



Workshop Summary

“Global/Local: What does it mean for global health educators and how do we do it?”

Consortium of Universities for Global Health Pre-Conference Workshop

March 25, 2015

Short Description of Workshop:

This pre-conference workshop was designed to study how universities, community partners, and NGOs are defining the concept “global/local” and “glocal” but more importantly, how they are operationalizing it. The goal of the workshop was to discuss the issue of global/local education from multiple perspectives and work with participants to arrive at conclusions and recommendations regarding global/local education and practice that can be shared with a greater audience. The workshop consisted of several plenary presentations, two rounds of lightning presentations, and two rounds of small group work including focused discussions and report outs. Over 110 people attended the workshop.

Primary Organizers:

- Virginia Rowthorn, JD, University of Maryland Carey School of Law and University of Maryland Baltimore Center for Global Education Initiatives
- Dr. Sharon Rudy, Director, USAID Global Health Fellows Program II
- Dr. Jody Olsen, University of Maryland School of Social Work and University of Maryland Baltimore Center for Global Education Initiatives
- Dr. Jane Lipscomb, Professor, University of Maryland Schools of Nursing and Medicine and Director, University of Maryland Center for Community Based Engagement and Learning
- Dr. Lori Edwards, Associate Director for Global Occupational Health, Office of Global Health, University of Maryland School of Nursing

Executive Summary of Workshop:

Participants at the workshop agreed that a new – and positive – trend in global health education is recognition of the local (U.S. domestic) component of global health. Programs that include this component of global health are often called “global/local” programs. In the global/local context, “local” usually means the global health student or practitioner’s home or

university community. For US-based global health university programs, “local” therefore refers to communities in the US and “global” typically refers to international systems or communities overseas. It is precisely because this description of global/local seems to raise outdated and complicated issues that a room full of educators met to initiate dialog on how to reframe global health in a way that explicitly acknowledges the universality of human health concerns and the importance of contextually appropriate solutions wherever they are needed. Global/local programs seek to break down or link two fields that have historically been siloed from each other - global health and community health and the university institutions, faculty, scholarship, funding and jobs that flow from these separate pathways.

Global health has always focused on the health of communities, but almost exclusively on communities outside the Global North and outside the students’ home environments. This was consistent with historical forces that encouraged the transfer of skills and services from countries with more resources to countries with fewer resources. However, workshop participants support the growing recognition that virtually all of the skills that characterize good practice in an international low-resourced setting are appropriate when working with vulnerable populations domestically and vice versa. In other words, the idea that one set of skills is needed for global health work (i.e. non-domestic work) and another for local work (i.e. domestic work) is mostly inaccurate and squanders opportunities for shared research and solutions. Participants also agreed that the intrinsic value of global/local programs is that they firmly place students on the same globe as those they seek to help which may encourage greater humility, greater empathy, and greater ties between health care professionals and patients/communities. Flowing from this perspective is likely to be a greater focus on the health needs of vulnerable communities in our own backyard, an openness to bi-directional learning, and learning how to adapt low cost/high impact innovations for use in the United States and other countries.

As educators, the global/local perspective naturally raises important definitional questions regarding the difference between public health, community health, global health, and international health – and all the trappings that accompany these different fields. It also makes us question whether we need to expand our portfolio of international placements to include domestic placements as well.

Although global/local is a critical component of global health education, workshop participants agreed that linking global and community health education conceptually and practically is complicated – the terms we use are unclear and how best to structure curriculum to meet the goals of global/local is unclear in the absence of best practices and well-publicized models.

Critical preliminary conclusions from the workshop – recognizing that no consensus was sought – are the following:

- **Reframe Global Health Education to Encompass the Global/Local Link:** Global health education should be reframed as the study of global health themes (e.g. chronic and

infectious disease, gender-based violence, social determinants of health) for which contextually appropriate local solutions are required. Under this framework, global health education should include the study of successful interventions that can be shared globally and adapted locally and methods to reduce the barriers that inhibit sharing and adoption of such interventions. However, some noted that there should be a way to distinguish generalizable knowledge and the normative work of international organizations such as the WHO – which is uniquely global - with what happens on the ground at the local level.

