Host community perspectives on trainees participating in short-term experiences in global health

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CONTEXT High-income country (HIC) trainees are undertaking global health experiences in low- and middle-income country (LMIC) host communities in increasing numbers. Although the benefits for HIC trainees are well described, the benefits and drawbacks for LMIC host communities are not well captured.

OBJECTIVES This study evaluated the perspectives of supervising physicians and local programme coordinators from LMIC host communities who engaged with HIC trainees in the context of the latter's short-term experiences in global health.

METHODS Thirty-five semi-structured interviews were conducted with LMIC host community collaborators with a US-based, non-profit global health education organisation. Interviews took place in La Paz, Bolivia and New Delhi, India. Interview transcripts were assessed for recurrent themes using thematic analysis.

RESULTS Benefits for hosts included improvements in job satisfaction, local prestige, global connectedness, local networks, leadership skills, resources and sense of efficacy within their communities. Host collaborators called for improvements in HIC trainee attitudes and behaviours, and asked that trainees not make promises they would not fulfil. Findings also provided evidence of a desire for parity between the opportunities afforded to US-based staff and those available to LMIC–based partners.

CONCLUSIONS This study provides important insights into the perspectives of LMIC host community members in the context of short-term experiences in global health for HIC trainees. We hope to inform the behaviour of HIC trainees and institutions with regard to international partnerships and global health activities.

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INTRODUCTION

Although medical students from high-income countries (HICs) have been participating in rotations in low- and middle-income countries (LMICs) for many decades, these international experiences have recently increased in popularity, as has the presence of global health curricula in medical schools.[1] Short-term experiences in global health (STEGHs) allow students to witness health care in unique cultural and geopolitical contexts.[2,3] Students are generally supervised by local or HIC health care providers, and experience varying levels of independence in their clinical activities: depending on the global health programme, some students may be placed in foreign contexts strictly as observers, whereas others actively participate in, or independently provide, medical services.[4,5]

An abundance of benefits to students visiting from HICs, referred to in this paper as 'HIC trainees', have been described. These include increases in skills and confidence, a better understanding of the social determinants of health, the ability to function optimally with limited resources, cultural sensitivity, novel disease familiarity, appreciation of the physician–patient relationship, and the desire to enter primary care and work with medically underserved populations.[2,6–15] Whereas an abundance of research has focused on the benefits to HIC trainees, the benefits and drawbacks for LMIC host communities have not been well described.[6,7] Some speculate that LMIC host communities benefit from the provision of health care or capacity building, particularly when trainees are placed as providers, educators or caregivers.[8]

However, many take issue with these alleged benefits and refer to the unlicensed nature of HIC trainees, the novelties of language, culture and resources within LMIC host communities, and the relatively short-term duration of HIC trainee international experiences. Direct improvements to community health resulting from HIC trainee clinical activities are not supported broadly in the literature.[9] Others argue that HIC trainees may actually have adverse effects on host community members, contributing to negative self-images and feelings of dependence, objectification or unworthiness.[10–12] For community benefits to be realised, it is likely that HIC trainee global health experiences should be nested within longitudinal partnerships between HIC organisations and LMIC communities, and should recognise the costs of hosting HIC trainees.[5,13–15]

Power imbalances between globally mobile HIC trainees, their home institutions and LMIC host communities complicate global health immersion programmes, as do differences in objectives.[16,17] Personal development appears to be the overarching motive for trainees interested in travelling to LMICs.[18,19] Consequently, critics of these programmes decry them as representing 'developmental tourism' or 'voluntourism'.[20,21] Some suggest that the intent of the trainee is – like that of the tourist – short term, and that there is little sense of responsibility for continuity or follow-up.

