Trainees and clinicians from high-income countries are increasingly engaging in global health (GH) efforts, particularly in resource-limited settings. Concomitantly, there is a growing demand for these individuals to be better prepared for the common challenges and controversies inherent in GH work. This is a state-of-the-art review article in which we outline what is known about the current scope of trainee and clinician involvement in GH experiences, highlight specific considerations and issues pertinent to GH engagement, and summarize preparation recommendations that have emerged from the literature. The article is focused primarily on short-term GH experiences, although much of the content is also pertinent to long-term work. Suggestions are made for the health care community to develop and implement widely endorsed preparation standards for trainees, clinicians, and organizations engaging in GH experiences and partnerships.

Throughout our careers, we encounter responsibilities that require specific preparation and training. Individual “rites of passage” during medical school include learning proper scrub technique before entering the operating room and using weight-based dosing for management of pediatric patients. Institutions are held accountable to preparation and training standards: the “see one, do one, teach one” approach to medical training is now insufficient in the era of competency-based education. Trainees who do not take the time to adequately prepare for clinical experiences may be considered negligent and unprofessional; programs that do not comply with training standards outlined by the Accreditation Council for Graduate Medical Education risk losing accreditation; and providers seeking to incorporate new procedures into their practice, such as circumcisions or sedations, must first receive training and demonstrate competency.

No similar preparation standards exist for trainees and clinicians participating in global health (GH) experiences, although experts emphasize the importance of preparation, given the likelihood of encountering significant differences in language, culture, patient diagnoses and acuity, health care resources, and clinical practices. Despite the lack of preparation standards, it has become increasingly common over the past several decades for trainees and health care professionals from high-income countries to engage in short-term GH experiences in resource-limited settings, often regardless of previous experience, adequate preparation, or coordination with local partners. Personal motivations cited in the literature for these travelers include a desire to help address GH inequities, pursue interest in GH as a topic of study, experience exotic travel/escapism, improve clinical diagnostic and technical skills, respond to faith-based motivations or to a...
perceived calling toward GH work,\textsuperscript{23,25} improve one’s professional prospects through networking or by “resume building,”\textsuperscript{22,23,26} or gain esteem of friends and family.\textsuperscript{27–29}

Although many benefits from participation in GH experiences have been cited for the visiting trainees and clinicians, insightful critiques have arisen regarding the phenomenon of “medical voluntourism,” a (generally) pejorative term referring to health care personnel engaging in short-term experiences in underserved settings that is similar to “voluntourism,”\textsuperscript{26,27,30–34} which describes travelers seeking experiential or altruistic alternatives to traditional vacations.\textsuperscript{35} Multiple authors have documented ethical, professional, cultural, sustainability, community, and patient safety concerns associated with medical voluntourists, particularly when the visitors are not adequately qualified, prepared, or supervised.\textsuperscript{24,36–40}

Despite this awareness, there has been minimal formal evaluation of the positive or negative impacts of short-term GH experiences, particularly in regard to the short- or long-term effects on the communities served.\textsuperscript{25,41} Many have offered calls to action to address the issues surrounding short-term GH experiences\textsuperscript{3,11,14,34,37,40,42–49} including frequent recommendations for improved pretravel preparation for the visitors.

It is beyond the scope of this paper to identify the auspices under which GH engagement is done “correctly” or “incorrectly.” Instead, the authors recognize that (1) health care professionals are increasingly traveling from high-income countries to resource-limited settings for the purposes of GH experiences\textsuperscript{37,40,50} (Table 1); (2) people are motivated to engage in GH for a variety of reasons, including geographical disparities in provider coverage; (3) GH engagement often occurs on a short-term basis because of time constraints; and (4) regardless of the circumstances, preparation is a fundamental substrate for health care providers considering working in global, resource-limited settings.

