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GLOBAL HEALTH: DYNAMIC ROLES FOR THE APRN/APN

Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has.

—Margaret Mead

Advanced practice nursing is on a rapidly unfolding evolutionary path globally, dictated by need, vision, and opportunity. The need for cost-effective quality health care providers is universal. Technology and communications have allowed global connections, thus effectively making the world small. Educational systems and methods have concurrently evolved. Individuals and organizations involved in health care delivery have seen and learned from each other at a pace not seen before. Patients, people, and providers have continued and, in some instances, accelerated transitory movements, relocating regionally and internationally. These factors have resulted in several occurrences regarding the role of the advanced practice registered nurse (APRN): (a) the advanced practice role is emerging and evolving in many countries; (b) those in the advanced practice role need to understand the global community in order to serve, educate, and treat that community; and (c) the migration of people has created global communities that can be served by APRNs.

GLOBAL APRN ROLES AND TRENDS

One of the most confusing aspects of advanced practice nursing pertains to the titling, definitions, and interpretations of the various APRN roles throughout the world. Only recently has the United States settled on consistent terms and definitions through the *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, and Education* (APRN Consensus Work Group & National Council of State Boards of Nursing APRN Advisory Committee, 2008). The APRN Advisory Committee, through the consensus model, settled on the global term *advanced practice registered nurse* (APRN). The consensus model further delineated four roles: certified

registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), and certified nurse practitioner (CNP). APRNs in the United States are to be educated in one of these four roles but must also be educated in one or more of six population foci: the family/individual across the life span; adult-gerontology; pediatrics; neonatology; women's health/gender related; or psychiatric/mental health. The consensus model is broader than merely setting titles—its underlying purpose was to create a document that "defines APRN practice, describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation" (p. 4). The model is still in the process of implementation in U.S. states and territories.

Just as the United States has struggled over titles, terms, and role interpretations, the same can be said of advanced practice nursing outside the United States. Many countries have chosen to recognize and encourage expanded roles for nurses beyond that of registered nurse, having done so uniquely and with great variety. The International Council of Nurses (ICN) reports that 70 countries have or are developing advanced practice roles for nurses. In 2002 the ICN defined an APN as a registered nurse who has acquired the expert knowledge base, complex decision-making skills, and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which he or she is credentialed to practice. A master's degree is recommended for entry level. This term, *advanced practice nurse* (APN), is the commonly accepted international term. Despite the definition, defining characteristics, competencies, and scopes of practice, there is tremendous variation in titles, education, credentialing, policies, recognition, and support worldwide. A 2008 Web-based survey identified 13 different titles for APNs in countries recognizing advanced practice. The same survey also showed the following in respondent countries: 71% had some sort of APN education, 50% cited the master's degree as the primary credential, 72% had formal recognition of the role, and 48% had licensure or renewal requirements (Pulcini, Jelic, Gul, & Loke, 2009). Although showing tremendous advancement of the role, these data establish a clear need for some uniformity of role underpinnings.

A meeting was convened in 2014 to discuss APN practice around the globe as the importance for improved access to cost-effective, quality care in parts of the world where the APN role is absent or underutilized was recognized. The meeting brought together 30 health leaders from around the world. Attendees included representatives from the ICN, multiple universities, multiple ministries of health, the Organization for Economic Co-operation and Development (OECD), the Commission on Graduates of Foreign Nursing Schools (CGFNS), and other health organizations. The first recommendation of the report focused on removing the barriers to practice for APNs. These barriers are identified by the Global APN Nursing Symposium as follows:

- Lack of defined role for APNs
- Inconsistent educational and training standards

- Inconsistent or unnecessary regulation
- Unstable health care funding from government or third-party payers

Key findings were summarized as follows:

- APNs have the potential to play a much larger role in improving the health of people worldwide.
- Different nations are in different stages of developing their nursing workforce, and opportunities for advanced nursing practice vary significantly from country to country.
- Countries where APNs have a well-defined role and greater practice authority have increasingly used nurses to improve access to primary and preventive health care.
- APNs have been successfully deployed in both developed and developing countries to improve health.
- APNs around the globe have worked with governments, consumer groups, funders, investors, and business leaders to create innovative programs and interventions that improve people's health.
- APNs can be a cost-effective solution to existing health care access and quality problems, but additional data are needed to fully evaluate and capture the value of their services.

Based on these issues, the group recommended the following:

- Standardize the definition of the APN role.
- Improve the educational curricula for APNs while respecting each country's unique cultural and political context.
- Increase access to primary and preventive health care services by removing policy barriers that prevent APNs from practicing to the full extent of their education and training.
- Reform health care funding mechanisms to allow for APN-based practice models.
- Collect data and share information on APN quality and outcomes in a variety of countries/settings.

The full results of this meeting are detailed in the *2014 Global Advanced Practice Nursing Symposium—The Future of Nursing Across the Globe* document (Hansen-Turton, 2014).

Although the role will evolve according to unique regional issues, there are commonalities, such as the universal need for cost-effective quality care, APRNs can meet the need, and support for APRNs is through the development and maintenance of polices that provide the education, practice, and research frameworks.

BROADER GLOBAL TRENDS AND NEEDS

To prepare for a global experience, the APRN should understand the political, social, economic, and health care trends. Bass (2011) provided a comprehensive listing of megatrends to consider, detailed in Table 6.1. Megatrends

TABLE 6.1 Megatrends

Health	Education	Government and Society
• Longer life* • Healthier life* • Chronic is normal	• Better educated* • Distance education the norm	• Flattening world • Pockets of instability
Demographics	**Food and Agriculture**	**Environment**
• Older consumer	• Stable currently but linked to environment	• Business measure • Need to know
Economy	**Transportation**	**Energy**
• Water as currency	• Security challenged • Infrastructure affected • Tight economics	• Oil important, not king
Science and Technology	**Work**	**Business**
• Bandwidth is distance • Context is king	• Automation of *normal* • Skills gap and need for reskilling • Technology-enhanced employees	• New competitors • Competition everywhere
Security	**Religion**	**Law**
• Hacking is free	• Expanding impact	• Relative stability

*Not all the world may participate.
Source: Bass (2011, p. 1).

are defined as high-level trends that generally operate broadly, outside of industry and geography. Of interest to APRNs are the predictions of longer, healthier lives; disease as the norm; water as an economic factor; and distance education as the future. On this last issue, APRNs have been leaders, educating providers while maintaining quality outcomes. This has happened within regions and nations—can the process be duplicated globally?

Recently, the global health care megatrends have been elaborated. These megatrends are technological advances, personalized medicine, the demand for evidence-based medicine, increased influence by payers, over treatment decisions in emerging economies, aging populations, rising costs, global pandemics, environmental challenges that overwhelm the current system, nonphysician providers, the growing role of philanthropy, prevention, and medical tourism becoming the next big business opportunity (Dillon & Prokesch, 2014).

To celebrate its 100th anniversary the ICN (2002b) released the *Guidebook for Nurse Futurists* in 2002, listing societal, health, and nursing trends, detailed in Table 6.2. Although developed in 2002, the list is still valid today.

One trend that should be examined further is "population growth." The United Nations (2013) estimates the world's population will reach 9.6 billion by 2050. The prediction suggests populations in developed regions

TABLE 6.2 International Council of Nurses (ICN): Trends Affecting the Future of Nursing

TRENDS IN THE LARGER SOCIETY	HEALTH TRENDS	NURSING TRENDS
Information Technology	**Economic-Driven Health Care Reform**	**Nursing Education Changes**
• Rapid advances occur in information technology. • Communication worldwide is improved via international networks and advanced language translation. • Problems of information security and privacy need to be considered.	• Financial pressures exist to limit the costs of health care. • Health care is being restructured, with nurses increasingly being recognized as full partners in cost-effective health care delivery. • Economics conflicts with the needs of patients.	• Budget-constrained governments are less committed to supporting nursing education. • Inflexible nursing programs are out of touch with service needs and increasingly irrelevant to nursing practice. • Visionary and experienced nurses go into schools to teach and serve as mentors. • Nurses receive higher and broader education.
Social Change/Unrest	**Use of Technology in Caring**	**Advances in Nursing**
• Cooperation and embracing of diversity is what society increasingly expects of itself. • Political and social unrest, stresses from rapid change increase. • Fundamentalism, split between rich and poor, terrorism increase.	• More money goes to high tech. • High-tech drives our high touch. • Nurses humanize the use of technology and never forget the importance of personal caring and touch.	• Nurses are leading the health promotion effort throughout the world. • Nurses become the entry point into the health care system. • Internet-enabled technology helps nurses establish a strong research base for improving clinical practice.
Globalization	**Research and Development of New Therapies/Techniques**	**Turmoil in the Nursing Profession**
• Globalization of commerce and exchanges of information create greater prosperity and mutual understanding. • There is less of a nation-state orientation, more sense of global identity. • Economic problems are contagious in an interconnected global economy.	• Causes of cancer and AIDS are discovered. • Research focuses increasingly on problems of the poor, such as malnutrition, malaria, and water contamination.	• There is a shortage of nurses at the bedside with downsizing of the nursing profession. • Untrained personnel work as *nurses* worldwide. • International nursing organization specialization increases.

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TABLE 6.2 International Council of Nurses (ICN): Trends Affecting the Future of Nursing *(continued)*

TRENDS IN THE LARGER SOCIETY	HEALTH TRENDS	NURSING TRENDS
	• Developments in genomics take health care to a higher stage of customized care in which therapeutic selection is increasingly tailored to individual genetics. • The number of available, effective therapeutic agents increases dramatically.	
Environmental Hazards	**Empowerment of the Consumer**	**Working Environment for Nurses**
• Environmental problems have severe health effects and retard development in several nations (e.g., habitat destruction, topsoil loss, pollution, climate change, and water shortages and contamination). • Global adoption of *green* manufacturing and other environmentally advanced technologies reverses ecosystem-ruining effects. • Sustainable development principles are adopted throughout the world.	• People take a more active role in their personal health. • Health professionals are expert consultants for self-managed care. • People are empowered through technology: home testing and monitoring, online access to health information.	• Nurses are stressed, working with declining resources in settings where they often feel in competition with other health care providers. • Strikes and unrest over salary and working conditions are common. • Better pay and conditions are sought. • Effective global standards for nurses' working conditions are sought.
Changing Demographic/ Disease Patterns	**Focus on Community Health**	**Regulation and Governance of Nursing**
• Older populations worldwide place a burden on health systems. • Many cities in the South have populations of poor, unemployed, uneducated young people who are angry and violent. • Unmanageable urbanization causes public health breakdowns. • Immigration stresses society.	• There is a growing emphasis on delivering community-oriented health care. • Healthy community building becomes a major focus of public policy. • Breakdown of community and the resulting increases in crime, violence, and clinical depression are leading causes of morbidity and mortality.	• Self-regulation has given way to state or agency regulation. • Self-regulation is firmly established, and credentialing plays a large role.

