
Association of Schools of Public Health
Consortium of Universities for Global Health
International Academy of Physician Associate Educators
International Council of Nurses
International Federation of Gynecologists and Obstetricians
International Pharmaceutical Federation
International Union of Psychological Science
Liaison Committee on Medical Education
Movement for Global Mental Health
National League for Nursing
One Health Initiative
Sigma Theta Tau, International Nursing Honor Society
Society for Medical Anthropology
World Federation of Occupational Therapists
World Confederation for Physical Therapy
World Dental Federation
World Health Organization

Figure 1. List of Professional Society and Professional Organization Webpages Reviewed.

Domains of Global Health Competency

- Global Burden of Disease
- Globalization of health and health care
- Social and Environmental Determinants of Health
- Capacity Strengthening
- Collaboration, Partnering, and Communication
- Ethics
- Professional Practice
- Health Equity and Social Justice
- Program Management
- Sociocultural and Political Awareness
- Strategic Analysis

Level I: Global Citizen Level
Competency sets required of all post-secondary students pursuing any field with bearing on global health.

Level II: Exploratory Level
Competency sets 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.

Level III: Basic Operational Level
Competency sets required of students aiming to spend a moderate amount of time, but not necessarily an entire career, working in the field of global health.

Two sub-categories exist in Level III:

> **Practitioner-Oriented Operational Level**: Competency sets required of students: 1) practicing discipline-specific skills associated with the direct application of clinical and clinically-related skills acquired in professional training in one of the traditional health disciplines; and 2) applying discipline-specific skills to global health-relevant work from fields that are outside of the traditional health disciplines (e.g., law, economics, environmental sciences, engineering, anthropology, and others).
>
> **Program-Oriented Operational Level**: Competency sets required of students within the Basic Operational Level in the realm of global health program development, planning, coordination, implementation, training, evaluation, or policy.

Level IV: Advanced Level
Competency sets required of students whose engagement with global health will be significant and sustained. These competencies can be framed to be more discipline-specific or tailored to the job or capacity in which one is working. This level encompasses a range of study programs, from a masters level degree program, up to a doctoral degree with a global health-relevant concentration. Students enrolling in these programs are usually committed to a career in global health-related activities.

Figure 2. Four Proposed Levels of Global Health Competency.

Table 1. List of Competencies Categorized into 8 Domains for Global Citizen and 11 Domains Basic Operational Program-Oriented Levels

Domains and Competencies	Knowledge (K), Attitude (A), Skill (S)	Global Citizen Level	Basic Operational Program-Oriented Level
DOMAIN: 1. Global Burden of Disease. Encompasses basic understandings of major causes of morbidity and mortality and their variations between high-, middle- and low-income regions, and with major public health efforts to reduce health disparities globally.[16,20]			
1a. Describe the major causes of morbidity and mortality around the world, and how the risk for disease varies with regions.[16,20]	K	X	X
1b. Describe major public health efforts to reduce disparities in global health (such as Millennium Development Goals and Global Fund to Fight AIDS, TB, and Malaria).[16,20]	K	X	X
1c. Validate the health status of populations using available data (e.g., public health surveillance data, vital statistics, registries, surveys, electronic health records, and health plan claims data).[24]	K, S		X
DOMAIN: 2. Globalization of Health and Health Care. Focuses on understanding how globalization affects health, health systems, and the delivery of health care.[16,20]			
2a. Describe different national models or health systems for provision of health care and their respective effects on health and health care expenditure.[16,20]	K		X
2b. Describe how global trends in health care practice, commerce and culture, multi-national agreements, and multinational organizations contribute to the quality and availability of health and health care locally and internationally.[16,20]	K		X
2c. Describe how travel and trade contribute to the spread of communicable and chronic diseases.[16,20]	K	X	X
2d. Describe general trends and influences in the global availability and movement of health care workers.[16,20]	K		X
DOMAIN: 3. Social and Environmental Determinants of Health. Focuses on an understanding that social, economic, and environmental factors are			

www.ghcompetencies.org

Interim Analysis

- 35 respondents; 17 countries; 85% urban; 75% supervisors; 30% primary care; 55% hospitals; 21% NGOs
- 45% want more students; 55% current amount is right; 0% said less students
- 43% students come as learners
- 50% students come as learners and capable professionals (to practice, without additional training, the profession they are pursing)

Interim Analysis

- 32% students visiting my community GET more than they GIVE
- 10% students visiting my community GIVE more than they GET
- 49% students visiting my community GET as much out of the experience as they GIVE

Interim Analysis

Preparation Upon Arrival

20% Well prepared

60% Satisfactorily prepared

21% Less than satisfactorily prepared

Interim Analysis

- 34% Demonstrating humility most important
- 8% Demonstrating confidence most important
- 52% Demonstrating humility and confidence equally important

Interim Analysis

<u>Important or very important:</u>

74% Demonstrate humility about being in a new setting.