To date there has been scant research into host community perceptions of HIC trainees in STEGHs through qualitative interviews.[22] The majority of host perspective studies have focused on the impact of sending fully trained HIC medical providers to LMICs[7,23] or have utilised surveys as their methodology.[24] This study aims to describe in depth the benefits and drawbacks of such programmes from the perspectives of those hosting and supervising HIC trainees. Importantly, we also aim to investigate host views on the long-term partnership within which individual trainee activities are nested. We capture here the perspectives of LMIC host community collaborators, including physician preceptors, social workers, non-governmental organisation (NGO) directors, home-stay families, and programme administrators.

METHODS

Study setting

We conducted semi-structured interviews with LMIC host community collaborators with the US-based non-profit NGO Child Family Health International (CFHI) in La Paz, Bolivia and New Delhi, India.[25] Child Family Health International facilitates year-round global health education programmes and sends 600–700 undergraduate, graduate and post-graduate HIC interprofessional trainees annually to nine countries. From 1995 to 2010, CFHI ran a medical donation programme in which medical supplies donated by HIC organisations were transported by HIC trainees to international programme sites.

We selected La Paz, Bolivia and New Delhi, India as study sites because CFHI has organised HIC trainee programmes in both locations for over 10 years, which allowed us to make inquiries about the host communities' perceptions of the long-term partnership. The clear cultural differences between the two

countries are conducive to a more dynamic interview sample and add breadth to the research data.

In both sites, trainees rotate among various clinical settings (governmental hospitals, rural clinics and traditional medicine clinics). In India, trainees have additional opportunities to rotate in community-based health outreach efforts (local NGOs [e.g. needle exchange or domestic violence centres]). The programmes are generally 4 weeks in length, but can range from 2 to 16 weeks. When they undertake CFHI's pre-departure online module, students are made aware of their roles as 'learners' and are told not to practise beyond their level of training while overseas.

Data collection

Study participants were selected by the administrative coordinators or head physicians of the CFHI sites in Bolivia and India. Thirty-five of the selected study participants were available for interview (response rate unknown); 34% were LMIC host community physicians ($n = 12$), 26% were directors or social workers of local NGOs that offered opportunities for CFHI trainees ($n = 9$), 17% were programme administrators ($n = 6$), and 23% were home-stay family members ($n = 8$). All study participants had been born in their respective LMIC host community or had lived there for at least 20 years. Additionally, all participants had interacted with HIC trainees for 3–8 years. Women constituted 40% of the sample ($n = 14$). The programme site in India offered trainees additional opportunities to work with Indian NGOs and social workers, and consequently we were able to interview this additional cohort. Participant characteristics are displayed in Table 1.

Participants engaged in 45-minute, semi-structured, face-to-face interviews with a third-party interviewer, unaffiliated with CFHI. Interviews were conducted in the participant's office, home or hospital, according to the participant's preference. In Bolivia, interviews were conducted in Spanish, whereas in India, interviews were conducted in English. All participants in India were fluent in English. Interviews allowed for exploration of unanticipated statements and were tape-recorded to ensure accuracy and preserve organic speech flow. Data collection continued until data saturation. Interviewees were not compensated for their participation in the study. Institutional review board approval was granted by Stanford University.

Table 1 Low- and middle-income country host interviewee characteristics

Participant group	Bolivian, *n*	Indian, *n*
Physician preceptor	5	7
Local NGO director or social worker*	0	9
Programme administrator	2	4
Home-stay family member	5	3
Total	12	23

* Unlike the Bolivian programme site, the Indian site offered trainees additional opportunities to work with Indian NGOs and social workers; consequently, we interviewed this additional cohort
NGO = non-government organisation

Data analysis

We transcribed all interviews verbatim. To facilitate data analysis, we translated Spanish transcripts into English, and asked translators to listen to a sample of interviews and verify translations. We developed a grounded coding scheme based on previous studies of host perspectives of trainee impact in US service-learning placements.[26,27] We applied codes manually to a line-by-line analysis of each transcript. We subsequently analysed using thematic analysis,[28] using the qualitative data analysis software NVivo Version 10.0 (QSR International Pty Ltd, Melbourne, Vic, Australia) to apply codes and compare data. Throughout the coding process, we noted emergent themes and identified relationships and contrasts between original themes.[29] After at least three rounds of coding, we applied multiple matrices to identify similarities, contrasts and interrelations among the perspectives of the four key populations across India and Bolivia.[29] Once analysis was completed, we sent our results to two participants in both countries to seek feedback and confirmation through member checking. These participants expressed satisfaction that the research accurately reflected their opinions.