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TABLE 6.2 International Council of Nurses (ICN): Trends Affecting the Future of Nursing *(continued)*

TRENDS IN THE LARGER SOCIETY	HEALTH TRENDS	NURSING TRENDS
• AIDS, other new plagues, and antibiotic-resistant diseases spread. • New kinds of antibiotics limit the spread of new and old diseases.		
	Culture/Class and Its Relationship to Health	**Nursing Relationships With Other Health Professions**
	• Health status becomes more class-oriented. • Health for All strategies are pursued. • Scientific and technological advances create a widening gap where high-tech care is available to the affluent but not to others.	• Tensions between nursing and other health professions play out in educational and clinical settings. • Linkages between nursing and other health specialty groups increases. • Nursing is fully integrated into interdisciplinary health teams in all areas—health education, research, clinical care, management, and policy development.
	Rise of Alternative Medicine	
	• Hierarchical medicine has changed to comprehensive care interdisciplinary teams including alternative providers and nurses. • The most effective combination of various alternative approaches and conventional health care is now widely known and available. • The growth of medically pluralistic societies with effective evaluation of treatment outcomes provides more tools for people to improve their health.	

Source: ICN (2002b; pp. 13–16).

will remain unchanged; however, in 49 of the least developed regions, population growth is expected to double. More than half of these countries will be in Africa. This is significant because these areas struggle with limited resources and health care delivery.

The predicted population explosion can be explained by increased life expectancy. A variety of improved conditions in the world have led to a steady increase in life expectancy in developed and developing countries. By 2045–2050 the global life expectancy will likely be 76 years, and by the end of the century, it is thought life expectancy will be 89 years in developed countries and 81 years in developing countries (United Nations, 2013). With increased life expectancy comes issues. For example, there will be more wheelchairs and walkers than baby carriages in portions of Europe, there will be fewer family caretakers and income-earning adults to support the aging populace, and people will expect better health than their parents and grandparents (Massachusetts Institute of Technology, 2014).

However, despite the expectation of improved health, the reality will likely be more individuals with chronic disease. With ever-increasing diseases, such as obesity, diabetes, hypertension, and cardiovascular disease, this issue becomes even more significant as developing countries attempt to deal with increasing numbers of people with these noncommunicable diseases while still struggling with significant communicable disease (Anjana et al., 2011).

Another trend is the reorientation of health care systems toward primary care. The 2008 World Health Organization (WHO) *World Health Report—Primary Health Care, Now More Than Ever* cited shortcomings in the ability of health systems to meet health goals (WHO, 2008). These include disjointed systems that have focused specialization in wealthy countries, single-disease agendas in poor countries, and an absence of holistic delivery of health care. To that end, the report made four recommendations: universal health coverage, people-centered services, healthy public policies, and leadership from businesses, the private sector, and communities for health.

Another trend is the availability of health care workers. In 2006 the WHO issued the *World Health Report—Working Together for Health* (WHO, 2006), which was devoted to an assessment of the global health workforce. The report disclosed an estimated shortfall of 4.3 million doctors, nurses, midwives, and ancillary health workers worldwide. Most of the shortfall will be in sub-Saharan Africa, but there will also be critical shortages in Central and South America, Southeast Asia, and the Eastern Mediterranean, detailed in Table 6.3.

Table 6.3 demonstrates disparities—for instance, sub-Saharan Africa has only 4% of the total health workforce but 25% of the world's burden of disease. The report goes on to discuss solutions, such as recruitment, education, pay, resources, worker input, lifelong learning, and technology. The report also discussed the problems of migration of health care workers and the importance of balancing choice of individuals to pursue work as needed against the backdrop of health care need, putting retention strategies in place, and working with richer countries to adopt responsible

TABLE 6.3 Estimated Shortages of Doctors, Nurses, and Midwives by WHO Regions

WHO REGION	NUMBER OF COUNTRIES		IN COUNTRIES WITH SHORTAGES		
	Total	**With Shortages**	**Total Workforce**	**Estimated Shortage**	**Percentage Increase Required**
Africa	46	36	590,198	817,992	139
Americas	35	5	93,603	37,886	40
Southeast Asia	11	6	2,332,054	1,164,001	50
Europe	52	0	NA	NA	NA
Eastern Mediterranean	21	7	312,613	306,031	98
Western Pacific	27	3	27,260	32,560	119
World	192	57	3,355,728	2,358,470	70

WHO, World Health Organization. *Source:* WHO (2006).

recruitment. This last issue is a particular responsibility of the United States, United Kingdom, Canada, and Australia, as they are the primary recipients of medical migration workers (Zackowitz, 2014). To assist with this issue, O'brien and Gostin (2011) recommend the following:

- Address the health worker shortage in the United States.
- Develop a plan to address the global health worker shortage.
- Provide global leadership in addressing the global health worker shortage.
- Reform U.S.–global health assistance programs in partner countries.
- Increase financial assistance for global workforce capacity development.
- Increase the number of health workers being trained in the United States.
- Empower an appropriate agency to regulate recruiters of foreign-trained health workers. (pp. 4–7)

The Institute of Medicine's (IOM's) *The Future of Nursing: Leading Change, Advancing Health* reiterates many of these same points:

- Promote targeted educational investment in foreign-educated nurses in the U.S. nursing force.
- Promote baccalaureate education for entry into practice in the United States.
- Harmonize nursing curricula.
- Add global health as a subject matter to undergraduate and graduate nursing curricula.
- Establish a national system that monitors and tracks the inflow of foreign nurses, their countries of origin, the settings in which they work, and their education and licensure.

- Create an international body to coordinate and recommend national and international workforce policies. (Nichols, Davis, & Richardson, 2011)

World leaders agreed on the millennium development goals (MDGs), eight goals and multiple measureable targets aimed at solving some of the most demanding problems of the time (United Nations, 2014). Every single goal, directly or indirectly, affects global heath. Anyone who provides or plans care for patients and populations needs to be familiar with the goals:

1. Eradicate extreme poverty and hunger.
2. Achieve universal primary education.
3. Promote gender equality and empower women.
4. Reduce child mortality.
5. Improve maternal health.
6. Combat HIV/AIDS, malaria, and other diseases.
7. Ensure environmental sustainability.
8. Develop a global partnership for development.

Significant progress has been made toward goal achievement, particularly poverty reduction, improved access to water, reduction in infectious disease, reduction in disparities of education, and increased participation of women in policy. At the same time more effort is needed to accomplish nutrition and mortality goals. (For the full report, see United Nations, 2014.) The effort now is moving toward sustainable development goals (SDGs), with stakeholders creating an ongoing development agenda.

A last trend is the controversial topic of global warming or climate change. Regardless of views, most agree that some recent weather events will likely recur and have profound effects on health. Warmer temperatures, warmer waters, melting ice caps, and elevations in sea level are thought to lead to hurricanes, insect migration, zones of increased humidity, and zones of drought. These directly affect health and exposure to disease, cause significant damage to lands and crops, and impair economies attempting to provide for people (Kai, 2011).

Agencies Involved in the Global APRN Experience

Numerous agencies are involved in nursing and APRN issues and function across borders and nations. The ICN has been guiding nursing since 1899 with a mission "to represent nursing worldwide, advancing the profession and influencing health policy" (ICN, 2014, para. 1). In 2000, the ICN and American Association of Nurse Practitioners (AANP; formerly the American Academy of Nurse Practitioners) created the International Nurse Practitioner/Advanced Practice Nursing Network (INP/APNN). This network is considered a primary global resource for APRNs and those interested in advancing the role (AANP, 2014).

WHO has also worked on nursing issues such as education, governance, retention, and migration of nurses but has not been as involved

with advanced nursing. Much WHO work has been devoted to workforce development of midwifery, rather than nurse midwifery. Similarly, the International Confederation of Midwives has done the same.

Other nursing organizations well known for supporting nursing around the world are Sigma Theta Tau International (STTI), the American Association of Nurse Practitioners (AANP), and the National Organization of Nurse Practitioner Faculties (NONPF). Currently STTI is working with world health leaders on the Global Advisory Panel on the Future of Nursing (GAPFON), which has been tasked to create a global nursing voice that will improve global health. STTI (2014) has been supportive to APRNs through grants, support of research initiatives, continuing education, conferences, and numerous publications, and AANP and NONPF assist APRNs educators to network, communicate, publish, and share common concerns related to international work.

Several organizations have influenced the standards of APRN practice and education in the United States. Although nations choose to self-determine if or how the APRN role develops, many use the same documents. Table 6.4 provides a partial listing of influential documents.