- **Global/Local as Social Justice:** Global/local programs should acknowledge the social justice barriers that prevent access to adequate health care in both domestic and international settings.
- **Global/Local as Transferable Skills:** Participants agreed that the many of the skills needed to succeed in global health and community health are similar (including profession-specific skills, cultural understanding and awareness, program design and evaluation) and more effort should be made to merge these two fields from education and employment perspectives.
- **Global/local should facilitate bi-directional learning:** Global/local programs should break down traditional “us/them” conceptions of global health and international aid that support a one-way flow of knowledge and services from the Global North to the Global South.
- **Create opportunities for students to experience global/local link:** Global/local programs should create mechanisms to give global health students an opportunity to integrate their global health education with local community engagement both didactically and experientially. For example, a social work student who works in an HIV/AIDS clinic in Thailand should be introduced to a setting in his/her home community in which social workers support individuals with HIV/AIDS either before or after the international experience. This meets the university’s obligation to its own community and models a domestic career path for a social worker interested in HIV/AIDS work.
- **Elements of a global/local course:** The following model elements of a successful global/local course or experiential learning experience emerged from small group discussions. A global/local program should . . .
 - Teach global health themes from international and domestic perspectives.
 - Focus on health care disparities.
 - Include ethics/social justice/human rights training.
 - Teach transferable skills while building professional skills.
 - Incorporate short-term community experience locally or internationally.
 - Include a short-term experience that meets community needs in short periods of time with students.
 - Engage the community, especially with immigrant populations, in the local and global aspects of an initiative.
 - Work early with community to identify needs.
 - Be sustainable.
 - Connect the university with local health care centers and advocacy groups.

- Work across schools and programs to break down silos and encourage interprofessional education.
- Include a reflective component.
- Use the same evaluation processes for both international and local engagement.

Although the overwhelming tenor of the workshop was positive, some participants noted that the path ahead is not easy. University-level barriers include administration and faculty resistance to a new conception of global health, rigid silos that make innovation difficult, and limited funding for cross-disciplinary initiatives. Also, although participants believe that global/local is the right thing to do for our students, for global health, and ultimately for the health of the world's populations, there is no evidence that a global/local approach improves health outcomes or health disparities. More research is in order. Caution was noted that academia must take into consideration the importance of ensuring that the educational experience not only prepares students for their career but also contributes to their being attractive candidates for employment.

Recommendations:

Several recommendations for follow-up activities emerged from the workshop:

- Words and definitions matter – the global health community should agree in principal on a definition of global/local or “glocal”. It is important to decide if global/local refers to a concept or a method of education. As an educational concept, is it something we teach or something we do or both? Is it part of the didactic curriculum, experiential learning, immersion experiences, and/or global health practice? How does global/local play out in the practice, employment and funding context?
- Models of successful global/local programs should be compiled and shared to facilitate development of new programs.
- A series of elements, themes, competencies and best practices should be developed in the global/local area to:
 - Train global health and community health faculty.
 - To inform curriculum development.
 - To facilitate creation of experiential and immersion learning programs, with an emphasis on creation of domestic programs in which global/local themes can be taught.
- Universities should consider shared curriculum across community and global health programs. One suggestion was to view global health through the lens of community engagement and social justice. In other words, start with community engagement and build global concepts on top of this foundation.

As a next step, the organizers will seek publication of an article detailing the outcomes of the March 25, 2015 workshop to initiate national dialog on these issues. Workshop leaders will work with CUGH to organize follow-on meetings to work on the recommendations that emerged from the workshop. The organizers will reach out to workshop participants who want to stay involved and, if possible, be part of a follow-on pre-conference workshop next year that focuses on global/local best practices and models.

Detailed Description of Workshop

Workshop Background: The number and scope of global health programs is growing rapidly in universities across the country. At the same time, most universities are also restating and enhancing their commitment to active community engagement, often in the form of efforts directed at impacting the social determinants of health in the community and to increase inclusiveness of community partners in the educational process. Increasingly, universities are trying to find ways to link their global health and community engagement initiatives. The terms “global/local” or “glocal” are frequently used to describe these efforts. These terms express an important but poorly articulated agreement that global health education’s international focus must be linked – conceptually and in practice – with the great needs in our own communities. However, the concepts underlying these terms are undertheorized and many universities struggle to make the global/local link in the absence of a conceptual framework and successful models to guide them in this pursuit.

A review of the literature indicates that very little work has been done to define the conceptual link between global and local health education and practice. This gap has led to a number of downstream consequences, including siloed global health and community health educational programming; an absence of educational models that successfully link global and local health; limited pathways for sharing lessons and innovations from the local level to the global level and vice versa; and rigid career paths that limit movement between both fields. Global/local calls into question whether the existing fields of global and community public health need to be collapsed to recognize that the boundary between global and local health is porous – and even artificial – and that public health concepts relevant at the local level are relevant at the global level and vice versa.

Although the “why” behind this effort is easier to answer than the “how” – the answers to both questions are complex and require an analysis of multiple fields and areas of scholarship including global and community public health; global citizenship; service and experiential learning concepts; program design and evaluation; and cultural competence among others. A review of global health literature and programs indicates that the term “global/local” is used in many different, and sometimes, conflicting ways. Reaching a common understanding of why global and local education needs to be linked is more than an academic exercise in parsing definitions, it is a critical first step to ensuring that this critical focus is part of global health education.