RESULTS

Rise in local prestige

Nearly all physicians in both India and Bolivia (83%, $n = 10/12$) claimed that working with a US-based organisation and hosting HIC trainees

increased the prestige of their medical centre in the eyes of the community. Physicians reported that their patients were impressed that HIC trainees had travelled from far away to learn from the patient's local personal physician. An Indian physician stated:

> 'Most of our patients are appreciative, and some think, "My doctor has visitors from other countries. Okay, the doctor is so learned because he is teaching the foreign student."'

The presence of HIC trainees was perceived by patients to elevate the local physician's skills and the quality of care provided.

This effect appeared to be more pronounced for rural or small town-based providers and those serving predominantly low-income patients. A homeopathic medicine physician described the HIC trainees as a 'racial advertisement' for his clinic. A programme administrator reported that rural clinics hosting HIC trainees had grown in popularity since trainees had begun to arrive about 10 years earlier and attributed this growth to the 'name and fame' that accompanies the title of CFHI preceptor.

Local physicians told stories in humorous tones about patients who cherished the knowledge of HIC trainees, perceiving the trainees as possessing high qualifications beyond their actual level of training. One doctor described patients who brought in their old medical files for HIC trainees to look over, hoping they could recommend additional treatment or an astute diagnosis. The physicians unanimously agreed they did not find their patients' attention to the trainees frustrating. One physician noted:

> 'White skin is an advantage for us... we should use it.'

Physicians explained that local community members equated the trainees' visible foreignness (White or other race) with wealth, power and influence.

High-income country trainees bolstered the legitimacy of local NGOs serving socially marginalised populations. The director of an Indian transgender centre explained:

> 'Your visits help us because the community can see that other people are also supporting us. Maybe they see you, foreign students, and funding agencies, and then the community thinks we are doing good work.'

Host community collaborators regarded their HIC collaborators' willingness to work with them as representing recognition of their skills, and endorsement of their clinic, hospital or NGO.

Serving as global citizens

Global health immersion programmes transform local physicians' day-to-day clinical duties by requiring them to engage in the role of educator; they teach HIC trainees and broaden their perspectives of the world. Multiple physicians stated that their motivation for receiving HIC trainees was to fulfil their role as a 'global citizen' and that they were happy to have an influence beyond their country's geographic borders. A Bolivian physician said:

> 'This opportunity makes me feel important... I can build something more that is not only in my country, but outside my country.'

All physicians reported that the ability to teach HIC trainees from around the globe leads to greater job satisfaction.

Although the stay of HIC trainees is short, physicians were eager to use this opportunity to inspire civic engagement among HIC trainees. Physicians felt a sense of duty to teach HIC trainees from affluent nations about the difficulties of LMIC health care systems. One physician stated of US-based trainees:

> 'I believe they are leaving Disneyland.'

Host community physicians hoped that HIC trainees would draw from these experiences when making career decisions. Although 25% ($n = 3$) of physicians reported hoping that HIC trainees would come back to work in Bolivia or India after finishing training, the remaining 75% ($n = 9$) of physicians did not expect students to reappear. Rather, they expressed a desire for HIC trainees to return home with a dedication to public service and a better understanding of underserved populations in their own countries. Some Bolivian physicians hoped that HIC trainees would develop a deeper sensitivity towards Latino patients. One Bolivian physician said:

> 'I believe the American students come here to become world leaders. If you only know your place, you are going to be a local leader. But if you open yourself to the world, you're going to be a world leader.'

Physicians expressed gratitude for the opportunity to shape young HIC trainees.