TABLE 6.4 Documents With Potential International Influence

American Association of Nurse Practitioners	• Clinical Outcomes: The Yardstick of Educational Effectiveness • Nurse Practitioner Cost-Effectiveness • Nurse Practitioner Curriculum • Quality of Nurse Practitioner Practice • Scope of Practice for Nurse Practitioners • Standards of Practice for Nurse Practitioners
American Association of Colleges of Nursing	• The Essentials of Baccalaureate Education for Professional Nursing and Tool Kit • The Essentials of Master's Education in Nursing (2011) • The Essential of Master's Education for Advanced Practice Nursing (1996) • The Essentials of Doctoral Education for Advanced Nursing Practice (2006)
National Organization of Nurse Practitioner Faculties (NONPF)	• Multiple examples of competencies for nurse practitioners available on the NONPF website. Intended for entry into practice, the competences are numerous, population-specific and separately include those for both master's and doctoral levels.
American College of Nurse Midwives	• Faculty Degree Requirements • Mandatory Degree Requirements for Entry Into Midwifery Practice • Midwifery Education • Midwives Are Primary Care Providers and Leaders of Maternity Care Homes

(continued)

TABLE 6.4 Documents With Potential International Influence *(continued)*

American Association of Nurse Anesthetists	• Scope of Nurse Anesthesia Practice (2013) • Standards of Nurse Anesthesia Practice (2013) • Quality of Care in Anesthesia
National Association of Clinical Nurse Specialists	• Clinical Nurse Specialist Core Competencies (2010) • Position Statement on the Importance of the CNS Role in Care Coordination (2013) • Impact of the Clinical Nurse Specialist Role on the Costs and Quality of Health Care (2013)

Recently, certification organizations are beginning to examine educational programs and to certify some APRNs who go to schools outside the United States. Given the variability of roles and education of international APRNs, there is little migration of APRNs across borders. Currently the Commission on Graduates of Foreign Nursing Schools (CGFNS) is working on an APRN education comparability tool to address the underlying issues. These issues are problems confronting APRNs from other countries coming to the United States to practice, nurses entering U.S. APRN programs, and the APRN role enactment in their home country (Schober, 2011). At some point the process of accrediting APRN schools outside the United States may become desirable.

Preparing the APRN for Global Experiences

International advanced practice nursing partnerships have become a popular method of exchanging nursing knowledge in that they provide a forum for access to international practice experiences and a forum for research in international health care issues. In today's global health care environment, APRNs educated in global health are prepared to network with international multidisciplinary health care providers to develop and deliver quality care. These partnerships have included long-term work assignments and medical brigades (previously called missions) of varied lengths, most with the goal of developing sustainable health care access. How this goal is carried out depends on the needs and plans of the supporting partners and may vary by time of year, current needs of the partner, and the political climate.

Aside from international experiences that occur in the United States, many health care providers are willing to volunteer on both short- and long-term undertakings outside the United States. World disasters like the 2010 Haiti earthquake that created catastrophic damage have prompted the need for increasing emergency medical relief and continuing sustainable medical work. Nongovernmental organizations (NGO) have teams who arrive regularly to provide sustainable help for this nation.

Ethics and Responsibilities: Approach to Care

A critical foundational element for any international experience involves the development of appropriate ethical and cultural approaches by involved

health care. Ethical practice involves respectfully approaching those in need, treating them fairly and equitably, and thoughtfully approaching human rights (Hunter & Crabtree, 2010). A culturally competent health system is "one that acknowledges and incorporates—at all levels—the importance of culture, assessment of cross-cultural relations, vigilance towards dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs" (Batancourt, Green, Carrillo, & Owusu, 2003, p. 294). Chase and Hunter (2010) describe *cultural competence* as a skill that can be learned and emphasize that the APRN should be not only culturally competent but culturally responsive, defining that as someone capable of relating in an ethnorelativistic, not ethnocentric, fashion. With an ethnorelativistic approach, the APRN provides care centered on the values and perspectives of the patient and the community. Resources to educate and assess those skills can be obtained through the National Center for Cultural Competence, assessable at http://nccc.georgetown.edu/index.html. They also emphasize that the APRN be not only culturally competent but culturally responsive, defining that as someone capable of doing what has been described in an ethnorelativistic, not ethnocentric, fashion. With an ethnorelativistic approach, the APRN provides care centered on the values and perspectives of the patient and the community.

A related issue pertains to the ethics and cultural sensitivity surrounding the level of participation in global experiences—short term (1 day to 1 month) versus long term (1 month to 2 years) versus permanent (2 years or more). APRNs have participated at all levels. The controversy stems from concerns that any effort without proven benefits to the patient or community is not ethical. Although patients who receive corrective lenses, are cured of an infection, or have a completely decayed tooth pulled may value the intervention, some want the measure of value to be based on level of sustainability. Martiniuk, Manouchehrian, Negin, and Zwi (2012) cited that benefits of short- and long-term medical brigades included transferring medical knowledge, helping communities convey their plight, and giving communities hope that problems might be solved. Negatives included problems of sustainability (unless that was specifically countered), limited relations with nearby health care systems, and lack of data analysis. The authors recommended the following to optimize global efforts: cross-cultural dialogue and efforts, determined efforts toward efficacy, transparency, and coordination with existing organizational programming. These are clear messages to any APRN considering such work or evaluating a program before joining.

Fulbright Programs and Project HOPE

Two organizations with long histories of providing high-quality opportunities for international nursing experience are the Fulbright Program and Project HOPE. The older Fulbright Program offers U.S. nursing professionals, educators, and scholars the opportunity to study, teach, and/or conduct research abroad through the Fulbright U.S. Scholar Program and the Fulbright Specialist Program. These are competitive programs that are open

to most academic disciplines. The Fulbright initiative was spearheaded by Senator William J. Fulbright as a way to promote peace and mutual understanding at the close of World War II. Funding began in 1946, and now its programs are active in more than 155 countries. The Fulbright Scholar Program publishes the grant opportunities each spring with an application deadline of August 1. Many grant applications require a letter of invitation, so it is helpful to review the online catalogue early, speak with the Fulbright staff about the grant specifics, and communicate with the host institution about obtaining an invitation letter. The Scholar Program funds travel and a generous living stipend. These grants may be for teaching, research, or a teaching–research combination, and the time commitment (3 to 12 months) is specified in the grant opportunity. In contrast, the Fulbright Specialist Program offers an opportunity for experienced professionals and academics to collaborate on projects defined by the non-U.S. institution for 2 to 6 weeks. Travel and in-country costs are covered. However, the Fulbright Specialist Program does not fund activities such as direct patient care requiring a nursing license. See www.cies.org for more detail on the Fulbright programs.

Project HOPE, founded in 1958, began with a peacetime-deployed hospital ship and now provides land- and ship-based global nursing practice and education experience. Opportunities include but are not limited to 4- to 8-week ship-based nursing practice as well as 6-month teaching opportunities in countries such as China and project-based work, including implementing a tuberculosis (TB) control program in Tajikistan. Details can be found on the Project HOPE website, www.projecthope.org and Facebook site. For most volunteer positions the individual is expected to pay his or her own travel expenses and their daily living expenses.

Health Care Medical Brigades

Emerging health care needs such as Ebola, severe acute respiratory syndrome (SARS), and Middle East respiratory syndrome (MERS) require global partners working together to develop strategies to treat and prevent the spread of these diseases. The term *health care* is used to designate an interdisciplinary approach to deliver care internationally. An interdisciplinary team of health care individuals is needed to improve overall health care. A well-rounded team is composed of physicians, nurses, APRNs, dentists, health educators, nutritionists, social workers, pharmacists, physical therapists, occupational therapists, counselors, and students from all disciplines.

Countries such as the United States, Canada, Switzerland, Germany, England, and Australia have large numbers of NGOs and universities that send out health care teams regularly for the purposes of providing direct patient care, supervised experiences for students, and opportunities to network on research and education. Table 6.5 lists volunteer international health care websites and information to assist in planning a medical brigade.

Pretravel Preparations

Pretravel preparation should begin at least a year in advance. In preparing for a trip, the team leader should review online information about the

TABLE 6.5 Volunteer International Websites/Information to Assist in Planning

U.S. State Department Travel Warnings and Consular Information Sheets—provides country-by-country information relevant to health, safety, visa and entry requirements (travelers may be unable to board planes if they do not have the necessary visa), medical facilities, consular contact information, drug penalties, etc. http://travel.state.gov/travel/cis_pa_tw/tw/tw_1764.html
CIA Publications and Factbooks—includes among its sections World Factbook (provides a wealth of information on virtually all countries), Handbook of International Economic Statistics, CIA Maps and Publications Released to the Public. www.cia.gov/cia/publications
Centers for Disease Control and Prevention (CDC)—provides information for foreign travel and recommended immunizations. www.cdc.gov
Ford Foundation—is one of the largest U.S. foundations active in national and international health. www.fordfound.org
Hesperian Foundation—publishes low-cost, practical books for use in all aspects of international health practice at the community level. www.hesperian.org
Library of Congress Country Studies—provides detailed information on many of the countries of the world prepared by the Federal Research Division of the Library of Congress. The site has an impressive search engine that can search across the database for any combination of words, ranks the hits in order of closeness to your search terms, and then provides links to the desired text. http://lcweb2.loc.gov/frd/cs/cshome.html#toc
Teaching Aids at Low Cost—lists and distributes many health-related teaching aids that are provided in low-cost format and often in multiple languages for use by health care providers and patients in developing countries. www.talcuk.org
World Health Organization—http://www.who.int/topics/travel/en/
American Council for Voluntary International Action—is a consortium of more than 150 nonprofit organizations working worldwide in health, educational development, and other related fields. It is a source of jobs and volunteer resources. The site includes hotlinks to all of its members. www.interaction.org
Doctors Without Borders USA—is the famous French-originated organization (Medecins Sans Frontieres) that sends fully qualified health professionals into some of the most challenging parts of the world. Because they do not have job descriptions contracted for nurse practitioners, nurse practitioners function in the role of nurses. www.msf.org
Foundation of Integrated Education and Development (FUNEDESIN)—is a clinical rotation program that provides clinical experiences in the Amazon region of Ecuador. It is open to all levels of students and health professionals in the fields of medicine and nursing. Further information can be found on the website. (http://www.funedesin.org). The application pack can be requested by e-mailing clinic@funedesin.org.
Global Health: Making Contacts—contains a gold mine of international health resources and projects, including job opportunities. It provides links with a long list of governmental and nongovernmental agencies and organizations, people, academic institutions, and organizational directories relevant to health. The sections are conveniently grouped according to major mission, affiliation, type, etc. www.globalhealth.pitt.edu

(continued)

TABLE 6.5 Volunteer International Websites/Information to Assist in Planning *(continued)*