Although educators are using the term “global/local” in different ways, many have created innovative programs that are helping students make the link between what they observe internationally and what exists in their own communities. These programs emerge from individual graduate schools, interprofessional global health centers, undergraduate institutions, governmental and non-profit organizations. However, because they have never been linked under a single rubric, the successes and challenges of these programs are not shared and no best practices have emerged to help others create their own global/local programming.

The organizers of the pre-conference workshop created the session to take a first step toward a common understanding of global/local education and sharing best practices.

Goals of Workshop:

1. *To study the conceptual and practical link between learning on the global level and learning on the local (community) level.*
2. *To discuss the value to students, universities, funders and employers of linking global health and local/community learning conceptually and practically.*
3. *To study ways that lessons and innovations learned at the global health level can be translated to the local level and vice versa.*

Agenda

- Opening and Organizational Comments - Dr. Sharon Rudy, Director, USAID Global Health Fellows Program II
- Opening Presentation: "Lessons from Ebola: A Global/Local Crisis" (Dr. Jody Olsen, University of Maryland School of Social Work and Executive Director, University of Maryland Center for Global Education Initiatives)
- Lightening Presentations: Conceptual Issues in Global/Local Education and Practice
 - *"All Over the Map: The Search for Coherency in the Concept of Global/Local"* (Virginia Rowthorn, JD, University of Maryland School of Law and University of Maryland Center for Global Education Initiatives)
 - *"Global/Local: A False Dichotomy?"* (Dr. Neal Sobania, Professor, Department of History, Pacific Lutheran University and Editor, Putting the Local in Global Education: Transformative learning through domestic off-campus programs (Stylus 2015))
 - *"Global/Local Education: It's all about the 'context'"* (Dr. Jane Lipscomb, Professor, University of Maryland Schools of Nursing and Medicine and Director, University of Maryland Center for Community Based Engagement and Learning)
 - *"Social Accountability/Prestige/Proximity: Toward Collapsing the Wall Between Global and Local Health Education and Practice"*(Dr. Jessica Evert, Executive Director of CFHI and Clinical Faculty Member, Department of Family and Community Medicine at the University of California, San Francisco)
- Small group discussion and report out to larger group
- Presentation: "Global to Local: A Working Model in Seattle" (Adam Taylor, Executive Director, Global to Local)
- Lightening Presentations: Practical Issues in Global/Local in Education – How Do We Do It?
 - *"Global/Local In Practice: Models and Best Practices"* (Lori DiPrete Brown, Associate Director for Education and Engagement, Global Health Institute, University of Wisconsin-Madison)
 - *"Global/Local in Practice: Models and Best Practices"*(Dr. Elisabeth Maring, Director of Global Health Initiatives, Maryland Institute for Applied Environmental Health, University of Maryland School of Public Health)

- *“The Global/Local Divide: the Impact on Career Paths and Employment Opportunities”*
(Dr. Sharon Rudy, Director, USAID Global Health Fellows Program II)
- *“Bridging the Gap: Working Globally and Locally”*
(Dr. Linda Cahaelen, Health Development Officer, USAID Global Health, Office of Population and Reproductive Health)
- Small group discussion and report out to larger group
- Conclusion (Dr. Lori Edwards, Associate Director for Global Occupational Health, Office of Global Health, University of Maryland School of Nursing)

All the presentations are online: <https://www.umaryland.edu/global/cugh/presentations/>

Summary of Workshop Discussion

Session One: Conceptual Issues in Global/Local Education and Practice

The first session was devoted to the *concept* of global/local – what does the concept mean, why is it hard to define, what are some important underlying theories and why is it important to global health? In her introductory remarks, [Dr. Jody Olsen](#) (University of Maryland School of Social Work) discussed the recent Ebola crisis to illustrate the point that a global health problem (Ebola) creates local problems (infection, fear of infection, infrastructure shock, etc.) that are similar in nature no matter where the problem arises but manifested differently depending on local factors. She pointed out that the Ebola crisis created a strong “us-them” divide across nations and that a primary goal of global health educators should be to teach the universality of health themes and the skills to share and adapt appropriate local strategies.

