Global Health Curriculum for FM Residency Toolkit Implementation Guide

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Introduction

The term “Global Health”(GH) means different things to different people and has no universally agreed upon definition. Definitions range from “an area for study, research, and practice that places a priority on improving health and achieving health equity for all people worldwide" to “those health issues that transcend national boundaries and governments and call for actions on the global forces that determine the health of people” and more recently “collaborative trans-national research and action for promoting health for all”. (1) It is often used interchangeably with the term “international health”, although we can think of global health locally as well, using the term “Glocal.” A glocal approach means “presenting global knowledge within a local context that respects human rights.” Global health experiences (especially international) are becoming more popular with 25%-38% of medical students (increased from 15% in 1998) and 40%-68% of residents have a global experience during their training as of 2019.(2,3,4) The 2015 CERA Survey of Family Medicine Program Directors showed that 74.3% of programs offered international or domestic GH experiences.(4)

Residency is an optimal time for a global experience. A Duke University study found that 81% of Duke residents reported that an international rotation had the most significant positive impact on their medical training of any experience they had. Residents who have done an international rotation may be more likely to have future practices that include immigrants and low-income patients on public assistance and may be more likely to practice in underserved areas both domestically and abroad. (5) These residents may

also be more likely to practice internationally to reduce the global gap in health care. (6) Participants in global health experiences report growth in clinical, physical exam and language skills; increased awareness of cultural and socio-economic factors that affect the health of patients; and demonstrate future practices with values such as idealism, community service, and humanism. In addition to the above, medical students are being selective in choosing residency programs based upon the availability and quality of global opportunities. (4,6,7)

Although these experiences are increasing in popularity and frequency and bring value to training as detailed above, there is no agreed upon curriculum or guidelines for Family Medicine graduate medical education in global health. This toolkit is intended to help bridge that gap.

Development of the toolkit

This toolkit was created as a collaboration between the Society for Teachers of Family Medicine's (STFM) Global Health Educators Collaborative (GHEC) and the American Academy of Family Physicians Center for Global Health Initiatives (CGHI). The authors received funding through an STFM Foundation Grant to fund the work.

First, gaps in residency training were identified by review of current curricular resources and updated literature review regarding global health in training programs. This highlighted increased interest by residents and programs in GH engagement and an increased understanding of principles for ethical engagement in global health. Key curricular resource gaps included a lack of ACGME requirements or guidance on GH engagement, no universally-accepted medical school or fellowship-level objectives for GH experiences and no curated residency-level resources specific to Family Medicine in GH.

Then, a literature review and examples of curricula from single-institution global health programs and other specialty residencies were used to create a competency based first draft of the curriculum. The main resources that were used to create this curriculum were the AAFP GH competencies guide, CUGH GH curriculum guide, the Global Health in Pediatric Education: Implementation Guide for Program Directors (Editor Dr Nicole St Clair, 2018), The University of Arizona Family Medicine Residency GH curriculum, and the Family Medicine Global Health Fellowship Competencies, A Modified Delphi Study (El Rayess, *et al* in *Family Medicine,* 2017*).*

In the Fall of 2019, interested faculty within STFM GHEC/AAFP CGHI partnered with international stakeholders on initial draft discussion and feedback. In the Fall of 2020, sessions on tips for starting or improving residency-level GH experience/pathways were presented at both the Global Health Summit and STFM's Annual Spring Conference. In Winter of 2020, webinars were hosted on ethics of GH engagement, and the project grant from STFM Foundation was obtained in the Spring of 2021. During the Spring of 2021, the goals and objectives to frame the curriculum toolkit were drafted and several stakeholder meetings were held (including

both domestic and international partners) to obtain feedback on the proposed curriculum toolkit. The mostly finalized curriculum toolkit was presented at the AAFP Global Health Summit 2021 and more feedback was received from stakeholders. During the presentation, the newest version of the toolkit was presented to the stakeholders group for review and additional changes were made. The implementation guide was introduced at that time as well. Additional stakeholder review and feedback on the toolkit and implementation guide was obtained at the 2022 STFM Annual Spring Conference and by email.