Broadening world views

Although several LMIC physicians wished that their local Bolivian and Indian students had opportunities to work in HIC health care settings first hand, all felt these aspirations were unrealistic as a result of cost-related barriers and a lack of infrastructure. In light of this, some physicians saw hosting HIC trainees as an opportunity to expose their local students to foreign health care, albeit indirectly. This exposure led to a number of benefits to local students according to local physicians; realising the minimal differences in skill and ability between themselves and HIC trainees, LMIC students gained increased communication skills, self-confidence and maturity.

Both home-stay families and physicians stated that local youth developed enhanced English language skills and broadened perspectives with regard to future career opportunities through working with HIC trainees. A physician running a rural adolescent clinic noted that, through interactions with HIC trainees, local youth now 'expect to have the opportunity to travel to other countries and study'. In both India and Bolivia, home-stay families commented that HIC trainees motivate adolescent home-stay children to develop their proficiency in English in the hope of increasing their travel opportunities and professional potential.

Resource enhancement

All host physicians reported that outside donations and funds enabled them to provide better health care services. Some HIC trainees transported medical supplies donated by HIC organisations to international host clinics. Doctors highly valued these donations, which included items such as gloves, syringes, bandages and stethoscopes. Physicians perceived the quality of these HIC supplies as superior to those available in their own country and said that having these supplies elevated their confidence.

Improved local networks and leadership development

Medical directors – local physicians who lead medical initiatives for each CFHI programme – are responsible for developing long-term relationships with a network of community-based physician educators. They reported that, in creating a cadre of local community-based preceptors, they were able to build a network of like-minded, public service-oriented colleagues. Programme administrators also reported benefiting from CFHI's local network, claiming to have gained increased leadership skills by managing relationships with the physicians and NGOs who precept HIC trainees.

Perceived hesitancy and apathy of trainees

In both Bolivia and India, 50% of physicians ($n = 6/12$) expressed exasperation that some HIC trainees were reluctant to touch patients in clinic. Physicians agreed that the HIC trainees stood at a distance and watched as if, in the words of one interviewee:

> '. . .they want to sit in a glass cubicle and look at people.'

Referencing the historic caste system, one Indian doctor felt HIC trainees behaved as if his patients were 'untouchables'. Summarising the general sentiment, one physician stated:

> 'Some students have had a lot of fear about sickness. Then I didn't know why they are studying medicine.'

Many physicians (67%, $n = 8$) noted that some HIC trainees were not proactive and did not ask questions. An Indian physician said:

> 'Quite a lot of them have been, you know, not interested much. . . But something has to come from them. I cannot just go blabbering on and on and on. So if the student is not showing an initiative. . . then maybe we don't feel like teaching those students. Then the rapport is not good.'

Physicians were largely involved with CFHI because they loved teaching, and they recalled hurtful moments when students had appeared bored in the clinic.

All physicians and programme administrators across both countries commented that HIC trainees generally did not take the initiative to do community work beyond required rotations. In these situations, it became apparent to host communities that the students' intentions were to enjoy themselves instead of giving back. A programme administrator stated:

> 'Students can do more, but don't do more. That's the sad part. Students want to have fun: rafting, trucking, going [to] the mall, partying late into the night. Students want to have fun. But it should not be fun only.'

This carefree behaviour contributed to the perception that trainees' intent to undertake the programme abroad was based mainly on the wish to build their résumé and gain enjoyment.

Unfulfilled promises

Programme administrators and physicians recounted their disappointment at the lack of continuity in relationships with HIC trainees. A physician stated:

> 'They just come and go. In their perspective, it's just a programme they're doing, and then they go back.'

Host communities in LMICs were hurt by the short-term mentality of some HIC trainees.

Programme administrators in both Bolivia and India stated that the worst thing an HIC trainee could do was to make unfulfillable promises. Many HIC trainees had promised physicians or NGOs that, upon returning home, they would fundraise, send supplies or return to India or Bolivia the following summer; the majority of HIC trainees had not yet carried out their commitments. Some host community members expressed resentment towards HIC trainees for whom they had helped set up research projects; the majority of these students did not remain in touch or provide collaborators with research results.