To start the first lightning panel, [Virginia Rowthorn](#) (University of Maryland School of Law) discussed the findings of her literature review regarding how the terms global/local and glocal are currently used in the health field and in other fields. Interestingly, both terms are better defined and theorized in non-health fields, particularly in the sociology and business literature. For instance, in the business field, “glocal” refers to adapting a global brand or product to local tastes. McDonalds is a world leader in “glocalization” with their adapted food products that appeal to local palettes. Rowthorn asked whether the established definitions in other fields can help bring clarity to the same concepts in global health. Rowthorn’s review of the health literature revealed that there are no papers that describe the meaning of global/local or glocal (although some papers use the terms without describing their origin). Rowthorn also reviewed the different ways that universities are using the terms global/local and glocal and found that there is no common definition. Of the definitions she encountered, Rowthorn grouped them into seven usages:

- Sometimes global/local is used to refer to shared themes that are present across the globe with different local manifestations (e.g. gender violence – a theme that looks different in India and in the United States).

- Some global/local programs are framed as an educational method to teach the personal and interpersonal skills (aka “soft skills”) that are relevant for community organizing and social justice work at both the domestic and international level. These programs often focus on cultural competence skills.
- Other global/local programs are designed to teach hard skills or technical/professional skills from different perspectives in different settings. Many clinical programs adopt this approach.
- Sometimes global/local is used to mean reverse innovation, or adapting demonstrated strategies utilized in one context to another context.
- Global/local is sometimes used in reference to bi-directional partnerships that conduct the same work in different settings or form part of the same collaborative project.

[Dr. Neal Sobania](#) (Pacific Lutheran University), a national expert in undergraduate study abroad, went one step deeper beyond the definitional level to ask the critical question – is global/local a false dichotomy? He used Dr. Kevin Hovland’s definition of “global learner” to underscore the point that all university students must become global learners and in doing so, the distinction between global and local fades. The characteristics of a global learner are:

- Global Knowledge: students understand multiple worldviews, experiences, histories and power structures.
- Global Challenges: students apply knowledge and skills gained through general education, the major, and co-curricular experiences that address complex, contemporary global issues (problems and opportunities).
- Global Systems and Organizations: students gain and apply deep knowledge of the differential effects of human organizations and actions on global systems.
- Global Civic Engagement: students initiate meaningful interactions with people from other cultures and take informed and responsible actions to address ethical, social, and environmental challenges.
- Global Identities: students articulate their own values as global citizens in the context of personal identities and recognize diverse and potentially conflicting positions vis à vis complex social and civic problems.

Dr. Sobania is leading a new trend in undergraduate education called “study away” which allows students to take part in transformative immersion experiences wherever they occur – domestically or internationally – and emphasizing that global *is* local. A major theme in this area is that off-campus study is not being so much about location as it is about learning.

[Dr. Jane Lipscomb](#) (University of Maryland School of Nursing) also tackled the artificial line between global and local by focusing on “context” – in other words, the relevant contextual factors (culture, politics, history) that must be taken into consideration whenever work is conducted in an unfamiliar setting be it local or global. She asked, “[d]oes the importance of context to health differ globally and locally?” Finally, [Dr. Jessica Evert](#) (UCSF School of

Medicine) asked some of the harder questions in this space, namely, questions of privilege and elitism. If, as Dr. Evert does, we consider global health simply providing health care or working toward health equity for vulnerable patients in an unfamiliar setting, then global health can take place internationally or locally. However, for different historical reasons, global health is often accorded more prestige than providing services in one's own community. In fact, she points out, since all health care is provided locally, the concept of global health may simply be a "a concept fabricated by developed countries to explain what is regular practice in developing nations" and one that diverts us from fully appreciating health systems all over the world which need strengthening, including our own.

Small Group Discussion: to stimulate discussion on the topics raised in the presentations, participants were invited to join small groups to discuss one of the following questions raised by the presentations:

- What do the terms global/local and glocal means in the context of global health education? Is global/local a false dichotomy?
- Is there anything to be gained from an international education experience that can't be captured in a well-designed domestic education experience?
- Is there any reason for universities or students to prioritize a local education experience over an international education experience?
- Can and should universities meet local needs under the global health rubric?
- What are the unique challenges to community engagement in one's own backyard?
- Why does it sometimes *seem* easier to make progress in international settings than local settings?
- Why is it so challenging to think of local being global?
- Why should we continue to offer separate curriculum in global health and community engagement?

Summary of Session One Discussion Groups

What do the terms global/local and glocal means in the context of global health education? Is global/local a false dichotomy?

The critical point that emerged from this discussion group is that there is no clear definition of "global/local" or "glocal" in the context of health. However, most participants agreed that the exercise of agreeing on a definition should be recognized as secondary in importance to actually creating programs that put the definitions and concepts into practice.

However, several important points emerged from the discussion:

1. Many participants believe that both global/local refers to understanding health and health disparities in context. There was a great emphasis among most, but not all, participants that global/local must focus on health disparities and issues of social justice.