Global Service Corps—provides short- and long-term opportunities to volunteer in health, education, and environment projects in Kenya, Costa Rica, and Thailand. www.globalservicecorps.org
International Foundation for Education and Self-Help (IFESH)—provides assistance and opportunities for service much in the fashion of the U.S. Peace Corps. The primary focus is sub-Saharan Africa. Through its International Fellows Program (IFP), the Foundation has provided 9-month overseas internships for Americans who are graduate students or recent college and university graduates. Fellows are placed with development-focused organizations working overseas. www.ifesh.org
International Healthcare Opportunities Clearinghouse—provides listings of organizations with Internet links of online resources, courses, and books on international health, as well as information about how to get funding. It has a search engine that can locate organizations according to diverse search criteria and provides links to home pages of organizations where available. http://library.umassmed.edu/ihoc/
International Health Medical Education Consortium (IHMEC)—provides information about courses, curricula, annotated websites, foreign language study courses, and other materials useful for faculty and students interested in international health. Go to the Resources section of the IHMEC home page. www.globalhealtheducation.org
International Medical Corps (IMC)—is a private, nonsectarian, nonpolitical, humanitarian relief organization established in 1984 by volunteer U.S. physicians and nurses. The home page lists IMC's programs and job openings for doctors, nurses, and other health professionals. www.internationamedicalcorps.org
MPA International—is a nonprofit Christian relief and development organization, promoting the total health of people living in the world's poorest communities. www.map.org
Medical Missions Foundations—has multiple opportunities. www.mmfworld.org
Direct Relief—has many opportunities in the United States and abroad. www.directrelief.org
Humanitarian Medical Relief—has more than 60 possibilities for volunteer service and includes a link to Flights for Humanity, a nonprofit Christian organization that flies patients to medical centers for treatment. http://humanitarianmedical.org
International Health Database under the American Medical Association—has numerous opportunities. http://ama-assn.org//ama/pub/about-ama/our-people/member-groups-sections/medical-student-section/opportunities/internation-health-opportunities.page
Volunteer Humanitarian Opportunities—contains more than 40 opportunities for volunteer service. www.projects-abroad.org
Heal the Nations Christian Medical Missions—focuses on India and Uganda. www.mtghouse.org
American Medical Resources Foundation—donates used, but fully functional, medical equipment to hospitals serving the poor worldwide. www.amrf.com
Hearts in Motion (HIM)—is a nonprofit, nondenominational agency that focuses on the needs of less fortunate children and families. Each trip runs about 10 days and costs about $1,000 for airfare and lodging. http://www.heartsinmotion.org/index.php

(continued)

TABLE 6.5 Volunteer International Websites/Information to Assist in Planning *(continued)*

International Volunteer Work in India–Delhi—as Mark Twain recounted in *Following the Equator,* India is "the land of dreams and romance, of splendor and rags, of palaces and hovels, the country of a hundred nations and a hundred tongues." www.crossculturalsolutions.org
Monitoring Freedom—Human Rights Around the World—includes expatriate resources and resources for Americans fleeing America. Allows users to search the largest expatriate database of embassies, international jobs, and offshore financial services websites. www.escapeartist.com/jobs/overseas1.htm
International Grants and Funders—provides international grants and funders. www.grantspace.org
Global Volunteer Network—is a resource for those interested in volunteering. www.globalvolunteerntwork.org
Doctors of the World, USA: Volunteer/Recruitment—offers a wide array of opportunities for health professionals to contribute to ongoing efforts to alleviate suffering and help improve human rights around the world. http://doctorsoftheworld.org/get-involved/volunteer/
Healing Touch International: Clinics—is a listing of Healing Touch Clinics that are open to the public. Some clinics are by appointment only, and payment is by donation. Clinic choice can be made on the website. www.healingtouchinternational.org
The Medical Foundation, About Us—History—discusses the work of the Medical Foundation for the Care of Victims of Torture, which began more than 25 years ago under the auspices of the Medical Group of Amnesty International. www.freedomfromtorture.org
Mercy & Truth Medical Missions—desires to serve the public as much as possible. Mercy & Truth Medical Missions is a fee-for-service clinic. www.mercyandtruth.com
Global Health Outreach—organizes short-term medical group missions. Christian Medical & Dental Association, under Medical Missions tab. www.cmdahome.org
Medical Education International—medical education teams with Christian Medical & Dental Association, under Medical Missions tab. www.cmdahome.org
Northwest Medical Teams International—provides contact information under AERDO tab. www.aerdo.org/members/organizations/northwest_medical_teams.html
Heal the Nations—provides Christian Medical Missions links, a list of volunteer health care organizations, both Christian and secular. www.healthenations.com/links.html
United States Agency for International Development (USAID)—provides economic and humanitarian assistance. www.usaid.gov
Christian Connections for International Health—promotes international health. Has a job search section. www.ccih.org
"Nuestra Senora de Guadalupe"—based in Ecuador, organizes short-term medical missions into the remote areas of the Amazon basin. The Mission at Guadalupe also has a clinic that is looking for providers for longer terms. www.guadalupe-ec.org

(continued)

TABLE 6.5 Volunteer International Websites/Information to Assist in Planning *(continued)*

American Baptist Churches in the U.S.A International Ministries (ABC)—goals are theological eduction, evangelism, economic development, education, and health. http://internationalministries.org
International Medical Volunteer Association—provides information about volunteering and links to various international organizations. www.imva.org
Doctors for Global Health—a private, not-for-profit organization promoting health, education, art, and other human rights throughout the world. www.dghonline.org
University of Washington—provides information on overseas medical opportunities. www.globalhealth.washington.edu
University of Kentucky—offers weeklong medical brigades three times each summer at permanent UK clinic in Santo Domingo, Ecuador. www.uky.edu/international/shoulder_to_shoulder
American Medical Student Association—strives to extend the scope of our members' medical education through institutes, international exchanges and career development opportunities. www.amsa.org/global/ih/ihopps.cfm
MAP/Reader's Digest International Fellowships—a global Christian health organization that partners with people living in conditions of poverty to save lives and develop healthier families and communities. www.map.org
Save the Children—focuses on outreach efforts related to maternal, newborn, and child health. www.everybeatmatters.org

host country/sponsor, especially data related to finances and bringing medications and supplies. If the brigade is outside the United States, the State Department warnings specific to the country should be reviewed. Networking and developing a relationship with the host country/sponsor may require an initial visit to determine the needs. Issues such as requirements of the host country/sponsor for current provider licenses, medications, and supplies that are approved by the country/sponsor should be determined early in the pretravel period. Transportation and lodging will also need to be worked out with the host. One country (Burundi) requires visa applications be submitted a letter of invitation from the people with whom the volunteer is staying or documentation of hotel reservations.

There are a variety of ways team members may fund their trip expenses. Some pay the total amount out of pocket. Others will rely on fund-raisers to support all or part of the team's expenses. Some organizations do a one-third method, when the individual pays a third, the organization pays a third, and the last third is from donations or fund-raiser activities (Samaritans Now, 2014).

Funding needs to be discussed at one of the early team meetings—finances can become a source of friction in the group. Airline tickets are the most costly budget item. Some airline companies will provide group rates and allow extra baggage for free. Airlines request contact at least 60 days in advance to set up the team trips.

Team members frequently ask how much cash they should bring. In many cases, it depends on the economy of the host county. For example, costs in Thailand are higher than those in Guatemala.

Many countries (e.g., Ecuador, Guatemala) require preapproval for medications, and the expiration date on medications must be at least 6 months into the future. The preapproval requires listing expiration dates, names of the pharmaceutical company that produced the medication, and quantities of the medications. All documents must be notarized. Table 6.6 lists pharmaceutical organizations that will provide medications to health care teams. Some organizations require a physician's signature. If ordering medications outside the United States, for instance, from Action Medeor in Germany, U.S. Customs and Border Protection will need to be contacted for a list of brokerage firms that will support bringing the medications into the United States for transport to the host country. Some companies allow APRNs to purchase low-cost medications, and others require a physician or pharmacist to do the purchasing. This requirement is based on state regulation of the involved APRNs. Another source to review is www.who.int/medicines/areas/access/sources_prices/international_medicine_price_guidesprice_lists.pdf.

Some university pharmacy departments compound medications for interdisciplinary faculty/student medical brigades or assist in purchasing and packaging of medications. Some pharmaceutical companies will donate over-the-counter medications. Good sources of over-the-counter medications are APRN conferences. At the end of the conference, companies are willing to donate their remaining products. Table 6.7 provides a list of recommended medications for a trip. Occasionally, there is a request from the host administrator for a specific medication—for example, something to treat hyperthyroidism.

Team Meetings

Team meetings are essential to building a strong cohesive team. The meetings should include discussion of cultural traditions and behaviors; boundary setting; cultural differences and cultural sensitivity; and issues of dealing with extreme poverty, serious illnesses, abuse, and starvation. Illicit drug use and drunkenness are not acceptable behaviors on a medical brigade trip. Other issues to address are flights and lodging, itinerary, work schedules, local regional health issues, and practical tips for the trip. See Tables 6.8 to 6.13 for trip preparation materials.

The team should plan at least one or two tourist activities, such as sightseeing to the Taj Mahal and the Red Fort in the Delhi area. Shopping is also a fun experience for most team members, so selecting a hotel close to a shopping area is recommended.

Setting Up a Medical Camp

The host country/sponsor organization selects the sites for the camps and arranges the overall setup. For example, when working in the slums of New Delhi, the host rents tents that can be used in areas for slums that do not have school buildings. In some countries, established clinics, schools,

TABLE 6.6 Medical Brigade Pharmaceutical Resources

Agency	Website	Phone or E-mail/ Contact Person	Application	Pharmaceutical Supplier	Comments
Cross Link International	www.crosslinkinternational.net/RequestsForCrossLink.shtml	(703) 534-5465	www.crosslinkinternational.net/App.shtml		Receiving agency must be a Christian faith–based organization.
Brother's Brother Foundation	www.brothersbrother.org/medical.htm	ccramer@brothersbrother.org; Chris Cramer		Yes, and small trays of basic surgical instruments	Most medications are good for 4–6 months. No cost for medications and shipment in the United States.
Catholic Medical Mission Board	www.cmmb.org/What/medical_shipments.htm#	ktebbett@cmmb.org	www.cmmb.org/pdfs/HealingHelpMedicalMissionsApp.pdf		Requires submission of an online application.
MAP	http://www.map.org/site/PageServer?pagename=travel_Forms	(800) 225-8550 or online contact: www.map.org/site/Survey?SURVEY_ID=1320&ACTION_REQUIRED=URI_ACTION_USER_REQUESTS	www.map.org/site/DocServer/MAP_Travel_Pack_Program-_All_Forms.pdf?docID=4781		Requires submission of an online application.
Kingsway Charities	www.kingswaycharities.org/index.php/our-charity/supply-request/	(800) 321-9234			Receiving organization must be Christian faith–based.
Vitamin Angels	www.vitaminangels.org/contact-us	(805) 564-8400			Not for short-term medical teams.

