CHAPTER 1

Selecting and Negotiating Partnerships for Collaboration

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> To create and develop without any feelings of ownership, to work and guide without any expectation and control, is the best quality.
>
> *Lao Tzu*

Nursing has a long heritage of seeking to improve health and prevent illness through collaboration and partnership. Libster (2011) points to nurse-led partnerships with governments, medical and religious communities, hospitals, colleges and universities, and other organizations spanning hundreds of years. As long ago as the 17th century, the Daughters of Charity, one of the earliest established nursing programs, grew from a partnership between a priest named Vincent de Paul and a woman, Madam Louise de Marillac, to care for the sick (Libster, 2011). In the nearly 400 years since the founding of the Daughters of Charity, nursing has extended from caring for the sick in their homes to full engagement in global health partnerships. Nurses have always worked to improve health and achieve equity in health. Global health is defined by Koplan et al. (2009) as:

> an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide. Global health emphasizes transnational health issues, determinants, and solutions; involves many disciplines within and beyond the health sciences and promotes interdisciplinary collaboration; and is a synthesis of population-based prevention with individual-level care. (p. 1995)

This example demonstrates the longstanding involvement of nursing in successfully partnering toward health promotion, illness prevention, and care of individuals and populations. This chapter discusses the initiation of a partnership and explains how nursing and personal roles are established. It also explores important components of seeking a partnership, approaching potential partners with whom you have never worked, and dealing with unrealistic expectations while in a host country.

The American Association of Colleges of Nursing (2010) compiled a summary of literature on successful partnerships in nursing that is congruent with the Leffers and Mitchell partnership model (2011). Central to these partnerships are:

- Mutual trust and respect
- Communication

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- Shared vision
- Commitment

These components are not necessarily separate and distinct steps, but rather mutually supportive and interdependent aspects of successful partnerships. For example, the process of creating a shared vision can strengthen (or weaken) a trusting relationship. Trust can support open communication and vice versa. However, each of these components is worth discussing separately.

MUTUAL TRUST AND RESPECT

Partnerships are voluntary collaborative agreements wherein parties agree to work together, sharing benefits and risks as well as competencies and responsibilities. Wheeler (2012) compares trust to trusting relationships. Trust is defined as "a psychological state in which positive expectations are held regarding the motives and intentions of another actor" (Ruzicka & Wheeler, 2010, p. 70). A trusting relationship involves acting on that trust and has been defined as "one into which actors enter in order to realize benefits which would otherwise not be available to them. They do so in the knowledge that this increases their vulnerability to other actors whose behavior they do not control, with potentially negative consequences for themselves" (as cited in Wheeler, 2012). Although it is important that nurses maintain professional roles, trusting relationships with host partners are key to successful partnerships.

Personal Relationships

Research on successful partnerships points out that it is helpful to have a personal relationship. In fact, personal relationships can be foundational to a partnership (Beal et al., 2011; Breslin et al., 2011). It is interesting to note that Mikhail Gorbachev pointed to the personal relationship he and President Ronald Reagan developed as being essential to ending the Cold War. In his memoirs, Gorbachev called it "the human factor" (as cited in Wheeler, 2012). Many articles on partnerships in nursing, especially articles addressing programs abroad, speak to the importance of face-to-face contact (Breslin et al., 2011; Hope, 2008; Sostman et al., 2005). Furthermore, visiting the location can also help build context for the collaboration. These interactions can go a long way toward developing comfort and trust.

For effective interpersonal relationships, it is important to share information about yourself and, if applicable, the institution you represent. There must be a clear understanding of all partners' roles and responsibilities. The process of establishing these roles is discussed in subsequent chapters. However, it is important to keep in mind that governments and institutions are not capable of entering into *personal* relationships. Embedded trust can develop from personal relationships and extend to the institutions (Notter, 1995). This, in turn, can facilitate expansion in terms of participants and programs. Although embedded trust can be a distinct benefit (as is evident in the relationship between Gorbachev and Reagan), it will not substitute for personal face-to-face interaction. That is not to say that a partnership should be limited to two or three individuals. In fact, a web of relationships can strengthen the partnership and facilitate sustainability—but initially it may start with one or two motivated individuals.

COMMUNICATION

Good communication is essential to successful partnerships. According to Ross (in Kanani, 2012), "Partnership failures can usually be linked to some level of miscommunication. This can range from misperceptions about the objectives, expected results, operating approaches and/or roles and responsibilities" (p. 2). Clearly, communication means more than just

language. Diversity in language, cultures, and perspectives is to be expected when working globally. And as diversity increases, so do the communication challenges.