2. Many noted that global/local is the catchphrase for a set of transferable skills that can be applied anywhere.
3. Another meaning of global/local raised in this group is a strategy and mechanism to engage students returning from an international global health experience in a related local experience to teach the universality of global health concerns and to demonstrate to future professionals how they can address health disparities and social justice in the United States, where most students are likely to engage in their career.
4. Another definition of global/local supported by many participants related to reverse innovation or sharing of successful local strategies at global level and vice versa.
5. An updated definition of global health should emphasize that health is always local for some population and therefore global health should be defined as a method of bridging gaps and reciprocal sharing of information about into health conditions that affect us all in unbalanced ways.

Related to the definitional discussion was a common sentiment that we need a more inclusive and robust definition of global health. The current conception of global health, by the very use of the word “global,” creates an us/them dichotomy. Further, some participants, particularly those from non-U.S. universities, noted that global health is a Western concept and can be “othering”.

Definitions and terms carry a great deal of weight, particularly with funders. Discussants noted that the use of the term “global” has resonance for global partners and funders, but not with NGO and governmental funders that fund community work. Therefore, use of the accepted taxonomy has important funding ramifications that must be considered.

A critical dissenting voice argued that global/local is not a false dichotomy – that, in fact, there are significant differences between both areas of research and practice and that the boundaries cannot be collapsed without serious thought and reframing. One participant who works with an inner city indigenous community in the vicinity of her U.S. university noted her concern that suddenly what she’s doing is considered “global” and that her project was co-opted by the university’s global health program without the conceptual discussions necessary to frame this transition. There is some concern among those engaged in community engagement that their work and funding sources may be overlooked or diverted by more prestigious global health programs. These concerns should be addressed and consensus reached before moving ahead with programmatic changes.

Is there anything to be gained from an international education experience that can’t be captured in a well-designed domestic education experience?

This question is important because most global health programs exclusively offer students the chance to study and practice internationally. Students clamor for these experiences and possibly focus on global health studies specifically because these international experiences are available. However, if global health programs only offer international experiences, the global/local divide is emphasized and institutionalized.

Participants noted the value of a disruptive immersion experience that trains students to manage complicated logistical issues, handle the complexity of unfamiliar situations with unfamiliar people, and to work outside their comfort zone. If these experiences happen in a structured way with the opportunity to prepare and reflect, immersion experiences both global *and* local can expand the students' concept of culture, help develop empathy, foster interprofessional learning, and create global citizens. Many participants responded positively to the work of speaker Dr. Neal Sobania from Pacific Lutheran College and his focus on “study away” instead of “study abroad”. His view is that valuable immersive experiences can take place where need exists domestically and internationally. This perspective is something that many participants agreed should be embraced by global health programs.

Is there any reason for universities or students to prioritize a local educational experience over an international experience?

This question follows from the previous question. If we agree in theory that global health programs should offer international AND domestic immersion experiences, is there any reason to support one over the other? Generally participants felt that both types of experiences should be offered and supported equally because both have value. However, as one participant noted, “there is a disconnect in academia which posits that students need to go outside their school and outside their community to see ‘real life’. We miss opportunities to recognize the real lives of some of our students and encourage a diversity of ideas right here at home.”

Some participants argued that local health engagement should be prioritized over international engagement to highlight the point that health is always delivered at the local level and what is global for one person is local for another. Engaging locally engenders a sense of responsibility and an obligation to follow-through that may not happen at an international site for a limited period of time. However, participants noted that many international experiences meet a local need that would not be met otherwise. Some argued that prioritizing domestic community health experience over international health experience is troublingly ethnocentric in a world that is becoming more global, not less. As such, many agreed that a global health educational paradigm that teaches the common humanity and needs of communities near *and* far provides a correct and balanced approach where specific location preferences for study are not required.

A significant value of a local experience discussed at the workshop is the cost to the student participant. Local experiences allow less affluent students the opportunity to participate in the transformative experience of immersion learning. Another significant value of local engagement activities for students is meeting the responsibility of a university to support the community of which it is a member. The global obligation of universities is less clear, harder to articulate, and may actually be served by teaching students to be good stewards of the different populations in their own community. Further, it is easier to ensure the quality of local immersion experiences because oversight is easier from a proximity perspective and because

faculty are more likely to have stronger, more familiar ties with local community leaders and the ability, therefore, to create a sound community-focused experience for students.

A crucial piece emphasized by many participants was that the undergraduate experience helps shape students for graduate and professional school. It is critical to reach out to educators at the undergraduate level who work in the area of study abroad. Increasing numbers of undergraduate students want to engage in study abroad and universities are scrambling to create a broad range of opportunities to meet this growing demand. Some scholars have accused study abroad programs of not meeting the critical didactic criteria that ensure the value of the programs to students and to the communities where they study. Further, as mentioned earlier, study abroad overwhelmingly focuses on international experiences notwithstanding a growing effort to build the “study away” concept. Participants agreed that attention has to be given to thoughtful study abroad at the undergraduate level to build a pipeline of students who will be open to a broader vision of global health.