Globus Relief	www.globusrelief.org/partneringwithglobusrelief	Christopher Dunn, chdunn@globusrelief.org		Yes and medical equipment	They try to make pharmaceuticals below cost.
medWish International	www.medwish.org/handcarryinfo.html	(216) 692-1685 or info@medwish.org	www.medwish.org/handcarryinfo-app.html	No, only medical supplies	
Project Cure	http://projectcure.org/get-assistance	patricebaker@projectcure.org	www.projectcure.org/get-assistance/medical-kits#application	Yes	Most medications provided will only have 3 months remaining on their dating.
FAME	www.fameworld.org/home.aspx?iid=14334	(317) 358-2480 or medicalmissions@FAMEworld.org			Must be a faith-based organization.
International Aid	www.internationalaid.org/Health_Products.html	healthproduct@internationalaid.org		Yes, and lab-in-a-suitcase (www.internat-ionalaid.org/Lab-In-A-Suitcase_files/LIS%20Brochure%20New.pdf)	Need to complete online application.
Action Medeor	www.medeor.org	Inge.ricken@medeor.de	info@medeor.de	Yes	Product catalogue: http://medeor.de/en/medeor-market-en/price-indicator.html

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TABLE 6.6 Medical Brigade Pharmaceutical Resources *(continued)*

Agency	Website	Phone or E-mail/ Contact Person	Application	Pharmaceutical Supplier	Comments
World Medical Relief	www.world medicalrelief.org/	info@world medicalrelief.org, Carolyn Racklyeft	www.world medicalrelief.org/	Yes	Accommodates medical brigade teams with pharmaceuticals. Medications do not usually have a year before expiring but such medications can be purchased at lower cost. Need to fill out an online application.
Americares	www.americares.org/ whatwedo/mop/	cmarion@ americares.org, Cia Marion	www.americares.org/ whatwedo/mop/ mopapplication.pdf	Yes	Most medications are short-dated (3–6 months out), but they do have a few longer-dated medications. Suggest a $200 donation.
Blessings International	www.blessing.org	Fax number for ordering is (918) 250-1281	www.blessing. org/wp-content/ uploads/2012/09/ Blessings-Instructions. pdf	Yes	First-time users must fax a copy of their check for the estimated amount of the order with their application form.
Direct Relief International	www.directrelief.org	SJohnson@ directrelief.org	www.directrelief. org/wp-content/ uploads/Volunteer Application2013.pdf	Has medication and supplies for volunteers on disaster relief.	Participates in disaster relief worldwide.

Heart-to-Heart International	www.hearttoheart.org		https://hearttoheartinternational.wufoo.com/forms/heart-to-heart-international/	Yes	Physicians, optometrists, dentists, podiatrists, and pharmacists can apply for a standard Ready Relief pack of medications or a custom order.
Interchurch Medical Assistance	www.interchurch.org	(877) 241-7952 or (410) 635-8720	imainfo@imaworldhealth.org	They have medicines and supplies for their own projects. They run their own programs in Haiti, South Sudan, Domiinican Republic, Congo, Tanzania, and Indonesia.	They deliver prepacked medicine and supply boxes to treat up to 1000 patients.
Project HOPE	www.projecthope.org	(800) 544-HOPE	Application to be a volunteer for Project HOPE can be found at https://projecthope.csod.com/ats/careersite/JobDetails.aspx?id=35	They have medication and supplies for their own country.	Project HOPE has worked in more than 120 countries.

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TABLE 6.7 Recommended Medications for International Medical Brigades

Analgesics, antipyretics, nonsteroidal antiinflammatory drugs (NSAIDs)	Antiinflammatory drugs
Anesthetics	Antimalarial drugs
Antiallergics	Cardiovascular drugs
Antiamoebic drugs	Dermatologic preparations, disinfectants
Antiasthmatic drugs, antitussives	Diuretics
Antibacterials, antifungals, antiviral drugs	Gastrointestinal drugs
Antidiabetics	Laxatives
Antidiarrheal drugs	Ophthalmologic preparations
Antiepileptics	Psychotherapeutic agents
Antihelminthics, antifiliarial drugs	Vitamins and food supplements

TABLE 6.8 Short-Term Health Care Mission Team Leader Responsibilities

1. Begin planning the trip a year in advance. Decide on the type of project, dates, and location. Work with host country/sponsor team members to plan the medical brigade and determine the needs of the people.
2. Solicit application for team members and select a team. Interview and select team members about 6 months in advance so that they can request time off work.
3. Develop a budget that includes air flights, all transportation, housing, and food. Share the information with the team. Develop a plan for financing the trip.
4. Set up a schedule for team meetings and posttrip debriefing. The first meeting should cover issues such as waivers, trip insurance, cultural sensitivity, appropriate behaviors for the trip, what to do in case of illness, how to obtain passports (if needed), how to obtain visas (if needed), needed immunizations, the approximate cost of the trip, and any issues the team members may have.
5. The team leader is responsible for coordinating medications and supplies to be taken on the trip. Each team member should pack the medications and supplies he or she is taking and make a list to give to the team leader. The number of bags allowed and the weight of the bags are determined by individual airlines. Some airlines allow only one checked bag free; others will allow up to three. Other luggage will need to be paid for, usually $25 to $75 per bag.
6. The team leader and host country/sponsor leader are responsible for the daily activities and debriefing activities. Should a team problem occur, the team leader and host country/sponsor leader should work together to resolve the issue.
7. Plan a posttrip debriefing meeting to discuss issues that occurred on the trip and since returning home. This meeting may need to take place on the last evening the team is together—some teams are composed of team members from other countries.

TABLE 6.9 Recommendations of What to Take for Medical Brigades to Developing Countries

Lightweight (silk?) sleeping bag for warm climates—spray with DEET and put in zip lock bag for penetration of the DEET into the material Miranda@nznature.co.nz ($2 NZ = $1 US)	Nonsteroidal antiinflammatory drug (NSAID) of choice (carry on the plane)—helps with jet-lag
Aluminum foil blanket for warmth, if needed	Clothes pins and roll of heavy string or lightweight rope
Mosquito net and repellant containing DEET (not in pressurized spray can)—recommend spraying suitcase and clothing with DEET before travel	Duct tape, colored (can help visualize bags or brigade items)
Citron wrist/ankle band to ward off mosquitos (effective for 400 hours)	Otoscope/ophthalmoscope (battery powered for places where there is no electricity) A ready-to-go bag that has stethoscope, blood pressure cuff, otoscope, ophthalmoscope, pens, urine dip sticks, scissors, duct tape, O_2 saturation monitor (inexpensive from Amazon.com), Doppler (relatively inexpensive from Amazon.com), reliable thermometer, etc.
Sunscreen	Flashlight or headlight (frees hands to fight off the elements), backpack (one that will carry water bottles)
Ciprofloxacin (enough for 3 days), for diarrhea, or use when starting to run a fever—is not effective in all countries	Belly pack—keep passport (in a zip lock bag) and money in your pack
Pepto-Bismol tablets (chew 2 before each meal)	Passport must be in a safe place at all times!
Imodium AD	Hat and lightweight rain poncho
Toilet paper, one roll—others may be purchased in country	Lightweight clothing that dries fast or scrubs—work well for seeing patients. What is worn depends on the culture. In India, females on the team wear the traditional dress of shalwar kameez and dupatta. Avoid wearing shorts and tank tops.
Nutritious snacks	Tennis shoes or boots with socks—recommended to protect from insect bites
Chocolate that will not melt	Colored photocopy of passport to give to the team leader
Personal medicines	Lightweight long-sleeve and long-leg pajamas with tight cuffs—keeps the mosquitoes and other insects off the skin

(continued)

TABLE 6.9 Recommendations of What to Take for Medical Brigades to Developing Countries *(continued)*

Language dictionary and medical language dictionary	Leatherman or other knife in *checked bag*
Gifts for people who help and children (stickers, blow-bubbles, inexpensive toys—chosen according to age and safety)	Country-specific electrical adapter plugs and voltage converters, if needed. For information: www.rei.com/learn/expert-advice/world-electricity-guide.html
Water bottle—bottled water usually can be bought in country	Extra batteries of standard sizes—in-country batteries may not be reliable
Flip-flops or Chacos for the shower	Locks for suitcase—not for use on flights but to use when working or away from them for the day
Towel, washcloth, and soap; hand wipes	Camera, extra camera batteries if battery-dependent camera
Toiletries (inexpensive shampoo or conditioners, if expensive Customs may inspect)	Learn to adapt and do without for a short time—think: patience, perseverance, and stamina

TABLE 6.10 Pretravel Safety Precautions

Review online travel recommendations:

- From the host country's embassy and other reliable resources
- Immunizations and medications (available at www.cdc.gov)
- Review State Department travel warnings (available at http://travel.state.gov/travel).
- Notify the State Department of trip purpose/travel itinerary (http://travel.state.gov or 888-407-4748).
- Collect team member licenses and colored copies of team member's signed passports/visas.
- Prepare a team emergency kit.
- Set up two or three team meetings. A conference call may be helpful using www.freeconferencecall.com.

