"We Learn From Them, They Learn From Us": Global Health Experiences and Host Perceptions of Visiting Health Care Professionals

Christian Kraeker, MD, FRCPC, MSc, DTM&H, and Clare Chandler, MSc, PhD

Abstract

Purpose
It is increasingly common for health care professionals from developed countries to travel to developing regions of the world to learn or teach. This project aimed to describe the perceptions held by health care professionals in a developing region toward those who visit their communities to learn or teach.

Method
Semistructured interviews were conducted in July, 2011, with nine health care professionals from the University of Namibia School of Medicine. Questions revolved around participants' perceptions of benefits, harms, and ethical impressions of a health care professional visiting from a developed country. Interviews were tape-recorded, transcribed, and analyzed qualitatively using an inductive, iterative approach.

Results
The interview analysis identified three main narratives that shaped participant perceptions of visits: (1) culture, context, and concern, (2) expectations, intentions, and miscommunications, and (3) partnership and the desire to share and gain knowledge.

Conclusions
Participants' comments supported actively seeking out information regarding cultural and environmental context before visiting, completing a needs assessment to ensure that activities are needed and relevant, attempting to formulate long-term sustainable relationships, and traveling with the appropriate attitude. These themes provide valuable insight into how international educational collaborations can be created in order to be mutually beneficial.

It is increasingly common for health care professionals from developed countries to travel to developing regions of the world to learn or to teach.[1,2] Many medical schools provide students and residents with opportunities to travel to developing countries where they can learn firsthand about medical care in these settings.[1] Throughout this article, we refer to these educational experiences abroad as global health electives or global health experiences.

In Canada, almost every medical school allows its trainees to travel abroad on a clinical global health experience,[3] and a U.S. survey in 2008 showed that 59% of responding schools reported the availability of a global health experience.[4] The popularity of these types of activities suggests that students and faculty find them valuable, and there is literature defining the potential positive effects of these experiences for medical trainees from developed countries. Such benefits include learning about diseases not previously encountered, improving physical examination skills, developing a greater appreciation for public health practices, shifting career goals to a more general practice, and enhancing professionalism and cultural sensitivity.[5,6] However, there is a paucity of literature studying the outcomes of these activities for host institutions and health care professionals from developing countries and those individuals' opinions about the process.

Policy makers are starting to recognize the importance of studying the perspectives of individuals at host institutions in developing countries. For example, Crisp[7] recommends that "medical, nursing and health care schools should work with others to ensure that experience and training placements in developing countries are beneficial to the receiving country." Others have called for innovative ways to evaluate and demonstrate the effect that global health experiences "have on the communities and institutions where the students are based."[8] And recently, an international collaboration named the Working Group on Ethics Guidelines for Global Health Training developed guidelines for considering the ethical implications of these types of activities.[9]

We carried out research to understand the perceptions of individuals at host institutions in developing countries about health care professionals traveling to those countries for the purpose of learning or teaching. The primary objective of the project was to identify and document these perceptions. A further objective was to identify potential for strengthening relationships between these groups. To the best of our knowledge, this is the first study that has attempted to document the perceptions held by our partners in a developing country.

Method

Participants

Participants were affiliated with the University of Namibia School of

Dr. Kraeker is assistant professor, Department of Internal Medicine, McMaster University, Hamilton, Ontario, Canada.

Dr. Chandler is lecturer in social science, Department of Global Health and Development, London School of Hygiene and Tropical Medicine, London, United Kingdom.

Correspondence should be addressed to Dr. Kraeker, Juravinski Hospital, 711 Concession St., Room A3-61, Hamilton, Ontario, Canada L8V 1C3; telephone: (905) 521-2100, ext. 42471; fax: (905) 575-7320; e-mail: kraeker@mcmaster.ca.

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Medicine in the city of Windhoek, which receives regular visitors from abroad for educational purposes. This was a purposive convenience sample. A local health care professional identified potential participants. These included any local health care professional who had come into contact with any health care professional from a visiting country who was present with the purpose of either learning or teaching. Nine individuals took part in 8 interviews (7 one-on-one interviews and 1 interview with two participants). There were three female and six male participants, and their experience working with visitors from abroad varied from months to years.