What are the unique challenges to community engagement in one’s own backyard?

This question goes to a sense that working in the local domestic community may be perceived as harder by some faculty and students than working in international settings. The noted impediments to working locally:

1. Process barriers:
 - a. Legal, regulatory, and school-level barriers seem overwhelming at the community level, e.g., the need for permits, approvals, not wanting to step on the toes of other faculty already working in the community, not wanting to conflict with bigger university-level community goals.
 - b. Priority of student needs/ interests over that of the community.
2. Community perception barriers:
 - a. More judgment of local poverty that dampens spirit of service.
 - b. Familiarity/unfavorable feelings toward local politicians and familiarity/despair with intransigent local problems.
 - c. Assumption that we understand the context and reasons for poverty locally and therefore students will not learn as much locally as they will globally.
 - d. Mutual skepticism between the community and academic institutions and lack of strong community partners.
 - i. Too many needs assessments have been done without positive outcomes can lead to local skepticism.
 - e. Lack of clarity around value added to communities by student/faculty engagement in the community.
3. Funding and career barriers:
 - a. Community-level funding is more complicated to secure.
 - b. Less career return on investment for community activities than global activities.
 - c. Community work is perceived as “less sexy” than global work.
 - d. Research saturation at the local level.
4. Perceptions of global work as “easier”:

- a. Feasibility of change perceived to be easier abroad
- b. Power dynamic and ability to leverage resources is more favorable abroad for a speedier and more effective result
- c. Working abroad offers faculty protected time for engagement and research

This issue raises the concern that some educators may not adhere as closely to legal, regulatory, and ethical norms in other countries as they do – or would have to – here in the United States. The existence of real and perceived barriers raises many difficult and sensitive questions that need to be addressed in order to reframe and encourage community engagement. Participants noted that these barriers are very costly to community engagement efforts and strip local communities of vast student energy and resources. These barriers must be addressed head on by universities, community engagement faculty and global health faculty. Linking global and local education is both a start to these conversations and an end result.

Why does it sometimes seem easier to make progress in international settings than local settings?

As noted in the prior discussion, there is sometimes an unspoken sense among students and faculty that progress (i.e. results, solutions) seems easier to achieve in low-resourced settings than in the United States and therefore such experiences are more satisfying to students and faculty. Participants agreed that results are not “easier” to achieve internationally but that sensation can arise because outsiders do not see the complexity of local needs because of language barriers, unfamiliarity, and the deference shown to outsiders. Also, some interventions that may be useful in low income settings such as handwashing and oral care seem easier to advance than more complicated health system improvements. Participants strongly agreed that this perception among students is a reflection of inadequate teaching on these critical points, improper understanding of the root causes of health disparities, and superficial attitudes toward solving them.

Why should we continue to offer separate curriculum in global health and community engagement?

If, as many participants agreed, global health and community engagement are two sides of the same coin, does it make sense to teach students the same didactic material in two separate curricular paths? The general consensus was “no” but no clear path emerged regarding how to break down existing silos. Shared curriculum does take place in public health programs which require students to take the same core requirements in addition to courses in their global health or community health concentrations. However, outside of the public health context, shared curriculum across global health and community health programs is less common.

One suggestion was to view global health through the lens of community engagement and social justice. In other words, start with community engagement and build global concepts on top of this foundation. Another series of suggestions built on Jane Lipscomb’s talk regarding context. Students should learn about working in communities and providing appropriate care

in different contexts and how to engage in unfamiliar contexts domestically and abroad. In other words focus on adaptation, cultural competence, and humility first then let students choose if they want to practice those skills domestically or abroad with the understanding that the same skills apply in either setting. In a similar vein, other participants suggested that core training should be in social justice and that all students should have a placement that puts them in touch with vulnerable populations domestically or internationally.

However, proposing shared curriculum may lead to push back from students and faculty who would not want global and local training joined because they have no interest in the other, they fear loss of funding, or they have a successful teaching/research niche that they don't want to upset. Some participants asked - do universities have a responsibility to be disruptive in this area?

Why is it so challenging to think of local being global?

This question was posed at the workshop to help the organizers and participants understand why the divide exists between global health and community health and why global health programs focus on international work. Discussants agreed that global has come to mean something exotic and different from what we experience in our daily life. Working in the community is often integrated into our daily lives and therefore does not satisfy the urge many students and faculty feel to experience new places and people. However, many noted that this points to the fact that universities have not created transformative immersion domestic experiences that can meet this urge.