Working with partners from other cultures requires cultural humility and fluency, as explained elsewhere in this book. Culture can have a powerful effect on communication. Anthropologist Edward T. Hall's theory of high- and low-context culture can help anticipate challenges in communication (Hall, 1976). Although we are all individuals, we are acculturated from a very young age. Hall's theory of intercultural communication can help when used as a general approach for communication. For example, high-context cultures (Latin American, African, Asian, Mediterranean, Slav, Native American) are generally cultures of few words. Much is left in between the lines, to be understood through context and nonverbal clues. People from high-context cultures generally are collectivist, intuitive, and relational, valuing interpersonal relationships. Low-context cultures (North America and Western Europe) value communication that is straightforward and direct. People from these cultures are individualistic, logical, and action-oriented (Fussell, Zhang, & Setlock, 2008; Goman, 2011). Views on time can also affect communication. Cultures that have a sequential approach to time speak of it almost as money ("waste time," "spend time," "save time," even "buy time"). Synchronistic cultures do not see time as something to be bargained for, but rather as something to be experienced. The work of Triandis (1995) added the dimension of task versus relationship orientation (whether people focus on accomplishing tasks or on establishing rapport). The additional challenge of computer-mediated communication (CMC) can potentiate these challenges. Fussell, Zhang, and Setlock (2008) show that cultural background affects CMC. This reinforces the need for face-to-face encounters in developing partnerships. Studies on partnerships point to the need for open and free communication (Beal et al., 2012; Bosworth et al., 2006; Breslin et al., 2011; Everett et al., 2012; MacPhee, 2009). This can be more complicated when relying on CMC but is worth the extra effort.

SHARED VISION

Shared Decision Making and Problem Solving

Partnerships are driven by a need or desire to accomplish something that a partner cannot accomplish alone (Long & Arnold, 1995). This begs the question, "What is the goal of the partnership?" This is the first step of the initiation phase. The other two phases (execution and closure/renewal) are all based on the goal. All stakeholders must be involved in the initiation phase. Understanding and sharing each other's mission and values provides a foundation for developing congruent goals for the partnership. Personal expectations of the partners are explored in the next chapter.

In her book *Expanding the Pie* (2012), Susan Rae Ross posits an eight-step "Partnership Decision-Making Process," depicted in Table 1.1. Six of the eight steps are related to the initiation phase, an indication of its importance. Although Ross's work was developed specifically to facilitate work between businesses and nongovernmental organizations (NGOs), the steps outline key considerations when entering into any partnership. Step 1, "conduct an internal assessment," is appropriate for large and small organizations—even individuals. What are your reasons for entering into this partnership? What can you bring to the partnership? If you are part of a larger organization, does the effort dovetail with your broader mission? This self-exploration will help you to move through the identification of partners (Step 2) and with your approach to selected partners (Step 3). What is the basis for the partnership? Can individual goals of each partner be aligned?

Step 4 (due diligence) is essential to both creating a shared vision and developing trust. It also aids identification of any potential risks to the partnership. It is important to recognize that partner incompatibility is a potential pitfall. Why does this partner wish to engage with you? What are the risks? Are there any conflicts of interest? What do you know about the partner organization's structure and decision-making processes (Cohen, 2003; Ross, 2012)?

TABLE 1.1 Steps in the Partnership Decision-Making Framework

Steps	Task
Step 1: Conduct an internal assessment	• Determine rationale for the partnership • Determine type of partnership desired • Assess organizational capacity to support partnership
Step 2: Identify, research, and short-list potential partners	• Develop selection criteria • Research potential partners
Step 3: Approach potential partners and make the business case	• Leverage key contacts • Identify decision makers • Organize the initial meeting • Make the business case
Step 4: Conduct a due-diligence process to select an appropriate partner	• Create a due-diligence process • Use a due-diligence matrix • Select partners
Step 5: Negotiate the partnership	• Determine the element of partnership agreement • Decide on partner structures • Decide on partner systems
Step 6: Initiate the partnership	• Create plan to launch the partnership
Step 7: Execute and implement the partnership	• Execute work plans • Communicate; hold regular meetings • Redesign strategies as needed
Step 8: Evaluate and reassess the partnership	• Assess indicators to measure partnership effect and value created • Assess indicators to measure partnership efficiency