The purpose of this article is to (1) outline the current scope of involvement of medical trainees and clinicians in GH experiences as most commonly encountered (eg, from high-income countries to resource-limited settings on a short-term basis); (2) highlight specific considerations and issues pertinent to GH engagement that inform the need for preparation; (3) summarize recommendations that have emerged from the literature for preparing trainees and clinicians for GH experiences; and (4) propose next steps to optimize preparation practices for health care professionals seeking to engage in GH experiences.

Although we will focus primarily on considerations pertinent to short-term GH engagement (defined here as <8 weeks in duration and involving both clinical and nonclinical experiences, such as research, education, quality improvement, public health, and community-based efforts) in this article, much of the information is also relevant for long-term work, because the initial engagement and preparation processes for both have overlapping features.

The authors are mindful that variable terminology exists in the literature pertaining to GH. For the purposes of this article, the authors will define GH as “collaborative trans-national research and action for promoting health for all”;\textsuperscript{72} will refer to international collaborators as “hosts” and “in-country partners”; will refer to medical students, residents, and fellows collectively as “trainees”; and will refer to physicians, physician assistants, and nurse practitioners collectively as “clinicians.” When referring to both trainees and clinicians, the authors will use the word “providers.” When discussing “preparation,” we are referring to preparation of the individuals from high-income countries who plan to engage in resource-limited settings. Preparation of host providers is a separate topic that warrants additional investigation that is outside the scope of this article but is an important consideration in the preparation framework for visitors and in-country hosts.

**SCOPE OF GLOBAL INVOLVEMENT**

It is difficult to estimate the number of providers from high-income countries who engage in short-term GH experiences in resource-limited settings each year, particularly when considering all specialties, all countries, and all types of health-related work, because there have been no systematic efforts to measure this flow of providers. The authors of one study estimated that in the United States alone, nearly 3 billion dollars in volunteer hours were spent on international efforts in 2007, not including travel expenses, with ~21% of the work being medically related.\textsuperscript{33,40,41}

Much of the published data about the involvement of US health care professionals in short-term GH concerns medical trainees. A review of the medical trainee scope of global involvement is summarized in Table 1, with a further breakdown of pediatric providers summarized below:

- Pediatric residents: In the 2013–2014 academic year, 99% of US pediatric residency programs responded to a survey pertaining to GH training. During that year, ~7% of pediatric residents participated in GH electives, which was consistent with a 2008 study’s findings that 21% of pediatric residents completed a GH elective during their full 3 years of training.\textsuperscript{50,62} Fifty-eight
TABLE 1 Estimates of US Undergraduate Medical and Graduate Medical Trainee Involvement in GH

