Global Health Nursing
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Global Health Nursing
Building and Sustaining Partnerships

Michele J. Upvall, PhD, RN, CRNP
Jeanne M. Leffers, PhD, RN
Editors

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Foreword

Global health, as a field of study, has undergone unprecedented transformation. As the world has evolved demographically, environmentally, and technologically, so too has the definition of global health. It has changed from being defined as infectious diseases, tropical medicine, or health care for developing nations to the health and well-being of populations in all nations. It is no longer just a field of study in which health care providers offer their knowledge and care, based on Western wisdom, to people less fortunate in faraway lands. It is now an area of study and investigation built on the premise that the health of the world is predicated on mutual respect among populations and reciprocal learning of best practices. It is also based on the transmission and receipt of knowledge from different corners of the world, collaborative practices, and partnered international teams working through volunteerism, nongovernmental organizations (NGOs), governments, academic institutions, and international organizations, all to keep populations well, prevent illness, and maximize health. Learning from others is also an ultimate overall goal of global health. It is through full collaboration, as well as a strong sense of accountability among all these sectors, that progress on improving health globally can be accelerated. Effective partnerships are essential to delivering equitable, high-quality, accessible global health care.

And while the complete engagement of these collaborations is essential to making the world healthier, it all starts with how we prepare the next generation of health care professionals to have the passion for making a difference. With the transformation of global health—or because of it—academic institutions have experienced unprecedented interest in learning about and partaking in global health experiences. As educators in health professional schools, we have committed ourselves to educating and graduating globally minded health care professionals who are ready to address worldwide issues and who are well equipped to translate research findings into policy and practice in the United States and globally. This yearning for being part of the world and expanding horizons to understand the different health contexts has resulted in a proliferation of student and faculty exchange programs as well as a need for clinicians whose experiences and learning are not bound by borders. With increases in population movements resulting in migration and immigration, and owing to the many wars that have driven people out of their countries seeking refuge, health care professionals have seen the necessity to understand the different sociocultural and ecological contexts for populations displaced for whatever reason.

Alongside the increase in interest, great strides in global health have been made that are partly owing to large-scale social and technological revolutions. For example, the decrease in infant mortality in 2012 has enabled more children than ever before to live to celebrate their fifth birthday (UNICEF, 2013). Antiretroviral drugs have increased the length and quality of life of those living with HIV. And unprecedented technological advances, such as telecommunications, mobile phone technology, the Internet, and broadband technology, have aided in bridging the gap between those who have access to health care information and those who don’t, and while these advances are testaments to how far we’ve come, current global health issues and challenges serve as indications of how far we still have to go. The poliovirus, for example, is once again rearing its ugly head in Israel and parts of...
Europe (Butler, 2013). With regard to the reduction of maternal mortality, progress remains slow. Every day, 800 women die from preventable causes related to pregnancy and childbirth because of a lack of access to a skilled health professional (doctor, nurse, midwife) to administer interventions that prevent and manage life-threatening conditions resulting from childbirth (WHO, 2012). Also, the impact of climate change and natural disasters on global health are being felt around the world. For example, the recent devastation and destruction of health care services in the Philippines as the result of supertyphoon Haiyan has put millions of survivors at risk of contracting life-threatening diseases.

All these happenings in global health support the timeliness of this book because of the absolute need for theories, evidence, and guidelines to support culturally competent and ethically sound global experiences. This book is built on a sound theoretical background that honors the principles of equity and justice, which should undergird and permeate all educational curricula, research, and evidence-based practice to advance global health and ensure health equity. The theoretical frameworks should stimulate productive research programs and the values of respect, civility, reciprocity, and collaboration that are manifested in the various chapters.

This book provides the readers, whether faculty members, clinicians, or students, with frameworks of prototypical experiences to prepare them for exchange and/or reciprocal work in other countries. The authors demonstrate how they prepared for their assignments, experiences, or missions by studying context, history, and sociocultural structure. There are examples of reciprocal exchanges of knowledge, ways by which goals were mutually modified, best practices of partnerships, and mutually agreed-upon goals and outcomes by host countries and the hosted clinician/faculty/student. Some of the authors also provide comparative data between countries. The volume also provides exemplars of courses, clinical experiences, reflective diaries, and final-outcome report writing. These and other pragmatic guidelines will be welcomed by those who provide the experiences and those who actually live through these experiences.

I commend the editors for their choice of chapters, and the authors for writing the chapters. This is a timely collection of chapters made very coherent by the editors’ well-articulated, theoretical framework as well as by their conclusion. This book should be read by every person who is embarking on a global health experience or who is working or caring for immigrants and refugees. It will provide him or her with a context as well as with a framework for culturally competent and ethical practice.

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Nurses have shared stories of their global health experiences for decades, and many of these stories have significantly affected the nursing profession and the patients at the center of nursing care. Florence Nightingale and her efforts in the Crimea serve as a classic example of how nurses affect health globally. On a more contemporary note, organizations such as the American College of Nurse-Midwives (ACNM) have actively promoted the health of women and newborns globally over the past 30 years (Kennedy, Stalls, Kaplan, Grenier, & Fujoka, 2012). At an individual level, we see increased participation of nurses in volunteer organizations, nongovernmental organizations (NGOs), academic and research institutions, religious organizations, and governments to promote health worldwide. Even the tourism industry has aligned its profit motive with an appeal to good intentions through the rise of “voluntourism,” whereby nurses can provide short-term care in local clinics, hospitals, or schools while also touring the local area or country.

Often in our efforts to help improve the health of the world’s population we assume that our compassionate attitudes and good intentions will make a difference and are primary to facilitating health. But enthusiasm and compassion are not enough, regardless of practice setting, and the nurse who is a novice to global health may feel bewildered and confused when his or her efforts fail or are refused. We do not live or practice nursing in isolation, and our good intentions—though important—are not enough to guide practice anywhere in the world. We foster a collective sense of humanity by reflecting on our actions and asking how we individually, and as a profession, do good or do harm through our efforts in global health (McBride & Mlyn, 2012).

The premise of this book is one of connection and relationships. Globalization is a force through which we recognize our connections, promoting the concept of partnerships and shared responsibility. This book presents a framework for nursing to build and, ultimately, sustain partnerships. Exemplar case studies written by nurses working in global health follow each chapter to illustrate specific elements of a strong partnership. These nurses offer their stories from many different perspectives and backgrounds and include nurses working across national boundaries as well as those nurses effecting change within their own countries.

Our guiding principle for this book and its chapters is that partnerships are paramount in creating sustainable outcomes. Varying degrees of partnership integration can include coordination, cooperation, and close collaboration (Rosenberg, Hayes, McIntyre, & Neill, 2010). No matter their degree of partnership, nurses are ethically and morally obliged to be concerned with the world’s suffering. We are connected: first through our humanity, then through our professional values and social responsibility as nurses. But we also recognize that many mistakes will be made by everyone along the global health road. Mistakes and challenges are learning opportunities; with kindness and forgiveness the outcomes of cultural humility should arise from them. And take courage: We may not always comprehend the full effect of our partnerships. By reflection we may identify an effect, but we must also appreciate the role of serendipity in our planning and be comfortable with varying degrees of ambiguity.

From our perspective, global health nursing can be defined as follows:

Individual- and/or population-centered care addressing social determinants of health through a spirit of cultural humility, deliberation, and reflection in true partnership with communities and other health care providers.
Partnership is the central element of global nursing practice. Nurses must collaborate closely as an integrated team with host country partners to achieve optimum cross-cultural care reaching beyond disease management to build the capacity of partners and to avoid leaving holes in health care services upon departure. That partnerships occur both within a country’s borders and across borders emphasizes the transnational component of global health. Through partnership we address health problems and their underlying social determinants, which affect all of us in varying degrees. Dichotomistic terminology such as “third world” and “first world” as well as “developing” versus “developed” nations distances partners and promotes an attitude of “us” and “them.” Use of such labels conjures stereotypical images of people in the direst of circumstances as portrayed through media, which are not necessarily accurate. We use the terms low resource and high resource to encourage a less value-laden and more neutral perspective.

Although many international organizations promote a strong partnership model between host countries and visiting nurse volunteers or partners, the growth of unsustained short-term programs leaves ethical challenges and issues to be addressed (Crigger, 2008; Levi, 2009). Also, power imbalances persist among those receiving assistance and those providing it. Horton (2013) strongly, and correctly, condemns using the term partner in cases in which no partnership truly exists.

In our roles as global health nurse advocates and members of the Health Volunteers Overseas (HVO) Nursing Education Steering Committee, we have witnessed both strong, successful partnerships and partnerships that have faltered at various points. We believe that nurses seeking to develop or to enrich the global health partnerships they have already established will appreciate a model of partnership that includes practical considerations for ongoing development. Nurses serving in direct international clinical practice and nurse educators providing global learning opportunities for students, consultants, and researchers can also benefit from the theoretical foundation we provide and from the accompanying case studies. Reflective questions at the end of each case study can help stimulate critical and anticipatory thinking. We do not provide an extensive review of other readily available books that apply, more generally, to all health care providers. These books include global epidemiology of disease, international public health, infectious disease treatment, emerging infectious disease, and tropical medicine. Although such books are important as references for nurses who work globally, they do not focus specifically on nursing practice and the role of nurses in global health. We instead focus on the profession of nursing within the context of global health.

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Acknowledgments

The global health context is a rich environment in which to meet and learn from others. Our own experiences in global health and the outstanding global health work done by nurses we encountered in global settings inspired this book. We acknowledge our partners worldwide who advance health for people across the globe. This book has provided numerous opportunities for us to network and learn about the work of those who have contributed to this book. We deeply appreciate their willingness to share their experiences as they truly live the partnership process in global health. As co-editors, we have learned from each other as well, and our friendship has deepened over these many months of work.

We are grateful to the members of the Health Volunteer Overseas (HVO) Nursing Education Steering Committee for supporting and encouraging this project. The idea for this book grew out of a discussion from this committee as we recounted both success stories and “not-so-successful” stories. We committed ourselves to creating a forum for these stories and to providing guidance to others through chapters explaining the theory behind the stories. We express our special thanks to Linda James, project manager, for her support of nursing education at HVO.

Our family and friends gave us the fortitude to keep reading, writing, and revising throughout the publication process. Our global health work would not have been possible without the support of our families over many years. Jeanne is deeply grateful to her husband, Jim, and to her children—Matt and his family, John, and Annie—for their loving support. Michele greatly appreciates the support, patience, and love of her husband, Richard, and of her children, Leah, Jonathan, and Rachel. Both our families have stood with us no matter where in the world we have found ourselves living.

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Share

Global Health Nursing: Building and Sustaining Partnerships
Introduction and Perspectives of Global Health

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Globalization represents a paradigmatic shift in our relationships as individuals and as a nursing profession. We are now connected through the global economy, technology, and the larger sociopolitical environment across and within continents (www.globalization101.org). Globalization exemplifies our interdependence and requires a holistic view of our world. We are connected in myriad ways: culturally, economically, politically, psychologically, and spiritually (Crigger, 2008). Our understanding of health and the meaning of health for individuals and communities is also changing by the process of globalization. Health is no longer viewed as static, an either/or dichotomy with presence or absence of disease, but rather as dynamic and defined within the context of society. The World Health Organization (WHO) defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 1948, p. 100). But how is global health defined? How is it similar to or different from international health or public health? Can these entities be combined? If so, what are their synergies? Exploring these questions while reviewing historical development and nursing perspectives of global health provides the foundation for understanding a conceptual model of partnership for global health embodied by social justice and equity.

INTERNATIONAL HEALTH, PUBLIC HEALTH, OR GLOBAL HEALTH

No clear consensus exists differentiating international and public health from global health, so various combinations of the terms have been developed, such as international public health, global public health, and global health promotion (Fried et al., 2010; Khubchandani & Simmons, 2012; Merson, Black, & Mills, 2006). Often the term international health is used synonymously with global health, but a closer look at each of the definitions (including that of public health) is important to clear communication among disciplines (Campbell, Pleic, & Connolly, 2012) and, ultimately, to evaluating health outcomes across professional and geographical boundaries (Dyar & deCosta, 2013).

International Health

Traditional definitions of international health represent a concrete and perhaps static view of health with providers from resource-rich countries crossing borders to countries with few resources. Sharma and Atri (2010) view international health as “the science and art of
examining health problems in multiple countries, primarily those that are developing, and finding population-based solutions to their problems” (p. 6). Koplan et al. (2009) reviewed the concept of international health in their search for a comprehensive definition of global health and determined that international health efforts are targeted at low-income countries, and primarily at infectious diseases and maternal and child health issues.

These perspectives of international health illustrate what is referred to as a medical model approach to the world’s health challenges. The focus is on diagnosis and treatment with the goal of curing the health problem or disease. While this approach has benefited the world in controlling communicable disease, it has not been totally successful, and in fact it represents what Frenk et al. (2010) designate as a form of professional tribalism—one profession operating either in isolation or in competition with other professions. For example, poliomyelitis is endemic in Pakistan and Afghanistan (Sultan & Khan, 2013) despite ongoing community campaigns to eradicate it. Efforts to control poliomyelitis may be more successful if both medical and public health professionals used a more collaborative approach to address this health challenge rather than working alone.

Public Health

Public health may be viewed as a subset of international health in which local and national governments are concerned with the health of communities. Winslow (1920) published one of the earliest definitions of public health:

[T]he science and art of preventing disease, prolonging life, and promoting physical mental health and efficiency through organized community efforts toward a sanitary environment; the control of community infections; the education of the individual in principles of personal hygiene; the organization of medical and nursing service for the early diagnosis and treatment of disease, and the development of the social machinery to ensure to every individual in the community a standard of living adequate for the maintenance of health. (p. 30)

A more succinct definition from WHO (2013) is “all organized measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole.”

The American Public Health Association (APHA) defines public health from a disease prevention and health promotion perspective, inclusive of groups from small communities to nations. Policy and research are emphasized in order to understand and strategize priorities for health (www.apha.org/NR/rdonlyres/C57478B8-8682-4347-8DDF-A1E24E82B919/0/what_is_PH_May1_Final.pdf?gclid=CNqJ5trQ97cCF5sx7AodR2I/A2A). Currently, the three priorities of the APHA (www.apha.org/advocacy/priorities) include:

- Building public health structure and capacity
- Ensuring the right to health and health care
- Creating health equity

These priorities, approached from a multidisciplinary perspective, are concerned with issues of social justice and distinguish public health from international health and a medical model. Again, health is more than absence of disease. All populations are entitled to health, including the alleviation of forces, such as poverty, that degrade health. Merson, Black, and Mills (2006) combined international and public health in their definition of international public health: “the application of principles of public health to health problems and challenges that affect low and middle income countries and to the complex array of global and local forces that influence them” (p. xiv). The confusion among terms continues with attempts at defining global health.
Attempts to distinguish public health from global health and provide a comprehensive definition of global health are ongoing. Fried et al. (2010) declare that there is no differentiation and cite principles of “global public health.” Their core beliefs of global public health emphasize health for all with health seen as a public good that must be addressed using an interprofessional approach. Fried et al. (2010) note the interdependence of populations, such that by strengthening local populations the global health system will be stronger.