The Community-Campus Partnerships for Health (CCPH), based out of the University of Washington (http://depts.washington.edu/ccph), provides a rich resource for partnership development that can be adapted even if neither partner is university based. CCPH speaks of the "glue" that holds partnerships together. This can include policies, procedures, and processes developed in collaboration. But the first principle of partnership is to have a shared mission. Cauley (2000) lists three stages in the development of a partnership—identification, development, and maintenance—and cautions against trying to rush the mission statement. As stated above, the process of articulating a shared mission can provide opportunity to build trust. As with Ross's work, begin with, *What do I bring to this partnership?*

Green-Moton, Palermo, McGranaghan, and Travers (2006) give an example of an exercise that may aid the development of a shared vision. It is designed for both small and large groups:

> Participants take 15 minutes to generate a list of key words and phrases that characterize a common vision for their partnership(s), based on the issue(s) they are addressing or hope to address. Small groups report what they have listed and the large group identifies common themes.

COMMITMENT

After the initial work is done and the partnership is developed, the hard work of sustaining commitment to the partnership begins. During this time it will be necessary to "check in" with partners. It is particularly important to be aware of power inequities that can develop

(Green-Moton, Palermo, Flicker, & Travers, 2006; Tierney et al., 2013). As partnerships evolve, it may be necessary to restate the mission and revise policies, procedures, and processes. There may even be an opportunity for expanding or contracting the partnership itself. It is always important to remain inclusive even at the risk of expedience—it is at this point that the trusting relationship gets further reinforced through open communication and sustained commitment.

Over time, partnerships can be expected to evolve. The evaluation process can be used to strategize and plan for sustainability. Process evaluation is normally done to monitor a program (e.g., number of immunizations given, number of patients served, number of students taking part in an exchange program). In addition, process evaluation offers the opportunity to revisit the mission and policies and to monitor the health of the partnership. Resources for developing process evaluation questions can be found through the various websites of the Centers for Disease Control and Prevention (www.cdc.gov/healthyyouth/evaluation/pdf/brief4.pdf) and the CCPH (http://depts.washington.edu/ccph/cbpr/index.php).

Process evaluation can determine whether goals and objectives are well aligned. Anonymous surveys or reflective discussions can help identify areas of strength and for growth. However, threats and weaknesses will also be identified and should not be ignored.

When problems arise in partnership, it is important to address them. Conflict resolution is rarely simple. Add a cultural dimension, and things are further complicated. The process of team development is well known to nurses (forming, storming, norming, and performing). Research on teams indicates that successful teams are comfortable dealing with conflict and are committed to, and learn from, resolution.

Unfortunately, that research was done on mostly North American organizations. For some cultures, the group is more important than the individual. Harmony and group conformity is sought, sometimes at the expense of personal interests. Although everyone may seek to avoid conflict to some degree, persons from individualistic societies may be more direct in dealing with conflict ("meet it head on"; "take the bull by the horns"). In fact, culture may determine whether conflict even exists. An elderly Chinese man in Canada denied having had any conflict at all in the past 40 years. Consistent with his Confucian upbringing, he saw the world with a vision of harmony rather than of conflict (LeBaron & Grundison, 1993).

In her essay "Culture and Conflict," Michelle LeBaron speaks of cultural fluency as "a key for disentangling and managing multilayered, cultural conflicts" (LeBaron, 2003, para. 25). In addition to awareness of distinctions in communication as articulated by Hall, cultures have different ways of "naming, framing, and taming" conflict. It is important to understand the context of a perceived conflict. Cultures have different ways of meaning-making, and not knowing these may make it easier to attribute negative motives to a behavior.

Working to develop partnerships across cultures can be rewarding and challenging. How we approach the partnership and whether the inevitable changes involves "recognizing and acting respectfully from the knowledge that communication, ways of naming, framing, and taming conflict, approaches to meaning-making, and identities and roles vary across cultures" (LeBaron, 2003, para. 25).

As stated above, partnerships are voluntary collaborative agreements wherein parties agree to work together, sharing benefits and risks as well as competencies and responsibilities. This voluntary nature of relationships does not mean, however, that partnerships are self-sustaining. The steps toward negotiating and maintaining a relationship are succinctly elaborated by Ross (2012) in Table 1.2. Through a literature review and interviews with NGOs and business leaders, Ross has identified 10 elements of a partnership agreement that include everything from creating a shared vision and maintaining communication to deciding to end a partnership.

