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NAFSA Global Learning Colloquium: Health Professions

Addressing Healthcare Inequities Around the World

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Controversies in Global Health Competencies: Definition and Assessment

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Recent publications …

The Problem With Competencies in Global Health Education

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

Acquired and Participatory Competencies in Health Professions Education: Definition and Assessment in Global Health

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

The problems....

1. Insufficiently **inclusive** of input from LMICs/global south
   - Often developed by committee in HIC programs
   - Often serves primarily HIC program interests

2. Insufficiently **context** specific
   - Generic - to be transferable across contexts (convenient!)

3. Unresolved **"individualist/collectivist"** divide
   - HICs vs LMIC cultural/learning differences

4. Inadequate **assessment** methods

HIC contexts of “Global Health”

- **Predominant current model of global health/education in HICs**
  - Trainees from HICs perform elective work for month(s) in LMICs
  - Effectiveness? Logistics? Ethics? Colonialist/other legacies?
  - Learning dissonances on both sides

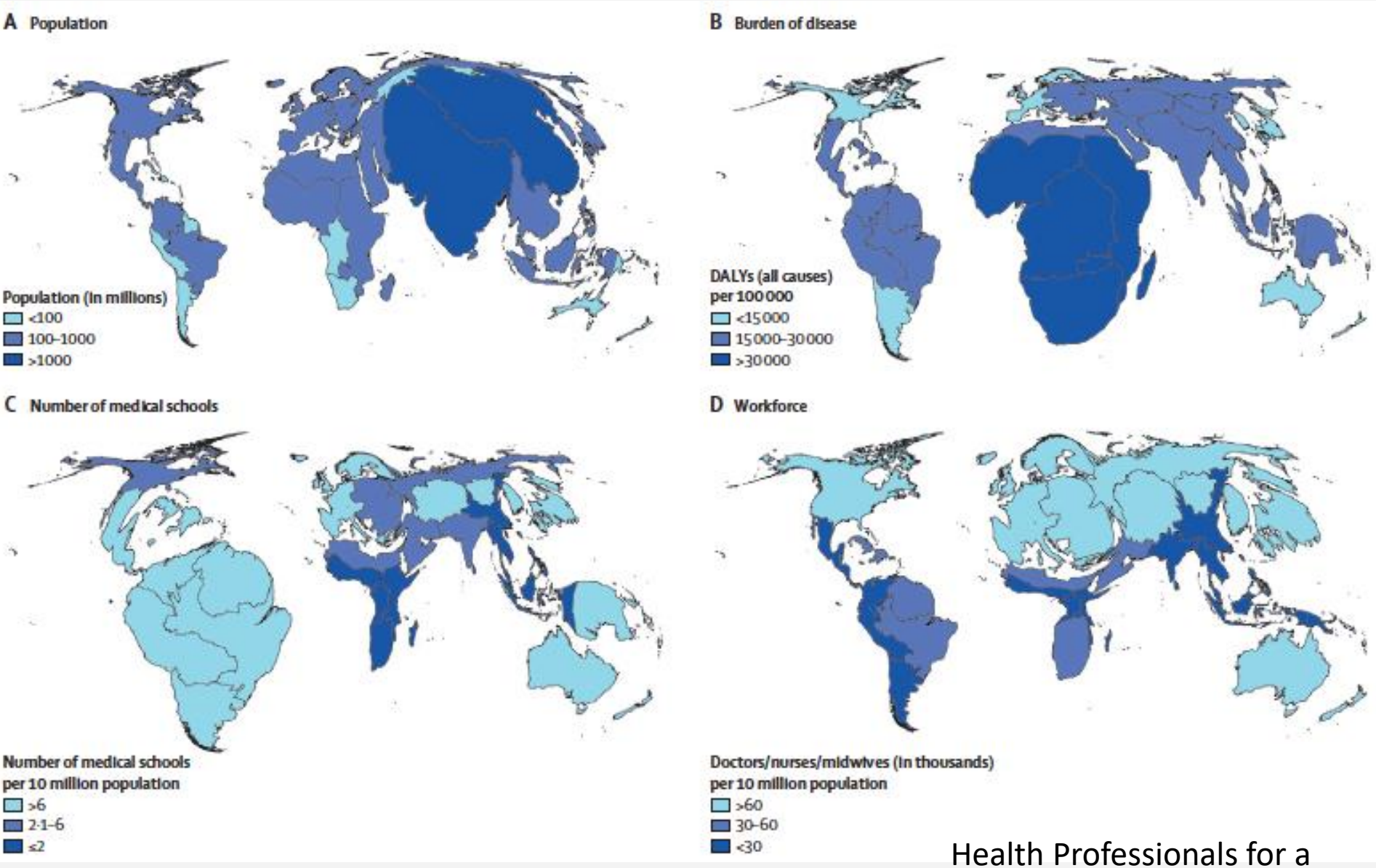
- Alternative models? -‘glocal,’ long term immersion, bidirectional?

- How did we get here? What can we improve?