A Note on Implementation

This toolkit is intended to be utilized as a guide to develop the GH curriculum for a Family Medicine residency program. It was developed to be comprehensive in nature and covers a broad list of topics. It is not intended to be a list of what a program *must* include in a global health track, but what a program *could* consider to include based on its resources, goals, and resident interests. We are cognizant that program resources, curricular time, and needs vary greatly. In such, this toolkit is a guide that an individual program can use to instruct development of their own curriculum and how they want to implement various components of the toolkit. This can be useful whether a program is reviewing an existing curriculum or creating a new one.

It was developed for Family Medicine specifically. In such, it is broken down by Core Competencies from the ACGME (Patient Care, Medical Knowledge, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, and Systems Based Practice). Within each Core Competency we have listed Learning Objectives that map to ACGME Family Medicine Milestones and then have detailed specific core content, optional content, and a list of resources for each section. The toolkit was structured this way for ease of use and also to ensure that a program's GH curriculum works in conjunction with other curricula to ensure residents meet their Core Competencies and Milestones. Lastly, as the toolkit was developed for Family Medicine, many of the core content areas are meant to be across the lifespan (for example management of pneumonia can be extrapolated to mean management in adult, pediatric, and pregnant patients).

The toolkit was developed and written under the working assumption that residents will be adequately supervised at a local or international site and that the host site will be involved in planning a resident international rotation. We strongly recommend consulting local GH partners about how best to prepare residents for a rotation at their site. This toolkit is not meant to speak for or replace the invaluable wisdom and experience of local GH partners. Similarly, it is of vital importance that residents engage in global health work in an ethical manner and that they have the same level of supervision and guidance at an international site as they do in the U.S.

Lastly, while our intention was to be comprehensive, we are aware that we could not fully cover all pertinent topics for a program or their international site(s). We recommend you consult additional resources as needed to create the most robust GH curriculum specific to your program.

Ethical Best Practices

It is critical to make ethical considerations when designing and implementing a GH program. Residency programs that already have GH partnerships can review their relationships for bi-directionality. Programs working on initial steps of building formal relationships with LMIC partners should review key components of bi-directional relationships. Longitudinal partnerships between HIC and LMIC partners are emphasized in current GH education best practices. Programs and trainees looking to be involved in GH education should review the historical context of learners in LMICs and where they foresee their curriculum fitting into that history.

See ***Decolonization of Global Health*** for additional resources on this discussion.

The following are some of the ethical considerations and suggested solutions based on the 2010 Working Group on Ethics Guidelines for Global Health Training (WEIGHT) Consensus Guidelines. (3,8)

1) <u>Trainees may lack understanding and sensitivity to local culture.</u>
   Develop well-structured programs and implement formal training, with a focus on language, culture, and safety for the country they will visit.
   For example:
   - Require trainees complete global health and ethics courses before travel
   - Require trainees complete a "geo-journal" for country of planned visit with reports on geography, currency, cultural customs, language and health care system
   - Ask local healthcare providers how things are done and for the in-country treatment guide *ahead* of the rotation if possible
2) <u>Trainees may practice beyond their abilities or without proper local medical knowledge.</u>
   Clarify goals and expectations for all parties and clarify level of training and experience for host institution and trainee.
   For example:

- Effectively collaborate and communicate with identified health care partners in host country
- Require ethics and cultural humility courses for trainees
- Provide training on practice guidelines from WHO and/or Ministry of Health in country to be visited

3) <u>There may be potential for harm.</u>
   Develop, implement, regularly update formal training for trainees and mentors, both local and foreign perspectives regarding norms of professionalism/standards of practice, cultural competence and humility, and dealing effectively with cultural differences. Aspire to maintain long-term partnerships so that short-term experiences may be nested within them.
   For example:
   - Provide training on WHO/local practice guidelines and have trainees complete "geo-journal"
   - Trainees work in well-established, locally based health care systems, rather than on short-term "medical brigades"
   - Only use brigades that have established community partnerships and local decision-makers/stakeholders
4) <u>Global experiences may be self-serving.</u>
   Recognize that the primary purpose of the experience is GH learning and appropriately supervised service. Consider local needs and priorities, reciprocity, and sustainability regarding optimal structure of programs.
   For example:
   - Encourage trainees to contribute to local health care community
   - Ensure final trainee evaluation is from identified rotation supervisor in host country
   - Establish effective supervision and solicit feedback from trainees and host institutions
   - If desired by local partners, engage in quality improvement programs to track health care outcomes (ie, blood pressure control)

In addition, Melby et al (9) proposed four ethical principles to consider when designing and implementing an educational Short Term Experiences in Global Health (STEGHs) to optimize community benefit and learner experience. While we recognize that a residency GH track may not be able to implement all the components of each principle, we encourage you to keep these principles in mind when framing GH experience.