85% Demonstrate awareness of the influence that culture has on patients and healthcare.

23% Had previous experience traveling outside their home country.

59% Demonstrate an understanding of culture shock.

32% Speak the local language at least at a beginner level.

65% Demonstrate an understanding of realities working and living in a low-resource setting.

69% Demonstrate a sense of social justice.

68% Prioritize the importance of and practice introspection and reflection.

The Problem With Competencies in Global Health Education

Quentin Eichbaum, MD, PhD, MPH, MFA, MMHC

Academic Medicine

ACQUIRED AND PARTICIPATORY COMPETENCIES IN GLOBAL HEALTH EDUCATION: DEFINITION AND ASSESSMENT

--Manuscript Draft--

Consortium of Universities for Global Health

Acquired & Participatory Competencies

- **Acquired Competency**
  - knowledge & skills
  - Ophthalmology – Medical Knowledge
    - *"Must demonstrate competencies in their knowledge of cataract surgery, contact lenses, corneal and external disease, eye abnormalities, glaucoma…"* (IV.A.5.b)

- **Participatory Competency**
  - Communication, collaboration etc
  - Ophthalmology – Interpersonal and Communications Skills
    - *"…communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds."*

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Conclusions

1. Competencies may be **context-free or context-linked**

2. Some competencies may be individually "acquired" as knowledge/skills and transferred across contexts, but others (most?) are situated in dynamic social settings, linked to contexts, and are learned through "participation."

3. *Acquired* and *participatory* competencies require different methods of assessment – more work on assessing participatory competencies

4. More inclusive process (global south); more nuanced classification

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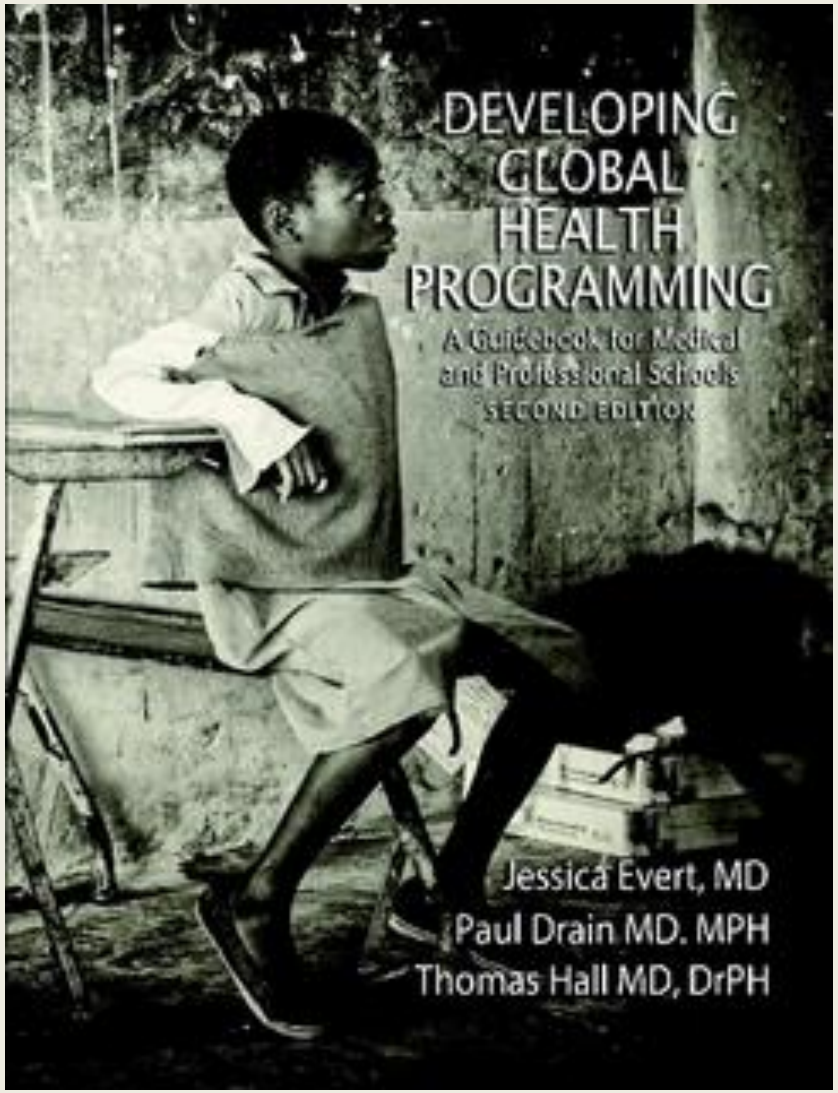

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Jessica Evert MD
jevert@cfhi.org
www.cfhi.org