INTERNATIONAL STUDENT EXPERIENCES

All the elements for developing a partnership are necessary for a successful international student experience. However, as these types of experiences become more common, special attention should be given to promoting true partnerships among students and faculty. Kulbok,

TABLE 1.2 Elements of Partnership Agreement

Partnership area	Key questions	Key considerations
Formality of the agreement	How formal/informal should the partnership be?	Memoranda of understanding (MOUs) may or may not be legally binding.
Vision	What is the vision of the partnership?	Does it benefit everyone? Has everyone "bought into" the vision?
	What is the effective time frame of the partnership?	
Partnership objective	What are the objectives of the partnership?	Objectives should be SMART (specific, measurable, achievable, realistic, and time-bound).
	How does each organization contribute to the objectives?	Agreement on key indicators, as well as how they will be measured, is essential. For example, will the partners use third-party auditors or independent evaluators?
Roles and responsibilities of each organization	Clearly identify the assets and resources each partner will provide, including financial human resources, skills, products, office space, intellectual property, and networks.	A specific scope of work statement can be included in the body of the agreement or provided as an attachment.
Exchange of resources	If either partner is going to provide specific resources to the other partner, such as a grant, then the funding amount and activities should be clearly articulated, along with payment agreements, schedules, and reimbursement policies. This can be discussed in the agreement, and a separate legally binding document can be developed and attached.	
Partnership management	How will the partnership be managed? Is a specific structure required? What systems are needed to support the partnership?	This may be as simple as agreeing to a monthly or quarterly meeting in which to approve activities and monitor progress. It should include who should be represented at the meetings, responsibilities for note-taking, and communication among the partners.
	Which department or staff will be the key liaisons for the partnership?	
Partnership decision making	How will decisions be made between partners?	
Partnership communication	How will partners communicate within their organizations?	Use of intranet, newsletters
	How will the partners communicate with each other?	Updates from partner meetings
	How will the partners communicate externally?	What information can be put on each partner's website?

(*continued*)

TABLE 1.2 Elements of Partnership Agreement (*continued*)

Partnership area	Key questions	Key considerations
	What permissions are needed from each organization to allow their partner organization to use their logos? Co-branding?	What is the approval process for each organization's discussing the partnership with external parties?
	Who owns the data about the partnership? With whom can the data be shared?	
Grievance/Dispute process	What are the levels of grievances?	
	How will each level be settled?	Mediation vs. arbitration
	Who will represent the organization in a dispute process?	
	What makes a fair grievance?	
Termination parameters	Under what conditions can either organization terminate the partnership?	What type of notification is required to terminate the partnership?

Mitchell, Glick, and Greiner (2012) reviewed the literature on student international experiences from 2003 to 2010. Their findings highlight the need for published reports that discuss two-way exchanges between students of higher and lower income countries. Too often emphasis is placed on the student from the high-income country going to another country with a high UN development index rating (e.g., European countries, Australia, Japan, Norway) rather than countries considered low-income that are struggling with the issues of poverty and other social determinants of health. Second, published reports of the student experience should include authorship from the country hosting the international student. Including authors from all countries involved in the partnership can increase the capacity for conducting research and developing scholarship. Third, all students, including those from the host country, should receive additional education addressing the cultural differences among all the partners. Finally, experiences that extend beyond the university setting should be considered partnership opportunities for students. Students can benefit from working with NGOs and other agencies active in low-income countries. There is tremendous opportunity for international student partnerships that challenge students to extend themselves beyond providing basic clinical procedures, moving them away from "us and them" to true partnerships.

Three case studies follow that highlight the processes of selecting and maintaining partnerships. The first case study provides the perspective of an NGO, Health Volunteers Overseas (HVO), in developing relationships with partners outside of the borders of the United States. Practical information on the process of volunteering is shared, including the role of volunteers and dealing with the challenge of continuity.

The second case study offers the perceptions of an international student pursuing a doctoral degree in the United States. Having a dream, facing the reality of living and studying in a land completely different from her home country, and wondering how her life will be changed when she returns home are all discussed in a spirit of openness and honesty. Themes from this case study can be compared to the research of the Arab/Muslim international student experience from entry to the United States to reentry in the home country by McDermott-Levy (2011, 2013).

The final case study focuses on a community partnership in existence for over 20 years. Although this partnership has evolved over the years, some of the pioneering individuals are still involved, as are some of the original institutional partners—but the program itself has expanded.

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CASE STUDY 1.1

Selecting an International Project Site: Health Volunteers Overseas

Nancy Kelly

CONTEXT

It is generally recognized that one of the most serious systemic problems in the delivery of health services in developing countries is the lack of appropriately trained health care providers. The World Health Organization focused on this problem in its 2006 World Health Report, *Working Together for Health*, and Health Volunteers Overseas (HVO), a private nonprofit organization dedicated to improving the availability and quality of health care in developing countries through the training and education of local health care providers, is actively addressing this concern (www.hvousa.org/whoWeAre/mission.shtml). By investing in education and training, HVO is focusing on building local capacity and empowering local health personnel. A key concept underlying the implementation of all of HVO's projects is that of sustainability.