EDUCATION OF HEALTH PROFESSIONALS FOR THE 21ST CENTURY:
A GLOBAL INDEPENDENT COMMISSION

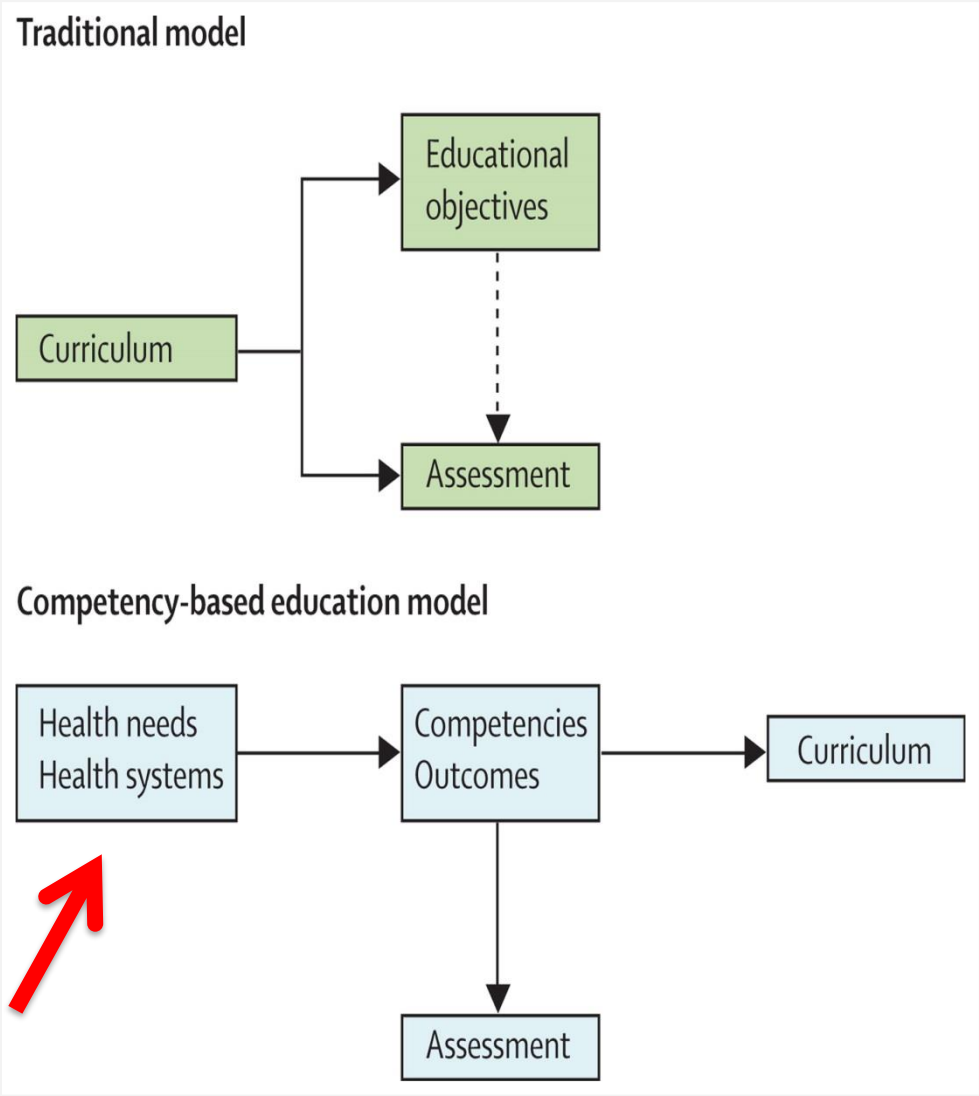
Health Professionals for a New Century –

transforming education to strengthen health systems in an interdependent world



Health Professionals for a New Century, Lancet 2010

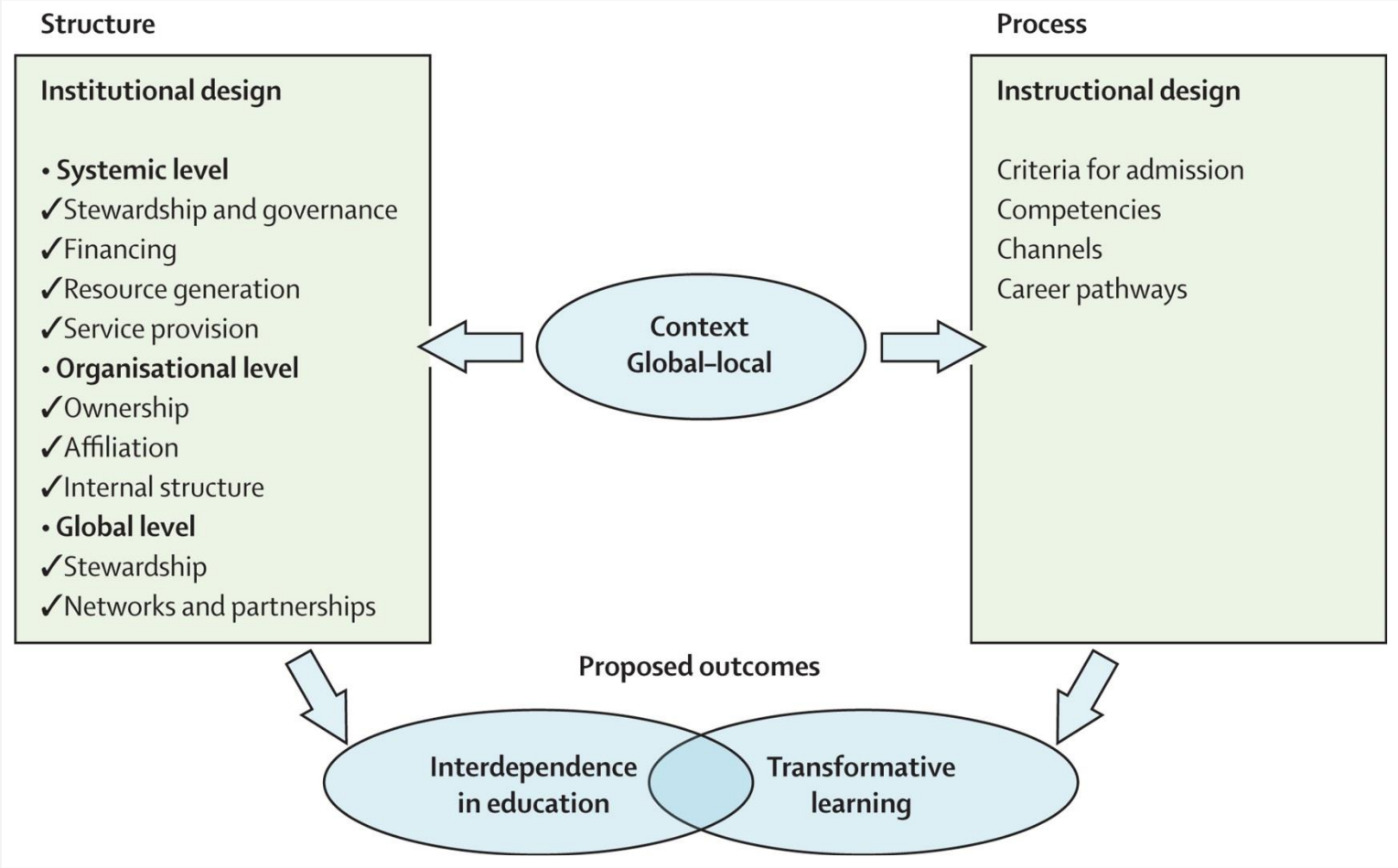
‘Health and Systems Needs’ VS ‘outdated static curricula’