Lack of cultural sensitivity

A common frustration for host community collaborators was HIC trainees' insensitive and, at times, ignorant behaviour. Trainees were cited as taking insensitive photographs and rejecting customary hospitality offerings of tea and food. Host community members noted that HIC trainees travelling together in large groups of classmates or friends tended to be particularly insular.

Lack of equal opportunity

An observation that came up in conversations with LMIC host community collaborators was the frequency of visits by US-based staff of CFHI. Host community collaborators recognised the importance of face-to-face meetings to develop relationships, but believed it was possible for US staff to visit too often. After a certain point, host community members questioned the purpose of the frequent visits and sometimes tallied travel costs. A programme administrator stated:

> '[CFHI] is gathering the medical directors [and US staff] and flying them in for one night, during the peak holiday time. And paying for the hotel stays and food. . . I don't think that, as a socially responsible organisation, we should do that.'

Host community members recognised the great expense of these trips and sometimes felt that such spending did not align with their mission.

Some LMIC host community collaborators expressed disappointment that they had not received recognition or promotions commensurate with those of US-based staff. Local programme administrators saw US employees promoted from the position of coordinator to that of director and wondered why they had not received similar acknowledgement, given their long tenures with CFHI. Additionally, some LMIC host community collaborators wished that they had opportunities to travel to the US or to visit CFHI sites in other countries. Although many acknowledged the positive impacts of working with HIC trainees and US-based staff on their careers and personal development, some felt CFHI did not provide professional development opportunities comparable with those offered to US-based staff.

DISCUSSION

Although global health continues to gain momentum both within the medical field and interprofessionally, there are gaps in LMIC perspectives.[30] Our study begins to address the lack of understanding about LMIC community perspectives in the context of hosting HIC trainees. Multiple benefits and several drawbacks of hosting HIC trainees were reported by LMIC-based supervising physicians (Table. 2). The other key host community stakeholders consistently reported benefiting in other ways: (i) programme administrators gained improved networking and leadership skills; (ii) local NGOs attained increased prestige and networking, and (iii) home-stay families developed enhanced proficiency in English and broadened world views.

In reflecting upon the benefits of HIC trainee visits, host community members did not mention

Table 2 Benefits and drawbacks of hosting high-income country (HIC) trainees as reported by host supervising physicians

Benefits
Increased prestige for local physicians and their practices
Opportunities for leadership, networking, and developing global connectedness
Increased job satisfaction
Health resources and supplies brought by HIC trainees
Opportunities for local students to interact with HIC trainees
Increased motivation to pursue professional development opportunities commensurate to HIC-based staff
Drawbacks
Frustration associated with HIC trainee hesitancy and apathy
Disappointment regarding short-term, transactional relationships between HIC trainees and hosts
Disappointment in HIC trainee failure to fulfill commitments
Frustration with lack of parity in professional development opportunities between HIC and host country staff

improved patient care or community health outcomes, although these are the benefits perceived by some HIC trainees and are often touted in recruitment for global health international programmes.[31,32] Rather, locally practising physicians commonly cited the presence of HIC trainees as boosting their job satisfaction, global connectedness and prestige. Our findings reinforce the belief that the presence of HIC trainees improves the professional image of the host clinical site.[24,33] This supports the notion that HIC trainees in the roles of learner, admirer and observer of local physicians support global health. Our results confirm the suggestion that a main motivation for teaching HIC trainees is to fulfil the supervising physician's role as a global citizen, indicating that benefits are perceived to extend beyond the individual HIC trainee.[22,33,34] These results have implications for those establishing or continuing international programmes as the presence of HIC trainees can be seen to represent an endorsement of a particular clinic or provider. This may be a reason to ensure that HIC trainees are placed with quality health care providers within the community so that the locally defined, highest standard of care is endorsed by global partnerships. Further research exploring the intersections of race and international health-related programmes, as well as LMIC host preceptors' conceptualisations of 'global citizenship' are needed.