HVO has developed a series of dynamic institutional partnerships with a wide variety of nongovernmental organizations, government ministries, and teaching institutions around the world (for a list of these partnerships, visit www.hvousa.org/whereWeWork/institutions.shtml). These partnerships are the result of years of relationship building and provide HVO with the opportunity to develop and sustain its educational programs. The initiation of a new partnership may come from one of several sources—a HVO volunteer may recommend pursuing an opportunity with a new organization, or HVO may receive a request from an organization that has heard of HVO's work in other settings. It is not uncommon for a facility to seek additional projects in other program areas after a project has been successfully established and the value of the educational input has been demonstrated. For example, HVO recently established a series of new projects (nursing education, physical therapy, and orthopedics) at a hospital in Bolivia. The request came from a contact who had previously worked with HVO at a hospital in Cambodia. Her familiarity with HVO's mission and her understanding of HVO's methods were critical factors in her decision to ask HVO to consider this new partnership.

HVO depends on the commitment and skills of dedicated volunteers to accomplish its goals. These volunteers bring different backgrounds, experiences, and perspectives to their assignments but all share a commonality: HVO volunteers understand that the long-term solution to the health care problems found in developing countries depends on the training and education of the health professionals in those countries. Faced with serious resource constraints, as well as an immense burden of disease, developing countries must deal with enormous needs in the health care sector but have limited ability to educate and support the workforce needed.

HVO operates under the premise that only through the development of local expertise and institutional capacities will countries be able to handle the health care challenges they face. Countries must develop the expertise to identify and address their own health care problems and to create their own appropriate solutions. The training and education of health professionals is the critical component in this process. Projects must be carefully planned from the outset. Resources in developing countries—whether human, financial, or technological—are extremely limited, and demands for basic services go unmet. Planners thus must rationally, practically, and efficiently allocate these scarce resources based upon realistic objectives and sensible priorities.

Good Intentions Simply Are Not Enough

We must look critically at the needs of a country to decide what can reasonably be accomplished at a site within a certain time frame. Then we must ask whether HVO is the organization best suited to undertake the project. These are difficult questions that are sometimes glossed over or ignored entirely in the initial enthusiasm of starting a project. Unfortunately, this can result in a disappointing project with few tangible results, disgruntled volunteers, and little in the way of long-term effects.

THE HVO MODEL

Unlike many organizations involved in international development and relief efforts, HVO relies almost exclusively on short-term volunteers to staff its projects. The short time frame of the assignments (generally 1 month) facilitates the participation of many medical, dental, and health professionals who would otherwise be unable to share their knowledge and skills overseas.

What are the fundamental components of the HVO model?

1. HVO projects are developed, monitored, and staffed by *volunteers, HVO's primary resource*.
2. Projects are designed to *share knowledge and skills* with professionals in developing countries.
3. Volunteers are encouraged to teach skills that are appropriate to a given country's level of development and with an understanding of the serious competition for resources that exist in this setting. The use of *appropriate technology and local materials* will lessen the developing country's dependence on a foreign organization.

Basic Parameters

Over the years, HVO has learned that there are certain conditions that must be present in order to facilitate the development of a new project. Without these conditions in place, an HVO project, no matter how needed or wanted, simply will not work.

First, a certain amount of *political stability* is essential to setting up an effective training project. Consider the realities of starting a project in a country mired in a difficult and draining conflict. Will personnel be able to participate in training activities under these circumstances? The government or local hospital authorities may not be able to spare them from active duty. They may be physically unable to come to the training site as a result of fear and intimidation. They may wonder what the point is of additional training, seeing that they have no supplies, no equipment, no support staff, no money, and, most importantly, no hope for the future.

Second, there must be *local support* at all levels for the initiation of an HVO project. HVO should not be seen as a threat or as an avenue of professional advancement at the expense of others. Too often, expatriate volunteers become pawns in the local politics found

in any medical or educational institution. This can be avoided through a careful assessment of the degree and strength of local support. If the dean or any other person in a leadership position at a potential project site is against a project being started, that person's feelings should be taken into serious consideration. This lack of interest or support can translate into serious problems when the project is being implemented.