TABLE 6.11 Travel Preparations

Documents	Passport	Application is available at http://travel.state.gov/passport Cost: $140 (adult first-time passport book and card) + $25 execution fee. Expedited services are an additional $60. Should not expire within 6 months after return to United States.
	Visa(s)	May be required by individual country; check http://travel.state.gov/visa/ to determine visa requirements. Cost: Varies, but often around $150 to $200, when added to cost of FedEx, new photos, and the visa itself.
	Immunization record	Some countries require verification of specific immunizations (especially yellow fever) to enter the country. Immunizations can be expensive for first-time trip members. The receiving country may require a photocopy of the yellow fever immunization when applying for a visa. Information is available at http://wwwnc.cdc.gov/travel/default.aspx.
Travel Arrangements	Flights	Flights can be arranged online, but commonly used travel sites (e.g., Travelocity, Cheap Flights, Expedia) are often unable to book international travel to more remote settings. Help may be obtained from a travel agent or the airline. Consider choosing airlines that add frequent flyer miles based on connecting flights with partner airlines. An example is Delta/KLM/Kenya airlines to Nairobi. An excellent site for host country maps is www.WHO.int/maps.
	Lodging	Hotels or other lodging facilities may not accept credit cards; other hotels may not accept *all* credit cards. If going to a malaria-endemic country, a bed net or net sleeping bag and mosquito repellant may be recommended. Recommendations of prophylactic medications can be reviewed at www.cdc.gov/travel. If air-conditioning is available, sleeping quarters need to be kept as cold as possible.
	Food/water	Familiarity of types of food that will be available is helpful; if food security is a potential problem, bringing protein bars, trail mix, and water purification tablets may be necessary. A quality water filter is the Pre-Mac travel well "Trekker" (www.shop.eri-online.com).

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TABLE 6.11 Travel Preparations *(continued)*

Health Care	Medications	The Yellow Book 2014 from the CDC (http://wwwnc.cdc.gov/travel/page/yellowbook-2014-home.htm) is a comprehensive resource for health risks and recommendations for every country, including medications. The Yellow Book is also available for Android and iOS mobile devices. The iTunes store has a Yellow Book app for iPads and iPhones. In-country medications, if available, may not be correctly formulated or may be contaminated. They may also be expensive. One Zofran ODT is $5 in Ecuador.
		When possible, enough medication (regularly taken medications and any prophylactic medications) to last the entire trip should be brought; some countries may require copies of prescribed medications, especially controlled substances; consider over-the-counter medications for pain, fever, nausea/vomiting, diarrhea, constipation, cuts/scrapes, and insect bites. The team leader should obtain an emergency kit.
	Bed nets	These provide protection in malaria-endemic countries.
	Insurance coverage	Health insurance out-of-network coverage needs to be checked; evacuation insurance (e.g., www.medexassist.com) needs to be considered. Medicare/Medicaid does not provide coverage outside the United States.
Communication	Itinerary	All participants should carry a paper copy of the itinerary. An additional copy of the travel itinerary (flight, hotel, ground transportation) should be left with someone at home. Flight departures should be confirmed the day before traveling back to the United States.
	In-country contacts	The names and numbers of in-country contacts should be left with someone at home; include country codes as part of the phone number.
	Cell phones	Cell phone and data access can be expensive when used internationally; coverage and charges should be checked before departure to avoid huge bills upon return; purchase of an in-country cell phone is another option, with a SIM card to which more air time can be added as needed. Downloading WhatsApp to a smartphone for free text messaging when WiFi is available may be useful. Phone providers should be notified of travel outside the United States and may need details of the trip itinerary.

TABLE 6.11 Travel Preparations *(continued)*

Money	ATM cards	Money exchange should be done before leaving the country. Banks can help with this process. ATM machines are becoming more available in developing countries, but it cannot be assumed one will be available in all locations; PIN number should be four numbers (many foreign ATM machines do not have letters, just numbers). Use of debit cards can be a problem; it is often safer to use credit cards. The card provider needs to be contacted before leaving; otherwise, the card may be terminated or useless. Special debit cards can be purchased for travel (e.g., Contour card). These can be thrown away when the balance is gone. Use outside the United States needs to be verified.
	Traveler's cheques	Although fairly obsolete in many developed countries, traveler's cheques may still be used in some less developed settings.
	Credit cards	In developing countries, many businesses (hotels, restaurants, shops) do not accept credit cards; if intending to use credit cards, the credit card company will need to be notified of travel plans.
	Cash	All participants need to bring a certain amount of cash, exchanged as described earlier. In addition to personal expenses, there are always opportunities to help others (e.g., obtaining an oxygen tank for a young adult with tetralogy of Fallot). A working understanding of local currency is important to avoid overpaying or underpaying or being short-changed; there are smartphone apps that will help clarify currency exchanges. Cash should be carried in a money belt or belly pack. Some countries (e.g., Thailand) have a better exchange rate for larger bills.

TABLE 6.12 Packing Suggestions

Checked Luggage	Airline luggage limits need to be reviewed. Frequent flyer programs allow three free bags for Elite members. Unnecessary personal items (e.g., expensive jewelry/equipment) need to be left at home. Personal medical equipment without batteries may be checked. Expensive personal or other medical equipment with batteries will need to be in carry-on bags. Pack: Water filter, if bottled water will not be available (www.eri-online.com/ ERI_Equipment.html) Clothing appropriate for the weather and culture DEET

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TABLE 6.12 Packing Suggestions *(continued)*

	Itemized list of medications and supplies
	Gifts for hosts and children
	Towel and washcloth
Carry-on Luggage	Lightly packed, there may be limits of 10 kg.
	Include:
	Extra change of clothes (in case luggage gets lost or delayed)
	Toiletries
	Travel documents
	Personal medications and medical equipment
	Belly pack
	Cell phone

TABLE 6.13 Airline, Hotel, and Transportation Safety

Airline Safety	If there are unusual items being transported, the airline needs to be checked with in advance.
	Unruly passengers need to be avoided.
	Passport needs to be carried on the body.
Hotel Safety	Rooms between the second and sixth floors are recommended.
	Hotel business card should be carried in a wallet/belly pack, with the wallet in a front pocket.
	The hotel escape plan should be reviewed.
	Clothes, wallet, and shoes should be kept in the same place for emergency exiting.
	Participants should be observant and avoid crowds.
	Room safes are not safe.
Transportation Safety	Gasoline shortages are not uncommon in resource-poor settings; it is important to verify that your transport has enough gasoline to complete journeys.
	Some modes of transportation are relatively unsafe (e.g., mini-buses). In some countries (e.g., Guatemala), public buses are not safe.
	Some cities have very high rates of traffic accidents, particularly after dark.

or churches/temples can be used for the camp. Occasionally, setup may be under a tree.

Setup needs to include a patient check-in station (a triage nurse and interpreter) as the gatekeeper area for the flow of patients. Table 6.14 provides a list of common diseases seen in Central and South America. A similar analysis can be made for any region or country in order to prepare.

TABLE 6.14 Common Diseases/Disorders Exemplar—Central and South America

Burns/trauma/work injuries	**Eye**
Shoulder, neck, back, and leg pain	Conjunctivitis
	Cataracts
	Glaucoma
	Blindness
	Pterygium
	Pinguecula
Cardiac	**Fungal infections**
Hypertension	Vaginal: vulvar candidiasis
	Feet
	Oral
	Skin
	Tinea versicolor
Ear, nose, throat (ENT)	**Gastrointestinal conditions**
Cerumen impaction	Parasites: pinworms, amoebas, *Giardia*
Otitis media	Gastritis
Otitis externa	Peptic ulcers
	Diarrhea/constipation
Endocrine	**Genitourinary**
Type 2 diabetes	Urinary tract infections
Hypothyroidism	Benign prostatic hyperplasia
	Prostatitis
	Bacterial vaginosis
	Irregular menstrual cycles
	Pregnancy
	Chloasma

(continued)

TABLE 6.14 Common Diseases/Disorders Exemplar—Central and South America *(continued)*

Musculoskeletal problems	**Other infectious diseases/ mosquito-borne diseases**
Arthritis: osteoarthritis and rheumatoid	
Post trauma pain	Sexually transmitted infections
Back pain	Dengue fever
Myalgias	Malaria
	Chikungunya (Africa/India/Caribbean)
Neuropsychologic conditions	**Respiratory diseases**
Depression	Colds
Headaches	Chronic cough
Seizures	Bronchitis
Peripheral neuropathy	Asthma
	Pneumonia
	Environmental allergies
Nutritional disorders	**Skin**
Malnutrition	Rashes
Dehydration	Scabies
Anemia	Infections
Hyperhidrosis resulting from lack of B vitamins	

Many organizations have developed forms for recording patient identification information, vital signs, allergies, current medications, significant medical history, and a list of problems the patient wants treated. Teams will need to consider limiting the number of problems they can deal with per patient because there are often many people waiting to be seen. Occasionally, providers are faced with unknown diagnoses.

Although individuals usually queue up on the basis of first come, first serve, or the sickest first, there is often crowding and claiming rank and status. On a medical mission in a Delhi slum, a Mercedes pulled up, and an elegantly dressed woman went to the front of the line. No one seemed to be bothered by this, except the team members.

Referrals/Transfer to the Hospital

Before opening the clinic, organizers need to check with hosts about referrals and transferring patients to the hospital. In some countries individuals refuse to go to the hospital because of bad care and high mortality rates. These individuals may also become angry that the team is unable to resolve their problems. The host country/sponsor administrator is the best person to deal with these issues.

Home Visits

Team members may be asked to do a home visit on an individual who cannot come to the clinic or who is dying. For safety, it is best that several members of the team accompany the interpreter. Culturally, this is often a very positive experience for the team members because they have the opportunity to experience what the individuals deal with on a daily basis. Wound care may require daily visits.

Team Member Injuries/Serious Illnesses

Typically, most team member illnesses can be treated by the team. However, if a team member is seriously injured, evacuation may be required. Evacuation may also be required for serious illnesses. Contact information for the in-country U.S. embassy can be obtained at http://travel.state.gov. The emergency number for the U.S. embassy is (888) 403-4747. Trip insurance is highly recommended because evacuation can cost more than $50,000 and in-country treatment can also be very expensive. Most U.S. medical insurances and Medicare/Medicaid do not provide coverage outside the United States. Trip health insurance can be obtained at http://travel.state.gov/travel/tips/brouchures/brochures_1215.html.

The online brochure from the Smart Traveler Enrollment Program (STEP) contains excellent information on safety and preparedness. The link is http://travel.state.gov/tips_1232.html.