Study abroad organizations market heavily to the undergraduate population and make overseas travel very appealing and novel. Because of the cost and resulting prestige of overseas travel, many parents want to provide this "opportunity" to their children, possibly without fully understanding the potential educational and ethical complications of engaging with vulnerable communities for short time periods. Further, some participants noted that a colonialist legacy may still exist that creates a "savior mentality" toward people in other nations while at the same time creating an inability to see parallel needs locally. Global health programs may reinforce these unarticulated feelings which lead to unidirectional learning and that ultimately disadvantage local engagement.

Session Two: Practical Issues in Global/Local in Education – How Do We Do It?

The second session focused on global/local in practice and the impact of the global/local divide on career paths. This panel was designed to help universities go beyond conceptual discussions and take concrete steps to link their global and local programming. There are a variety of global/local programs underway in the U.S. but all were developed in isolation because there are no agreed upon definitions, competencies or best practices that guide the development of global/local programs. In the absence of these clear markers, progress in the global/local field will be harder to achieve.

The session began with a talk by [Adam Taylor](#), Executive Director of Global to Local, a Seattle-based NGO that uses global health strategies, techniques, methodologies, and technologies to increase the health status of local underserved communities. The organization was started by the King County Department of Public Health and Swedish Medical Center and funded by corporate entities. The organization's mission is consistent with one of the definitions of global/local that participants agreed on – creating a mechanism to adapt effective global strategies on the local level. Global to Local is relatively unique in the United States for its focus on adapting strategies developed outside the US for use domestically. Global to Local did not emerge from a university setting although it does use student volunteers and has a number of local faculty members involved in various ways. Taylor walked participants through the process that Global to Local used to create its current portfolio of activities. The talk was well received because it provided one practical roadmap that has achieved measurable success and ongoing funding.

One acknowledged university leader in the global/local area is University of Washington Madison's Global Health Institute. Associate Director [Lori DiPrete Brown](#) spoke about the Institute's initiatives in this area that are undertaken to make the "local to global connection in health science education." The primary lesson of her talk was that the global/local perspective can be added to existing global and local activities if done with intentionality and university-wide support. The primary challenge she noted were the ongoing need to prepare instructors as mentors and role models.

[Dr. Elisabeth Maring](#), the Director of Global Health Initiatives at the Maryland Institute for Applied Environmental Health at the University of Maryland School of Public Health spoke about the cutting edge programs her school supports to link global and local education. Again, the range of programs that UMD offers is varied and, like University of Wisconsin, each program employs a slightly different conception of the global/local link.

[Dr. Sharon Rudy](#), Director of the USAID Global Health Fellows Program II, discussed research her program conducted to study the hiring practices and biases of global health employers. She surveyed 49 experienced global health program directors in 2015. 85% of the respondents thought that academia could and should do a better job preparing professionals for global health work. Key skill gaps included proposal design and project management, collaboration and teamwork. A critical point Dr. Rudy raised was that these are likely the same skills valued by individuals who work in community engagement. The survey respondents advised graduate students to get experience via overseas field projects and said they would tend not to hire those with only local or domestic experience unless they needed a specific skill set. Non-clinical skills gaps among those with only local experience included:

- Understanding the context and realities of global health
- Flexibility
- Adaptability
- Creativity
- Cultural sensitivity and cross-cultural communication
- Knowledge of key players, systems, and processes

These results indicate that, although academia may be coming around to the understanding that global and local health work requires the same set of skills, employers are not there yet. As a result, the siloing that occurs in academia is played out in the employment world which may not be ready for students trained outside of established silos. Dr. Rudy recommended a bifurcated approach to this employment conundrum: change the minds of employers by actively increasing their positive perceptions of the value of local experience and at the same time, increase practical overseas work and field experience so that students interested in global work can meet the qualifications of global health employers.

The final speaker, Dr. Linda Cahaelen, a Health Development Officer with the USAID Global Health, Office of Population and Reproductive Health Program spoke about her career experiences working in both the local and global fields. Dr. Cahaelen was able to transfer her local skills to global work and has been very successful in her field but she had to be very intentional and convincing to make the shift – again highlighting the divide between global and local health work.

To stimulate discussion on the topics raised in the presentations, participants were invited to join small groups that tackled one of the following questions raised by the presentations:

- What teaching methodologies are most effective to teach students the link between global and local and health and how do our teaching methods change?
- What are key features of successful global/local university programs?
- Is it critical to have prior international work experience/study to succeed in a global health position and, if so, why?
- What can the higher education sector do to advocate for integrated funding for local and global initiatives so that there are incentives for sustainable programs of two-way learning?

Summary of Session Two Discussion Groups

What teaching methodologies are most effective to teach students the link between global and local and health and how do our teaching methods have to change?