Principle 1: <u>"Skills building in cross-cultural effectiveness and cultural humility are critical components of successful STEGHs"</u>

- High Income Country (HIC) medical education does not fully prepare one to work abroad
- It is necessary to engage in pre-departure training and other extracurricular professional development
- Encourage "explanatory models" and communication skills, such as using the Listen, Explain, Acknowledge, Recommend and Negotiate (LEARN) framework
- Once in Low and Middle Income Country (LMIC) setting, HIC trainees may render services within scope of their training and ability under supervision if determined appropriate locally
- Language and cultural incompatibility, lack of familiarity with formularies, resource level, and local standards of care usually limit trainee independence
- HIC trainees should travel across the border with the same ethics and professionalism as their home institution

Principle 2: "STEGHs must foster bidirectional participatory relationships"

- Emphasize local capacity-building and program priority-setting with participation between HIC and LMIC stakeholders
- Employ bipartisan collaboration and community engagement to determine scope of STEGHs
- Develop bidirectional relationships between local community and visiting institution through involvement of other disciplines (e.g., anthropology, public health)
- Reverse innovation and exchange of opportunities should be supported
- Make community development a priority over skills of learners or stature of visiting institution

Principle 3: "STEGHs should be part of longitudinal engagement that promotes sustainable local capacity building and health systems strengthening"

- Tackle locally identified needs by leveraging resources
- STEGHs should not be conducted as short term solutions to long-term complex problems

Principle 4: "STEGHs must be embedded within established community-led efforts focused on sustainable development and measurable community health gains"

- Comprehend how poverty and inequality, public health infrastructure, and human resources for health play a role in advancement of long-term population health

- Recognize that downstream clinical efforts may not decrease morbidity or mortality only delay it and take into account upstream underlying cause
- Appreciate the limit of short term efforts that are recurring and/or solitary

Decolonization of Global Health

The concepts of decolonization and the "savior complex" are weighty and nuanced conversations that should be held with trainees when preparing for experiences in global health. The following articles may be helpful for reflection and discussing both the explicit and more subtle manifestations of these phenomena.

Eichbaum QG, Adams LV, Evert J, Ho MJ, Semali IA, van Schalkwyk SC. Decolonizing Global Health Education: Rethinking Institutional Partnerships and Approaches. Acad Med [Internet] 2021;96(3):329–35. https://pubmed.ncbi.nlm.nih.gov/32349015/

Holst J. Global Health - emergence, hegemonic trends and biomedical reductionism. Global Health. 2020 May 6;16(1):42. doi: 10.1186/s12992-020-00573-4. PMID: 32375801; PMCID: PMC7201392. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7201392/

Kwete, X., Tang, K., Chen, L. *et al.* Decolonizing global health: what should be the target of this movement and where does it lead us?. *glob health res policy* 7, 3 (2022). https://doi.org/10.1186/s41256-022-00237-3

Prasad, S., Aldrink, M., Compton, B., Lasker, J., Donkor, P., Weakliam, D., Rowthorn, V., Mantey, E., Martin, K., Omaswa, F., Benzian, H., Calgua-Guerra, E., Maractho, E., Agyire-Tettey, K., Crisp, N. and Balasubramaniam, R., 2022. Global Health Partnerships and the Brocher Declaration: Principles for Ethical Short-Term Engagements in Global Health. *Annals of Global Health*, 88(1), p.31. DOI: http://doi.org/10.5334/aogh.3577

The White-Savior Industrial Complex - The Atlantic [Internet]. Available from: https://www.theatlantic.com/international/archive/2012/03/the-white-savior-industrial-complex/254843/

The White Savior Industrial Complex in Global Health - BMJ Global Health blog [Internet]. Available from: https://blogs.bmj.com/bmjgh/2020/03/11/the-white-savior-industrial-complex-in-global-health/

Overview of the Toolkit

The toolkit is organized by competency with Objectives for each competency, then Core content, Optional content and Resources for the content, which can be seen below.