“...a slow-burning crisis is emerging in the mismatch of professional competencies to patient and population priorities because of fragmentary, outdated, and static curricula producing ill-equipped graduates for underfinanced institutions.”

(Frenk et al., LANCET 2010)

‘Interdependence-**Context**-Transformation’



Frenk et al., LANCET 2010

Contexts: Global VS Local?

- *Adaptation locally but harnessing of resources globally in a way that confers capacity to flexibly address local challenges while using global knowledge, experience, and share resources… (Frenk et al. Lancet 2010)*

- *"Global policies can be helpful in offering strategies and standards for care delivery, but they must be adapted to local context to minimize unintended negative consequences …"*

(Bleakley, Bligh and Brown 2011)

Interdependence -

from **'isolated silos"** to **"networks, alliances & consortia"**

"Laudable efforts to address these deficiencies have mostly floundered because of the so-called tribalism of the professions – ie the tendency of the various professions to act in isolation from or even in competition with each other."

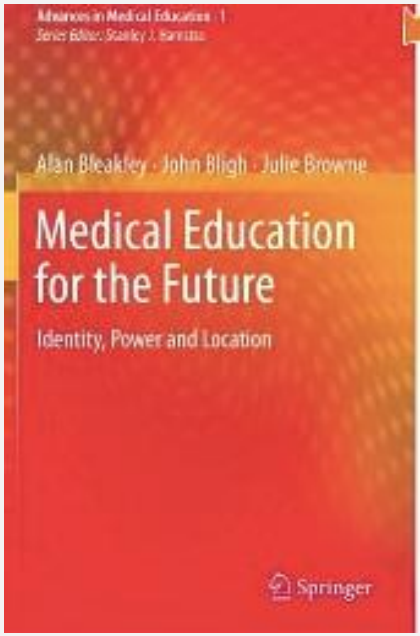
"Shift from isolated to harmonized education and health systems…from stand-alone institutions to

networks, alliances and consortia."

Wanting to conform to 'Western' standards

- *"Nervousness about not being seen to conform to Western educational imperatives permeates…. [African] medical education…."*

- *"…medical educational strategies cannot be cooked up in [Western] Universities and then exported. They must be **context specific** and fit the purpose, formulated in the heat of practice."*



Exporting (franchising?) Western Standards

Thinking the post-colonial in medical education

Alan Bleakley, Julie Brice & John Bligh

Medical Education, 2008

"At its extreme, this emphasis on standardizing risks echoing the homogenizing process of Western-inspired 'McDonaldisation.' In this case, however, what is being traded in the global marketplace is knowledge rather than hamburgers."

The Centrality of Context

"All aspects of the educational system are deeply affected by the local and global contexts. Although many commonalities might be shared globally, there is local distinctiveness and richness."

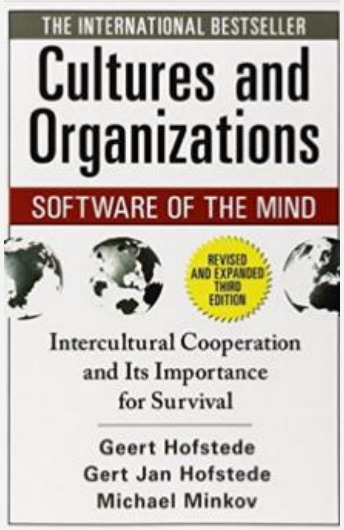
Frenk et al. Lancet 2010

Contexts – free or linked?