We obtained ethics approval from the London School of Hygiene and Tropical Medicine. The University of Namibia School of Medicine provided a letter of support for the proposed project.

Study design

We developed a brief interview guide designed to explore topics such as general experiences and perceptions and participants' perceived benefits, harms, and ethical implications of visiting health care professionals (see Appendix 1). The principal investigator (C.K.) conducted the semistructured interviews with participants in July 2011. During the interviews, participants were asked to reflect on their previous experiences with visiting health care professionals from developed countries. The interviewer did not differentiate between those visiting for a brief period of time or as a part of a long-standing educational collaboration. All interviews were tape-recorded, but, for the purpose of confidentiality, the names of the participants were not identified on the recordings. We obtained informed consent from each participant.

Analysis

The interviews were transcribed by one of the authors (C.K.), and we analyzed the data using an inductive, iterative approach, as described by Auerbach and Silverstein.[10] This method is designed to allow the researcher to generate hypotheses from the data rather than to impose existing theories. The principal investigator (C.K.) repeatedly read the interview transcripts and coded them by hand for relevant text and repeating ideas, grouping these into themes that represented narratives shared by groups of participants. The coinvestigator (C.C.) verified the coding and themes and had no disagreements with the initial classifications. In the last interviews, few new ideas or themes relevant to the research questions were apparent, and no more interviews were carried out.

Results

All project participants were health care professionals from Windhoek, Namibia. The project sample included four physicians, two medical trainees, one pharmacist, and two university lecturers. Analysis of the transcripts resulted in the identification of three narratives, which we report in detail throughout this section.

Culture, context, and concern

The importance that local health care professionals placed on their surrounding environment, culture, traditions, and languages became evident during the fieldwork and discussions. Participants' comments revealed that a visiting student's or teacher's lack of understanding about the local culture not only could cause offense but also could render the visit ineffective, both for patients and local health care professionals. An example would be teaching or providing culturally inappropriate care:

> And, ah, of course the other thing that is cultural, is that as I've said, cultural diversity of this country is quite, quite heavy. A question which the doctor is asking can push the patient back, because you are infringing on their customs, infringing in their culture, and all these are things that need to be taken into account.

Participants also perceived visiting health care professionals as attempting to impose their visions of health and health care onto the local environment. Local health care professionals felt that visitors were often trying to apply Western concepts of medicine and standards of care in a setting where resource limitations often make such concepts impossible to implement. The local health care professionals acknowledged that although the ideas brought by visitors were good, they were rarely relevant in the environmental context. This caused frustrations for both parties. As one participant recalled:

> … they were teaching how you must, bare minimum, physically examine and take a history from a patient. And we're sort of sitting there saying, yeah the thing is we can't do that because most of us don't speak, for example, [the local dialect]. Half the time the nurse doesn't speak it either, most of the health care staff aren't actually Namibian, so it would have been helpful for them to have perhaps worked out that background before coming in, and also to have a slightly less kind of judgmental stance about it.

The local health care professionals also suggested that visitors attempt to minimize the negative effects potentially caused by their presence by taking it on themselves to observe and learn about the local practice environment before actually starting to teach or work:

> I tell him first to observe, learn, identify the needs of this community…. How these patients come in, how do they behave, how do they react to a health worker, and when a doctor comes how do they behave. When you see all of those things … when according to your observations you start working. Then I know you will make an impact, because you know the needs, behaviors, social needs, economic, even of the environment where you are working in. Yeah, then this person will know because he will understand … this patient woke up from a shanty house in Katatura, slept in the darkness, waited for the sun to rise for him to see where is his water to wash to come to this hospital.

Expectations, intentions, and miscommunications

This narrative emerged from participants' perceptions about health care professionals who visit from either academic institutions or nongovernmental organizations to teach or carry out various health-related projects. Participants often felt as though the recipients of these efforts had no input as to the education they would be receiving. This resulted in duplication of training, frustrations, and a strong feeling of time being wasted.