In-Country Debriefing

Ideally, debriefing should occur each evening in an informal setting. Discussion includes listing what activities went well and what activities should be improved. A list of needed medicines/supplies that are to be purchased while in the country should be compiled and then shared with the host in case the host is able to facilitate the purchase at a discount. A running list of recommendations for the next trip is another task for the team leader. Should team conflicts occur, the team leader and the host deal with the issues.

Post trip Debriefing

Team members need to be given the opportunity to process life-changing experiences, air feelings and reactions, and discuss what worked and what needs to be changed for the future medical brigades. The team leader may need to talk to individuals who had traumatic experiences in caring for patients. Team members may need to receive parasite medications. View Table 6.15 for recommendations on parasite treatments.

ROLE OF THE APRN IN GLOBAL RESEARCH

From a global perspective, the role of the APRN researcher is dynamic and vital to informing and articulating the APN role, shedding light on

TABLE 6.15 Parasitic Treatments

Parasite	Treatment (not recommended during pregnancy or lactation)
Worm (roundworm, hookworm, pinworm, whipworm, etc.) Common local beliefs about symptoms: excess salivation, itchy nose/throat, grinding teeth, craves sweets Roundworm: asymptomatic, but while in lungs produces a nonproductive cough Hookworm: mainly asymptomatic, but early manifestations may be epigastric pain or diarrhea, chronic iron-deficiency anemia Whipworm: chronic abdominal pain, anorexia, bloody or mucoid diarrhea, rectal prolapse Pinworm: chronic anal itching (worse at night), rarely abdominal discomfort, weight loss	**Adults and children 2 and up:** Mebendazole 100 mg twice daily × 3 days or Albendazole 400 mg × 1 dose **Children younger than 2 years**: For ascaris, piperazine 50–75 mg/kg daily × 2 days or For pinworms, piperazine 40 mg/kg daily × 7 days
Giardia Often asymptomatic, early: diarrhea, abdominal pain, bloating, belching, flatus, nausea and vomiting; diarrhea is common, but upper abdominal discomfort predominant Chronic: occasionally diarrhea, most common flatus, loose stools, and sulfurous burping; can cause weight loss	**Adult:** Albendazole 400 mg once daily × 5 days or Metronidazole 250 mg three time daily × 5 days or Metronidazole 2 g daily × 3 days or Tinidazole 2 g × 1 dose **Children:** Albendazole 400 mg once daily × 5 days or Tinidazole 50 mg/kg once daily × 5 days or Metronidazole 5 mg/kg three times daily × 5–7 days
Amebiasis Lower abdominal pain, little diarrhea, malaise, weight loss, abdominal or back pain; can mimic acute appendicitis; small amount of stool but lots of mucus or blood; few have fever	**Adult:** Metronidazole 500–700 mg three times daily × 10 days or Tinidazole 2 g × 2 days (liver abscess × 3 days) **Children:** Metronidazole 15 mg/kg three times daily × 10 days or Tinidazole 50–60 mg/kg/day × 3 days (liver abscess × 5 days)

the health care needs of disadvantaged populations internationally, and establishing a body of evidence of advanced practice nursing knowledge. The scope and perspectives of APRN research are broad ranging and may encompass epistemology; ethnography; role definition, justification, and expansion; exploration of the notion of competence and role-specific competencies; scope of practice and role potential; and disease- and intervention-specific research within APRN roles from an evidence-based practice perspective.

This research reflects both the APRN's own practice perspectives and also those of the national and international health care environments and jurisdictions in which APRNs work. APRN-related research is not confined to APRNs themselves, and the APRN role may be the subject of international research. For example, taking an international perspective and supported by the WHO, Lassi, Cometto, Huicho, and Bhutta (2013) published a systematic review and meta-analysis of 53 studies from the scientific literature comparing the quality of care provided by providers such as APRNs and that by what are considered higher level providers within developed and developing countries, such as the Africa region. The review concluded that there was no difference between the quality, effectiveness, and outcomes of care provided by the two groups of practitioners.

State of APRN Research in the World

Although the APRN role is well established in North America, the role continues to evolve internationally in both developed and developing countries, giving rise to a body of research literature with an evidential and exploratory focus. Researchers use the traditional available resources but also enjoy the use of Google Scholar or access to the Joanna Briggs Institute (JBI) and the JBI Library of Systematic Reviews, available at http://connect.jbiconnectplus.org/JBIReviewsLibrary.aspx. The following journals are also resources and publish international APRN research:

- *American Association of Nurse Practitioners*
- *International Journal of Evidence-Based Healthcare*
- *International Journal of Nursing Practice*
- *International Journal of Nursing Studies*
- *Journal of Advanced Nursing*
- *Journal of Nursing & Care*
- *International Nursing Review*

The following brief review considers APRN research emerging from Australia, Ireland, Japan, Jordan, the Netherlands, and Scandinavia.

Australia

In Australia, where some APRN roles role have been recognized for well over a decade, the research focus tends toward qualitative reviews of the evidence of the effectiveness of the role and discipline-specific

interventional research. The focus of the Australian studies presented in this section reflects the scope of practice and the emerging trends in APRN research worldwide. In a systematic review Ramis, Wu, and Pearson (2013), explored the experience of being an APRN within Australian acute care settings. The findings from the study's meta-syntheses reinforced the complexity of the identity, education, and scope of practice of the APRN role.

Kucera, Higgins, and McMillan (2010) explored Australian APRNs' lived experiences and proposed an APRN futures model derived from their narrative analysis of nurses' stories. Earlier Australian studies focused on APRN role definition, role confusion, decision making, and practice autonomy within changing health care environments. In 2006 Gardner, Chang, and Duffield proposed an APRN framework and a "research-informed model of service incorporating operational structures and role parameters" (p. 382).

The Australian Nurse Practitioner Study (AUSPRAC), funded by the Australian Research Council (ARC), undertook a 3-year study of the work, processes, and outcomes of Australian nurse practitioners. An important outcome of the AUSPRAC study was publication of *The Nurse Practitioner Research Toolkit* to guide APRNs in practice, service, and outcome-related research (Gardner, Gardner, Middleton, & Della, 2009).

Ireland

A University of Ireland study by Dowling, Beauchesne, and Murphy (2013) used concept analysis to clarify the meaning of advanced practice nursing from an international perspective and concluded further research and international collaboration are required to establish internationally consistent terminology.

Japan

Kondo (2013), in a review article published in the *Journal of Nursing & Care,* explored the role and contribution of nurse practitioners internationally and the potential for, and barriers to, implementation of the advanced practice role in Japan. In a 2014 article published in *International Nursing Review,* Fukuda et al. reviewed the first nurse practitioner graduate program in Japan and provided an overview of the research and project planning phases preceding implementation of the NP program.

Jordan

Zahran, Curtis, Lloyd-Jones, and Blackett (2012) presented an ethnographic approach to a study of the perceived concept of the introduction of the advanced nurse practitioner and APRN training programs in Jordon. The authors related their findings from the broader APRN literature to the context-specific Jordanian nursing educational and practice environments.

The Netherlands

Noordman, van der Wijden, and van Dulmen (2014) employed a pretest/posttest design to examine the effects of video feedback on the communication skills of APRNs.

Scandinavia

A study by Slatten, Hatlevik, and Fagerstrom (2014), *Validation of a New Instrument for Self-Assessment of Nurses' Core Competences in Palliative Care,* explored the concept of competence as a core prerequisite for APRN quality of care within Scandinavia. The instrument—Nurses' Core Competence in Palliative Care (NCPC)—was developed in Norway in 2007. Findings from this study identified five domains of competence within the palliative care APRN role: knowledge of symptom management, systematic use of the Edmonton symptom assessment system, teamwork skills, interpersonal skills, and life-closure skills.

CONDUCTING GLOBAL RESEARCH

Conducting international nursing research requires an overarching commitment to caring in the context of the local culture. Globally, respect for persons, beneficence, and justice are the foundation for responsible community engagement in the research process. This aligns with the ICN's *Code of Ethics for Nurses,* which states that the universal mandates for nursing practice, and therefore, nursing research, are respect for human rights—the right to life and choice, to dignity, and to be treated with respect. Practically, this requires that APRNs follow the ethical mandates of the professional practice of nursing as they plan and conduct research. Furthermore, all nurse researchers are expected to know the rules and regulations governing human subjects research where the study will be conducted. Yearly, the U.S. Department of Health and Human Services' (DHHS's) Office for Human Research Protections provides an updated international compilation of human research standards (www.hhs.gov/ohrp/international/index.html) and the DHHS's Office of Research Integrity provides a primer on the responsible conduct of research (http://ori.hhs.gov/ori-introduction-responsible-conduct-research). In short, all researchers should know international as well as local professional codes, government regulations, and institutional polices.

All research codes and policies address the issue of informed consent. However, specific cultural factors, such as decision-making processes and issues of literacy, need to be addressed in the research process (Krogstad et al., 2010). In areas where there is a tradition of communal decision making, community leaders may need to be engaged before potential participants are asked to consent. Also, where there is low literacy and consent is obtained verbally, the researcher must recognize the risk of inconsistent information being shared. To minimize the risk of uninformed consent, an adaptation of *teach back* can be employed

whereby the participant's level of understanding is evaluated before consent is confirmed (Krogstad et al., 2010).

Often, APRNs may be planning to conduct research as they are providing clinical care. This sets up special concerns. Four particular issues have been identified (Laman, Pomat, Siba, & Betuela, 2013). They include the risk of putting a priority on accomplishing the research activity over patient care, confusing the patient's expectation for clinical care with his or her participation consent, setting up inappropriate inducements, and providing *one-time* clinical services that are not sustainable by the host area. According to international nursing ethical standards, patient care must always take precedence over research. As well, local ethics committees can provide important perspectives to minimize patient confusion, counterproposals for what may be considered *inappropriate inducements,* and partnership with the researcher to work toward creating sustainable clinical services. Overall, nurses engaged in conducting international research must think globally about gaining new scientific knowledge but act wisely at the local level, always moving in accordance with nursing's consistent commitment to ethical practice.