- **If context-free**
  - Competent practitioner is “generally competent”
  - Competencies can be taught and practiced independent of the particularities of the context
  - Competency in one context predicts competence in others
- **If context-linked**
  - Practitioner is competent with respect to specific contexts
  - Competency MUST be linked & taught with respect to context
  - Competence in one context does NOT predict competence in others

Individualist-Collectivist Disjunction

- **INDIVIDUALIST - high income countries (HIC)**
  - USA, European, Australia, NZ…(global north)
  - Understand themselves through individual achievement
  - Intrinsically competitive
  - Learning is acquired and possessed by the individual
  - Learning is transferable across contexts



- **COLLECTIVIST - low-and middle income countries (LMICs)**
  - Developing countries (global south)
  - Understand themselves in terms of group they below to
  - Intrinsically participatory, collaborative, place group's wishes over own
  - Learning is "situated/distributed" within and arises through participation and from dynamic social interaction
  - Learning is context-dependent and not fully transferable across contexts

Assessment – shortcomings in LMICs

Low resource settings….

1. **Inadequate direct observation**
   - Lack of faculty, over-crowded hospitals, clinics

2. **Lack a frame or reference to assess HIC trainees**
   - What are they expected to know?
   - How should they compare alongside local trainees?
   - How to assess visiting HIC trainees alongside local trainees'?

Assessment – shortcomings in LMICs

3. **Inadequacy of "checkbox" format**
   - Convenient but mechanistic
   - Recognition bias (*"seen that, done that"*) > hazard of overconfidence!

4. **Inadequate intrinsic "competence" of LMICs settings**
   - Coraccio and Englander (2013)- importance of clinical microsystems in which one trains
   - Asch (2009) expt – competence of specific training environment affected trainee's subsequent competence

5. **Lack of continuing education (CME) to maintain competency**
   - Competency wanes over time
   - Settings in LMIC can change quickly – epidemiology, sociopolitical
   - Overconfidence?

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…"* (ACGME -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."* (ACGME – IV.A.5.d)

MEPI/PEPFAR 2014 conference – Maputo, Mozambique

- ☐ Can interpret viral loads and CD4 counts in patients with HIV/AIDS.
- ☐ Counsel a dying patient.

Competency Domains of four major global/public health organizations

- acquired vs participatory competencies?

Association of Schools of Public Health (ASPH) – Global Health Competency Model (Final Version 1.1) (2011)[19]	World health Organization (WHO) Global Competency Model [20]	Consortium of Universities for Global Health (CUGH) – competency domains for initial Competency Ranking.[21]	Joint US/Canadian Committee on Global Health Core Competencies 2008-2009.[22]
1. Capacity Strengthening	1. Communicating in a credible and effective way	1. Global burden of disease	1. Global burden of disease
2. Collaborating and Partnering	2. Knowing and managing yourself	2. Globalization of health and healthcare	2. Health implications of travel, migration and displacement
3. Ethical and Professional Practice	3. Producing results	3. Social and Environmental Determinants of Health	3. Social and economic determinants of health
4. Health Equity and Social Justice	4. Moving forward in a changing environment	4. Capacity strengthening	4. Population, resources and environment
5. Program Management	5. Fostering integration and teamwork	5. Teamwork/collaboration and communication	5. Globalization of health and healthcare
6. Socio-cultural and Political Awareness	6. Respecting and promoting individual and cultural differences	6. Ethical reasoning	6. Healthcare in low-resource settings
7. Strategic Analysis	7. Setting examples	7. Professional practice	7. Human rights and global health
		8. Health equity and social justice	
		9. Program management	
		10. Social, cultural and political awareness	
		11. Strategic analysis	
		12. Communication	

Participatory Competencies - assessment

- Not amenable to standard observational/psychometric methods
- Require multidimensional approach involving input from other co-assessing healthcare teams/individuals including trainee – not just single preceptor!
- Qualitative and mixed methods from social sciences
  - Self-directed
  - Narrative
  - Ethnographic
  - Realist enquiry
  - other

Self-Directed Assessment Seeking

Eva and Regehr (2008)

- Trainee proactively seeks feedback and assessment from a range of relevant sources (being empowered by faculty, system) and translates this feedback into improving performance.

- Collectivist aspects – involve peers, teachers, other sources of info
  - More reliable than single assessor (Moonen van Loon et al, 2015)

- Low resource/collectivist settings > “Transprofessionalism” (Lancet 2010) include ancillary health workers in low resource settings

Self-Directed Assessment Seeking-

Aligns with these concepts in global health education:

- Transprofessionalism & transformative learning (Frenk, 2010)
  - Interprofessional collaboration (Corracio & Englander 2013)
- *Resourceful learning* (Eichbaum, 2015, 2016)
- *Desirable difficulties* (Koriat, 2004)
- Metaphors/models of sharing (Eichbaum, 2015, 2016; Holmboe, 2015)

Insufficiency of 'Cultural Competence'

- Loaded with assumptions and perceptions
  - Complex intersections with individual identity, life experience etc
  - Boundaries blurring with global movements > stereotyping
- Often taught as individually **acquired/possessed** knowledge rather than **participatory/situated**
  - *"Culture is not an abdominal exam."* Kumagai & Lypson -2009
- Cultural humility or awareness– better, still problematic…

Limitations and legacies of **”Curriculum”**

"Fragmentary, outdated, static Curricula..."

(Frenk et al., LANCET 2010)

"...a slow-burning crisis is emerging in the mismatch of professional competencies to patient and population priorities because of fragmentary, outdated, and static curricula producing ill-equipped graduates for underfinanced institutions."