This narrative also included the idea that those visiting often provided education that was somewhat at odds with the capabilities of the local environment. In the participants' experience, the expectations held by the recipients of these visits were not upheld. One participant, for example, recalled:

> The staff were always quite excited 'cause they get someone visiting from overseas

> and, you know, view them as an expert who's going to be terribly helpful, but very often … what they are teaching will be very much at odds either with what our guidelines were, which were not perfect, or what we physically would be capable of doing. So often there was this kind of inappropriate perception of how much time, you know, you can spend with a patient and how much detail you can go into, which would be 20 minutes, 30 minutes per patient as far as our visiting health care professionals were concerned, which is clearly not feasible with over 4,000 patients. And also it would very often lead to staff getting quite unhappy because they couldn't get on with their work.

Many participants said they wanted to be more actively involved in deciding who would come to teach or advise and what the purpose of those visits would be. A general lack of communication seemed to underlie this feeling. Visit recipients wanted to be able to identify and promote the needs of their own community and to be a part of the collaborative process:

> … if you are invited it means that we have already seen the shortcoming, and we want to reach out and get somebody to come and help us. So it came from our side because we already identified our shortcomings.

Partnership and the desire to share and gain knowledge

Despite the criticisms of the global health experience process and of visiting health care professionals that emerged in the first two themes, participants demonstrated a strong yearning to improve the process for mutual benefit. Participants generally felt that there was more to gain than there was to lose with these visits, and this feeling formulated the basis of the third narrative.

Participants expressed a strong desire to continue receiving visiting health care professionals, both learners and teachers. They could imagine the process being of great value to both parties, but only if the educational collaboration were carried out as an equal partnership between the visiting health care professionals and the recipients of the visits. However, beyond equality, participants advised that the visitor's "heart" should fully embrace the newly found community, which would in turn allow the visitor to be accepted:

> Don't think that "I'm only here for two weeks," but think that you are going to be here for the rest of your life, and that you are part and parcel of the community which accepted you to do out your activity, helping you to study. And at the same time one could make a change that could change them, not to step on them and, say, use them, but to take them along the way.

Overall, participants perceived international collaboration to be a very good and healthy process for all involved. However, such collaborations must be characterized by equal partnership, cooperation, and commitment, whereby participating individuals identify objectives that would be mutually beneficial and met with a positive attitude on both sides of the partnership.

Participants did not vocalize any negatives associated with a medical trainee completing a short-term global health experience within their environment. In fact, some even encouraged these global health experiences, even when the participants perceived no personal benefit or any benefit toward the local patient population. There was a strong feeling that the local environment had something to offer, and participants were eager to open their visitors' eyes to the truths and wonders of their country:

> It's very good for people to come and see how people do with limited resources and still provide quite a reasonable job. It's often for somebody who comes out of a sheltered employment setting like you guys, you come into the real world and you see that we're doing similar stuff with similar results with much less resources. If colleagues of yours come to visit for a little while and see how we do things, we learn from them, they learn from us.

Discussion and Conclusions

Interview participants expressed narratives that represented both positive and negative experiences with and impressions of health care professionals who travel to developing countries to learn or teach. The participants were passionate about their country, culture, and the way they go about providing health care to their patients. They spoke with authority and enthusiasm about how visitors should engage themselves with their world. The three narratives can be used to guide practical applications for the global health experience process.

First, the findings from this sample suggest that visitors are often perceived to present themselves with little consideration of the environment where they will be learning and teaching. Showing an appreciation of local priorities and cultures was greatly valued by participants, who emphasized the importance of their own adaptations of medical practice according to the different cultures of their own country. Participants clearly expressed a desire for visiting health care professionals to respect the cultural environment, including culturally based traditional medical practices and capabilities of the local health care system, even when the end result might not coincide with a more Westernized definition of health. This does not imply that local health care professionals necessarily agreed with all culturally based traditional care, but they recognized its vital role in the environmental context.