Third, *the primary language of instruction must be English, or else adequate translators must be available* at the site. Although some HVO volunteers are fluent in other languages, HVO is not in a position to undertake a training project in a country where volunteers need to speak French, Portuguese, or other non-English languages unless funds are available for translation services.

Fourth, *volunteers must want to go* to a site. A project, no matter how well designed, will be a complete failure if no one signs up to go. This lack of interest is often the result of perceptions (and misperceptions) about a country or the result of strong emotions generated by a past event. Repeated wars, floods, famines, and other natural or manmade disasters can create an image of despair and desperation that leads volunteers to think that their efforts will be for nothing.

Finally, *volunteers must believe that their time and efforts are going to make a difference*. This must hold true throughout the volunteer experience—before, during, and after their service. For most HVO volunteers, their assignments are life-changing experiences that broaden their understandings of the world, of their profession, and of their own capabilities. As one HVO volunteer wrote in a post-trip report:

> I think I have become not only a different person but a better person because of this opportunity. My eyes were opened to a whole new world where a population doesn't have much in regards to resources but has a lot of heart and graciousness. (Jantzi, 2008)

Successful Selection of a Site

The process of identifying a possible project site and assessing the viability of a potential partnership is a critical first step in the design of a project. This phase of the project development requires a significant investment of time and requires that the site assessor have strong communication and cross-cultural skills as well as a commitment to key values and concepts such as partnership and mutual respect, mutual goal setting, and collaboration. HVO's mission is grounded in the concept that capacity building and sustainability are the keys to long-term effects. Working from that premise means that all HVO projects are by definition partnerships involving intense collaboration between HVO and the host institution and the personnel at the site. Decisions about the design of the project—what to teach, whom to teach, how to teach—must be the product of dialogue between the partners. This dialogue needs to be open, frank, and ongoing. This can be a challenge in a cross-cultural setting where linguistic differences may contribute to miscommunication or where cultural or social expectations are not in alignment.

A critical part of the assessment is asking a series of open-ended questions and listening carefully to the responses. Asking follow-up questions for clarification is essential. By the end of the assessment, the following questions should have been answered:

- Is there a genuine need?
- Is the project desired by the intended beneficiaries?
- Do the objectives of the project fall within the scope of HVO's mission?
- Is the project likely to achieve its objectives?
- Is the project technically appropriate and economically viable?
- Will the project survive the test of time? Will it be sustainable?
- What are the constraints? Can they be overcome?

It is also important when planning a training project to determine whether the problems being addressed can be resolved through education and training. Many training projects attempt to address problems that really result from a lack of resources, not inadequate skills.

HVO projects are to be established with the full knowledge, support, and consent of the host government and institution. HVO attempts to ensure that each project is consistent with the national strategy for health and human resource development. HVO projects should complement the existing health structure and reinforce national health priorities and goals.

Project Design

After this input has been gathered and assimilated, the next step is to start conceptualizing the project. Again, this should be a collaborative process with input regarding whom should be trained and the type of training/education needed. Any independent training effort should be fully integrated into the country's health and education systems to ensure that those who participate are appropriately recognized and compensated. It does no good to teach someone new skills if he or she is not allowed to use them.

There will need to be discussions about what kind of volunteers are needed to staff the project—type of experience, years of clinical experience, emphasis on clinical or teaching credentials, and so forth.

Finally, there should be agreement on how to define success. What changes (both short- and long-term) are expected in terms of attitudes, behaviors, knowledge, skills, or level of functioning of the beneficiaries? What will be the effects of this project?

Develop Goals and Objectives

After these components have been identified, develop an explicit set of goals and objectives. This requires determining (1) a time frame for the project and (2) a realistic assessment of what can be accomplished in that time frame—the intended results.

These goals and objectives will serve as a yardstick to determine whether the project has been successful over time. Evaluation of a project is impossible without clearly defined and quantifiable goals and objectives. Setting goals and objectives should be done in consultation with the developing country partners. They need to agree with and be supportive of the proposed activities. If there is only lukewarm support for these goals and activities, the project is not likely to succeed.

Goals and objectives should be reviewed annually and, if necessary, revised to ensure that they match site needs and situational changes. Projects in developing countries are often subject to unexpected problems or constraints. Rather than ignoring these developments, a realistic reassessment is critical to be effective.

Objectives should be simple, clear, and easy to understand and quantify. Both HVO and the partners must have a clear understanding of what the project will accomplish over a specific period of time—2, 3, or 4 years—and annual reviews are necessary to determine whether a project's design needs to be modified or totally revamped.