<table>
<thead>
<tr>
<th>US Trainees</th>
<th>Year(s) of Data Collection</th>
<th>Scope of Global Involvement and Recent Trends</th>
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<tr>
<td>Graduate medical education</td>
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<tr>
<td>Anesthesiology residents</td>
<td>2010</td>
<td>91% of anesthesiologist resident survey respondents reported interest in GH, with 15% completing a GH elective during residency.</td>
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<tr>
<td>Emergency medicine residents</td>
<td>2009, 2013</td>
<td>An estimated 74%–80% of US emergency medicine residency programs reported at least 1 resident participating in a GH elective during the surveyed year.</td>
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<tr>
<td>Family medicine residents</td>
<td>1998</td>
<td>In 1998, 45% of family medicine residency program survey respondents offered some form of GH elective.</td>
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<tr>
<td>Neurology residents</td>
<td>2012</td>
<td>Just over half of US neurology residency program survey respondents allowed GH electives. Of those, 55% of programs had 0%–9% of residents participating annually and 21% had 10%–19% of residents participating annually.</td>
</tr>
<tr>
<td>Ophthalmology residents</td>
<td>2012</td>
<td>54% of ophthalmology residency program survey respondents offered GH electives.</td>
</tr>
<tr>
<td>Orthopedic residents</td>
<td>2014, 2015</td>
<td>26% of orthopedic residency program survey respondents offered GH electives.</td>
</tr>
<tr>
<td>Otolaryngology residents</td>
<td>2010</td>
<td>23% of US otolaryngology departments identified GH initiatives within their departments; 50% of those initiatives supported resident involvement.</td>
</tr>
<tr>
<td>Pediatric residents</td>
<td>1995, 2006, 2008, 2014</td>
<td>58% of pediatric residency programs offered GH opportunities in 2014, up from 25% in 1995. An estimated 7% of pediatric residents went abroad during the 2013–2014 academic year; a 2008 survey of graduating residents indicated that 21% had completed a GH elective during their cumulative 3 years of training.</td>
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<tr>
<td>Pediatric subspecialty fellows</td>
<td>2008, 2011</td>
<td>Pediatric subspecialty fellowship GH opportunities advertised on the AMA-FREIDA Web site rose from 16% to 23% when comparing 2008 and 2011 online data from a convenience sample of 6 pediatric subspecialties.</td>
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<tr>
<td>Plastic surgery residents</td>
<td>2015</td>
<td>64% of plastic surgery residency program survey respondents sponsored resident participation in GH mission trips.</td>
</tr>
<tr>
<td>Psychiatry residents</td>
<td>2008</td>
<td>42% of psychiatry residency program survey respondents offered GH electives.</td>
</tr>
<tr>
<td>Radiology residents</td>
<td>2010</td>
<td>4% of radiology residents indicated their residency programs offered international radiology rotations, although 72% expressed a desire to pursue international medical aid work in their career.</td>
</tr>
<tr>
<td>Surgical residents</td>
<td>2008</td>
<td>Surgery resident interest in GH has been reported as high; however, in 2008 only 25% of general surgery residency program respondents offered clinical experiences abroad for trainees.</td>
</tr>
<tr>
<td>Residents, all</td>
<td>2013</td>
<td>A query of 1856 ACGME-accredited residency program websites found that 380 (20%) offered GH programs (55% with elective-based rotations, 23% with research programs, 15% with extended curriculum-based field training, and 6% with other or uncategorized GH programs).</td>
</tr>
</tbody>
</table>

AMA-FREIDA, American Medical Association Fellowship and Residency Electronic Interactive Database Access

percent of residency training programs offered international field experiences, and 25% of programs reported having a GH “track,” or specific residency-based curriculum focused on GH50;

- Pediatric subspecialty fellows: An online review of fellowship training programs accredited by the Accreditation Council for Graduate Medical Education within a convenience sample of 6 US pediatric subspecialties was performed for the 2011 calendar year. Of the 360 programs reviewed, 23% listed GH opportunities on the American Medical Association Fellowship and Residency Electronic Interactive Database Access and 16% on individual program websites65; and

- Practicing pediatricians: The American Academy of Pediatrics (AAP) last surveyed a random sample of 1000 pediatrician members on GH in 1989 and is in the process of incorporating GH-related questions into the 2017 Periodic Survey. In 1989, of the 708 respondents, 2% were participating in overseas programs and 46% were interested in serving overseas (68% preferring to provide clinical care and 26% preferring to teach) (AAP, unpublished observations, 1989). In 2013, a mixed-methods survey of physician leaders who had completed the Robert Wood Johnson Foundation Clinical Scholarship Program revealed that 44% of the 97 pediatricians had participated in GH experiences since completing the fellowship, with 82% of those indicating involvement within the past year.73 The aforementioned pediatric provider groups have a variable array of resources available to them for preparation for GH engagement, including institution-specific preparation curricula for trainees (when available); simulation curricula; continuing medical education preparation courses for clinicians; and preparation training.
However, to date, there have not been preparation standards set forth for these provider groups, and there has not been a mechanism to track degree of access to (or participation in) preparation activities, with the exception of a survey of residency training programs performed in 2013. Notably, of the residency programs that offered international field experiences in 2013, only 66% offered pre-travel preparation (the type and extent of preparation methods were not queried in this survey).50

**SCOPE OF GLOBAL EXPERENCES**

In addition to the wide range of clinical specialties engaged globally, the types of experiences vary greatly. Short-term clinical experiences can range from setting up tent clinics using donated medical supplies to joining a local medical team in a hospital setting. Research involvement may range from participating in informal needs assessments to robust research projects approved by institutional review boards. Similar spectrums of involvement exist for short-term GH work involving education and technical support, advocacy and policy efforts, community-based programs, and public health initiatives.