Other groups and individuals have also defined global health (see Table I.1). The definition of Koplan and colleagues (2009) has been widely accepted, but others view it as lengthy and unwieldy. Beaglehole and Bonita’s (2010) simpler definition views global health as building on national public health efforts and action based on research to support policy based on evidence.

In an effort to determine Canada’s strategic role in global health, the Canadian Academy of Health Sciences agreed on Koplan et al.’s definition of global health, but only after an inductive analysis of other definitions. Their analysis determined primary and secondary characteristics for any definition of global health. Primary characteristics included equity; a global conceptualization of health with the goal of health for all; causes or contextual factors of health such as the social, economic, and physical environment; means or methods for practicing global health; and solutions for addressing health issues. Secondary characteristics address the source of obligation for carrying out global health activities, typically resource-rich entities; a multidisciplinary approach defining the values and goals of the actors, or agents; and determining whether global health should be proactive or reactive or a combination of the two (Campbell, Pleic, & Connolly, 2012).

The definition and practice of global health is evolving despite lack of agreement on a single operational definition of global health (Khubchandani & Simmons, 2012). Rowson et al. (2012) frame the global health definition debates around three central aspects of a definition useful for educators of global health. In the first aspect, the object of knowledge, global health refers to the scope of problems and not just to geographical location. In addition, commonalities and differences need to be accounted for and are often related to context. For example, poverty occurs in all parts of the world, but knowing what causes poverty and how to address it requires knowledge of the local context.

### TABLE I.1 Definitions and Core Concepts of Global Health

<table>
<thead>
<tr>
<th>Definition</th>
<th>Core concepts</th>
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<tr>
<td>“. . . health problems, issues, and concerns that transcend national boundaries and may best be addressed by cooperative actions . . . goal of improving health for all people by reducing avoidable disease, disability, and deaths” (Institute of Medicine, 2009a, p. 5)</td>
<td>- Transcend boundaries</td>
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<td>- Cooperation</td>
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<td>- Health for all</td>
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<td>- Reduce disease, disability, death</td>
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<td>“an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide. Global health emphasizes transnational health issues, determinants, and solutions; involves many disciplines within and beyond the health sciences and promotes interdisciplinary collaboration; and is a synthesis of population-based prevention with individual-level care” (Koplan et al., 2009, p. 1995)</td>
<td>- Includes study, research, and practice</td>
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<td></td>
<td>- Improves health for all</td>
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<td>- Transnational</td>
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<td>- Determinants of health</td>
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<td>- Multidisciplinary</td>
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<td></td>
<td>- Interprofessional collaboration</td>
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<td></td>
<td>- Synthesis of individual care and population prevention</td>
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<tr>
<td>“collaborative trans-national research and action for promoting health for all” (Beaglehole &amp; Bonita, 2010, p. 1)</td>
<td>- Collaboration</td>
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<td>- Transnational</td>
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<td></td>
<td>- Combines research with action</td>
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<td>- Provides health for all</td>
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The second aspect of any definition of global health should address types of knowledge. Multidisciplinary approaches are critical to understanding the underlying social, political, and economic determinants of health problems. Global health is more than having an intervention to cure a health problem. Rather, health is interconnected to social, political, and economic context and thus requires a multifaceted approach.

Finally, the purpose of knowledge for global health must be considered. It is not enough to approach global health from the perspective of how it is practiced—we must also ask why it is practiced. This approach goes beyond simple acceptance of equity as the primary value in global health to require critical thinking about power in relationships and to question all values related to global health. Developing partnerships in working toward mutually agreed-on global health goals promotes a sense of power with others as opposed to power over others.

A BRIEF HISTORY OF GLOBAL HEALTH

Concern about health and communicable disease dates back to the ancient civilizations of Mesopotamia, India, China, Egypt, and Greek and Roman civilizations. The Romans in particular contributed to public health with the development of sewer systems and aqueducts, as well as a system of military medicine (Sharma & Atri, 2010). While care of individuals and populations have always been of concern to society, examining historical antecedents of health promotes understanding of the shift from international to global health (Brown, Cueto, & Fee, 2006).

Present-day global health is rooted in the history of international health and colonization. European expansion brought disease and deaths to those who were subjugated by colonial forces, with public health viewed as a means of creating more wealth through expansion of power. Controlling disease enabled colonial forces to keep the workers healthy enough to extract resources and enrich the colonial powers (Unite for Sight, n.d.).

Nursing was not immune to the forces of colonialism, as Racine and Perron (2012) note in their discussion of professional imposition or imperialism. They relate the experiences of 19th-century British nurses in what is now Sri Lanka as an example of an exotic view of “the other,” or cultural voyeurism. In their letters to the Overseas Nursing Association, these nurses wrote about the conditions of the hospital and their relationships with local providers. To be working in what was then known as Ceylon was an adventure, with the British nurses claiming superiority and emphasizing the difference between themselves and the locals. How different were these nurses from nurses and students of today who, without preparation in global health and cultural humility, perpetuate a similar attitude of distinction and superiority (Racine & Perron, 2012)?

WHO as a force for international health emerged from the precursor to the current United Nations, the League of Nations Health Committee; the United Nations Relief and Rehabilitation Administration; and the Paris-based L’Office Internationale d’Hygiène Publique in June 1948, the result of 3 years of meetings.

The Pan American Sanitary Bureau resisted integration into WHO and maintained its autonomy. Today, the Bureau is known as the Pan American Health Organization (PAHO) and is the WHO regional representative for the Americas. After being renamed in 1958, the agency focused its attention on controlling and eradicating infectious diseases such as smallpox, polio, and Chagas disease, developing research centers throughout Latin America to seek local solutions to local problems. More recently, PAHO has emphasized income inequity as a major problem affecting health (Fee & Brown, 2002).

Alma Ata Conference and Primary Health Care

During the 1960s, colonial powers ceded direct government control in many countries, with independence arising particularly throughout Africa. This new political environment
affected WHO and the world of international health as well. The discord between control of infectious disease and recognition of socioeconomic forces influencing health forced a transformation of WHO. Mahler, who served as the director-general of the WHO from 1973 to 1988, convened the Alma Ata conference in Kazakhstan in 1978, in which the Declaration for Primary Health Care was passed by the delegates and “Health for all in the Year 2000” became the rallying cry (Brown, Cueto, & Fee, 2006).

The Alma Ata Declaration affirmed health as a human right, recognizing the inequality of health among those living in low-resource and resource-rich countries. Economic and social development was noted to be of basic importance to achievement for all, with people having the right and responsibility to participate in their own health care. Primary health care was to address health at the community level and existed within a referral system beginning with local clinics and continuing to comprehensive, tertiary care centers. Specific elements of primary health care included health education, nutrition, safe water and basic sanitation, maternal and child health care, immunizations, treatment of common diseases, provision of essential drugs, and family planning (WHO, n.d.).

The shift of thinking from international health to global health began with the Alma Ata Declaration, but as the World Bank and the field of health economics emerged, the WHO began to lose its power and the forces of neocolonialism became increasingly evident. Developing countries turned to international lending agencies, bankrupting themselves and setting the health of their populations back by decades (Ruger, 2005). The World Bank replaced the influence of the WHO, which from 1988 to 1998 was plagued by budget crises and accusations of corruption. In 1998, under the leadership of Gro Brundtland, a physician and former prime minister of Norway, the WHO embraced a new vision of global health and finance, aligning public–private partnerships such as the Bill & Melinda Gates Foundation with immunization programs and the Roll Back Malaria campaign (Brown, Cueto, & Fee, 2006).

**Millennium Development Goals**

In 2000, world leaders gathered at the United Nations in New York City to adopt the United Nations Millennium Declaration. The declaration, now known as the Millennium Development Goals (MDGs), offers an outline and specific targets for ending extreme poverty by 2015:

- Eradicating extreme hunger and poverty
- Achieving universal primary education
- Promoting gender equality and empowering women
- Reducing child mortality
- Improving maternal health
- Combating HIV/AIDS, malaria, and other diseases
- Ensuring environmental sustainability
- Creating global partnerships for development

Although these ambitious goals will not be realized in 2015, progress has been made. For example, as more than 90% of children in poorer countries of the world were enrolled in primary school, a demand for more secondary schools has been created. In addition, the number of deaths of children younger than age 5 has decreased from 12.4 million in 1990 to 6.9 million in 2011. Clearly, more progress is needed, especially in sub-Saharan African countries, but the effects of developing strong global partnerships to implement the MDGs have been positive (United Nations, n.d.a).

The question remains, what will happen after 2015? Countries with few resources are experiencing the double disease burden of both communicable and chronic problems such as cardiovascular disease and obesity. The Committee on the U.S. Commitment to Global
Health convened by the Institute of Medicine (IOM, 2009b) made the following recommendations for advancing global health in the future:

- Scale up existing interventions, with the United States demonstrating leadership in addressing chronic health problems
- Generate and share knowledge through expanding research and evaluation efforts
- Invest in capacity building with long-term partnerships between foundations and corporations with universities, research centers, and health care systems in low- and middle-income countries
- Increase U.S. financial commitments to global health
- Engage in respectful partnerships

The case studies offered in this book provide a glimpse into the future of how the MDGs will be addressed and which direction should be pursued based on failed attempts and success stories. As a result of work in respectful partnership, goals may need to be redefined and revised along with the strategies for achieving those goals.

**GLOBAL HEALTH NURSING**

The more than 35 million nurses in the world represent the largest pool of health care providers (WHO, 2007). Nursing is well positioned to meet the challenge of global health. Nurses are responsive to the transitions of individuals and groups, including refugees and immigrants (Schumaker & Meleis, 1994), and health promotion and disease prevention are central to the role of the nurse as demonstrated through the work of Pender and the development of the Health Promotion Model (Pender, Murdaugh, & Parsons, 2006). Recognition of the determinants of global health is a central part of nursing’s holistic practice, and nursing students are taught to assess patients from a cultural, environmental, social, psychological, economic, and spiritual perspective. Nursing then is in an optimum position to face the challenges presented in global health according to the following definition of global health nursing:

Individual- and/or population-centered care addressing social determinants of health with a spirit of cultural humility, deliberation, and reflection in true partnership with communities and other health care providers.

Merry (2012) suggests that priority roles for nurses in global health include “advocacy, healing and alleviating suffering through caring, and increasing nursing capacity globally” (p. 28). Nurses should be and are advocates for patients at all levels—for the individual seeking health care as well as at the national and international levels through policy development. The nurse as healer and alleviator of suffering directly relates to health promotion and the provision of primary health care. MDGs of reducing child mortality, improving maternal health, and combating HIV/AIDS and other diseases are within the realm of nursing care.

The role of nurse as diplomat (Hunter et al., 2013) and the potential for nursing to be a primary force in global health diplomacy can promote global partnership. According to Novotny and Adams (2007), health diplomacy “is a professional practice that should inform any group or individual with responsibility to conduct research, service, program, or direct international health assistance between donor and recipient institutions” (p. 2). Nurses working in any setting, whether as volunteers or as paid employees, have the potential to act as health diplomats and promote partnership. Nurse researchers are also health diplomats and particular attention to ethical issues regardless of research setting is crucial to the nursing research role.

Increasing the capacity of nursing is central to the mission of a number of nursing organizations, including the International Council of Nurses (ICN) and the American Academy of Nursing (AAN), and thus merits a chapter of its own (Chapter 8). Position statements
from the ICN (1999) and WHO research on nursing mobility (2003) are reflected in the AAN’s proposed actions for addressing the global nursing shortage. These actions include conferences with world leaders for further action as well as conferences on global nursing and health research, creating a database and inventory of existing faculty and student exchanges, soliciting models for addressing global recruitment and faculty exchanges, collaborating with other international organizations and agencies, encouraging countries to develop policies of self-sufficiency for all health care providers, supporting technology and distance education, and taking an active role in policy and legislation supporting research funding (Rosenkoetter & Nardi, 2007, p. 313).

Ethical Positioning for the Practice of Global Health Nursing

An overview of the history of global health discusses nursing from a colonialist perspective and asks about nursing’s progress in an era of intense globalization. Nursing ethics have been taught in classrooms around the world, but do traditional ethical principles with their origins in deontology (i.e., following the rules and considering rights and duties) and teleology (or utilitarianism—considering the consequences and results of our actions) provide the guidance necessary in the context of global nursing partnerships? For example, what ethical guidelines are articulated when overseeing student and faculty exchanges? Virtue ethics applied to nursing seems to be a logical ethical stance for global health nurses. The desire to do good at home or across national boundaries is consistent with global health nursing. However, virtue ethics depends on context and the nurse must consider that what may be considered virtuous in one cultural setting may not be appropriate in another. Grace (2009) reminds us that there is no list of virtues that portrays a virtuous nurse and that “[c]ompassion for . . . suffering without knowledge of how to mitigate it and/or the motivation to alleviate is an empty virtue” (p. 80). Global health nursing must make progress in replacing the colonialist view of cultural voyeurism too often evident in global exchanges and clinical experiences with a more sustainable, inclusive perspective of global ethics (Crigger, 2008; Racine & Perron, 2012). Virtue ethics may offer some insight, but it is inadequate to address the reality of poverty and inequity in health care.

Davis and Tschudin (2008) remind us that “[w]hile it is extremely difficult for most individuals to have any impact on the development of globalization, it is possible for informed individuals working in groups and through various organizations to make a difference on specific aspects of this movement” (p. 6). How nurses make a positive difference in global health, beyond the position of “do no harm” and from the perspective of partnership, requires an understanding of human rights and social responsibility. Applying these concepts to global health nursing practice can facilitate the development of guidelines and best practices when working with students and health care providers in community to promote health.