A critical point raised during this discussion was that, before faculty can be expected to create global/local programming, they need to be trained in the theory and best practices that support it. Of course, this begs the question of whether theories and best practices have been identified. The organizers' research indicates that this is a novel area of inquiry and a first step forward is to identify the conceptual framework and best practices so that faculty can be trained appropriately. On the faculty level, others mentioned that the curriculum tends to be very rigid in professional schools and mentoring would be helpful to teach faculty how to creatively link global and local in a structured curriculum.

Another important point echoed by participants was the need for input from international partners. In a similar vein, many mentioned that neither global health nor community health programs tap into the international student body. Perhaps in the past, faculty were reluctant to call attention to the foreign upbringing of students so as not to single them out, but many agreed that the time may be right to formally recognize the rich value that foreign-born students bring to campuses. Such students may be willing to reach out to populations with similar backgrounds outside the university and can also share their experiences on particular topics while in the classroom to enrich discussion.

In terms of actual teaching strategies, one participant created a course that involved local and global modules on particular topics such as gender violence (i.e. what it looks like in our own community and what it looks like in a community the students are not familiar with). Another suggestion raised multiple times was the need to find ways for students to practice their skills locally and internationally and providing opportunities for reflection on the experiences in both situations.

Another specific teaching tool discussed was mapping a particular community's needs in the U.S. and a community's needs overseas and connect common points. This type of "community mapping" exercise is often used by Peace Corps volunteers as they enter a community and could be of great value to show the common bonds – and critical differences – among populations.

The appropriate use of technology was discussed as the greatest friend to promote bi-directional learning. Interested faculty members can work with local and global partners and be creative in thinking about how to link learners in different settings. One frequently discussed idea was using Skype or similar technology to bring students in different settings together to discuss a case study or conduct a simulation. Time differences present a problem in this area but creative scheduling can address this concern.

What are key features of successful global/local university programs?

There was general consensus that linking global and local programming requires engaging the local community in identifying and meeting local need. This is a central tenet of community engagement AND global health and should be followed in creating any new initiatives to make sure that programs should have value for communities and students.

The following suggestions emerged from the small group discussion. A successful global/local course or immersion/experiential learning course should include certain attributes including:

- Teach global health themes from international and domestic perspectives.
- Focus on health care disparities.
- Include ethics/social justice/human rights training.
- Teach transferable skills while building professional skills.
- Incorporate short-term community experience locally or internationally.

- Include a short-term experience that meets community needs in short periods of time with students.
- Engage the community, especially with immigrant populations, in the local and global aspects of an initiative.
- Work early with community to identify needs.
- Be sustainable.
- Connect the university with local health care centers and advocacy groups.
- Work across schools and programs to break down silos and encourage interprofessional education.
- Include a reflective component.
- Use the same evaluation processes for both international and local engagement.

Is it critical to have prior international work experience/study to succeed in a global health position? And why?

Since much of the workshop was focused on linking – and maybe even collapsing – global and local education, the organizers agreed that it is critical to make sure we do not lose anything in the process. Therefore, for global health students, we asked attendees if there is anything unique that comes from an international experience that cannot be gained from a local experience. The general consensus was “maybe”. It is clear that employers still require this type of experience to get a global health position. However, this does not necessarily mean that the essential social and cultural leadership skills gained overseas could not be gained locally.

Global employers often ask for five years of international experience. This may prejudice students from low resource families who might well be able to gain relevant experience locally but find that it’s not valued by global employers. However, many participants noted that international experience takes students out of their comfort zone and encourages flexibility and openness that may be harder to gain in their own community. This goes to the value of well-designed domestic “study away” experiences that allow students to move out of their comfort zone and learn community engagement skills in resource-constrained communities in their own backyard.

What can the higher education sector do to advocate for integrated funding for local and global initiatives so that there are incentives for sustainable programs of two-way learning?

This last critical question focuses on next steps – how to fund the global/local initiatives we believe are important to break down the artificial barriers between global and local health education. Participants agreed that the most important step in any university-level innovation is to gain the “buy in” of senior program and university officials. Because global health is an interprofessional field, support by the highest university-level deans is critical. Also, it is important to develop the vocabulary needed to communicate effectively with funders, global folks, and local partners. Many agreed that an important first step of this initiative would be to

agree on some general terms and “start speaking the same language.” We also need to disseminate success stories of global/local programs and bi-directional partnerships.

Workshop Conclusions and Next Steps:

See Executive Summary for conclusions and next steps. In sum, as global health educators, we need to make sure that students understand the common humanity, common problems, and the potential for common solutions across the entire globe. Student drive change and we need to give them the didactic background and experiences they need to drive that change.