Regardless of the type of experience, in all situations, the host population engages with the visitor on some level, and there are risks associated with hosting health care providers who are suboptimally prepared. Many of these risks are discussed in the next section.

**SPECIFIC CONSIDERATIONS AND ISSUES**

Despite the fact that the nature of GH involvement can vary widely, there are several common challenges providers should anticipate when preparing for and working internationally. Figure 1 provides an overview of issues that frequently arise when working in a different country, including logistical and cultural challenges, navigating an unfamiliar health system with limited resources and different workflow expectations, and encountering different clinical contexts with disease patterns and presentations rarely encountered in the provider’s home setting. In this section, we will address 6 of these considerations.

**Logistics**

To date, there is not a systematic method for tracking how providers become involved in short-term GH work. Anecdotally, providers engage through a variety of outlets including making independent arrangements through personal connections, working with nongovernmental organizations, joining faith-based medical mission teams, or participating in established academic institutional partnerships. Regardless of the route of engagement, providers must consider several important issues, including whether they have been invited, what the direct and indirect costs are of participating, whether there is a memorandum of understanding between partners, what type of paperwork is needed (eg, medical license and registration, visas and work permits, malpractice coverage), whether it is a safe and appropriate time to travel to the region, and whether they have health and evacuation insurance. In addition, basic travel logistics such as transportation, lodging, and communication can be challenging to coordinate when traveling to remote parts of the world. Many of these questions and logistical issues can be addressed by working through an established partnership and/or by working closely with a mentor (local or at the host destination) who is familiar with the setting and type of experience.

**Personal Health and Safety**

Working in a different country and health care system with different

![Figure 1](https://example.com/figure1.png)
epidemiologic patterns poses unique concerns for the provider’s own personal health and safety. These include increased risk of injury such as road traffic incidents (the leading cause of death of US citizens in foreign countries) and increased exposures to potentially life-threatening infectious diseases, either as occupational hazards (eg, HIV or tuberculosis) or in relation to the regional disease patterns (eg, traveler’s diarrhea or malaria). Additionally, providers may face challenges accessing personal health care. The emergence or exacerbation of mental health concerns in the context of increased stress, high patient morbidity and mortality, and navigating culture shock during GH experiences has also been reported. Outside of personal health, there may be safety risks inherent in traveling to places with political, social, religious, or racial unrest.

Practical Obstacles and Emotional Responses Encountered in Resource-Limited Settings

In addition to logistical considerations, there are several common challenges providers experience when working in different clinical settings without access to familiar resources. Many of these practical obstacles (eg, not knowing how to manage a condition without the resources you are accustomed to using) may manifest as emotional challenges (eg, frustration). In 2014, Butteris et al summarized several of these emotional themes informed by practical challenges as follows:

• Frustration is often caused by knowing what one would normally do to manage a clinical condition and finding that the normal approach is not possible because of a lack of familiar supplies and resources. These limited resources may include a lack of medication or equipment, decreased laboratory and/or imaging support, fewer human resources, and team structures or clinical roles that differ from what one is used to (eg, task shifting and differing expectations of the role of nurses or medical students);
• Floundering occurs when one is faced with managing unfamiliar medical conditions and not knowing what to do or where to get help;
• Failure is experienced when a patient does not respond as expected or when one is faced with higher mortality and morbidity, and
• Futility is experienced when one is unable to change the course of a disease process or address the higher burden of disease and death and when dealing with the (mis) perception that hosts may not care as much about patient losses, compared with providers at one’s home institution.