Human Rights

The Universal Declaration of Human Rights adopted by the General Assembly of the United Nations in 1948 relates rights and health as follows (United Nations, n.d.b):

1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection. (Article 25)
Human rights and nursing’s flexibility in conceptualizing human rights provide a foundation for a global nursing ethics. Crigger (2008) identifies five qualities for developing global nursing ethics, one of which is identified as an openness to new approaches in human rights. Crigger suggests that combining the approach of Sen’s (2004) notions of freedoms with Nussbaum’s theory of human flourishing (1998) may promote consensus in defining human rights. The central human functional capacities for human flourishing identified by Nussbaum include:

- Having a normal life span—that is, one which is not short or impacted by poor quality of life
- Having health, sufficient food, shelter, intimate relationships, and relocation; security against bodily and emotional harm
- Being able to avoid pain and experience pleasure
- Having the ability to imagine, think, reason, and be educated
- Loving and being loved; experiencing human emotion
- Planning one’s own life . . . seeking work that is fulfilling and productive
- Being able to engage freely in social interactions
- Living in relation to animals and nature
- Playing and being able to experience recreation
- Leaving autonomously as one chooses with certain “guarantees” of non-interference (Crigger, 2008, p. 24)

Applying human rights to communities and population-based nursing care is the focus of rights-based public health nursing (Ivanov & Ode, 2013) and by extension, global health nursing. All actions of the nurse operating within a rights-based ethic of care should contribute to realization of human rights. Program development and policies in nursing must reflect understanding of the issues of health and social well-being with evaluation metrics providing assurance that human rights are not violated through nursing actions (Ivanov & Oden, 2013).

Social Responsibility

Nursing care is often focused at the individual level even in global health nursing. Shifting our thinking to the level of society must increase awareness of nursing’s responsibility to society as a whole. Nursing does have “a social responsibility to address those issues affecting the health of the world’s people, including concerns related to poverty, access to care in politically unstable climates, and environmental conditions affecting health” (Tyer-Viola et al., 2009, p. 110). The Nursing Social Policy Statement articulated by the American Nurses Association (ANA, 2010) also addresses the social responsibility of nursing by promoting quality health care for all individuals. At a macro level, concerns affecting the health of societies discussed by Tyer-Viola et al. (2009) include nursing migration and the global nursing shortage.

How nurses address the needs of society at a global level requires more attention and focus in nursing education. Service-learning activities are one way to promote awareness of social responsibility, but these types of projects must be designed with rather than for the community. Similarly, interest in providing global health experiences for nursing students has increased. However, we must ask who really benefits from these efforts. Some organizations such as the Consortium of Universities for Global Health (CUGH) directly address issues of equity and focus on long-term partnerships of mutual benefit to all (http://cugh.org/about-us). Other organizations have created best practice guidelines for developing and maintaining global health experiences (Crump & Sugarman, 2010). These efforts illustrate shared responsibility as the basis for creating partnerships (Dybul, Piot, & Frenk, 2012). Good intention is not enough in the practice of global health nursing. Global health nursing is not practiced in isolation but rather is realized only through partnership and mutual learning.
CONCEPTUAL MODEL FOR PARTNERSHIP AND SUSTAINABILITY

Nurses must ground their practice in scientific evidence to provide the most effective nursing care to individuals, families, and populations. When nursing practice extends to a global health focus, there is limited evidence to guide practice. Although some nursing research focuses on the health beliefs, health practices, and health outcomes of many population groups and diseases, the research has not examined the actual nursing role for effectiveness and ethics. The literature includes reports on the impact of global health experiences on the nurse or nursing student who works in a setting across national borders. However, these reports contain little measuring the impact on the host partner or the health outcomes (Bentley & Ellison, 2005; Casey & Murphy, 2008; Kulbok, Mitchell, Glick, & Greiner, 2012; Reising, Allen, & Hall, 2006). Central to all nursing practice is the relationship between the nurse and those cared for by the nurse. Due to the limited evidence to support global health nursing, we elected to use the Conceptual Model for Partnership and Sustainability in Global Health (Leffers & Mitchell, 2011), which is built on evidence from nurse experts in global health.

In a qualitative study to better understand the key elements of global health nursing, Leffers and Mitchell (2011) interviewed 13 global health nurse experts. The outcomes of analysis of the interviews led to the development of a conceptual model for partnership and sustainability. The nurse experts, whose experiences included roles as researchers, educators, clinicians, and consultants, all emphasized the importance of collaboration and partnership as well as the ongoing sustainability of the program or nursing intervention. Emergent themes include nurse partner factors and roles, host partner factors, resources, collaboration, cultural bridging, capacity building, organizational factors, leadership, partnership, and sustainability. The model shows the partner factors for partnership, the process for partnership, and sustainability of global health nursing interventions (see Figure I.1).

Nurses most often participate in global health endeavors through an organization, whether governmental, nongovernmental, or academic. As a result, the nurse factors that the individual nurse brings to the relationship, such as his or her cultural perspective, personal attributes, personal expectations, and knowledge of the host country, are also affected by the organization sponsoring the nurse role. Specific attributes that the nurse brings to the global health experiences include needs for personal comfort, space, and privacy; a spirit of adventure; flexibility; openness to the perspective of others; willingness to collaborate with others; and fears. Other nurse factors include the nurse’s particular skill set and expertise; expectations of the nursing practice role in the host country; and expectations of the people, lifestyle, and environment of the host country—as well as some degree of previous knowledge of the host country. Furthermore, the nurse’s ability to identify personal biases that impact cross-cultural collaboration is central to the nurse and host partner relationship. The mission and philosophy of the organization with which the nurse partner works will reinforce the individual nurse factors as noted above. For example, if the global health organization offers extensive orientation for nurse participants, the expectations and personal biases might differ from those of a nurse who receives no orientation (Leffers & Mitchell, 2011).

Equally important to the nursing role and nurse partner are those factors of the host country partners. Host country partner factors include expectations of outsiders, particularly those from the country where the nurse lives, expectations of nurses who come from other countries, the nursing role overall, and the influence of the political, social, economic, and environmental status of the host country on the host partners. Furthermore, in many low-resource countries, there is a history of colonialism that will impact the host partner’s relationship with nurses from other countries. The formation and quality of the partnership is affected by the interaction of the nurse partner factors and the host country factors.

Resources are essential to any program or project to improve health in global settings. Frequently nurses who participate in global health nursing experiences are from higher resource countries and are more likely to share material or financial resources with the host country partners. This might include bringing donated supplies, sharing nursing textbooks...
Process for Partnership

**Partner Factors**
- Nurse partners
  - Cultural perspectives
  - Personal attributes
  - Personal expectations
  - Knowledge of host country
- Host partners
  - Expectations of other (in this case U.S. citizens)
  - Expectations of U.S. nurses
  - Impact of social, economic, environment and political status of host country
  - Wants/needs

**Sustainability of Interventions**
- Program Factor Inputs
  - Design & Implementation
  - Community Assessment
  - Organizational Setting
  - Resources
  - Broader Host Community
  - Socioeconomic & Political Climate
  - Community Participation
- **Outcomes**
  - Improved health outcomes
  - Continued innovations
  - Program activities continuance
  - Host country ownership
- **Processes**
  - Adaptation & Change
  - Ongoing Assessment
  - Leadership
  - Collaboration
- **Processes**

**KEY COMPONENTS**
- Partners
  - Nurse Partners
  - Host Partners
- Resources
  - Human
  - Financial
  - Material

**FIGURE I.1** Conceptual Model of Partnership and Sustainability in Global Health (Leffers & Mitchell, 2011). Reprinted with permission.
or materials, or donating their time in service, consultation, or education. For the nurse partners there is often the need to finance the global health experience in part or entirely. Depending on the program, there is a need for necessary equipment and supplies on site in the host country. Material resources can include specific technical or legal support from the sponsoring organization or institution. Human resources include the nurse partner and any other health professionals who serve in the host country setting.

Various themes emerged that addressed processes for building relationships. In the model these are described as cultural bridging, collaboration, capacity building, and mutual goal setting. Together these processes culminate in partnership as an outcome. However, partnership is a process as well, resulting from ongoing interactions between hosts and visitors in global health programs.

Every nurse expert interviewed for the study spoke of culture as essential to any relationship between nurse and host country partners. Terms used by the experts included respect for cultural differences, cultural competence, cultural sensitivity, and language barriers. The literature also includes terms such as cultural humility and cultural safety (Foster, 2009; Polaschek, 1998). Leffers and Mitchell (2011) elected to use the term cultural bridging that was offered by one of the nurse experts. We use this term as well to address the reciprocity between the nurse partner’s cultural perspective and that of the host partners and the host locale. Furthermore, the term addresses the process of promoting cultural humility and cultural safety.

Collaboration is another process for partnership in the model. The term broadly addresses how both the visiting nurse partners and host country partners develop their goals and program outcomes, how they negotiate roles and responsibilities, and how they continue their ongoing work over time to achieve sustainability. In the model mutual goal setting is included separately because most of the participants spoke about setting goals as a distinct concept from collaboration. Often the discussion of mutual goal setting was part of the explanation of community and needs assessment. Collaboration as an essential element of partnership building involves related topics, such as the mandate for mutual respect; assurance that the nurse partners will base the goals on the host partners’ needs; and integration of knowledge of culture, host country resources, and limitations. The conceptual model includes collaboration as a process for both building partnerships and creating sustainability.

Capacity building is an essential element for partnership formation and maintenance. Nurses who participate in global health endeavors are likely to enter a partnership developed by the organization or agency that sponsors the program and are likely to become part of an ongoing capacity building project with host partners. This can be an effort to build capacity for nursing or patient education, for nursing research, or for organizational and professional management. In many settings, visiting nurse partners work directly with nurses from the host country—an ideal situation. Thus, the host country nurses are collaborative partners in all aspects of the program. Frequently, nurse partners work with community health workers or nonprofessional host partners. Due to the severe worldwide shortage of human resources for health, nurse partners are likely to be involved with the education and training of nonprofessionals to build the capacity of the host country to meet its own health care needs. Working with nursing organizations or associations is an excellent way to build capacity for health for the host country. In those instances in which nurses join a voluntary nongovernmental organization (NGO) that provides direct care in a low- or middle-income country (LMIC), nurse partners must examine the project to ensure that capacity building is an element of the work.

Relationship building can begin at an individual level between one nurse partner and a host partner who generally serves in a key role in host setting. More likely, the partnership is between a group of visitors, who may not all be nurses, and partners in the host country. For either type of relationship building, the nurse partners should learn or conduct their own community assessment or needs assessment relevant to their program or project. A comprehensive community assessment includes examination of the traditional and
existing health care practices and community members’ perceived health needs, as well as identification of the host country health care system, community strengths, cultural brokers, and community leaders (Anderson & McFarlane, 2004).

Sustainability has not been well developed in the nursing literature but is more commonly used in global health program planning. To plan for parasite programs in LMICs, the WHO (2002) defined sustainability as “the ability of a project to continue to function effectively, for the foreseeable future, with high treatment coverage, integrated into available health care services, with strong community ownership using resources mobilized by the community and government” (as cited in Amazigo et al., 2007, p. 2071). Shediac-Rizkallah and Bone (1998) add key elements for sustainability that include “(1) maintaining health benefits achieved through the initial program, (2) continuation of the program activities within an organizational structure and (3) building the capacity of the recipient community” (p. 93). The Conceptual Model for Partnership and Sustainability in Global Health (Leffers & Mitchell, 2011) defines the formation and maintenance of partnerships as being essential for sustainability of programs. Outcomes of sustainability include improved health outcomes, continuance of the program or continued innovations, and transfer of ownership from a shared state to host partner control.

ORGANIZATION OF THE BOOK

Using the Conceptual Model for Partnership and Sustainability in Global Health (Leffers & Mitchell, 2011) to guide the focus of this book, we decided to combine chapters and case studies discussing not only what the reader can learn about global health nursing but also how to use principles of global health, partnership, and nursing to guide collaborative global health nursing practice. Each chapter is followed by one or more case studies from the lived experience of the authors that highlight aspects of the chapter topic. The case studies include examples from nurses whose focuses were on consultation, research, education, academic partnerships, and service. Reflective questions follow each chapter and case study.

Chapter 1, “Selecting and Negotiating Partnerships for Collaboration,” discusses the importance of program selection and early partnership experience. In this chapter we discuss types of existing partnerships and how nurses make the selection of an appropriate program to begin a partnership. Specific topics include matching philosophy, mission, and goals. We also discuss how nursing and personal roles are established and maintained during the initiation of a relationship and over time. We speak to how nurses maintain professional roles while building personal relationships with host partners. Using examples of how nurses locate an organization such as Health Volunteers Overseas (HVO) or how an academic or clinical program locates and builds collaborative relationships, we offer guidance for the early partnership experience. We offer comparisons between nurse-to-nurse consultation for education and practice and programs that involve nursing students. The first case study, contributed by Nancy Kelly, executive director of HVO, highlights the mission and goals of an organization, describing how an organization selects programs for nurse participation globally and how the nurse volunteer is integral to the overall partnership in host countries. The additional two case studies provide a student perspective of selecting a graduate program, detailing the experience of being an international student, while the third case study focuses on a locally based U.S. project with global implications.

Chapter 2, “Nurse and Visiting Organization Factors for Global Partnership,” addresses how cultural perspectives, personal attributes, expectations, and knowledge of host country influence a volunteer nurse’s experience. We address issues of language barriers, interpreters, and the need for language knowledge prior to working in-country. Also, we include information about how the expectations of the organization represented by the nurse impact the partnership. We include a discussion of the organizational vision/mission and the overall return benefit expected by the organization. Michele J. Upvall’s first case study illustrates nurse factors related both to the nurse as
a volunteer and to the mission of HVO in Bhutan. The second case study, authored by Jeanne M. Leffers and Gale Hull, uses an example of an academic partnership between a college of nursing in the United States and an NGO based in the United States that partners with health professionals in Haiti to meet health needs there. Specific issues related to student, faculty, and nurse mentor expectations, preparation, and in-country experience show the importance of culture, language, knowledge of host country, and personal attributes for building and maintaining successful partnerships.

Chapter 3, “Nursing Practice and Licensure Across Borders,” addresses nursing practice issues that extend beyond geography. Nursing roles in host country are addressed, community assessment as essential knowledge is highlighted, and we specifically address ethical issues when nurses practice in host countries, such as the importance of nursing licensure, mutual respect, and partnership. In addition, we address practical issues, such as health promotion while traveling, and travel requirements such as passports and visas. The chapter and case study authored by Diane C. Martins and Alicia J. Curtin describe a long-term collaboration between nurses and nursing students from the United States who partner with local community partners in the Dominican Republic.