Competencies	Objectives that map to milestones	Core content	Optional Content	Resources

The objectives map to the ACGME core competencies (Patient Care, Medical Knowledge, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, and Systems-Based Practice). The objectives are specific and thorough, encompassing what can be part of a residency level global health curriculum. It may not be feasible for every program to include every component, but the format is intended to provide a structure that can be easily adapted to different types of curricula and experiences. We have included core content that should be part of any robust global health training program, and optional content for residency programs that have more resources or are specialized. Resources are listed at the end for the content repositories that educators can access to build and implement into their own programs.

Logistics of Implementation for a Global Health Track

- Have a faculty champion who has experience in GH
- Create a mission statement for what you want to accomplish
- Create country-specific goals and objectives

We suggest each program determine the specific goals and objectives for GH training that fit the needs of the individual training program and that take into account the resources available to the program. These needs and resources vary across

family medicine residency programs, hence the global health training curricula will inevitably have variability in content and format as well.

There are many ways to present and explore content to GH track residents, for example:

- Lecture series: every 2 weeks to quarterly
- Seminars: monthly to biannually
- Simulation courses
- Online: modules/videos/TED talks
- Journal clubs: monthly-biannually
- Book clubs: 5/year
- Symposium: quarterly
- Local rotations: clinic for immigrants/refugees, asylum seekers, homeless, HIV/AIDS, leprosy, TB, travel health, rural, border health
- International rotations (1-8 weeks): clinical (in/outpatient), home/nursing home visits, QI/research, staff/patient education, community outreach. **See below for planning considerations related to away rotations.**
- Interdisciplinary engagement: students, residents, fellows, faculty
- Program/institutional presentation
- GH conference attendance & presentation: AAFP GH Summit, CUGH, GMHC

The specific curricular content should flow from your program's goals and objectives. There are many curricular content options in this toolkit, for example:

- Determinants of health
- Global burden of disease
- Ethics
- Health systems
- Research/lab skills
- Pharmaceuticals
- GH organizations
- Regional infectious diseases
- Maternal child health
- Malnutrition

- Chronic disease
- Environmental health
- Immigrant/refugee health

Consider how residents will be accepted on a track:

- Declare interest & apply to track
- Good academic standing
- Approval from GME & Program Director

Consider requirements for continuing on a track such as:

- Mentorship, rotation & trip planning meetings (monthly)
- Rotations meet ACGME guidelines
- Set educational goals & objectives
- Attend educational sessions
- Attend pre-travel prep & post-travel debrief
- Present on GH experience/project
- Mentor junior residents & students

Additional considerations for an established global health track - Sustainability, Scholarship, and Career Development

Sustainability is a key goal for global health tracks and partnerships to foster more enduring and meaningful relationships with local and international partners and communities. It significantly reduces time spent identifying, vetting, and establishing new programs, projects and partners. It is also beneficial to hosts who can spend a significant time orienting and entertaining new visitors (time better spent on their own systems and trainees). Whether coming from 10 or 1000 miles away, the burden of visitors is less if the visiting team is led by persons already familiar with transportation, safety, currency, language, daily schedule, hospital policy, formulary, etc. It is also more likely that your program will be able to understand and contribute to community priorities if you have established a stable and predictable engagement with the community.

Components of a sustainable program typically include faculty champion(s) with interest and experience in ethical GH engagement, GH allies (supportive of GH work but not actively teaching about GH or traveling), and commitment from the residency program for a GH track or travel. This commitment could include direct financial support for faculty or resident travel, GH continuing education, and/or faculty pay. Faculty pay should include consideration of support for local site preceptors. For programs sending faculty to training locations, it could also include 'in kind' support such as allowing flexible scheduling to allow faculty to travel with minimal

financial loss, increased number of CME days, arranging for malpractice insurance/worker's compensation to cover international work, and/or allotting a portion of an administrative assistant FTE to GH. The residency program could also demonstrate commitment by highlighting the track during recruitment season and allow flexibility in resident scheduling to allow for travel, training (such as GH-focused education half-days) or community work.