Although many of these scenarios may occur in one’s home setting (eg, encountering an unfamiliar disease or a poor patient outcome), the emotional responses may be intensified when working in an unfamiliar setting with different disease patterns, limited resources, and the lack of a local support network. Additionally, although these emotions were described for providers undertaking clinical GH experiences, similar themes exist for those involved in research and teaching in resource-limited settings, including frustration at navigating unclear institutional protocols for research, floundering in what may be seen as an inefficient system, perceived failure if asked to give a lecture with minimal attendance, or perceived futility if describing an educational intervention that may be unrealistic to implement.

Culture and Culture Shock

Many of the challenges providers face during short-term international experiences stem from working in a new cultural setting. Culture shock is a frequent and well-described phenomenon, which manifests as stress or discomfort experienced in an unfamiliar cultural environment caused by the absence of familiar meanings and cues.

Culture shock is often the result of attempting to navigate cultural differences at the societal level, ranging from practical things (eg, language, food, religion) to more nuanced issues, such as differential treatment of men and women, stereotypes of specific races and/or ethnicities, and/or views (and, at times, laws) pertaining to sexual orientation. Responses to these challenges may manifest even before entering the system in which the provider will be working. Within the health care system, cultural differences may be further magnified directly or indirectly through local perceptions of the cause of disease or illness, roles of traditional healers and/or front-line community health workers, different views on patient autonomy and shared decision-making, and differing expectations of medical providers’ roles in a more hierarchical system.

Pediatric providers in particular may struggle with cultural differences surrounding the perceived value of children to society and their varied rights (or lack thereof), including different expectations surrounding children contributing to the workforce or pertaining to children in arranged marriages.

Ethics

It is beyond the scope of this report to delve deeply into the literature regarding the ethics of GH engagement, but ethics of short-term GH experiences are an important consideration. Ethical best practices cited in the literature include, but are not limited to, ensuring that motivations for global engagement are ethically sound, aiming to work as part...
of mutually beneficial, sustainable partnerships;\textsuperscript{14}22,95; considering the burden of the visitors’ presence and resource redistribution\textsuperscript{15,21,22,37,96,97}, and strategizing about ways to minimize this burden (eg, longer experiences may allow providers to get beyond the steep learning curve common to these encounters).\textsuperscript{98} Providers should realize that their own “standards of care” are often culturally and contextually defined and may not be practical or even feasible for use in the new setting, which may have its own standard way of approaching a clinical or research problem.\textsuperscript{22,25,37} Providers may also encounter personal and professional ethical dilemmas while participating in GH experiences, including requests to practice outside of their knowledge base or scope or requests to supervise nonmedical volunteers assisting with medical work (eg, dispensing medications, helping with procedures) that may place patients and themselves at risk.\textsuperscript{15,43,88,99,100} One must consider the ethical and legal ramifications of providing health care outside of one’s home country.\textsuperscript{93} Providers may also face uncertainty about allocating limited resources\textsuperscript{37,99,101} or regarding distribution of donated (possibly expired) medications and supplies when there is no clear indication they are needed.\textsuperscript{21,25} Varied approaches to death by families and local providers, within systems in which end-of-life care policies are unclear or nonexistent, can also prompt ethical dilemmas for visiting providers.\textsuperscript{102,103} Additionally, ethical challenges may arise regarding participation in research (eg, when conducted without informed consent or institutional ethical approval), especially if faced with the time pressures of trying to complete work during a short-term experience.\textsuperscript{42,99,104}