Chapter 4, “Host Partner Factors for Partnership and Sustainability,” considers factors that the host partners bring to the relationship. Examples include their experience with volunteers or partners from the United States or elsewhere, differences in the scope of practice between nursing partners, and the role of the nurse and nursing profession in host countries. We discuss the impact of social, economic, environmental, and political factors on the host partners, the role of traditional medicine, and social determinants of health. The chapter and case study by Nancy Hoffart, Jenny Vacek, Myrna A. A. Doumit, Judy Liesveld, and Debra Brady highlight host factors in the development of a nursing school in Lebanon.

Chapter 5, “Resources for Global Health Partnerships,” emphasizes the importance of resources, whether human, material, or financial, that are essential in developing a partnership. Nurse partners from higher income countries frequently contribute resources to the host partners. We discuss the importance of appropriate selection of resources with consideration of sustainability and fit to the cultural needs in the host setting. Emphasis on the host partners’ and resources’ needs and constraints guides nurses to prepare effectively for global partnerships. We discuss how to seek funding for projects. The case study contributed by Sarah E. Abrams shows how a partnership between a university in the United States and an NGO in Uganda addresses their partnership in relation to the resources available and the resources required in the host setting. In addition, she highlights factors related to student participation in the project that impact required resources.

Chapter 6, “Capacity Building for Global Health Nursing,” provides an overview of capacity building. In particular, we discuss how partners work together to use the human, organizational, and scientific resources of the host setting to strengthen the skills, competencies, and abilities of the host partners. In addition, we discuss how to modify interventions based on area resources. The case study by Marie J. Dreiver, Valentina Sarkisova, Natalia Serebrennikova, Barbara Mandleco, and Janet L. Larson shows how the partnership between nurses from the United States and Russia helped build capacity among nurses to conduct nursing research.

Chapter 7, “Bridging Cultures,” addresses the essential requirement that nurse partners seek to bridge cultural differences with respect and cultural humility. We discuss how nurses demonstrate respect for host partners, for example, through communication and dress. We emphasize the importance of mutual learning among all partners. The first case study, by Jessica Larrett-Smith and Luisa Barton, speaks to the topic of culture from the perspective of First Nations in Manitoba, Canada. The second case study, contributed by Jacqueline Maria Dias of the Aga Khan University in Pakistan, addresses how cultural bridges were built between the university and other hospitals and programs throughout the country.

Chapter 8, “Collaboration With International Organizations,” addresses specific issues involved with collaboration across international organizations. This includes how nurses work with a ministry of health in another country and the role of nurses who work with
NGOs. We emphasize the importance of empowering and engaging global nursing leaders in other countries. In particular, we discuss the issues involved when an academic institution develops a partnership across international borders and the need to collaborate with a variety of organizations. The first case study by Julia Plotnick describes the importance of working with nurses to facilitate and strengthen nursing organizations globally. In particular, her experience helping local nurses build their nursing associations in Romania during the 1990s and in Rwanda in 1995 demonstrates the importance of nursing organizations. The second case study, by Anne Slaney and Catherine Uwimana, features the collaboration among the Clinton Health Access Initiative, the Rwandan Ministry of Health, and the Rwandan Nurses and Midwives Association for the Rwandan Human Resources for Health program.

Chapter 9, “Making Collaborative Research Work,” discusses important aspects of nursing research in international settings. Nursing evidence is essential for the advancement of nursing practice worldwide. Increasingly, nurses are involved with nursing research across international borders. This chapter explores issues of culture, the effect of nurses from high-income countries conducting research in low- and middle-income countries (Harrowing, Mill, Spiers, Kulig, & Kipp, 2010), and ethical considerations for international research (Ketefian, 2000). The case study by Linda Ciofu Baumann features a research partnership to improve diabetes care in Uganda.

Chapter 10, “Maintaining Partnerships Through Leadership,” explores the elements of sustainability to address the leadership required to maintain the partnership, how visiting partners must step back and support leadership by host health care providers, and how to continually monitor and assess the project. The first case study, from Marilyn Lotas of Case Western University and Marcia Petrini from Wuhan University in China, describes the development of the relationship of the schools of nursing and the challenges of collaboration. The second case study, written by Leah J. Hart, Peter Johnson, and Geoffrey Menego from Jhpiego (an affiliate of Johns Hopkins University), discusses challenges from the perspective of an NGO working in Kenya.

Chapter 11, “Ongoing Project Support,” examines what happens when volunteers return home. The chapter addresses strategies to maintain long-term relationships through the use of technology (including e-health and m-health) to support partnerships when the visiting nurse partners return home. The need for resources for support is also reviewed. The first case study, by Ruth McDermott-Levy and Miguel Angel Estopinan, features a collaborative project in Nicaragua to build the capacity of community health workers using cell phone technology. The second case study, contributed by Jeanne M. Leffers, Speciosa M. Mbabali, Rose Chalo Nabirye, and Scovia Nalugo Mbalinda, highlights how the Internet and communication technology can foster ongoing relationships with host partners in Uganda when the nurse partner returns home.

Chapter 12, “Sustainability of International Nursing Programs,” discusses long-term projects that have ended with their outcomes achieved. In particular we speak to the continuity of program activities led by the host partners. The case study by Mary E. Riner and Marion E. Broome outlines their collaboration to re-establish nursing education in Liberia.

Chapter 13, “Host Country Ownership,” describes the outcome goal for host partners for collaborative projects. The ultimate goal of all projects where visiting partners from higher income countries collaborate with host partners from low- or middle-income countries is host country ownership of the project or programs. This chapter examines this goal in light of program sustainability. The first case study, by Jill B. Derstine and Pamela Hoyt-Hudson, features collaboration between faculty from Temple University in the United States, Hue University in Vietnam, and the Dreyfus Health Foundation. The second case study, written by Manila Prak of Cambodia, shares the challenges to host country ownership in a case study describing a hospital-based in-service program in Cambodia.

In the Conclusion, “Moving Forward for Global Health Nursing,” we draw conclusions and make recommendations for the future of global health nursing.
REFERENCES


CHAPTER 1

Selecting and Negotiating Partnerships for Collaboration

Elizabeth Downes

To create and develop without any feelings of ownership, to work and guide without any expectation and control, is the best quality. 

Lao Tzu

Nursing has a long heritage of seeking to improve health and prevent illness through collaboration and partnership. Libster (2011) points to nurse-led partnerships with governments, medical and religious communities, hospitals, colleges and universities, and other organizations spanning hundreds of years. As long ago as the 17th century, the Daughters of Charity, one of the earliest established nursing programs, grew from a partnership between a priest named Vincent de Paul and a woman, Madam Louise de Marillac, to care for the sick (Libster, 2011). In the nearly 400 years since the founding of the Daughters of Charity, nursing has extended from caring for the sick in their homes to full engagement in global health partnerships. Nurses have always worked to improve health and achieve equity in health. Global health is defined by Koplan et al. (2009) as:

an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide. Global health emphasizes transnational health issues, determinants, and solutions; involves many disciplines within and beyond the health sciences and promotes interdisciplinary collaboration; and is a synthesis of population-based prevention with individual-level care. (p. 1995)

This example demonstrates the longstanding involvement of nursing in successfully partnering toward health promotion, illness prevention, and care of individuals and populations. This chapter discusses the initiation of a partnership and explains how nursing and personal roles are established. It also explores important components of seeking a partnership, approaching potential partners with whom you have never worked, and dealing with unrealistic expectations while in a host country.

The American Association of Colleges of Nursing (2010) compiled a summary of literature on successful partnerships in nursing that is congruent with the Leffers and Mitchell partnership model (2011). Central to these partnerships are:

- Mutual trust and respect
- Communication
Shared vision
Commitment

These components are not necessarily separate and distinct steps, but rather mutually supportive and interdependent aspects of successful partnerships. For example, the process of creating a shared vision can strengthen (or weaken) a trusting relationship. Trust can support open communication and vice versa. However, each of these components is worth discussing separately.

**MUTUAL TRUST AND RESPECT**

Partnerships are voluntary collaborative agreements wherein parties agree to work together, sharing benefits and risks as well as competencies and responsibilities. Wheeler (2012) compares trust to trusting relationships. Trust is defined as “a psychological state in which positive expectations are held regarding the motives and intentions of another actor” (Ruzicka & Wheeler, 2010, p. 70). A trusting relationship involves acting on that trust and has been defined as “one into which actors enter in order to realize benefits which would otherwise not be available to them. They do so in the knowledge that this increases their vulnerability to other actors whose behavior they do not control, with potentially negative consequences for themselves” (as cited in Wheeler, 2012). Although it is important that nurses maintain professional roles, trusting relationships with host partners are key to successful partnerships.

**Personal Relationships**

Research on successful partnerships points out that it is helpful to have a personal relationship. In fact, personal relationships can be foundational to a partnership (Beal et al., 2011; Breslin et al., 2011). It is interesting to note that Mikhail Gorbachev pointed to the personal relationship he and President Ronald Reagan developed as being essential to ending the Cold War. In his memoirs, Gorbachev called it “the human factor” (as cited in Wheeler, 2012). Many articles on partnerships in nursing, especially articles addressing programs abroad, speak to the importance of face-to-face contact (Breslin et al., 2011; Hope, 2008; Sostman et al., 2005). Furthermore, visiting the location can also help build context for the collaboration. These interactions can go a long way toward developing comfort and trust.

For effective interpersonal relationships, it is important to share information about yourself and, if applicable, the institution you represent. There must be a clear understanding of all partners’ roles and responsibilities. The process of establishing these roles is discussed in subsequent chapters. However, it is important to keep in mind that governments and institutions are not capable of entering into personal relationships. Embedded trust can develop from personal relationships and extend to the institutions (Notter, 1995). This, in turn, can facilitate expansion in terms of participants and programs. Although embedded trust can be a distinct benefit (as is evident in the relationship between Gorbachev and Reagan), it will not substitute for personal face-to-face interaction. That is not to say that a partnership should be limited to two or three individuals. In fact, a web of relationships can strengthen the partnership and facilitate sustainability—but initially it may start with one or two motivated individuals.

**COMMUNICATION**

Good communication is essential to successful partnerships. According to Ross (in Kanani, 2012), “Partnership failures can usually be linked to some level of miscommunication. This can range from misperceptions about the objectives, expected results, operating approaches and/or roles and responsibilities” (p. 2). Clearly, communication means more than just
language. Diversity in language, cultures, and perspectives is to be expected when working globally. And as diversity increases, so do the communication challenges.

Working with partners from other cultures requires cultural humility and fluency, as explained elsewhere in this book. Culture can have a powerful effect on communication. Anthropologist Edward T. Hall’s theory of high- and low-context culture can help anticipate challenges in communication (Hall, 1976). Although we are all individuals, we are acculturated from a very young age. Hall’s theory of intercultural communication can help when used as a general approach for communication. For example, high-context cultures (Latin American, African, Asian, Mediterranean, Slav, Native American) are generally cultures of few words. Much is left in between the lines, to be understood through context and nonverbal clues. People from high-context cultures generally are collectivist, intuitive, and relational, valuing interpersonal relationships. Low-context cultures (North America and Western Europe) value communication that is straightforward and direct. People from these cultures are individualistic, logical, and action-oriented (Fussell, Zhang, & Setlock, 2008; Goman, 2011). Views on time can also affect communication. Cultures that have a sequential approach to time speak of it almost as money (“waste time,” “spend time,” “save time,” even “buy time”). Synchronistic cultures do not see time as something to be bargained for, but rather as something to be experienced. The work of Triandis (1995) added the dimension of task versus relationship orientation (whether people focus on accomplishing tasks or on establishing rapport). The additional challenge of computer-mediated communication (CMC) can potentiate these challenges. Fussell, Zhang, and Setlock (2008) show that cultural background affects CMC. This reinforces the need for face-to-face encounters in developing partnerships. Studies on partnerships point to the need for open and free communication (Beal et al., 2012; Bosworth et al., 2006; Breslin et al., 2011; Everett et al., 2012; MacPhee, 2009). This can be more complicated when relying on CMC but is worth the extra effort.

**SHARED VISION**

**Shared Decision Making and Problem Solving**

Partnerships are driven by a need or desire to accomplish something that a partner cannot accomplish alone (Long & Arnold, 1995). This begs the question, “What is the goal of the partnership?” This is the first step of the initiation phase. The other two phases (execution and closure/renewal) are all based on the goal. All stakeholders must be involved in the initiation phase. Understanding and sharing each other’s mission and values provides a foundation for developing congruent goals for the partnership. Personal expectations of the partners are explored in the next chapter.

In her book *Expanding the Pie* (2012), Susan Rae Ross posits an eight-step “Partnership Decision-Making Process,” depicted in Table 1.1. Six of the eight steps are related to the initiation phase, an indication of its importance. Although Ross’s work was developed specifically to facilitate work between businesses and nongovernmental organizations (NGOs), the steps outline key considerations when entering into any partnership. Step 1, “conduct an internal assessment,” is appropriate for large and small organizations—even individuals. What are your reasons for entering into this partnership? What can you bring to the partnership? If you are part of a larger organization, does the effort dovetail with your broader mission? This self-exploration will help you to move through the identification of partners (Step 2) and with your approach to selected partners (Step 3). What is the basis for the partnership? Can individual goals of each partner be aligned?

Step 4 (due diligence) is essential to both creating a shared vision and developing trust. It also aids identification of any potential risks to the partnership. It is important to recognize that partner incompatibility is a potential pitfall. Why does this partner wish to engage with you? What are the risks? Are there any conflicts of interest? What do you know about the partner organization’s structure and decision-making processes (Cohen, 2003; Ross, 2012)?
The Community-Campus Partnerships for Health (CCPH), based out of the University of Washington (http://depts.washington.edu/ccph), provides a rich resource for partnership development that can be adapted even if neither partner is university based. CCPH speaks of the “glue” that holds partnerships together. This can include policies, procedures, and processes developed in collaboration. But the first principle of partnership is to have a shared mission. Cauley (2000) lists three stages in the development of a partnership—identification, development, and maintenance—and cautions against trying to rush the mission statement.

As stated above, the process of articulating a shared mission can provide opportunity to build trust. As with Ross’s work, begin with, What do I bring to this partnership?

Green-Moton, Palermo, McGranaghan, and Travers (2006) give an example of an exercise that may aid the development of a shared vision. It is designed for both small and large groups:

Participants take 15 minutes to generate a list of key words and phrases that characterize a common vision for their partnership(s), based on the issue(s) they are addressing or hope to address. Small groups report what they have listed and the large group identifies common themes.