In exchange for these commitments, GH leaders within the residency can provide robust track, faculty and international rotation evaluations and document how residents on the GH track are meeting educational milestones via the track curricula. Please see the **Evaluation** section of this toolkit for more detail. GH leaders can reduce the burden of GH training on a residency by applying for funding for travel and training, cooperating with other academic departments to develop and teach curricula, and reducing risk by adequately training residents and other faculty prior to travel. GH leaders can highlight the presence of a track or travel opportunities as an attractor to high-quality residency applicants.

Scholarship: Increasing visibility of Family Medicine in GH through academic publications and presentations serves the global host faculty and departments and the US-based GH residents, faculty and departments. It also elevates the critical place of primary care in achieving improvements in health for communities at risk. Publications should always be co-authored with international partners (unless of course this is declined by the international partner). Network with colleagues at your institution, nationally and globally. Disseminate your work at conferences (eg, STFM conferences, AAFP Global Health Summit, CUGH, or other global health oriented conferences). There are many publication opportunities (eg, Family Medicine, FPM, STFM PRIMER, and many GH-specific journals). Accept requests to review manuscripts about global health topics, especially when authors are known to be from under-resourced communities, to facilitate their improvement and ultimate publication. Research to better understand best practices in under-resourced communities is an especially important activity but requires a foundation of respect for communities and their priorities, specialized training, and funding structures that empower leaders in the community being studied. The ethics of research in at-risk populations is beyond the scope of this toolkit.

Career Development: A common question asked by medical students and residents in global health is 'What's next? How can I incorporate global health into my career?' There are many paths to work in global health including work in the US and outside the US: direct clinical care, skills training, curriculum development, faculty respite, administration, quality improvement and more - ideally all in partnership with local health systems, governments, schools, training facilities, and other stakeholders. A single GH experience or even a residency-level track won't fully prepare you for independent GH work. However, it can set the stage for lifelong learning. The next steps can be more formal training such as a global health fellowship, work in the US to improve clinical, mentoring and teaching skills, and/or on-the-job learning as part of an internationally-based team. Connecting with other family physicians through groups such as the STFM Global Health Educators Collaborative or the AAFP Global Health Member Interest Group can help residents identify future mentors and collaborators.

Global health fellowships are not ACGME-accredited programs. This gives flexibility to the US-based program, the international partner(s), and the fellow to create a program designed to meet various training and service needs. For example, one fellow may desire obstetric ultrasound training and another need more training in fracture and wound care. An international partner may need help with curriculum development at first and then later wish to have support with faculty recruitment and development. The salary, travel, training, insurance and other costs of a fellow are often paid through a combination of self-support (i.e. working as a board-certified family physician in a clinic or hospital at the US-based fellowship), program funds, in-kind support, and/or grant monies. Several programs are offered only to family medicine physicians. Other fellowships will accept any primary care residency graduate. A list of available global health fellowships is found here: https://globalhealthfellowships.org/ Fellowships are commonly 12-24 months in length and often done immediately following residency. Applications are typically accepted in the fall and winter, but residents should check with each program as there is no common application or deadline.

Logistical considerations for global health experiences (international or local):

1. Goals of the experience (refugee health, immigration, border health, tropical medicine, etc.)
2. Previous experiences with the institution (have there been previous travel experiences and contacts)
3. Existing connections with faculty or residents
4. Timing (when in the year it can take place, alignment with resident schedule, length of experience, ACGME requirements for clinic continuity)
5. Partnerships with other institutions/organizations (find out which organizations in your city, state, or country have relationships with the country/region of interest)
    a. AAFP has a database with different locations and contacts: https://www.aafp.org/patient-care/global-health/health-database.mem.html
    b. Connect with STFM peers as part of STFM GH Collaborative: https://connect.stfm.org/home
6. Safety - Travel advisories by the CDC and US Department of State: https://travel.state.gov/content/travel/en/international-travel.html
7. Travel medicine requirements: https://wwwnc.cdc.gov/travel
8. Travel medical insurance
9. Costs/funding - It is important to consider cost and availability of funding for global health work early in the planning phase. Obtaining funding for global health work could be challenging. This may affect options for location and duration of experiences. It is important to consider who is paying for an international experience. Some examples of sources of funding are resident, academic institution, GH office, mission money, medical staff dues, department, program, resident education fund, grants, fundraising, etc. Some creativity may be needed in securing funding for global health work and leveraging

already existing funding is one such approach. In addition, we suggest creating budgets for global health work; this can be done by working with a financial counselor if available. AAFP list of funding resources for students and residents can be found at this link: https://www.aafp.org/family-physician/patient-care/global-health/education/scholarships-funding.html