The conceit of curriculum

Cynthia Whitehead, Ayelet Kuper & Fiona Webster

Medical Education 2012

"Arrogance about our potential to shape our health systems through our curriculum will not serve us well….The suggestion that medical education can fix society diverts attention from structural societal inequalities…We must take care not to suggest that the ills of society can be cured by medical curricula. "

Curriculum Outdate #1

Theoretical knowledge must precede applied medical practice?

"Medical education must continue to address (and redress) the primary historical symptom of the Flexner legacy – ***the disjunction between the pre-clinical and clinical years, reflected in the outdated notions that theory must precede practice and the abstract must precede the applied****. Rather, we call for early and intensive patient contact with integrated theory and practice informed by contemporary socio-cultural learning theory centered on workplace practice."* [Bleakley, Bligh, Brown, 2011]

Curriculum Outdate #2

Doctor-centered (paternalism) VS patient-centered

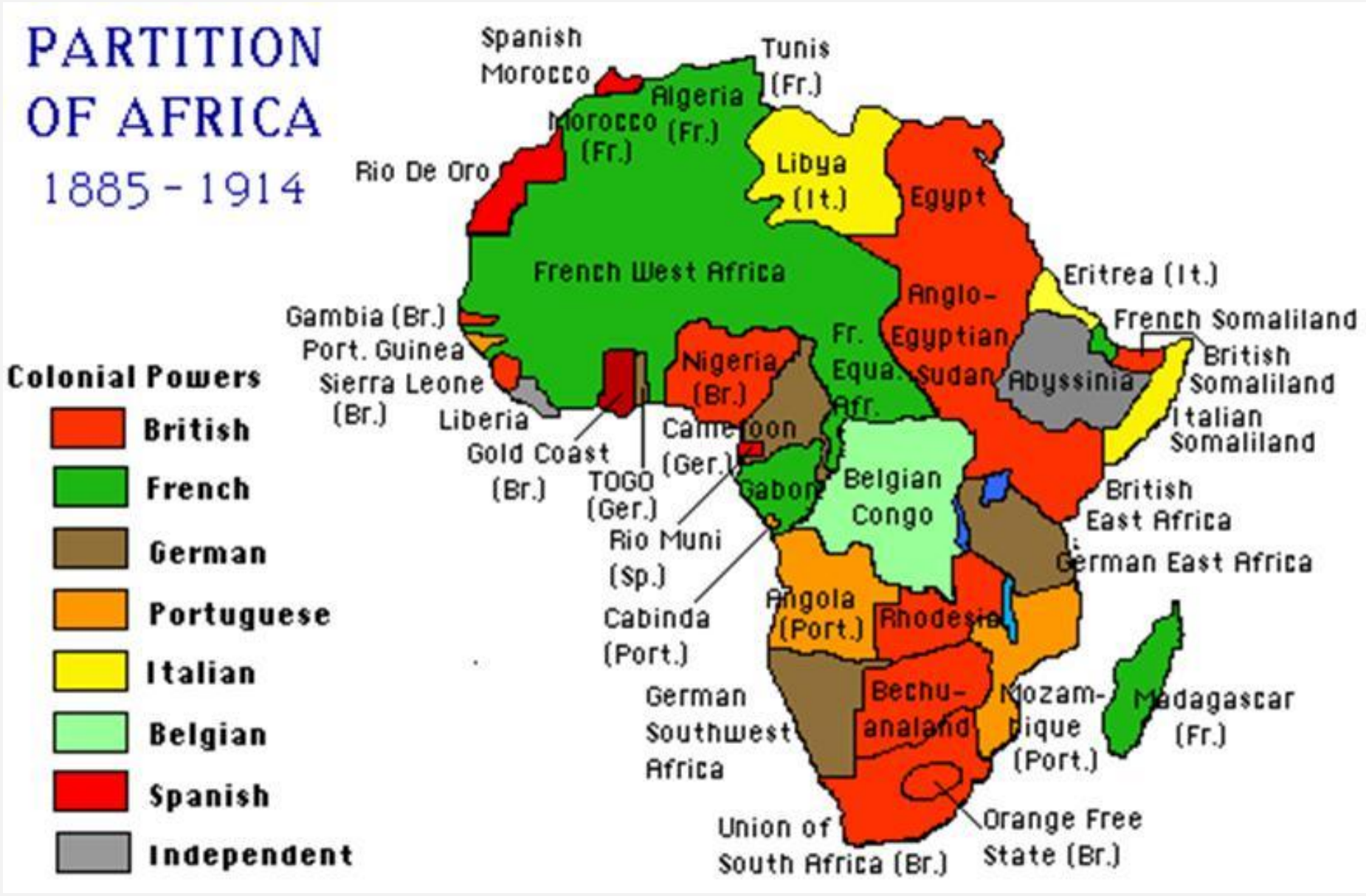
"…despite 30 years' worth of research-led development in teaching and learning communication in medicine, doctors in general communicate poorly and remain doctor-centered rather than patient centered" (Roter and Hall, 2006)

Global Health Equity

African legacies and backstories to the competency debate

OUR HISTORY WITH AFRICA - WRESTLING DOWN THE GIANT

Legacy of colonialism



Colonial Myth: West brought culture, education, written language…(competency?)… to the colonies

*"For colonialism this involved…**the destruction or the deliberate undervaluing** of a people's culture, their arts dances, religions, history, geography, education, orature and literature and the **conscious elevation of the languages of the colonizer**."*

Ngugi wa Thiong'o

Decolonizing the Mind, 1981

Colonialism and Medicine

(= today's global health)

A tangled relationship!