Our study is limited by several factors. Interviewees were recruited by local CFHI leadership, which potentially may have skewed the pool of respondents. However, recruitment was carried out by host community collaborators rather than by HIC-based CFHI employees as these individuals maintained the best networks of potential interviewees. The interviewer came from an HIC, which potentially may have altered the manner in which questions were asked or answered. As the majority of study participants are paid an honorarium by CFHI for teaching and hosting, interviewees may have feared that negative feedback might compromise their relationship with CFHI and present an economic risk. To minimise these concerns, participants were assured of their anonymity and of the interviewer's independence of CFHI. The distribution of participants (23 in India and 12 in Bolivia) was weighted towards Indian participants as the Indian site had a larger network of preceptors and an additional community health outreach component. Although we sought to confirm our findings with interview participants by member checking, we received feedback from only two participants. Furthermore, the generalisability of results may be limited as LMIC host community members are not homogeneous globally, and HIC trainee activities may take place in different philosophical contexts with NGOs other than CFHI.[14]

Our findings reveal conflicts that may result from activities that are considered to be best practice in global health.[5] Physicians in both countries cited HIC trainees' reluctance to physically touch patients, which was interpreted as indicative of trainees' prejudice against 'unclean' or 'untouchable' patients, as well as trainees appearing 'bored'. Meanwhile, increasingly stringent standards originating in HICs are calling for the activities of pre-health students to involve observation only, and for all students to avoid practising beyond their level of training, or even to narrow their scope of practice when in novel international settings.[5,35] Our results indicate a need for discussions between LMIC host community collaborators, HIC institutions and HIC trainees to detail how trainees can touch patients in a humanistic way without overstepping ethical or safety boundaries, while demonstrating active learning and engaged observation.

Host community collaborators were particularly sensitive to the making of unfulfilled promises by visiting HIC trainees. The short duration of STEGHs often transfers to a short-term mentality regarding commitments. Sending novice clinicians and trainees with short-term commitments, yet relatively

massive financial capital, raises concern that such programmes confer inappropriate amounts of influence to young travellers. Our results indicate that pre-departure training for HIC trainees should include the provision of information on the potential detrimental impact of making unfulfilled promises and lack of follow-through with host communities.[36]

Host community programme leaders believe that organisational spending and professional developmental opportunities disproportionately benefit HIC-based staff. Although HIC-based universities and non-profit organisations often have obligations to conduct site visits for risk management, monitoring and evaluation, and other reasons, these trips can appear unnecessary and even frivolous in the eyes of LMIC partners, particularly when they are coupled with tourism. Our results reinforce the tenets of Fair Trade Learning with regard to reciprocity for international partners of HIC-based organisations.[37] Programme leaders from LMIC host communities want parity with US-based staff in terms of travel opportunities, professional development and promotion structure; this unique finding is important for continuing quality improvements towards equitable global health partnerships.

CONCLUSIONS

This study describes the perspectives of LMIC host community supervising physicians and local programme leadership in the context of STEGHs. Our results indicate numerous benefits to host community members, including improvements in job satisfaction, local prestige, global connectedness, local networks, leadership skills, resources and sense of efficacy within their communities. Host collaborators call for improvements in HIC trainee attitudes and behaviours and the avoidance of unfulfilled promises. Findings also provide cautionary tales to ensure parity of opportunities for US-based staff and LMIC-based partners. Overall, this study begins to capture LMIC host community perspectives about the placement of HIC trainees. Additional studies in diverse geographic settings and disciplines, and within differing global health partnership structures, are needed.

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Conflicts of interest: JE is executive director and EJ is founder of Child Family Health International (CFHI) and hence are not independent of the organisation that is the subject of this research. Data collection and analysis were completed independently.

Ethical approval: this study was approved by the Institutional Review Board, Human Subjects Department, of Stanford University (protocol no. 24004; 27 April 2012).

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