**Impact on Hosts**

One of the important ethical considerations regarding short-term GH experiences pertains to the balance of burdens and opportunities for the hosts (Fig 2),\textsuperscript{14,45,95,105} The term hosts is broad and can include the providers directly involved in supervising these experiences, other providers in that setting or in the community who may be affected by the visiting providers’ experience, the clinical setting (hospital or clinic), and the patients themselves. Although host providers often endorse working with visiting providers and report benefits of collaboration and bidirectional teaching, they also report several burdens.\textsuperscript{96,106,107} Examples of burdens cited by host providers include decreased efficiency caused by the time spent orienting and supervising visiting providers who are unfamiliar with the local language, workflow, resources, and diseases and dealing with perceptions that the visiting providers may question their expertise or skills or view them more as tour guides than as clinical providers.\textsuperscript{96–97,106} Although some international hosts have administrative support to help with the logistics of maintaining partnerships and hosting visitors, this burden often falls on the local providers. Local providers not directly involved in hosting the visitor(s) may also be burdened economically, and local health systems may be undermined or marginalized when patients are routed to the visiting providers, who may erroneously be perceived as superior.\textsuperscript{21,37,108} Patients can also suffer directly by receiving inappropriate care that does not follow local guidelines or public health initiatives or when visiting providers are unable to provide adequate follow-up care.\textsuperscript{95,96,106}

**PREPARATION: CURRENT STATE**

To address many of the considerations and challenges listed in the previous section, a variety of recommendations have been offered in the literature pertaining to standards for preparation before engagement in GH work of any duration.* These recommendations address multiple themes, which are summarized in Table 2.

Despite the variety of recommendations that have been proposed for preparation, little is known about the type of preparation trainees are actually receiving across training institutions for various short-term GH educational experiences.\textsuperscript{50,128} It is even more challenging to determine the breadth and type of preparation being used, if any, for the short-term GH engagement of practicing clinicians outside of the auspices of residency and fellowship training, such as medical mission trips conducted through religious or nongovernmental organizations.

**PREPARATION: NEXT STEPS**

In this article, we have outlined what is known about the current scope of trainee and clinician involvement in GH experiences, highlighted specific considerations and issues pertinent to GH engagement, and summarized preparation recommendations that have emerged from the literature. Although there are many suggestions for different types of preparation, to date there are no widely endorsed “minimum preparation standards” for short-term GH experiences for providers. One perceived challenge in developing this type of standard is addressing the variety of experiences discussed earlier. A similar challenge exists when attempting to define core competencies for GH clinicians because the competencies required for educators, clinicians, advocates, and researchers vary significantly and are difficult to

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evaluate, especially after short-term involvement in resource-limited settings. Regardless of the challenges inherent in making 1-size-fits-all recommendations, baseline preparation for cultural, ethical, health, safety, and logistical considerations is applicable across all domains of GH experiences.

The authors hope that this summary of recommendations drawn from the literature will inform the development of policies pertaining to minimum preparation standards for providers considering GH experiences. Membership organizations, such as the AAP, are optimally positioned to develop such standards, and the AAP is currently developing a policy statement on preparation for short-term GH engagement. On the basis of the summary of preparation themes provided in Table 2 and author experience, we propose a list of “top 10” considerations for provider preparation for short-term GH engagement, with the caveat that preparation should be mindfully adapted to meet the specific needs of the traveler, the partnership, the host site, and in-country stakeholders:

1. Explore personal motivations for working globally: avoid poverty tourism, seeking opportunities to practice outside the scope of your expertise, “drop-in” visits outside of a sustainable framework, and paternalistic pursuits. Also ensure that you have a firm understanding of the importance of cultural and professional humility before global engagement;

2. Choose an ethically sound GH opportunity: review the Working Group on Ethics for Global Health Training recommendations pertaining to ethical partnerships and seek opportunities that are ethically sound, mutually beneficial, and preceded by clear communication and agreement with the hosts regarding the purpose and goals of your visit;