Colonialism and Medicine

"…The only excuse for colonization is medicine….the physician, if he understands his role, is the most effective of our agents of penetration and pacification."

(Herbert Lyautey – French colonial strategist)

Colonial Medicine and Its Legacies

Greene, Basilico, Kim, Farmer 2013

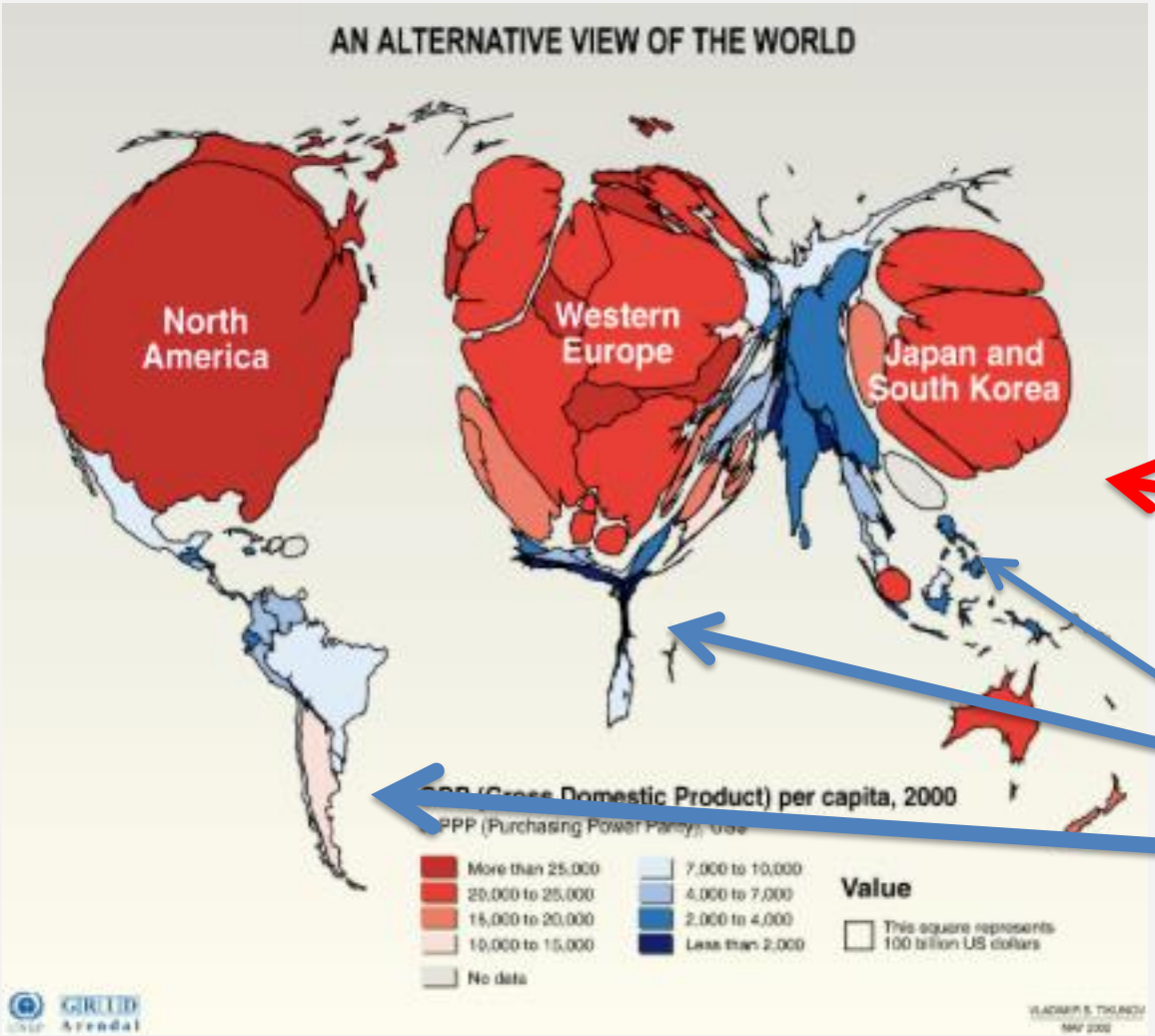
1. Colonial/tropical medicine for **imperial conquest & security** > medicine needed for colonial troops and indentured African labor

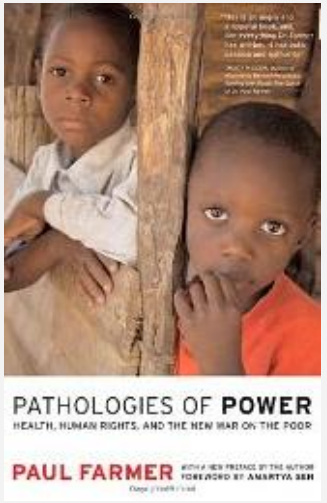
1. Colonial/tropical medicine as a place to test **medical/public health research and practice**
   - Very heath rates among British soldiers in West Africa(500 per 1000) versus very low for Africans – why?

2. Colonies seen as **infectious threat to civilized world** eg European cholera epidemics from populous slums of India? > medicine needed

The HIC-LMIC Power Differential

in research, education (competency?)