COMMITMENT

After the initial work is done and the partnership is developed, the hard work of sustaining commitment to the partnership begins. During this time it will be necessary to “check in” with partners. It is particularly important to be aware of power inequities that can develop.
(Green-Moton, Palermo, Flicker, & Travers, 2006; Tierney et al., 2013). As partnerships evolve, it may be necessary to restate the mission and revise policies, procedures, and processes. There may even be an opportunity for expanding or contracting the partnership itself. It is always important to remain inclusive even at the risk of expedience—it is at this point that the trusting relationship gets further reinforced through open communication and sustained commitment.

Over time, partnerships can be expected to evolve. The evaluation process can be used to strategize and plan for sustainability. Process evaluation is normally done to monitor a program (e.g., number of immunizations given, number of patients served, number of students taking part in an exchange program). In addition, process evaluation offers the opportunity to revisit the mission and policies and to monitor the health of the partnership. Resources for developing process evaluation questions can be found through the various websites of the Centers for Disease Control and Prevention (www.cdc.gov/healthyyouth/evaluation/pdf/brief4.pdf) and the CCPH (http://depts.washington.edu/ccph/cbpr/index.php).

Process evaluation can determine whether goals and objectives are well aligned. Anonymous surveys or reflective discussions can help identify areas of strength and for growth. However, threats and weaknesses will also be identified and should not be ignored.

When problems arise in partnership, it is important to address them. Conflict resolution is rarely simple. Add a cultural dimension, and things are further complicated. The process of team development is well known to nurses (forming, storming, norming, and performing). Research on teams indicates that successful teams are comfortable dealing with conflict and are committed to, and learn from, resolution.

Unfortunately, that research was done on mostly North American organizations. For some cultures, the group is more important than the individual. Harmony and group conformity is sought, sometimes at the expense of personal interests. Although everyone may seek to avoid conflict to some degree, persons from individualistic societies may be more direct in dealing with conflict (“meet it head on”; “take the bull by the horns”). In fact, culture may determine whether conflict even exists. An elderly Chinese man in Canada denied having had any conflict at all in the past 40 years. Consistent with his Confucian upbringing, he saw the world with a vision of harmony rather than of conflict (LeBaron & Grundison, 1993).

In her essay “Culture and Conflict,” Michelle LeBaron speaks of cultural fluency as “a key for disentangling and managing multilayered, cultural conflicts” (LeBaron, 2003, para. 25). In addition to awareness of distinctions in communication as articulated by Hall, cultures have different ways of “naming, framing, and taming” conflict. It is important to understand the context of a perceived conflict. Cultures have different ways of meaning-making, and not knowing these may make it easier to attribute negative motives to a behavior.

Working to develop partnerships across cultures can be rewarding and challenging. How we approach the partnership and whether the inevitable changes involves “recognizing and acting respectfully from the knowledge that communication, ways of naming, framing, and taming conflict, approaches to meaning-making, and identities and roles vary across cultures” (LeBaron, 2003, para. 25).

As stated above, partnerships are voluntary collaborative agreements wherein parties agree to work together, sharing benefits and risks as well as competencies and responsibilities. This voluntary nature of relationships does not mean, however, that partnerships are self-sustaining. The steps toward negotiating and maintaining a relationship are succinctly elaborated by Ross (2012) in Table 1.2. Through a literature review and interviews with NGOs and business leaders, Ross has identified 10 elements of a partnership agreement that include everything from creating a shared vision and maintaining communication to deciding to end a partnership.

**INTERNATIONAL STUDENT EXPERIENCES**

All the elements for developing a partnership are necessary for a successful international student experience. However, as these types of experiences become more common, special attention should be given to promoting true partnerships among students and faculty. Kulbok,
### TABLE 1.2 Elements of Partnership Agreement

<table>
<thead>
<tr>
<th>Partnership area</th>
<th>Key questions</th>
<th>Key considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formality of the agreement</td>
<td>How formal/informal should the partnership be?</td>
<td>Memoranda of understanding (MOUs) may or may not be legally binding.</td>
</tr>
<tr>
<td>Vision</td>
<td>What is the vision of the partnership?</td>
<td>Does it benefit everyone? Has everyone “bought into” the vision?</td>
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<td></td>
<td>What is the effective time frame of the partnership?</td>
<td></td>
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<tr>
<td>Partnership objective</td>
<td>What are the objectives of the partnership?</td>
<td>Objectives should be SMART (specific, measurable, achievable, realistic, and time-bound).</td>
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<tr>
<td></td>
<td>How does each organization contribute to the objectives?</td>
<td>Agreement on key indicators, as well as how they will be measured, is essential. For example, will the partners use third-party auditors or independent evaluators?</td>
</tr>
<tr>
<td>Roles and responsibilities of each organization</td>
<td>Clearly identify the assets and resources each partner will provide, including financial human resources, skills, products, office space, intellectual property, and networks.</td>
<td>A specific scope of work statement can be included in the body of the agreement or provided as an attachment.</td>
</tr>
<tr>
<td>Exchange of resources</td>
<td>If either partner is going to provide specific resources to the other partner, such as a grant, then the funding amount and activities should be clearly articulated, along with payment agreements, schedules, and reimbursement policies. This can be discussed in the agreement, and a separate legally binding document can be developed and attached.</td>
<td></td>
</tr>
<tr>
<td>Partnership management</td>
<td>How will the partnership be managed?</td>
<td>This may be as simple as agreeing to a monthly or quarterly meeting in which to approve activities and monitor progress. It should include who should be represented at the meetings, responsibilities for note-taking, and communication among the partners.</td>
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<tr>
<td></td>
<td>Is a specific structure required? What systems are needed to support the partnership?</td>
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<td></td>
<td>Which department or staff will be the key liaisons for the partnership?</td>
<td></td>
</tr>
<tr>
<td>Partnership decision making</td>
<td>How will decisions be made between partners?</td>
<td>Use of intranet, newsletters</td>
</tr>
<tr>
<td>Partnership communication</td>
<td>How will partners communicate within their organizations?</td>
<td>Updates from partner meetings</td>
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<td></td>
<td>How will the partners communicate with each other?</td>
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<td></td>
<td>How will the partners communicate externally?</td>
<td>What information can be put on each partner’s website?</td>
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(continued)
TABLE 1.2 Elements of Partnership Agreement (continued)

<table>
<thead>
<tr>
<th>Partnership area</th>
<th>Key questions</th>
<th>Key considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What permissions are needed from each organization to allow their partner organization to use their logos?</td>
<td>What is the approval process for each organization’s discussing the partnership with external parties?</td>
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<tr>
<td></td>
<td>Co-branding?</td>
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<td></td>
<td>Who owns the data about the partnership? With whom can the data be shared?</td>
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<tr>
<td>Grievance/Dispute process</td>
<td>What are the levels of grievances?</td>
<td></td>
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<td></td>
<td>How will each level be settled?</td>
<td>Mediation vs. arbitration</td>
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<td></td>
<td>Who will represent the organization in a dispute process?</td>
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<tr>
<td></td>
<td>What makes a fair grievance?</td>
<td></td>
</tr>
<tr>
<td>Termination parameters</td>
<td>Under what conditions can either organization terminate the partnership?</td>
<td>What type of notification is required to terminate the partnership?</td>
</tr>
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</table>

Mitchell, Glick, and Greiner (2012) reviewed the literature on student international experiences from 2003 to 2010. Their findings highlight the need for published reports that discuss two-way exchanges between students of higher and lower income countries. Too often emphasis is placed on the student from the high-income country going to another country with a high UN development index rating (e.g., European countries, Australia, Japan, Norway) rather than countries considered low-income that are struggling with the issues of poverty and other social determinants of health. Second, published reports of the student experience should include authorship from the country hosting the international student. Including authors from all countries involved in the partnership can increase the capacity for conducting research and developing scholarship. Third, all students, including those from the host country, should receive additional education addressing the cultural differences among all the partners. Finally, experiences that extend beyond the university setting should be considered partnership opportunities for students. Students can benefit from working with NGOs and other agencies active in low-income countries. There is tremendous opportunity for international student partnerships that challenge students to extend themselves beyond providing basic clinical procedures, moving them away from “us and them” to true partnerships.

Three case studies follow that highlight the processes of selecting and maintaining partnerships. The first case study provides the perspective of an NGO, Health Volunteers Overseas (HVO), in developing relationships with partners outside of the borders of the United States. Practical information on the process of volunteering is shared, including the role of volunteers and dealing with the challenge of continuity.

The second case study offers the perceptions of an international student pursuing a doctoral degree in the United States. Having a dream, facing the reality of living and studying in a land completely different from her home country, and wondering how her life will be changed when she returns home are all discussed in a spirit of openness and honesty. Themes from this case study can be compared to the research of the Arab/Muslim international student experience from entry to the United States to reentry in the home country by McDermott-Levy (2011, 2013).
The final case study focuses on a community partnership in existence for over 20 years. Although this partnership has evolved over the years, some of the pioneering individuals are still involved, as are some of the original institutional partners—but the program itself has expanded.

REFERENCES


CASE STUDY 1.1

Selecting an International Project Site: Health Volunteers Overseas

Nancy Kelly

CONTEXT

It is generally recognized that one of the most serious systemic problems in the delivery of health services in developing countries is the lack of appropriately trained health care providers. The World Health Organization focused on this problem in its 2006 World Health Report, Working Together for Health, and Health Volunteers Overseas (HVO), a private non-profit organization dedicated to improving the availability and quality of health care in developing countries through the training and education of local health care providers, is actively addressing this concern (www.hvousa.org/whoWeAre/mission.shtml). By investing in education and training, HVO is focusing on building local capacity and empowering local health personnel. A key concept underlying the implementation of all of HVO’s projects is that of sustainability.

HVO has developed a series of dynamic institutional partnerships with a wide variety of nongovernmental organizations, government ministries, and teaching institutions around the world (for a list of these partnerships, visit www.hvousa.org/whereWeWork/institutions.shtml). These partnerships are the result of years of relationship building and provide HVO with the opportunity to develop and sustain its educational programs. The initiation of a new partnership may come from one of several sources—a HVO volunteer may recommend pursuing an opportunity with a new organization, or HVO may receive a request from an organization that has heard of HVO’s work in other settings. It is not uncommon for a facility to seek additional projects in other program areas after a project has been successfully established and the value of the educational input has been demonstrated. For example, HVO recently established a series of new projects (nursing education, physical therapy, and orthopedics) at a hospital in Bolivia. The request came from a contact who had previously worked with HVO at a hospital in Cambodia. Her familiarity with HVO’s mission and her understanding of HVO’s methods were critical factors in her decision to ask HVO to consider this new partnership.

HVO depends on the commitment and skills of dedicated volunteers to accomplish its goals. These volunteers bring different backgrounds, experiences, and perspectives to their assignments but all share a commonality: HVO volunteers understand that the long-term solution to the health care problems found in developing countries depends on the training and education of the health professionals in those countries. Faced with serious resource constraints, as well as an immense burden of disease, developing countries must deal with enormous needs in the health care sector but have limited ability to educate and support the workforce needed.
HVO operates under the premise that only through the development of local expertise and institutional capacities will countries be able to handle the healthcare challenges they face. Countries must develop the expertise to identify and address their own healthcare problems and to create their own appropriate solutions. The training and education of health professionals is the critical component in this process. Projects must be carefully planned from the outset. Resources in developing countries—whether human, financial, or technological—are extremely limited, and demands for basic services go unmet. Planners thus must rationally, practically, and efficiently allocate these scarce resources based upon realistic objectives and sensible priorities.

Good Intentions Simply Are Not Enough

We must look critically at the needs of a country to decide what can reasonably be accomplished at a site within a certain time frame. Then we must ask whether HVO is the organization best suited to undertake the project. These are difficult questions that are sometimes glossed over or ignored entirely in the initial enthusiasm of starting a project. Unfortunately, this can result in a disappointing project with few tangible results, disgruntled volunteers, and little in the way of long-term effects.

THE HVO MODEL

Unlike many organizations involved in international development and relief efforts, HVO relies almost exclusively on short-term volunteers to staff its projects. The short time frame of the assignments (generally 1 month) facilitates the participation of many medical, dental, and health professionals who would otherwise be unable to share their knowledge and skills overseas.

What are the fundamental components of the HVO model?

1. HVO projects are developed, monitored, and staffed by volunteers, HVO’s primary resource.
2. Projects are designed to share knowledge and skills with professionals in developing countries.
3. Volunteers are encouraged to teach skills that are appropriate to a given country’s level of development and with an understanding of the serious competition for resources that exist in this setting. The use of appropriate technology and local materials will lessen the developing country’s dependence on a foreign organization.

Basic Parameters

Over the years, HVO has learned that there are certain conditions that must be present in order to facilitate the development of a new project. Without these conditions in place, an HVO project, no matter how needed or wanted, simply will not work.

First, a certain amount of political stability is essential to setting up an effective training project. Consider the realities of starting a project in a country mired in a difficult and draining conflict. Will personnel be able to participate in training activities under these circumstances? The government or local hospital authorities may not be able to spare them from active duty. They may be physically unable to come to the training site as a result of fear and intimidation. They may wonder what the point is of additional training, seeing that they have no supplies, no equipment, no support staff, no money, and, most importantly, no hope for the future.

Second, there must be local support at all levels for the initiation of an HVO project. HVO should not be seen as a threat or as an avenue of professional advancement at the expense of others. Too often, expatriate volunteers become pawns in the local politics found
in any medical or educational institution. This can be avoided through a careful assessment of the degree and strength of local support. If the dean or any other person in a leadership position at a potential project site is against a project being started, that person’s feelings should be taken into serious consideration. This lack of interest or support can translate into serious problems when the project is being implemented.

Third, the primary language of instruction must be English, or else adequate translators must be available at the site. Although some HVO volunteers are fluent in other languages, HVO is not in a position to undertake a training project in a country where volunteers need to speak French, Portuguese, or other non-English languages unless funds are available for translation services.

Fourth, volunteers must want to go to a site. A project, no matter how well designed, will be a complete failure if no one signs up to go. This lack of interest is often the result of perceptions (and misperceptions) about a country or the result of strong emotions generated by a past event. Repeated wars, floods, famines, and other natural or manmade disasters can create an image of despair and desperation that leads volunteers to think that their efforts will be for nothing.