3. Ensure that goals are openly addressed prior to the visit:
| Logistics and safety | Personal health (physical and mental) | Review basic and site-specific health precautions related to international travel and working in different clinical settings (eg, malaria prophylaxis, water and food safety, postexposure prophylaxis, occupational exposures, recreational exposures [including sexually transmitted infections], pretravel immunizations, and health insurance) | 3, 6, 9, 10, 11 |
| Safety | Consider personal medical and psychiatric history, because exacerbations of physical and mental illness are common during GH experiences. | 5, 6, 9, 10, 11 |
| Travel logistics | Identification of passport, visa, and customs requirements. | 6, 9, 10, 11 |
| Medical licensure | Contact the host site and the government to determine what is required for licensure, work visas, and registration to provide clinical care. | 13, 14 |
| Malpractice insurance | Determine personal malpractice coverage while working internationally and find in-country insurance. | 11, 14, 115 |
| Knowledge and skills | Medical knowledge | Participate in a comprehensive, longitudinal curriculum that addresses the diagnosis and management of common illnesses encountered in resource-limited settings (particularly diagnoses endemic to the region of interest). 2, 9, 10–12, 13, 27, 40, 55, 96, 109, 114, 117 |
| | Familiarize oneself with local disease patterns, reference materials, on-site formularies, and clinical practice guidelines, including resources available through the World Health Organization. 4, 14, 27, 46, 116, 119 |
| | Familiarize oneself with the host site health system’s organization, standard practices, resources, and challenges. 9, 16 |
| Health systems knowledge | Seek an overview of core concepts in preventive health, public health, and health development, particularly if engaging in humanitarian disaster response efforts, review the Sphere Project Humanitarian Charter and Minimum Standards in Humanitarian Response. 9, 106, 120 |
| | Engage in local advocacy efforts to reduce health disparities. 2, 37 |
| Procedural and practice skills (if applicable) | When applicable, refresh procedural skills for tasks that may be expected at the host site (eg, phlebotomy, intravenous line placement, lumbar puncture, etc). 37 |
| | Refresh general practice skills (if normally practicing as a subspecialist), given the likelihood of needing a wider breadth of competency in resource-limited settings. 37 |
| | Use simulation, case-based, and video-based modules that highlight creative approaches to diagnosis and management in resource-limited areas. 2, 37, 96, 109, 121 |
| Attitudes and behaviors | Personal motivations | Encourage introspection regarding personal motivations for engaging in GH experiences, and discourage participation if paternalistic attitudes prevail and/or individuals plan to practice outside of their scope of expertise without appropriate supervision. 12, 13 |
| Learner humility | Recognize that learning and teaching styles may vary significantly in different cultural paradigms, that host time for teaching is often limited, and that visitors may place a burden on host time and productivity. 12, 14, 132 |
| | Embrace the “observer” role during a GH experience, particularly for trainees and/or if requested by the host institution, and prioritize the needs of local trainees. 12, 13, 65 |
| | Respect the depth of understanding that local health care professionals have of the local health care system, resources, diagnoses, and challenges. 4, 12, 14, 46 |
**TABLE 2 Continued**

<table>
<thead>
<tr>
<th>Preparation Recommendations in the Literature</th>
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<tr>
<td><strong>Cultural humility</strong></td>
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<td><strong>Training</strong></td>
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<td><strong>Understanding of culture shock and reentry shock</strong></td>
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<td><strong>Professionalism and behavior</strong></td>
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<td><strong>Religion</strong></td>
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<td><strong>Language</strong></td>
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<td><strong>Needs and assets</strong></td>
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<td><strong>Sustainability</strong></td>
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<td><strong>Sustainability</strong></td>
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clearly identify your professional goals and scope of practice and ensure that they are in line with the host goals for your visit;

4. Gain insight into the in-country and on-site resources: when applicable, review formularies, diagnostic and other supplies, costs of treatments, payment systems, and other resources (eg, clinical, research, etc) at the host site;

5. Research the region, people, religion(s), local laws, and customs: engage in predeparture cultural studies and, when able, meet with people from the region or who have traveled and/or worked in the region;

6. Assess and prepare for on-site professional scenarios: identify the factors (eg, resources, endemic diseases, infrastructure, etc) that will inform modifications to your professional practice on-site and determine what additional training is required before the visit to adapt to those factors;