10. Institutional and ACGME requirements for international experience
    a. They may not be the same!
    b. July 2019 Family Medicine ACGME requirement:
        i. ***IV.C.4 a).(1)*** *Residents' other assignments must not interrupt continuity for more than 8 weeks at any given time or in any one year*
        ii. ***IV.C.4.a).(2)*** *The periods between interruptions in continuity must be at least 4 weeks in length*
11. Medical-legal requirements such as licensing, malpractice, work or student visas
12. Pre-departure orientation
13. Evaluation (see separate section below) - appropriate supervision by licensed practitioners as well as evaluation of trainees
14. Research - While research is not the primary focus of the toolkit, we would like to point out that additional ethical considerations need to be made if embarking on research during the track. When engaging in research in an international context, the same ethical principles that are followed in the United States need to be followed, but there are additional considerations that need to be made. At minimum, ethics approval from both the home institution and the international site are needed. Parker and Bull (2009) outline important ethical considerations for global health research (https://doi.org/10.1258/ce.2009.009025). A more detailed view of international research ethical guidelines by The Council for International Organization of Medical Sciences (CIOMS) can be found at this link: https://cioms.ch/publications/product/international-ethical-guidelines-for-health-related-research-involving-humans/. They also provide online training.

Evaluation

Evaluation of Residents

Evaluation of resident performance and ability to meet the core ACGME competencies is a necessary part of any rotation in residency training. The approval of any rotation abroad should include approval by the appropriate preceptor licensed to practice in the local country and acceptance of the responsibility of providing adequate oversight and evaluation of the trainee. This is more easily accomplished with clear goals and objectives for the global health rotation or experience. Involving local preceptors from

hosting institutions in the development of evaluation tools and feedback structure improves the efficacy of local leadership and efforts towards decolonization of this global health work.

Residency programs can use existing evaluation forms or software to elicit feedback from local site preceptors and post-travel debriefing with faculty mentors, though programs should keep in mind the importance of preceptor training, familiarity with the evaluation method, and access to the required forms and software. Best practice should include collaboration with local site preceptors in clarifying the goals/objectives/competencies to be evaluated for inclusion in resident performance evaluations.

Some programs may choose to utilize available self-study modules with built in knowledge assessments from the Resources section of the GH Toolkit. Completion or passing scores on these assessments could be incorporated into resident evaluation as well.

Evaluations of/by the resident should include reflections **in addition to** (if not instead of) things like debrief, report, knowledge assessment, performance assessment.

As with any trainee evaluation, clarifying competency and professional expectations prior to the start of a rotation/experience is critical to providing residents with the framework to succeed.

Possible evaluation modalities:

- Evaluation of the resident's performance by standard rubric
- Pre/post knowledge assessment
- Pre/post trainee reflections (see sample journal)

Evaluation of Faculty/Preceptors

Routine evaluation of rotation faculty/preceptors occurs in residency training, but there are additional nuances when applied to global health rotations/experiences. There can be additional cultural factors to consider in how feedback is received or delivered to continue building alliances with local site/institutional preceptors and directors. All partners can benefit from feedback to improve a program's ability to meet shared goals. Care should be taken to ensure benefits such as faculty development access and compensation for time/effort are available to local site preceptors. We emphasize that local site determination of goals/objectives/expectations and activity priorities for the global health experience are in need of robust support for a successful program.

Possible evaluation modalities:

- Faculty site visit
- Evaluations of the experience by the resident
- Post-travel questionnaire
- Post-travel debriefing (most common)
- Trip report
- Program review of communication/engagement/evaluation completion

Program/Site Evaluation

Programs should regularly evaluate whether their global health rotation or experience is meeting the stated goals/objectives. Many factors can change a rotation experience from how a program is initially implemented and the reality of the experience over time as program oversight/faculty mentors or local site institutional situation or preceptor/directors change.