Project Implementation

After HVO and its partners have defined the project, it is time to roll it out. As with the design and development phases, it is essential to communicate frequently with partners in the field to ensure that what was envisioned and discussed is in alignment with the actual implementation of the project. The same cross-cultural sensitivity, active listening, and attention to the collaborative aspect of the partnership is just as necessary during this phase of the project as it is in the design phase.

One of the keys to a successful project is to ensure that volunteers are properly briefed and that they have access to appropriate background materials as part of that process. HVO has addressed this need by creating an online platform, the *HVO KnowNET*, that serves as a central repository of documents, orientation materials, class notes and lectures, assessment reports, and curricula. Prospective volunteers can read past trip reports, access contact information from recent volunteers to a site, and participate in online discussions. Access to the extensive materials on the *HVO KnowNET*, combined with conversations with the project director, staff, and other returned volunteers, serves to frame expectations for the volunteer. Realistic expectations are critical to a volunteer's ability to be effective once at the site.

CONCLUSION

HVO has developed a reputation for designing strong, effective clinical education programs in developing countries that successfully use short-term volunteers. It must be acknowledged, however, that there are some serious limitations to the HVO model, including issues related to continuity of volunteer coverage and coordination between volunteers. There can be problems with volunteers adjusting to the challenges at a site—both on personal and professional levels. Proper vetting and briefing of volunteers is an essential component of this process, and most issues are related to inappropriate expectations or misplaced assumptions.

There are limited resources in developing countries to support the training and education of health care professionals. Educational materials that are taken for granted in the West (textbooks, journals, access to the Internet, models, charts, slides, and the like) are usually not available or are woefully out of date. There are few, if any, opportunities for continuing education for clinicians in the field, nor any real opportunities for faculty development. Health care providers often work in professional isolation, unable to network or communicate with other professionals in nearby countries faced with similar problems and constraints.

Against this backdrop of significant need sometimes comes a tendency to think that input from any organization or well-meaning (and qualified) health care professional is of value. After all, resources are so scarce that surely something is better than nothing. There is ample evidence in the literature and plenty of anecdotal evidence from well-meaning but flawed projects that have been in fact a barrier to progress (Easterly, 2007; Maren, 1997; Moyo, 2009; Riddell, 2008).

A Focus on Resiliency

HVO continues to focus on developing resiliency, seeking partnerships to leverage the synergy that occurs through collaborative efforts. Working together, HVO and its partners are building resiliency in individuals, in professions, and in health care systems. With each new development, HVO is striving to improve the availability and quality of health care for patients in resource-scarce countries. Ultimately, of course, it is the patients—both current and future—who benefit.

As one HVO trainee stated,

> After knowing HVO's work, I saw that I could do more. There was hope and there are things that we have managed to change. The training aspect is the most exciting and the most important. (Nakakeeto, 2011, p. 3)

REFLECTIVE QUESTIONS

1. The author outlined several preconditions that must be present at an institution under consideration. Are there any other preconditions you would add to this list? What, and why?

2. What do you foresee as possible difficulties in making a site assessment to determine whether an institution might be a viable project site?
3. How might cultural competence, language barriers, and cultural differences affect your ability to accurately assess the information you collect?
4. Why do you think setting "realistic expectations" is so important to a volunteer's ability to be effective during his or her assignment?

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CASE STUDY 1.2

Seeking Higher Education: From Egypt to the United States

Nermine Elcokany
Azza Hussein

It takes much courage to decide to live in another country far from home for an extended period of time. It becomes even more complicated when differences in language and culture are so vast. For me, Nermine Elcokany, the nursing profession is what provides cohesion with my nursing colleagues despite these differences. I hope my story of how I decided to come to the United States for further study and my experiences dealing with tremendous cultural change will give courage to others who are thinking about making this same change. To begin, it is important to provide a sense of the different worlds of nursing, academics, and women in Egypt compared to the United States.

CONTEXT: NURSING IN EGYPT

History

Egypt was colonized by the British people from the end of the 18th century to the mid-19th century, and trained nurses from England and France were working in the hospitals at that time. British physicians also replaced Egyptian professors in medical schools across the country, establishing a tradition of English as the language of choice for medical and university education (Ma, Fouly, Li, & D'Antonio, 2012).

Throughout this period, nursing involved two levels of education. The first level of education included students who joined nursing school after completing the 9th grade of education. After graduation, they worked as nursing assistants or aides. The second level of education involved 5 years of graduate training with these nurses, called *Hakima*. After graduation, they were licensed to practice nursing and midwifery or physical therapy (Ma et al., 2012).