Finally, volunteers must believe that their time and efforts are going to make a difference. This must hold true throughout the volunteer experience—before, during, and after their service. For most HVO volunteers, their assignments are life-changing experiences that broaden their understandings of the world, of their profession, and of their own capabilities. As one HVO volunteer wrote in a post-trip report:

I think I have become not only a different person but a better person because of this opportunity. My eyes were opened to a whole new world where a population doesn’t have much in regards to resources but has a lot of heart and graciousness. (Jantzi, 2008)

Successful Selection of a Site

The process of identifying a possible project site and assessing the viability of a potential partnership is a critical first step in the design of a project. This phase of the project development requires a significant investment of time and requires that the site assessor have strong communication and cross-cultural skills as well as a commitment to key values and concepts such as partnership and mutual respect, mutual goal setting, and collaboration. HVO’s mission is grounded in the concept that capacity building and sustainability are the keys to long-term effects. Working from that premise means that all HVO projects are by definition partnerships involving intense collaboration between HVO and the host institution and the personnel at the site. Decisions about the design of the project—what to teach, whom to teach, how to teach—must be the product of dialogue between the partners. This dialogue needs to be open, frank, and ongoing. This can be a challenge in a cross-cultural setting where linguistic differences may contribute to miscommunication or where cultural or social expectations are not in alignment.

A critical part of the assessment is asking a series of open-ended questions and listening carefully to the responses. Asking follow-up questions for clarification is essential. By the end of the assessment, the following questions should have been answered:

- Is there a genuine need?
- Is the project desired by the intended beneficiaries?
- Do the objectives of the project fall within the scope of HVO’s mission?
- Is the project likely to achieve its objectives?
- Is the project technically appropriate and economically viable?
- Will the project survive the test of time? Will it be sustainable?
- What are the constraints? Can they be overcome?
It is also important when planning a training project to determine whether the problems being addressed can be resolved through education and training. Many training projects attempt to address problems that really result from a lack of resources, not inadequate skills.

HVO projects are to be established with the full knowledge, support, and consent of the host government and institution. HVO attempts to ensure that each project is consistent with the national strategy for health and human resource development. HVO projects should complement the existing health structure and reinforce national health priorities and goals.

**Project Design**

After this input has been gathered and assimilated, the next step is to start conceptualizing the project. Again, this should be a collaborative process with input regarding whom should be trained and the type of training/education needed. Any independent training effort should be fully integrated into the country’s health and education systems to ensure that those who participate are appropriately recognized and compensated. It does no good to teach someone new skills if he or she is not allowed to use them.

There will need to be discussions about what kind of volunteers are needed to staff the project—type of experience, years of clinical experience, emphasis on clinical or teaching credentials, and so forth.

Finally, there should be agreement on how to define success. What changes (both short-and long-term) are expected in terms of attitudes, behaviors, knowledge, skills, or level of functioning of the beneficiaries? What will be the effects of this project?

**Develop Goals and Objectives**

After these components have been identified, develop an explicit set of goals and objectives. This requires determining (1) a time frame for the project and (2) a realistic assessment of what can be accomplished in that time frame—the intended results.

These goals and objectives will serve as a yardstick to determine whether the project has been successful over time. Evaluation of a project is impossible without clearly defined and quantifiable goals and objectives. Setting goals and objectives should be done in consultation with the developing country partners. They need to agree with and be supportive of the proposed activities. If there is only lukewarm support for these goals and activities, the project is not likely to succeed.

Goals and objectives should be reviewed annually and, if necessary, revised to ensure that they match site needs and situational changes. Projects in developing countries are often subject to unexpected problems or constraints. Rather than ignoring these developments, a realistic reassessment is critical to be effective.

Objectives should be simple, clear, and easy to understand and quantify. Both HVO and the partners must have a clear understanding of what the project will accomplish over a specific period of time—2, 3, or 4 years—and annual reviews are necessary to determine whether a project’s design needs to be modified or totally revamped.

**Project Implementation**

After HVO and its partners have defined the project, it is time to roll it out. As with the design and development phases, it is essential to communicate frequently with partners in the field to ensure that what was envisioned and discussed is in alignment with the actual implementation of the project. The same cross-cultural sensitivity, active listening, and attention to the collaborative aspect of the partnership is just as necessary during this phase of the project as it is in the design phase.
One of the keys to a successful project is to ensure that volunteers are properly briefed and that they have access to appropriate background materials as part of that process. HVO has addressed this need by creating an online platform, the HVO KnowNET, that serves as a central repository of documents, orientation materials, class notes and lectures, assessment reports, and curricula. Prospective volunteers can read past trip reports, access contact information from recent volunteers to a site, and participate in online discussions. Access to the extensive materials on the HVO KnowNET, combined with conversations with the project director, staff, and other returned volunteers, serves to frame expectations for the volunteer. Realistic expectations are critical to a volunteer’s ability to be effective once at the site.

**CONCLUSION**

HVO has developed a reputation for designing strong, effective clinical education programs in developing countries that successfully use short-term volunteers. It must be acknowledged, however, that there are some serious limitations to the HVO model, including issues related to continuity of volunteer coverage and coordination between volunteers. There can be problems with volunteers adjusting to the challenges at a site—both on personal and professional levels. Proper vetting and briefing of volunteers is an essential component of this process, and most issues are related to inappropriate expectations or misplaced assumptions.

There are limited resources in developing countries to support the training and education of health care professionals. Educational materials that are taken for granted in the West (textbooks, journals, access to the Internet, models, charts, slides, and the like) are usually not available or are woefully out of date. There are few, if any, opportunities for continuing education for clinicians in the field, nor any real opportunities for faculty development. Health care providers often work in professional isolation, unable to network or communicate with other professionals in nearby countries faced with similar problems and constraints.

Against this backdrop of significant need sometimes comes a tendency to think that input from any organization or well-meaning (and qualified) health care professional is of value. After all, resources are so scarce that surely something is better than nothing. There is ample evidence in the literature and plenty of anecdotal evidence from well-meaning but flawed projects that have been in fact a barrier to progress (Easterly, 2007; Maren, 1997; Moyo, 2009; Riddell, 2008).

**A Focus on Resiliency**

HVO continues to focus on developing resiliency, seeking partnerships to leverage the synergy that occurs through collaborative efforts. Working together, HVO and its partners are building resiliency in individuals, in professions, and in health care systems. With each new development, HVO is striving to improve the availability and quality of health care for patients in resource-scarce countries. Ultimately, of course, it is the patients—both current and future—who benefit.

As one HVO trainee stated,

> After knowing HVO’s work, I saw that I could do more. There was hope and there are things that we have managed to change. The training aspect is the most exciting and the most important. (Nakakeeto, 2011, p. 3)

**REFLECTIVE QUESTIONS**

1. The author outlined several preconditions that must be present at an institution under consideration. Are there any other preconditions you would add to this list? What, and why?
2. What do you foresee as possible difficulties in making a site assessment to determine whether an institution might be a viable project site?
3. How might cultural competence, language barriers, and cultural differences affect your ability to accurately assess the information you collect?
4. Why do you think setting “realistic expectations” is so important to a volunteer’s ability to be effective during his or her assignment?

REFERENCES

CASE STUDY 1.2

Seeking Higher Education: From Egypt to the United States

Nermine Elcokany
Azza Hussein

It takes much courage to decide to live in another country far from home for an extended period of time. It becomes even more complicated when differences in language and culture are so vast. For me, Nermine Elcokany, the nursing profession is what provides cohesion with my nursing colleagues despite these differences. I hope my story of how I decided to come to the United States for further study and my experiences dealing with tremendous cultural change will give courage to others who are thinking about making this same change. To begin, it is important to provide a sense of the different worlds of nursing, academics, and women in Egypt compared to the United States.

CONTEXT: NURSING IN EGYPT

History

Egypt was colonized by the British people from the end of the 18th century to the mid-19th century, and trained nurses from England and France were working in the hospitals at that time. British physicians also replaced Egyptian professors in medical schools across the country, establishing a tradition of English as the language of choice for medical and university education (Ma, Fouly, Li, & D’Antonio, 2012).

Throughout this period, nursing involved two levels of education. The first level of education included students who joined nursing school after completing the 9th grade of education. These nurses worked as nursing assistants or aides. The second level of education involved 5 years of graduate training with these nurses, called Hakima. After graduation, they were licensed to practice nursing and midwifery or physical therapy (Ma et al., 2012).

Nursing Education in Egypt Today

There are seven types of nurses in Egypt, but three types dominate. The first level is at the secondary level of education. Students can join these schools after completing 9 years of elementary preparatory education. Nursing in these schools is taught by qualified nurses (those who have a bachelor’s degree of nursing) and some physicians who teach the medical courses—for example, anatomy and physiology. These high schools are controlled by the Egyptian Ministry of Health and Population and provide markets with nurses equivalent to auxiliary nurses. The students who join these schools are usually from poor families who select a fast and cost-effective way of working and practicing...
nursing. The curriculum in these schools is not based on strong clinical reasoning or a theoretical base for nursing skills. The subjects taught are basic sciences of physics, chemistry, biology, health education, hospital administration, nutrition, and psychology, in addition to fundamentals of medical, surgical, obstetric, and mental health nursing. The curriculum in these schools is taught in Arabic in addition to an English-language course and requires the students to spend 3 days in hospital practice and 3 days in class each week (Farag, 2008; Ma et al., 2012).

After completing this program, the students should apply for the nursing license and join the Egyptian Nursing Syndicate. Employment is guaranteed to those nurses after at least 2 years of nursing practice in the governmental hospitals in a particular geographic location selected by the Egyptian Ministry of Health and Population (MOHP). Some graduates choose to join the technical nursing institute, considered a higher level of nursing education; others choose to practice as general nurses. Some nurses apply for 6 months of training to be specialized nurses in a specific area—for example, anesthesia, surgery, or normal labor and delivery. The secondary technical nursing education is considered the largest source of nursing graduates, providing approximately 94% of the available nursing workforce (El-Noshokarty, 2004). Moreover, those nurses are very young, ranging from mid-adolescence to young adulthood; the MOHP has identified these nurses as not being adequately prepared.

The second category of nursing education is carried out in the technical health institutes. The study at this level consists of 2 years of education and, after completion, on to general secondary school or nursing secondary school. This type of education was established in Alexandria in 1972 and in Cairo in 1973. The graduate gets an associate degree from one of these institutes. It is controlled by the Egyptian Ministry of Education. The courses taught in this curriculum are more in-depth than those in secondary nursing education.

In 1955, the Higher Institute of Nursing was established in Alexandria as the first higher institute in the Middle East and Africa. It was established by an agreement between the faculty of medicine and the World Health Organization (WHO). The teaching staff consisted of five visiting American nurses and a director assigned by the WHO. It was affiliated with the Faculty of Medicine. In 1992, the Supreme Council of Egyptian Universities granted independence to the Higher Institute of Nursing from the Faculty of Medicine (Ma et al., 2012). The institute, directed by the Egyptian Ministry of Higher Education and Scientific Research, offers a baccalaureate degree of nursing. It consists of a 4-year program in addition to 1 year of internship offered by the nursing faculties in collaboration with university hospitals. The bachelor’s degree is not awarded to the nursing students until they have completed the internship year. In the internship year, the student receives a small stipend and each month practices in different units affiliated with a university or teaching hospital. Each student is under the supervision of an assigned preceptor on different shifts and is evaluated each month before moving to the next month of practice or continuing in the same practice for another month.

Some faculties of nursing also offer three postgraduate programs—diploma, master’s degree, and doctorate degree—in nine nursing specialties. The diploma program takes 1 year after the bachelor’s degree. The master’s program takes from 3 to 4 years after the bachelor’s degree or the diploma degree. The doctorate program takes 5 years after earning the master’s degree.

Implications for Advancement of Egyptian Nursing

Nursing in Egypt is a skilled profession that has seen little change over the past 30 years. The primary challenges in nursing are centered on education, performance, accommodation, an image that is not highly appreciated, and a lack of motivation due to low salaries and incentives. The existing weaknesses in legislation regarding nursing have left nurses with minimal social and human rights benefits (WHO, 2012, www.emro.who.int/images/stories/cah/fact_sheet/Nursing_Profile.pdf).
The challenges facing nursing in Egypt are addressed through the collaboration between the Egyptian MOHP, the WHO, and other partners and universities who provide technical and financial support. Among these challenges are ensuring and supporting the upgrading of nurses’ performance in the health services through education and reviewing and updating existing regulations through supporting existing nursing syndicates (WHO, 2012, www.emro.who.int/images/stories/eah/fact_sheet/Nursing_Profile.pdf).

Obstacles to Nursing Advancement in Egypt

Achievement of goals is important, but many obstacles impair the advancement of professional nursing in Egypt, which in turn may inhibit personal goal acquisition. The obstacles that impair the advancement of nursing are similar to those faced in other countries: supply and demand for nurses, education level of nurses, long hours, working conditions, and low wages (Rashdan, 2007).

Supply and Demand for Nurses

One of the obstacles affecting the nursing workforce is the supply of nurses. “Egypt suffers from a severe shortage in the number of nurses in hospitals and public clinics. There are 276 nurses for every 100,000 people” (United Nations Development Program, and the Institute of National Planning, Egypt, 2005, p. 76). The distribution of nurses is not equal throughout Egypt. Unfortunately, there is a severe shortage in the governorates of Upper Egypt (rural area). The WHO (2006) estimates that approximately 2.36 million health care providers will be needed to deliver health care. Without action from countries addressing the supply and demand, the shortage of health care providers will worsen.

Education Level of Nurses

As we mentioned before, the majority of Egyptian nurses are diploma graduates from the nursing secondary schools (El-Noshokarty, 2004). In addition, they are very young. As a result of the multiple levels of entry into practice and various ages associated with admission to programs, there is a lack of role delineation for each graduate, which creates the mentality of “a nurse is a nurse.” It may be beneficial to determine the minimum level of entry into practice. To accomplish this task, there is a need to open channels of communication with all nursing education venues to ensure a sufficient number of nursing faculty possessing advanced degrees and willing to educate the professional nurse (Rashdan, 2007).

Long Working Hours

The research clearly documents staff nurse fatigue and its impact on patient safety (Balas et al., 2004; Rogers et al., 2004). Studies link fatigue to slow reaction times, lapses of attention, and errors of omission that compromise problem-solving ability (Tabone, 2004). In Egypt, nurse fatigue exists due to the shortage of nurses to handle the number of patients and the long hours worked because of the lack of enforcement of labor laws (Rashdan, 2007). The schedule of technical nurses sometimes contains 30 days of night shifts, which can be exhausting.