Programs should have a formal evaluation of the rotation/experience completed by the resident. A common way to review the rotation/experience is through post-travel questionnaires and/or post-trip debriefing with program faculty. Programs may also ask residents to provide a trip report or engage in reflective writing.

Routine review of the global health program is suggested to be included in your program's usual rotation/curriculum evaluation methodology. This may include site evaluation and review of evaluations of local-site preceptor(s) when updating Program Letters of Agreement (PLAs) for institutional compliance.

Possible evaluation modalities:

- Faculty site visit
- Evaluations of the experience by the resident
- Post-travel questionnaire
- Post-travel debriefing (most common)
- Trip report
- Reflective writing

Troubleshooting potential barriers:

Programs may find increased need for flexibility in feedback format or communication methods to be able to receive adequate feedback from local site partners. If there are internet connectivity barriers with local site partners, consider options such as electronic vs. paper, email vs. text, phone vs. WhatsApp or other locally accessible platforms with lower internet cost burden.

Programs may find limited constructive feedback or hesitancy by local site partners to report adverse experiences or concerns. Consider revisiting shared goals/objectives/expectations with local site partners with additional attention to potential cultural differences in interpretation or perceived consequences.

Core texts:

- WHO Hospital Management of children book (https://www.who.int/publications/i/item/978-92-4-154837-3)
- Oxford Handbook of Tropical Medicine
- We also recommend residents take an electronic or paper copy of the in-country guide and to ask the site if there are print materials that are needed.
- Evert J, Stewart C, Chan K, Rosenberg M, Hall T. Developing Residency Training in Global Health: A Guidebook. San Francisco: Global Health Education Consortium; 2008

Acronyms

AAFP- American Academy of Family Physicians
ACGME- Accreditation Council for Graduation Medical Education
CDC- Centers for Disease Control and Prevention
CERA- Council of Academic Family Medicine Educational Research Alliance
CGHI- Center for Global Health Initiatives
CME- Continuing Medical Education
CUGH- Consortium of Universities for Global Health
GH- Global health
GMHC- Global Missions Health Conference
HIC- High income country
LMIC- Low and middle income countries
STEGHs- Short Term Experiences in Global Health
STFM (GHEC)- Society of Teachers of Family Medicine (Global Health Educators Collaborative)
WEIGHT- Working Group on Ethics Guidelines for Global Health Training
WHO- World Health Organization

References

1. Beaglehole R, Bonita R. What is global health?. Glob Health Action. 2010;3:10.3402/gha.v3i0.5142.
2. Taguena J. 'Glocal' approach makes global knowledge local. Available at: https://www.scidev.net/global/opinions/glocal-approach-makes-global-knowledge-local/
3. Aldulaimi S, McCurry V. Ethical Considerations When Sending Medical Trainees Abroad for Global Health Experiences. Annals of Global Health. 2017 April. 83(2), pp.356–358.
4. Hernandez R, Sevilla J, Van Durme D, et al. Global Medicine in Family Medicine Residency Programs: A CERA Study. Family Medicine. 2016 July; 532-537.
5. Gupta AR, Wells CK, Horwitz RI, Bia FJ, Barry M. The International Health Program: the fifteen-year experience with Yale University's Internal Medicine Residency Program. Am J Trop Med Hyg. 1999 Dec;61(6):1019-23.
6. Drain P, Holmes K, Skeff K, et al. Global Health Training and International Clinical Rotations during Residency: Current Status, Needs, and Opportunities. Acad Med. 2009 Mar; 84(3): 320–325.
7. Liaw W, Bazemore A, Xierali I, et al (2014). Impact of Global Health Experiences During Residency on Graduate Practice Location: A Multisite Cohort Study. Journal of Graduate Medical Education. 2014 Sept; 6 (3): 451-456.
8. Crump JA, Sugarman J; Working Group on Ethics Guidelines for Global Health Training (WEIGHT). Am J Trop Med Hyg. 2010 Dec;83(6):1178-82. doi: 10.4269/ajtmh.2010.10-0527.
9. Melby MK, Loh LC, Evert J, Prater C, Lin H, Khan OA. Beyond Medical "Missions" to Impact-Driven Short-Term Experiences in Global Health (STEGHs): Ethical Principles to Optimize Community Benefit and Learner Experience. Acad Med. 2016 May;91(5):633-8.