Research designed and funded by….

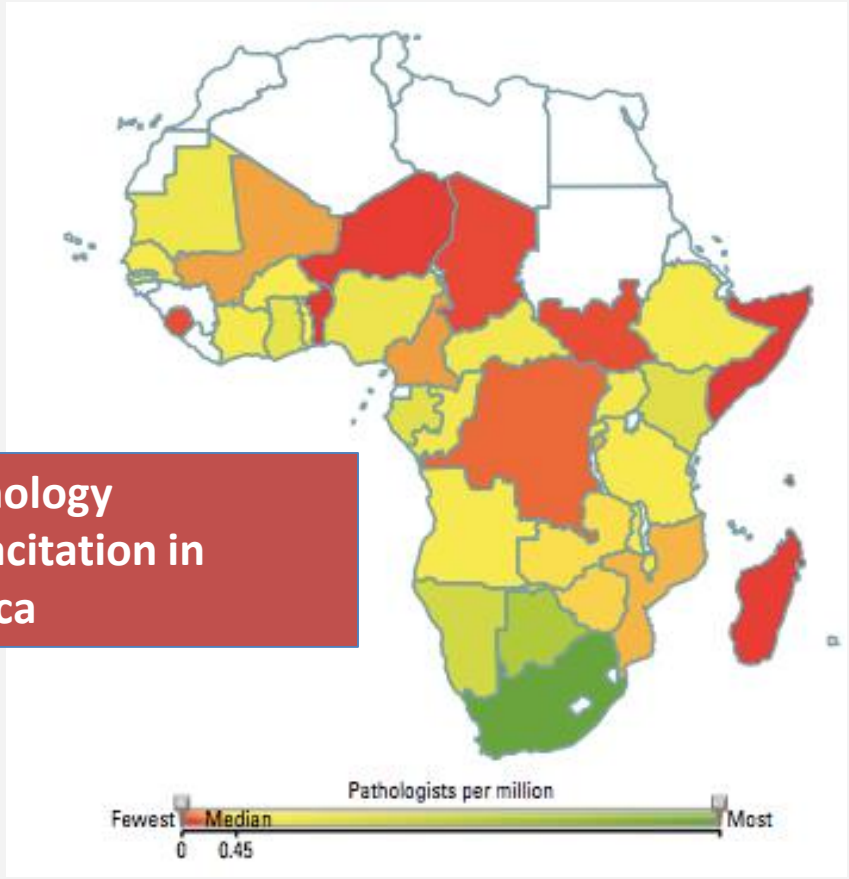
"International"/global health research done here

New Medical Schools in Africa

trying to find their (with colonial lions lurking)

Relevance of competencies in settings of severe under-Capacitation?