Working Conditions

Due to the financial constraints that face some hospitals and clinics in Egypt, especially those belonging to the governmental sector, some basic supplies can be unavailable, such as gloves and hygienic products for hand washing, which can lead to a high turnover of nurses (Farag, 2008; Rashdan, 2007).
Low Wages

In 1999, wages stood at 116 Egyptian pounds per month at minimum, with an average of 928 Egyptian pounds per month during 2004/2005. Many foreign companies related to Gulf hospitals offer high wages (10 times more than standard Egyptian wages) to attract workers (American Chamber of Commerce in Egypt, 2008). In some governmental hospitals, nurses who double a shift can get only 90 piasters, which is frustrating (El-Noshokarty, 2004).

After the Egyptian revolution of January 25, 2011, all Egyptian nursing categories have called for salary increases to counter high living expenses. The MOHP is currently responding to the call for improved wages.

A Call for Advancement in Egyptian Nursing

In order to meet the dynamic demands of Egypt’s booming population growth, there is a need to increase the number of competent professional nurses that are available to deliver health care. More attention should be paid to educating nurses to allow them to broaden the impact of nursing knowledge in a hospital or clinic, similar to how a pebble ripples across a body of water (Rashdan, 2007).

Regulation of Practice

A clear and specific Nursing Practice Act defining the scope of nursing practice that defines professional nursing is important to advancing the nursing profession in Egypt. Development of a Nursing Practice Act will safeguard the public health by shielding the public from unqualified and unsafe nurses. Creating a Nursing Practice Act will define entry into nursing practice, specify the scope of practice, and establish disciplinary procedures (Rashdan, 2007).

From Syndicate to Nursing Board

After graduation from the nursing secondary schools, technical nursing institutes, or the faculties of nursing, the graduates have to register automatically in the nursing syndicate to legally practice nursing in the hospitals. This syndicate is responsible for providing service of all the nurses all over the country. It provides social activities and workshops—continuing education programs that can help nurses improve their practice. Sometimes ceremonies are held to honor exemplary nurses from around the country. Nurses in Egypt are not required to pass a board exam to practice nursing.

Encouraging the Egyptian Nursing Syndicate to adopt an agency mission is very important. However, the nursing board needs to be responsible regarding all nursing practice–related issues in Egypt. This can offer protection to the citizens of Egypt and promote their welfare by ensuring that each person practicing as a nurse in the country is competent to practice safely. Moreover, the Egyptian Nursing Syndicate should adopt and enforce rules that regulate the practice of professional nursing, establish standards of professional conduct for those nurses who practice nursing in Egypt, and determine the health activities constituting the practice of professional nursing. The nursing board should delineate the scope of practice for each level of professional nursing (Rashdan, 2007).

Advancement and Growth of Continuing Education Programs

On successful completion of the nursing exam conducted by the MOHP in Egypt, nurses hold a lifetime license to practice. Consider a paradigm shift in the practice of nursing whereby continuing education is a requirement to maintain and continue practicing as a nurse within Egypt. Continuing education can be required, thereby to assure the public that
each nurse has current and updated knowledge of nursing science and the skills necessary for protecting the safety of patients receiving nursing care. Education is the most powerful weapon we have for changing the world (Rashdan, 2007).

**Foster Curriculum Changes in Nursing Education Programs**

Nurses are trained as generalists with little time spent in specialty areas. Curriculum changes will be required. Education should be learner-focused rather than teacher-centered. Curriculum changes need to incorporate the subspecialty areas—for example, oncology nursing, pediatric nursing, and neonatal intensive care nursing (Rashdan, 2007).

**Perform Needs Assessment in Current Nursing Education Programs**

It is important to perform an assessment of academic institutions to assess the number of graduates per year and their anticipated capacity of students. A needs assessment should be completed to analyze the fundamental needs of nurses and the locales of learning institutions. Educational programs are not meant to teach everything to students but rather to provide them with the skills to learn how to find information through problem-solving accomplished with simulation laboratories, clinical decision modules, critical thinking scenarios, and integration of evidenced-based practice (Rashdan, 2007).

**Improve the Image of Nursing in Egypt**

Nurses must continue to improve the image of nursing in Egypt by demonstrating to the public the professionalism of nurses there. Positive media coverage of events could make use of newspapers, magazines, television, or other forms of media. Nurses must seize the opportunity to highlight their contributions by writing letters to the editor to discuss what nurses do and how important nurses are to the delivery of health care for the people of Egypt. Nurses must position themselves at strategic levels of policy decision making to help develop policy and legislation to benefit the image of nursing and impact the delivery of health care (Rashdan, 2007).

**Advance Gender Roles in Nursing**

Nursing in Egypt is primarily a female occupation, and very few men are admitted to nursing programs in the university sector. In 2007, the Egyptian military sector graduated its first class of male subofficers, with a graduating class of 60 nurses. The employment of male nurses represents a positive advance in gender roles for Egypt (Rashdan, 2007). Male nursing students joined university nursing education in 2004. This has helped nursing become a more gender-balanced profession. Females continue to dominate the profession, and male nursing students display a lack of desire and enthusiasm attributable to the image of nursing in Egypt and a general feeling that nursing is a female job. From our experience with our nursing students, it was difficult for a male to become a nurse, taking on what is considered a female job. In the beginning, male students felt ashamed to tell others that they would be nurses, but after the first group of students graduated and entered the workforce, this image began to change, and male students are now more positive about the profession.

**Challenges to Egyptian Health Care Within the Context of Culture**

There are many challenges within any health care system, and cultural context always plays a role regardless of country. In Egypt some of the factors influencing health and the nursing profession include:
Female patients prefer to be examined by a female physician, especially for gynecological or obstetric purposes. Women feel shy and embarrassed talking about private issues like sexual issues with a male physician, so they prefer female doctors.

Egyptian patients like to hear good news about their health, but if they have a serious illness, it is better to report the seriousness of illness and its consequences to a selected member of the family.

Most Egyptian people don’t seek medical care unless they are in need. They don’t like routine checkups, lest they discover a disease—though the educated people have regular checkups.

Herbal medicine use is a common precursor to seeking medical advice.

THE DREAM: STUDYING NURSING ABROAD

In light of the challenges to nursing in Egypt, as a nursing educator, I was looking for new information that I could apply in my field. I wanted to develop my career, expand my nursing skills, and learn more about conducting nursing research. My story began 5 years ago when I started to think of studying nursing abroad. These years were spent comparing nursing in my country (Egypt) and nursing in Western countries. I had many ideas about nursing abroad from the media as I watched the television series *Grey’s Anatomy* and *ER*. They motivated me to practice nursing in my country and I noticed in these series that the nurse has an important role in the medical team. Essentially, the media and Internet were the instigators of my search.

AWARENESS AND SEARCH FOR INTERNATIONAL PROGRAMS OF STUDY

My first problem was to find a university for study. To do this, I contacted many universities to find a professor who matched my area of research. A second problem was to find a way (grant or scholarship) to cover my study and living expenses. The Internet was the only way
to look for a professor who matched my specialty in critical care nursing with an emphasis on pulmonary problems. In Egypt, I was a student in the PhD program at the University of Alexandria and had completed the coursework and data collection for my dissertation. The studies I envisioned would add to what I had learned and enable me to take this information back to my country.

I contacted many schools of nursing in the United States, and each school suggested another school for me. I was surprised to find that they read e-mails from people abroad. I felt that the nursing professors were helpful and willing to attract international students and help them succeed. After I found a professor (Dr. Leslie Hoffman) at the University of Pittsburgh, I was in contact with her for more than 18 months before receiving my scholarship. My dream then was not just to come to the United States as a visiting scholar, but to earn a degree in the United States. The value and quality of studying in the United States is well known and includes exposure to advanced technology in research, teaching, and nursing practice.

At our university, located in Alexandria, Egypt, we usually receive many announcements about scholarships, grants, and exchange programs between our university and other universities. The scholarship that I applied for was offered by the mission sector, which was managed by the ministry of higher education and scientific research. Major requirements for receiving support included being an assistant lecturer at the university, being younger than 30 years old, obtaining professor acceptance from a foreign university, having an acceptable TOEFL score, and completing the PhD coursework, along with other requirements. I learned that prior successful applicants were primarily from the medical field and other majors, such as engineering, agriculture, and veterinary medicine. Undeterred, I submitted my application. I was finally accepted during the revolution of January 25, 2011, 10 months after I applied. The scholarship provided me a small stipend to cover my living expenses.

Next came the process of obtaining a visa, and for that, I needed to journey to Cairo from my hometown of Alexandria, a 135-mile trip (3 hours by car or train). I had to leave at 5 a.m. each morning to arrive at the visa office at 8 a.m., but I persisted through all the paperwork and the required interview process.

EXPECTATIONS AND FEELINGS ASSOCIATED WITH STUDYING NURSING IN THE UNITED STATES

When first arriving in the United States, I had mixed feelings that included happiness and worry. I was happy because it was one of my dreams to go abroad, but at the same time I was worried about the language. In Egypt, we study nursing in English, but we do not use English when speaking with each other. Therefore, we learn a more formal way of speaking that does not include slang or common expressions used with each other. I was worried that I would be misunderstood by the people around me, including my advisor, if I didn’t catch the correct meanings of words. In addition, I worried about being away from my family and was concerned about the weather in a different climate. Before traveling to Pittsburgh, I had not been in a country with four distinct seasons, and I had never experienced snow.

REFLECTIONS ON IMMERSION IN A NEW CULTURE

Personal Feelings

I thought that living in a culture totally different from my home culture would be difficult. I was also concerned about communicating with different people. I decided from the start that as long as I was in a different country with a different culture, I must respect new rules, beliefs, and cultural differences. This attitude helped me a lot. At first, I was happy and impressed with the change. However, I did not feel that I truly “fit in.” My culture shock was not evident to the people around me, though. I knew my name, where I was living, and
who I was talking to, but at the same time I felt I had some clouds in front of my eyes. I was a little bit confused, but I was also excited by this new experience and new environment. I felt I had finally seen the other half of the world.

I was fortunate that I attended a class in my PhD courses in Egypt about cultural diversity. I remembered what our professor, Dr. Amany Gamal El-Din, said when she explained the concept of culture shock in detail. She had also earned her PhD from the University of Pittsburgh, so she was able to transfer her knowledge and experiences to me. I spoke with her often before leaving, and she gave me the idea of what life would be like in the United States.

In the beginning, I was excited and happy, feeling I had “made it.” I did what I was dreaming of: I came to the United States, my dream, but this enthusiastic moment didn’t last forever. After all the excitement, enjoyment, and happiness I initially experienced, I felt loneliness, homesickness, frustration, and anxiety and had trouble concentrating and being organized. I started to blame myself and wonder why I had come.

I missed my family and friends. I blamed myself for not reading more about American culture before arriving. The hardest thing for me was to understand what Americans were saying in the street. English is not my native language, and I found American slang extremely difficult. I was no longer able to express myself the way I wanted—this was the hardest adjustment for me.

Everyday life activities were different for me as well, and required significant adjustment. Transportation in the United States is different from in my home country. I solved this problem by trying to get the bus with friends and learning the maps for going from place to place. I found it funny that the people who were using maps included both international students and American citizens. I didn’t use a map in my country but found doing so was normal in the United States. When I went food shopping, I could not find what I liked, especially traditional Egyptian food, and I found myself using different units of measurement. I didn’t have a conception of an ounce, a pound, or a degree Fahrenheit—we usually use kilograms for weight, centigrade for temperature, and liters or milliliters for volume. The coins were also difficult for me to distinguish. Which coin was higher in value? I couldn’t find numbers on coins, so I assumed that the larger in size, the higher the value. Unfortunately, I learned, there is the dime! Over time, though, I learned the differences between coins and at the same time was encouraged by the new things I was learning—I liked the challenge and the new experiences I was having.

Socializing in the United States

There are big differences in social situations in Egypt and the United States. For example, in the United States I found that hand shaking is common when anyone is introduced. In my country, male friends can hug each other. In the United States a man can hug a woman, which is something not allowed in my country. I found that Americans have a very high degree of transparency. For example, on the bus, I can listen to an entire story told by someone speaking with a loud voice. In my country, we keep things private and say little in public.

I also observed that Americans like to have frequent parties in their houses. In addition, they go many places on weekends with others to the nearby park or stores, enjoying their day off. They use their weekend time to the maximum. I also found parks well equipped for many activities, which I found strange at first but now think amazing.

Because Egyptian culture is very different from American culture in many ways, in the time I have been in the United States I have also changed internally. I found that in the United States, people do not have time to look at each other or to judge each other, so they can do as they like in the street without any comment or judgment from nearby people. In Egypt, public behavior is judged by others. For example, clothing is different, for many reasons—such as religion, gender, and weather—influencing dress in Egypt. Most of the women in Egypt cover their body completely. If a woman has uncovered any of her body parts, she will be seen as attractive to people in the street, whether male
or female. For some this is in accordance with Islamic doctrine, but Christians also usually cover their bodies. Wearing shorts can be seen as disrespectful even in hot weather, except in some places such as beaches. Finally, another notable difference in social life is dealing with becoming an adult. Egyptian girls and boys are cherished and looked after by their parents until they get married, regardless of age. In the United States, however, it is possible to find many young persons living independently away from their families while unmarried.

Academic Life in the United States

I was shocked when I found that some students refer to their professors by name without using a title such as “doctor”—something not accepted in my country. In Egypt, I use my colleagues’ titles when saying their names. This is viewed as respectful to one’s senior colleagues. Also, in Egypt as a sign of respect, one does not speak to an older man or woman without adding “uncle” or “aunt” to the name.

Freedom in the classroom is also worlds away from my experience. For example, in Egypt we can’t sit in front of the teacher with crossed legs. To do so is considered disrespectful to the teacher—students who do so are considered impolite or thought to have grown up in a poor environment. In the United States, students are free to just sit or to do another activity while attending class. Students may eat in class or engage in other activities while attending the lecture. For example, I attended a class with PhD students and found one of the students knitting while attending the class—and the professor didn’t comment, leading me to consider this commonplace. But such students also engage in lecture discussions while doing these things—meaning that they are fully concentrating.

I was eager to gain experience from the United States and to know more about the actual practice of nursing. I asked my mentor to find an undergraduate course I could help teach as a volunteer in the lab or in the hospital. This was a great opportunity for me to learn more about clinical teaching, and my mentor facilitated this as well as other experiences, always offering to help me even without my having asked.

I gained experience in clinical teaching in the hospital by dealing with patients, seeing the hospitals and their many different machines, working with different categories of nurses, and seeing how nurses deal with the patients—and also dealing with different students. One memorable event was hearing the nurses sing to the patients before discharge. My initial impression was that the hospitals are like hotels, they are so advanced and so comfortable. Nurses here are required to do everything for the patients and it seems they have time to provide psychological support as well as physical care. They are talking, singing, smiling, and listening with the patients. I am now assured in my belief that the psychological aspect of care is more important than the physical part and can help in recovery.