7. Assess and prepare for personal scenarios during travel: ensure that basic travel logistics are addressed and safety precautions are taken (eg, coordinate registration with the Department of State Smart Traveler Enrollment Program, the purchase of traveler and evacuation insurance, travel vaccines, malaria prophylaxis [when applicable], postexposure prophylaxis, safe modes of transportation, etc);

8. Research and recognize culture shock: review the stages of culture shock and recognize them during your own experience. Before travel, identify resources to assist you during the rejection and/or frustration stage of culture shock;

TABLE 2 Continued

| Impact on hosts | Establish supervisory and hosting agreements that recognize the burden that visiting health care providers place on hosts and offer appropriate compensation.5,8,14,46,96,100,111 Choose a visit time and duration that is tailored so that the burden to the host is minimized.14,98,111 |
| Communication | Establish plans for routine communication, both with the traveler and, if applicable, between institutional partners.2,3,6,12,14,37,109 |
| Predeparture selection processes | Identify host personnel who are available to discuss situations of concern or conflict, both for the visitor and pertaining to the visitor.2,8,14,109 |
| Predeparture, on-site, and postreturn communication | Create an access line at the traveler’s home institution for trainees and clinicians to contact in the event of an emergency.6,109 |
| Partnerships | Clearly identify your professional goals and scope of practice and ensure that they are in line with the host goals for your visit; |
| Choosing opportunities | Research GH opportunities and attempt to engage in experiences that are part of sustained, mutually beneficial partnerships that have explicit agreements pertaining to institutional and individual roles and responsibilities.2,4,14,27,108,127 |
| Predeparture selection processes | Encourage application processes for GH experiences, including a query of goals and objectives. Select providers whose skill sets are appropriate for the site and who are adaptable and demonstrate cultural sensitivity and humility; discourage participation for those with paternalistic attitudes and/or those seeking to practice outside of their scope of expertise.2,3,8,14,109 |
| Clear expectations | Provide transparent goals and objectives (visitors and sending institutions) and ensure that the host institution has an opportunity to review them and modify them if necessary.2,8,14,109 |
| Evaluation | Encourage venues to provide the visitor with ongoing and timely feedback regarding performance, issues, or concerns.6,14 |
| Complete evaluations of the experience if requested by the host site, the partnership, and/or the training institution.4,6,9,14,109 |
| Use debriefing sessions as an opportunity to obtain feedback and inform others of changes for training partnerships.2,6,8,14,111 |
| Develop regular opportunities for partnerships and programs to participate in joint or mutual evaluation, review of agreements, and improvements.6,14 |
9. Establish home communication plans through private venues and identify times for debriefing postreturn: ensure that communication meets professionalism guidelines (e.g., avoid public blogging, posting clinical photos, etc.) and that there is an opportunity established for debriefing postreturn; and

10. Foster clear communication with hosts, including development of bidirectional preparation goals, exploration of opportunities for sustainable collaboration, and incorporation of evaluation: establish ongoing communication during and after the visit to optimize sustainability and future engagement, both individually and as part of an institutional partnership if applicable.

Preparation standards across specialties should be carefully developed by GH experts who have had experience with mutually beneficial international partnerships, and who recognize the impact that short-term visitors can have on host communities. The preparation standards should also be reviewed and endorsed by stakeholders from “sending” institutions (e.g., academic training institutions in high-income countries and nongovernmental organizations); host institutions in low-, low-middle- and middle-income countries; trainees and health care professionals across disciplines and subspecialties with experience in short-term GH engagement; ethicists; anthropologists; and patients in host communities. Once preparation standards for the health care community are defined, resources can then be identified to encourage travelers to seek ethically sound, partnership-based GH opportunities and comprehensively prepare before GH engagement.

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ABBREVIATIONS

AAP: American Academy of Pediatrics
ABP: American Board of Pediatrics
GH: global health

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