This narrative of culture, context, and concern has practical applications. Some medical schools have initiated "predeparture" courses that students and teachers must complete before traveling to a developing country for a global health experience.[3] These courses are quite variable in nature but generally involve information about tropical medicine, behaving ethically in the community, and the local culture. The Association of Faculties of Medicine of Canada and the Canadian Federation of Medical Students have published guidelines for what medical trainees should learn and consider before embarking on a global health experience.[11] Our findings suggest that these types of sessions are valuable preparations for establishing mutually beneficial relationships between visiting and local health care professionals during global health experiences. In addition, spending time observing and inquiring about local practices and priorities could aid in raising awareness of specific local issues that may contrast with previous experiences and expectations of visitors. This may prevent frustration, avoid tension between visiting and local health care professionals, and prevent causing offense to patients.

The second narrative—expectations, intentions, and miscommunications—also has practical applications.

Participants felt that giving local health care professionals a role in identifying what type of outside help was needed or wanted would alleviate some of their frustrations. A locally driven needs assessment could identify how visiting health care professionals could best address gaps in knowledge or skills, as has previously been suggested.[9] In this way, visitors could understand what is expected of them and prepare for the visit accordingly. In their "model for sustainable short-term international medical trips,"[12] Suchdev and colleagues[12] recommend creating an environment with "a common and specific sense of purpose" whereby the visitors have a "commitment to doing work the community needs and wants." Although Suchdev and colleagues speak mostly of medical teams visiting to carry out specific medical interventions (e.g., surgery), this philosophy and vision would lend itself to learning and teaching. Recently, Kolars and colleagues[13] provided an approach and framework to help strengthen the relationships between schools in the United States and Sub-Saharan Africa. This framework would prove useful for those embarking on mutually beneficial global education collaborations.

The third narrative—partnership and the desire to share and gain knowledge—revealed that participants were supportive of the process of health care professionals traveling to their country to learn or teach. Participants expressed a strong desire to enter into relationships where they could share their culture and help guide appropriate educational collaborations as opposed to being passive recipients. Participants were very proud of their knowledge base, especially when it came to conditions endemic in their country that might not be present in the visitor's own. Participants desired an attitude and a willingness from visitors to enter into a collaborative relationship built on respect and an understanding of each other's needs. This related to the commitment and manner of the visitor and not just the act of exchanging ideas, time, resources, and education.

Our findings are subject to a number of limitations. This was a small, exploratory study. The information was obtained from a single medical center, potentially limiting the generalizability of the results to settings that differ physically and culturally. The possibility of either interviewer bias or response bias is a limitation, as the principal investigator himself is from a developed country, and that could have altered the way the questions were asked or answered.

The narratives present in the participants' comments validate existing recommendations[9,12] for how academic medical institutions in developed countries can engage with those in developing countries. These include (1) actively seeking information about the cultural and environmental context of the host institution before and during the visiting process,[12] including "predeparture sessions" for health care professionals,[9,11] (2) attempting to formulate long-term relationships between academic institutions that are mutually beneficial and dedicated to improving each other's educational development,[9] (3) completing a formal needs assessment before engaging in structured educational projects to ensure they are wanted, relevant, appropriate, and culturally acceptable at the host institution[9] because individuals at the host institution must be involved in determining what is right for their environment and context, and (4) traveling with respect, humbleness, and a genuine desire to learn from those who welcome visitors into their community.

Our work should prompt future studies of partnerships in education, clinical work, and research. These studies must be undertaken with the full partnership of those in the host institutions so that they can guide the international educational collaboration process. The ultimate goal would be to determine the effect that these activities have on host personnel, patients, and communities. The participants' narratives give a voice to those health care professionals who host global health experiences. We believe that those who work within the field of global health education are responsible for ensuring that the relationships and collaborations between academic institutions and organizations around the world are mutually beneficial, with clear measures of success, benefit, and harm for the host communities.[9]

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Appendix 1

Examples of Topic Guide Questions for Semistructured Interviews, University of Namibia School of Medicine, 2011

Can you describe any previous experiences with visiting health care professionals?

In your experience, what can be some of the positive aspects to visitors being present? What do you appreciate about them being present?

What are the negative aspects to visitors being present? Is there anything that visitors make more difficult or burdensome?

Why do you think people come to your institution from abroad?

Who do you feel should be allowed to come?

Is it important for the visitor to provide some sort of benefit?