ROLE OF THE APRN IN EDUCATION DELIVERY AND CONSULTATION

The global nursing shortage of both professional nurses providing care and of nursing faculty creates an environment where the pooling of professional resources is critical (Appiagyei et al., 2014; Bell, Rominski, Bam, Donkor, & Lori, 2013; Nardi & Gyurko, 2013). Nursing providers and faculty are increasingly able to come together to increase the capacity and quality of professional nurses through educational consultation. Technology use, communication that makes the world *small,* various iterations of distance education, and the ease and improvement of global transportation may profoundly change the landscape of APRN education globally. Currently, most examples of U.S. participation in APRN or other health care education and consultation has involved face-to-face work, with students coming to the United States or U.S. faculty going to the host country. The selection of clinical sites for APRNs requires particular vigilance—some distance programs expect students to come to the United States for this part of the program, work out experiences at U.S. facilities outside the United States (e.g., military bases, embassies), or scrupulously review the preceptor. One APRN involved in a long-term educational commitment is described in the sidebar.

Box 6.1 Kiwi Conversion: One NP's Educational Experience

In 2008, a good friend contacted me regarding an opportunity to teach with her at the Center for Postgraduate Nursing Studies for the University of Otago. They were looking for a senior lecturer for adult health and pharmacology. I was teaching these courses for Clemson University's graduate nursing program for several years along with working full time

(continued)

Box 6.1 Kiwi Conversion: One NP's Educational Experience—*(continued)*

as a family nurse practitioner. It had been my dream to work and teach internationally. To my surprise, in November 2008, I arrived in Christchurch, New Zealand to begin a career adventure.

Transfer of Registered Nurse licensure was accomplished prior to leaving for New Zealand. However, my nurse practitioner certification did not transfer as ANCC or AANP certification exams are not recognized by the Nursing Council of New Zealand. You must have a minimum of four years of experience and a clinical master's degree, create a portfolio, and pass a panel assessment for nurse practitioner competency (Nursing Council of New Zealand, 2014).

A learning curve both in spelling, health care systems, and nursing ensued. I came from private practice to a public and private health system where health care is a basic human right, not a privilege. A baccalaureate is required for registered nurses with opportunity for specialty certification. Nurse practitioners are expert nurses in specific areas with advanced knowledge and skills, who work independently and in collaboration with other health care professionals (Nursing Council of New Zealand, 2014). To obtain the qualifications for application for nurse practitioner status, I needed an advanced nursing practice position. In the United States, nurse practitioner positions are everywhere—in the newspapers, employment agencies, private practice, and health care institutions. I needed an advanced practice position that would enable me to gain the necessary experience. The director of University of Otago Center for Post Graduate Nursing Studies, Dr. Beverley Burrell, interceded, and I started working for Canterbury University's Student Health Center as a provider once a week. I am grateful and thankful for the support and guidance provided by the staff. In addition, I worked with a nurse practitioner in private practice and a family physician, both of whom provided letters of support. Portfolio development is both an aggravation and enriching experience. It requires you to fully evaluate your practice and qualifications for advanced practice nursing. In February 2011, I successfully passed panel assessment achieving primary care nurse practitioner certification.

The students were bright, creative, highly motivated, and involved with their community. It was a pleasure to teach and mentor such individuals. On September 4, 2010, a 7.1 earthquake struck Christchurch, New Zealand, followed by multiple aftershocks. In February 2011, a more devastating earthquake occurred, killing 185 people. Many of the institutions and individuals I loved were no longer standing or left for safer venues. Although I was safe, after much soul searching, I returned in 2012 and currently work with an Arizona Native American tribal community as a primary care nurse practitioner. Last week, I received an e-mail from two students who recently achieved primary care nurse practitioner certification, making me very happy. I remain active with the Advanced Practice Nursing Network of the International Council of Nurses and plan to work abroad again at the first opportunity.

—*Patricia Maybee*

Educational consultation can fall into roughly three categories of professional focus.

- **Individuals:** At this level, education consultation occurs within the context of medical brigades.
- **Communities:** Education consultation at this level can occur within the context of medical brigades but also within broader regional or national population health consultation similar to train-the-trainer scenarios (Lasater, Upvall, Nielsen, Prak, & Ptachcinski, 2012).
- **Professional:** Consultation regarding education at this level provides professional infrastructure enrichment, support, or capacity building. Areas for consultation include academic preparation and professional development (Kemp & Tindiweegi, 2001).

This professional consultation can occur in a country where a small group of visiting providers come to receive specialized training/experiences or can occur when a visiting professional can come into a country to provide training or program development. Both areas hold great promise for expanding capacity and quality, yet both raise concerns. Visiting consulters who leave their home for individualized or small group training may not use the training or may not return to their home country at all (Sherwood & Liu, 2005). Visiting single consultants may provide *train-the-trainer* types of experiences within the host country, but they may do so through a cultural lens that is not the same as the host consulter (Palmer & Heaston, 2009).

Process

A similar process undergirds the three categories of educational consultation. At its core, consultation is a process by which people or systems problem solve. This process involves two-way problem solving and is a dynamic method of seeking, giving, and receiving help. Sometimes those receiving the consultation have most of the answers and just need help reaching the goal or solution. The process has three phases: initiation, progression, and culmination.

Initiation

In starting an international education consultation, there are several questions that need to be answered clearly for all parties involved:

- What are the purpose and outcomes of the consultation?
- What questions/topics need to be addressed?
- What resources are available?
- What resources need to be developed?

Clear answers to these questions provide the basis for the interactions and focus of the consultation.

The first point upon which to seek agreement is in regard to the purpose and desired outcome(s). All parties should be specific as to the joint purpose: developing curriculum or programs, addressing specific organizational issues, and/or building infrastructure. That specific purpose will then define the objectives, and they should be concrete and defined and should reflect the consulter's culture, values, state of science, and resources. Each of the parties may have additional purposes that may be served by the consultation, but the primary purpose to be served and goals to be met should be those agreed on by the consultant and consulter (Memmott et al., 2010). For example, building the consultation within the framework of a service learning program emphases the centrality of the agreed-on purpose of the partnership while acknowledging the benefits of the partnership for all involved (McKinnon & Fealy, 2011).

In defining that purpose, the expected role of the consultant should also be clearly expressed. That definition should include expectations of performance (e.g., conducting classes, designing curricula, delivering continuing education) and time (in preparation, while on site, and upon departure) along with workspace (formal academic or in the field) and payment. Forms and amount of communication expected throughout the consultation should also be clarified. Finally, the shared nature of any intellectual property produced as a result of the consultation should be negotiated up front (George & Meadows-Oliver, 2013).

Building on that shared and defined purpose, the next point of agreement is that of the specific questions and topics to be addressed. Does the consulter desire specific subject matter expertise? Who is the intended audience/target learner? Are there programs for professional growth and development to be built or adapted locally or regionally? Are there national, regional, or local implications for practice, licensure, and credentialing that need to be considered and addressed? Awareness of cultural mores and expectations alongside the current practice ecology of the host country is critical for designing and refining content (Scanlan & Abdul Hernandéz, 2014).

Finally, both consultant and consulter need to discuss the resources available. Will translation of materials be needed? What (and in some cases if any) is the access to Internet and library resources? What are the resources necessary for sustaining achievement or reproduction of the final goal? Pioneering work in Somalia and China demonstrates that building capacity with no or minimal indigenous resources can begin by identifying community or governmentally directed needs (Doyle & Morris, 2014; Sherwood & Liu, 2005).

Resources for the consultant (office and living space, fees, and communication assistance overseas and within country through translators if necessary) should all be discussed before the onset of the consultation.

Progression

Once the consultation has begun and the traveler is in country, supports discussed in planning should be identified. Those supports may include translators, teaching and research assistants, evaluators, and collaborators.

Having a cultural *touchstone* or mentor within the host country who can translate expectations and social constructs will prove to be invaluable (Kim, Woith, Otten, & McElmurry, 2006).

Progression throughout the consultation is marked by timeline, benchmarks, and deliverables. All of these should be clearly delineated in the planning stages but may need to be shifted once the consultation is under way. Keeping in mind the scope, purpose, and deliverables of the consultation will keep the project on track. Doing so while attuned to the cultural climate will make the project successful. Clearly identifying the end of the consultation before beginning will help to bound expectations.

Culmination

As the consultation draws to a close, all involved should evaluate the effectiveness of the project. Scheduling for formative and summative evaluations should be set up before beginning the consultation. Several points to consider during evaluation are:

- Were there any secondary responsibilities for program planning, development, or delivery that needed to be met that were not discussed initially?
- Are any return trips needed?
- What follow-on work is needed to foster the consulter's success?
- Does the team that was assembled have plans for other work?
- Are there plans to gauge how the project is doing 3, 6, and 12 months out?
- Did the consultation meet its benchmarks?
- Did the consultation meet the consulter's expectations?
- What were the strengths and weaknesses of the project?
- Can any lessons learned be generalized?

Additional Considerations

Several points should be considered when preparing for international education consultation. The first is to be on guard against cultural tone deafness. The WHO has passed a resolution to set global standards for professional preparation of nurses (Nursing & Midwifery Human Resources for Health, 2009). However, all nurses practice in a local setting. Each setting has different boundaries on and expectations of nursing care. In addition, each setting has specific resources. Those resources determine not only care provision but also the sustainability of education and training for the care providers. Sustainability of projects that come out of the consultation process should be a key consideration in design (Mullan & Kerry, 2014).

Along the lines of sustainability, a point to consider within the consultation planning or delivery is what method or program has the sustainable potential for a *ripple effect,* that is, a far-reaching capacity for change and professional development (Memmott et al., 2010).

Finally, both the consultant and consulter should enter into their relationship with a clear understanding of the ground rules governing their partnership and an appreciation of potential power sharing that may need to occur within the team (Hunter et al., 2013). As international cooperation and collaboration are critical items necessary to expand both the supply of nurses and nursing faculty, educational consultation has the potential to expand and flourish for the advancement of all involved (Haq et al., 2008).

CONCLUSION

The world is opening up to APRNs who want to practice, teach, or conduct research in international settings. Pressing global health care needs and proven APRN track records in health care delivery, education, and research demonstrate this is a time for APRNs to collaborate with colleagues and other medical professionals to improve health for individuals and communities everywhere. Certainly the challenges and obstacles are great, but few professions are as flexible, dynamic, and urgently needed as that of the APRN.

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