Pathology capacitation in AFrica

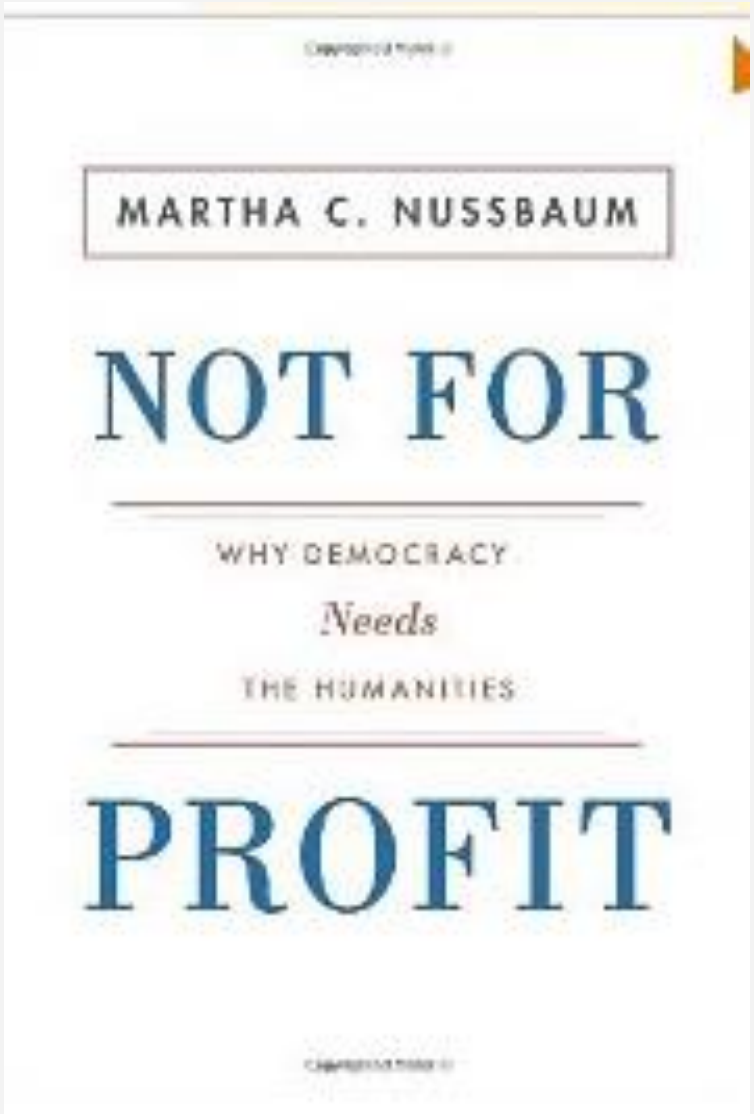


Country	Population (No.)	No. of Persons per Pathologist	Pathologists
Angola	24,906,000	2,075,500	12
Benin	10,567,000	NA	0
Botswana	2,156,000	359,333	6
Burkina Faso	18,184,000	2,273,000	8
Burundi	9,684,000	3,228,000	3
Cameroon	21,636,000	3,606,000	6
Central African Republic	5,462,000	1,365,500	4
Chad	13,439,000	6,719,500	2
Cote d'Ivoire	24,926,000	1,661,733	15
Democratic Republic of Congo	74,081,000	4,938,733	15
Ethiopia	89,060,000	1,619,273	55
Gabon	2,337,000	779,000	3
Ghana	27,379,000	912,633	30
Kenya	43,558,000	725,967	60
Madagascar	22,747,000	NA	
Malawi	16,056,000	1,784,000	9
Mali	17,512,000	3,502,400	5
Mauritania	3,716,000	1,238,667	3
Mauritius	1,262,000	84,133	15
Mozambique	25,392,000	3,174,000	8
Namibia	2,217,000	554,250	4
Niger	18,529,000	9,264,500	2
Nigeria	182,336,000	1,072,565	170
Republic of Congo	4,638,000	1,546,000	3
Rwanda	11,180,000	2,236,000	5
Senegal	13,950,000	1,992,857	7
Sierra Leone	6,432,000	6,432,000	1
South Africa	54,425,000	224,897	242
South Sudan	12,165,000	6,082,500	2
Tanzania	48,126,000	2,187,545	22
Togo	6,967,000	2,322,333	3
Uganda	35,225,000	1,467,708	24
Zambia	15,254,000	2,542,333	6
Zimbabwe	13,426,000	2,685,200	5

Final: Critical role the humanities in health professional education

"…education is not just about the passive assimilation of facts and cultural traditions, but about challenging the mind to become active, competent, and thoughtfully critical in a complex world."

– *Teach tolerance of uncertainty and ambiguity – something hard to capture with (acquired) competencies!*



Conclusions –
competencies in global health education?

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

5. Understand the **legacies and backstories of LMICs** in considering competencies and how to assess them in global health education

Thanks for your attention!
Questions?

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Questions for Discussion

1. What do you think might be the most effective methods for assessing competencies in low resource contexts?

2. Do you think cultural competence is a helpful designation and can be validly assessed?

3. Do you think there should be a global medical/health professional curriculum with international accreditation standards, or should curricula be homegrown and context specific?

Select References

- Bleakley A, Bligh J and Browne J (2011) *Medical education for the future: Identity, power and location*. Dordrecht, London: Springer.
- Bleakley A, Brice J and Bligh J (2008) 'Thinking the post-colonial in medical education', *Medical Education* 42 (3): 266-270.
- Bleakley, A. Medical Humanities and Medical Education. Routledge, 2015.
- Crane, JT. Scrambling for Africa: AIDS, expertise and the rise of American global science. Cornell UP, 2013.
- Crisp N (2010) *Turning the world upside down: The search for global health in the twenty-first century*. London: Royal Society of Medicine Press.
- Eichbaum Q, Hedimbi M, Ferrao G, Bowa K, Vainio O and Kumwenda J (2015) 'New medical schools in Africa–challenges and opportunities CONSAMS and the value of working in consortia', *Annals of Global Health* 81 (1): 23.
- Eichbaum Q, Nyarango P, Bowa K, Odonkor P, Ferrao J, Mashalla Y, Vainio O and Vermund SH (2012) '"Global networks, alliances and consortia" in global health education: The case for south-to-south partnerships', *Journal of Acquired Immune Deficiency Syndromes* 61 (3): 263–264.
- Eichbaum Q, Nyarango P, Ferrao J, Tlale N, Hedimbi M, Belo C, Bowa K, Vainio O and Kumwenda J (2014) 'Challenges and opportunities for new medical schools in Africa.', *Lancet Global Health Report* 2 (12).

Select References

- Eichbaum Q. The problem with competencies in global health education. Academic medicine, Apr 2015;90(4):414-417.
- Eichbaum, Q. Acquired and Participatory Competencies in Health Professions Education: Definition and Assessment in Global health. Academic Medicine. April 2017; 92(4): 468-479.
- Eichbaum, QG. Challenges and Opportunities for New medical Schools in Africa – CONSAMS. Academic Medicine. 89(8), 2014/
- Frenk J, Chen L, Bhutta ZA, Cohen J, Crisp N et al. (2010) 'Health professionals for a new century: transforming education to strengthen health systems in an interdependent world', *Lancet* 376 (9756): 1923–1958
- Hodges BD & Lingard l (Eds). The question of competence : reconsidering medical education in the twenty-first century. ILR press, 2012.
- Meredith, M. The Fortunes of Africa: a 5000 year history of wealth, greed and endeavor. Simon and Schuster, 2014.
- Mullan F, Frehywot S, Omaswa F, Sewankambo N, Talib Z, Chen C, Kiarie J and Kiguli-Malwadde E (2012) 'The Medical Education Partnership Initiative: PEPFAR's effort to boost health worker education to strengthen health systems', *Health Affairs*, 31 (7): 1561–1572.
- Nussbaum, MC. Not for Profit: why democracy needs the humanities. Princeton UP. 2010.
- Nelson et al. Oncologic Care and Pathology Resources in Africa: survey and recommendations. J Onc Care 34(1), 2016.