Unfortunately, in Egypt nurses have multiple duties and responsibilities. First, we don’t have respiratory therapists, so our nurses perform all the pulmonary activities patients need. Second, we have few or, at times, no nursing assistants. Egyptian nurses are also required to care for the mechanical ventilator and the other machines. All these responsibilities add stress to the nurses and can lead to burnout.

Observing and Adjusting to Life in the United States

As part of becoming adjusted to life in the United States, I started to observe everything around me, trying to collect ideas about Americans and American culture. One significant observation that continually amazed me was that I found Americans to always seem happy and positive. Their reaction to different situations is totally different from what I am used to in my country. I’m not sure whether this is a result of the natural environment—with all the green land in Pittsburgh—or whether all Americans behave so.
I also started to find people from other Arab countries, including Egyptians, to help me in my adjustment. Many are immigrants here and gave me hints about the culture and American people. I could see that they were happy, and they were a support to me, helping me realize that I’m not alone here in such a different culture.

After 5 months, I started to adjust. I used my sense of humor to adjust and I found help from others. My American academic advisor gave me a lot of support, guidance, and direction. I felt understood by my advisor. For example, she was driving us somewhere and a male Indian student started to sit beside me in the car, but she asked him to sit in the front seat instead. I can’t express the great feeling of happiness that I felt in that situation. I was so happy that my advisor recognized that sitting next to a male student was not considered appropriate in my culture and handled the situation so smoothly.

I also found many of my fellow students here to be totally independent, and so I started to be more independent. I lived for a long time with students from different cultures, including China and Russia, and being with them helped me deal with people in general. We were exchanging cultural differences together. I do find that people in Pittsburgh are friendly and welcoming toward international students.

CONCLUSION

In nursing education, students learn about differences between cultures and religions, so the teachers, students, and classmates probably knew a little bit about my traditions. I remember when I attended a clinical session with the undergraduate students in the simulation center and the teacher gave them many scenarios about different cultures and religions and how to deal with these differences. These activities help nurses deal with humanity with extra care and inspire others to serve without discrimination. I will always remember when I was in my undergraduate class on nursing ethics. The first rule I learned in the code of ethics was to accept the patient as he or she is, regardless of race, religion, and culture.

I like Americans, and yet I know that during my stay I was touched by only a few sides of America—in particular, academic and professional life. My perspectives are subjective, and I know I cannot uncover everything about the United States during my brief stay of 18 months.

I have seen a number of things I would like to take back with me as goals for change in Egypt:

- An effective board of nursing to control the practice of the nursing profession
- Passage of an exam such as NCLEX as requisite to beginning a nursing career
- Standards of practice for each category of nurses
- Increased funding in support of research
- Websites providing ideas and dialogue about nursing practice

Finally, I’m thinking seriously about how I can be helpful in my country when I return, and about how I will adjust when I go back. Can I be effective in changing something in the curricula? Can I be a factor of change in the nursing profession in general? If so, how? I have a lot of plans and ideas, but I will need strong support from the administrative level and the decision makers in my home institution. I don’t know if the people around me will motivate or frustrate me (probably both at times), but I’m hoping I can be a force for change.

REFLECTIVE QUESTIONS

1. What factors do you think would be important to you if you were selecting a nursing program in another country?
2. Think about study abroad for a prolonged period in another country. What challenges do you think you would face? How would you cope?

3. Compare the profession of nursing in Egypt with your country. How is nursing similar? How is it different?

REFERENCES

CASE STUDY 1.3

Developing and Sustaining Partnerships Through Global Health in Local Communities

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CONTEXT: FARMWORKER FAMILY HEALTH PROGRAM, UNITED STATES

Global health practice does not always require a passport. The United States is a remarkably diverse nation, where over 300 languages are spoken. In fact, over 55 million people speak a language other than English at home (Shin & Komanski, 2010). It is essential that health care workers be prepared to work with diverse cultures. This case study describes a “domestic as global” academic–community partnership that has been in existence for longer than 20 years. Clients of this partnership are largely migrant workers and their family members from Mexico, who are not necessarily working in the United States with appropriate documentation. They primarily speak Spanish, but some speak indigenous dialects. These workers harvest fruits and vegetables by hand, grueling work. We ask no questions of clients regarding documentation status during our 2-week summer rotation. However, for the sites where care is provided, migrant status is virtually 100% assured. Federally funded migrant health clinics can only treat clients who meet their definition for migrant status. Because of the fluidity of this population, there is little collaboration between these clinics.

The initial Farmworker Family Health Program (FWFHP) partnership, which began with one small group of undergraduate public health nursing students and one faculty member from a single school who engaged with a single south Georgia farmworker clinic, has evolved to encompass over 100 students and faculty members from five different universities along with community partners. The number of community partners has expanded to include not only the initiating federally funded migrant farm clinic, but also a summer school program, day care centers, two area health education centers (AHECs), businesses, faith communities, and, of course, the farmers and growers. Dental hygiene, nursing, pharmacy, psychology, and physical therapy students, volunteers, and faculty travel to a rural area of a southeastern state as part of a 2-week service learning cultural immersion experience, each adding to the overall scope of services.

PROGRAM OVERVIEW

The FWFHP is a collaboration of the federally funded Ellenton Health Clinic (hereinafter referred to as the Ellenton Clinic), located in Ellenton, Georgia, and five Georgia universities: Emory University (lead university), Georgia State University, Clayton College and State University, Darton College, and the University of Georgia. Other partners include the Colquitt County Health Department, the Colquitt County Board of Education, the Southern Pine Migrant Education Agency, and the owners of farms
and packing houses in the Colquitt County area. Additional budget-relieving in-kind support comes from churches and community organizations in the area. The FWFHP, coordinated by the Lillian Carter Center for Global Health and Social Responsibility in the Nell Hodgson Woodruff School of Nursing at Emory University, has served over 13,000 individuals in its 20-year history. Using students and faculty in the health professions, preventive and episodic health care is delivered over a 2-week period each summer in an intensive outreach setting that also serves as part of the clinical training programs of the universities. Each participating university pays the salaries of its faculty and makes some arrangement with its students regarding housing costs. Although the program is intermittently funded by small grants, no single current funding source covers all program expenses.

The team provides care for farmworker families to live, work, and go to school. In the mornings the team sees children enrolled in a migrant summer program at a local elementary school and day care. In the evenings the team caravans to various locations, including packing sheds, farmworker camps, and local neighborhoods. While the Ellenton Clinic is responsible for communication with and arranging for the various locations for our nightly schedule, the faculty is responsible for making sure students arrive at the farms or service sites together and on time. Participants meet in the parking lot of the hotel where we are housed at a designated time and all leave together for our destination. The leader of the caravan knows the directions to each farm, and a “caboose” faculty car also follows with the directions. Country roads are extremely dark, and the farms and their entrances are spread over four very rural counties. Earlier years without cell phone service posed a challenge, but improvements in technology have helped significantly.

Services provided at the migrant summer school program in the morning are structured around comprehensive physical examinations of children and adolescents. Parental permission is required for a child to be seen. Outreach workers from the Southern Pine Migrant Education Agency work alongside the Colquitt County Board of Education to sign children up for the summer school, and the Ellenton Clinic provides existing charts from their files and makes new charts for children without records. All records are property of the Ellenton Clinic, and all HIPAA regulations are observed. Undergraduate nursing students (BSNs) complete screenings of height, weight (body mass index [BMI]), blood pressure, hemoglobin, vision, and hearing. Nurse practitioner (NP) students do full physical examinations. Developmental assessments are carried out by physical therapy (PT) students. Dental services, including application of sealants and fluoride, are provided by dental hygiene (DH) students. Pharmacy (PharmD) students provide health education in the classrooms. Meanwhile, a small team of students and faculty work at the partnering farmworker clinic seeing patients and preparing the pharmacy. If health-related problems are detected, children who do not have a Medicaid provider listed on their permission form are referred to the Ellenton Clinic for follow-up. Health status letters in both Spanish and English are sent home to the parents of each child seen, whether a referral is necessary or not. Ellenton Clinic outreach workers handle emergent problems on an as-needed basis.

In the evenings BSN students complete height, weight, blood pressure, BMI, hemoglobin, and blood glucose screenings. A foot care station is staffed primarily by BSNs but also with other team members’ participation. DH, NP, and PT students have separate stations for their respective practices. The evening focus of care is acute complaints rather than comprehensive examinations. NPs can prescribe with collaborative practice protocols, and PharmD students operate a pharmacy dispensary on site out of the clinic’s mobile unit. Patients with chronic conditions are referred to the clinic for follow-up, with on-site clinic outreach workers arranging appointments and transportation. The clinic staff has provided interpretation services subsidized by one of the AHECs at the evening clinics. The need for more interpreters has led to inclusion of an additional team partner, the Emory Volunteer Medical Interpretation Services. This is a student-run organization made up of bilingual students formally trained as medical interpreters. The team starts seeing patients in the
evening clinics before sunset, often staying out past midnight. All members wait until the last patient and provider are done. Then we caravan home together, and in the morning we get up and do it again.

**PROGRAM HISTORY OF DEVELOPING TRUST AND A SHARED MISSION**

The executive director of the clinic and the lead faculty came to trust each other through a shared vision of improving access to health care for migrant farmworkers and their families. The FWFHP extends the work of the clinic and adds to the numbers of new annual visits they need to continue their federal funding. As the need for additional expertise became obvious, they jointly decided to invite other disciplines to join the nursing students, thus expanding the program’s services. The grueling work and conditions of farm labor result in multiple musculoskeletal complaints, and the benefit of having PT students on site became apparent. The nursing faculty reached out to the physical therapy department. A similar situation occurred with psychology, where an identified need carved out a role for an additional discipline.

A good exemplar of dovetailing interests is the example of dental hygiene. Dental disease is among the top five health problems in this population (Lombardi, 2001). Both the clinic executive director and nurses saw a great need for dental services for both the children and the migrant workers. About the same time, many of the dental hygiene programs in the state were transitioning to bachelor-level programs, needing sites for community rotations. These needs allowed for great synergy. Even more importantly, the application of dental sealants and fluoride has probably been the most positive measurable outcome of the program.

Mutual trust and respect has grown over the years. The program’s collaboration with the churches each summer has done much to raise community awareness regarding the plight of the farmworker. Because farmworkers are basically an “invisible” population working and living in these outlying rural areas, citizens of the four focal counties rarely see the labor or living conditions of these workers up close.

Two of the individuals who were founding partners have either retired or moved on, but leadership has not been lacking. The strong foundation built by years of work has fostered embedded trust between the involved institutions and has in fact led to a web of new personal relationships that have spun off to additional partnerships in different locations. For example, a member of the FWFHP nursing faculty runs a clinic caring for the uninsured and underinsured population of Atlanta. A member of the PT faculty now brings students to this clinic.

After 20 years of working together, even the site visits have evolved. Initially program faculty drove to the rural area for a day meeting a few months before the annual event. Then all participants (including all students) had a full-day orientation in Atlanta. Communication in preparation for the event now includes e-mails and conference calls and occasional “off-season” site visits. Medical records (the point of which is, after all, good communication) are developed by the Ellenton Clinic to meet their reporting requirements, with interstation transit front sheets developed in collaboration by all partners.

The 20 years together have not been without conflict. Working with partners requires compromise and negotiation. For example, the school system at the partner site determines the dates of the program. These may not always coincide with the best times for academic faculty and students, but as their guests and partners, it is imperative that we work with them based on their needs. In fact, one year the funding for the program was cut, and at the end of the first week we were told the last day would be the following Monday. We took this as an opportunity to look for new partners, which is when we began working with child care centers. This conflict thus turned into a benefit as NP students were able to complete physical examinations on children age 6 months to 3 years at a migrant Headstart program.

An ongoing conflict exists in the broader context of the program. We ask ourselves whether a program that provides care for migrant farmworkers perpetuates the inequities and conditions that put them at risk. Health care is rarely neutral or innocent. Placing
care in its full context is an important consideration for all health care providers. The act of delivering health care, like providing assistance in complex humanitarian emergencies, isn’t that complicated. It’s the operational context in which the assistance is provided that is the complicated part. In caring for farmworkers with health problems exacerbated by the working conditions, are we doing all we can to solve the problem? This question is put to students and faculty and provide for self-reflection and ethical discussion. The FWFHP objective is to care for as many people as possible. As we work through this conflict, it may lead to a review of our vision.

The program is evaluated by each student and faculty member every summer. Undergraduate student nurses use this course as the clinical component of their public health nursing course and are evaluated on both didactic and clinical standards used by the Emory School of Nursing. Reflection journals are kept by undergraduate student nurses, and interprofessional reflection groups meet each morning prior to beginning the day covering various questions reflecting on the previous day’s experiences. Other students’ clinical expertise is evaluated by their respective faculty and credit allocated accordingly. Annual student and faculty evaluations through a questionnaire combining Likert scale and open-ended responses are tallied at Emory School of Nursing. The results are distributed to the other participating schools and considered as a whole by the program faculty. The operations of the program are enriched by suggestions from both seasoned faculty and staff and fresh student participants. We seek continued improvement in the efficacy and efficiency of this important work. Other evaluation comes in the form of thesis or dissertation projects of students from varying disciplines that request use of our anonymous clinical data collected each year on all clients.

Unforeseen collateral benefits include the interprofessional education. Continuity of faculty from year to year fosters faculty role modeling of interprofessional teamwork and partnership. Through the FWFHP, students from the various disciplines collaborate and consult with each other on all sorts of patient conditions. This interprofessional program predates the calls from the World Health Organization (2010) and the Institute of Medicine (Greiner, 2003) for increased interprofessional education.
CONCLUSION

The FWFHP is a unique interprofessional service-learning program that promotes student learning, improves knowledge and skills, and impacts students’ attitudes. By partnering with a local clinic to support and expand its capacity at peak harvest season, health care professional students provide care for a vulnerable population. Students learn with, from, and about each other and the community they serve. The FWFHP is an example of a successful academic-community partnership.

REFLECTIVE QUESTIONS

1. Considering that farmworkers are often exploited by their crew bosses, is offering free health care to the workers helping or hindering those workers’ cause for just employment and access to health care?
2. Should health care professionals providing health care to migrant workers attempt to lobby for them in the political arena? How do you think this would affect the ongoing development of the partnership?

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