Nursing Education in Egypt Today

There are seven types of nurses in Egypt, but three types dominate. The first level is at the secondary level of education. Students can join these schools after completing 9 years of elementary preparatory education. Nursing in these schools is taught by qualified nurses (those who have a bachelor's degree of nursing) and some physicians who teach the medical courses—for example, anatomy and physiology. These high schools are controlled by the Egyptian Ministry of Health and Population and provide markets with nurses equivalent to auxiliary nurses. The students who join these schools are usually from poor families who select a fast and cost-effective way of working and practicing

nursing. The curriculum in these schools is not based on strong clinical reasoning or a theoretical base for nursing skills. The subjects taught are basic sciences of physics, chemistry, biology, health education, hospital administration, nutrition, and psychology, in addition to fundamentals of medical, surgical, obstetric, and mental health nursing. The curriculum in these schools is taught in Arabic in addition to an English-language course and requires the students to spend 3 days in hospital practice and 3 days in class each week (Farag, 2008; Ma et al., 2012).

After completing this program, the students should apply for the nursing license and join the Egyptian Nursing Syndicate. Employment is guaranteed to those nurses after at least 2 years of nursing practice in the governmental hospitals in a particular geographic location selected by the Egyptian Ministry of Health and Population (MOHP). Some graduates choose to join the technical nursing institute, considered a higher level of nursing education; others choose to practice as general nurses. Some nurses apply for 6 months of training to be specialized nurses in a specific area—for example, anesthesia, surgery, or normal labor and delivery. The secondary technical nursing education is considered the largest source of nursing graduates, providing approximately 94% of the available nursing workforce (El-Noshokarty, 2004). Moreover, those nurses are very young, ranging from mid-adolescence to young adulthood; the MOHP has identified these nurses as not being adequately prepared.

The second category of nursing education is carried out in the technical health institutes. The study at this level consists of 2 years of education and, after completion, on to general secondary school or nursing secondary school. This type of education was established in Alexandria in 1972 and in Cairo in 1973. The graduate gets an associate degree from one of these institutes. It is controlled by the Egyptian Ministry of Education. The courses taught in this curriculum are more in-depth than those in secondary nursing education.

In 1955, the Higher Institute of Nursing was established in Alexandria as the first higher institute in the Middle East and Africa. It was established by an agreement between the faculty of medicine and the World Health Organization (WHO). The teaching staff consisted of five visiting American nurses and a director assigned by the WHO. It was affiliated with the Faculty of Medicine. In 1992, the Supreme Council of Egyptian Universities granted independence to the Higher Institute of Nursing from the Faculty of Medicine (Ma et al., 2012). The institute, directed by the Egyptian Ministry of Higher Education and Scientific Research, offers a baccalaureate degree of nursing. It consists of a 4-year program in addition to 1 year of internship offered by the nursing faculties in collaboration with university hospitals. The bachelor's degree is not awarded to the nursing students until they have completed the internship year. In the internship year, the student receives a small stipend and each month practices in different units affiliated with a university or teaching hospital. Each student is under the supervision of an assigned preceptor on different shifts and is evaluated each month before moving to the next month of practice or continuing in the same practice for another month.

Some faculties of nursing also offer three postgraduate programs—diploma, master's degree, and doctorate degree—in nine nursing specialties. The diploma program takes 1 year after the bachelor's degree. The master's program takes from 3 to 4 years after the bachelor's degree or the diploma degree. The doctorate program takes 5 years after earning the master's degree.

Implications for Advancement of Egyptian Nursing

Nursing in Egypt is a skilled profession that has seen little change over the past 30 years. The primary challenges in nursing are centered on education, performance, accommodation, an image that is not highly appreciated, and a lack of motivation due to low salaries and incentives. The existing weaknesses in legislation regarding nursing have left nurses with minimal social and human rights benefits (WHO, 2012, www.emro.who.int/images/stories/cah/fact_sheet/Nursing_Profile.pdf).

The challenges facing nursing in Egypt are addressed through the collaboration between the Egyptian MOHP, the WHO, and other partners and universities who provide technical and financial support. Among these challenges are ensuring and supporting the upgrading of nurses' performance in the health services through education and reviewing and updating existing regulations through supporting existing nursing syndicates (WHO, 2012, www.emro.who.int/images/stories/cah/fact_sheet/Nursing_Profile.pdf).

Obstacles to Nursing Advancement in Egypt

Achievement of goals is important, but many obstacles impair the advancement of professional nursing in Egypt, which in turn may inhibit personal goal acquisition. The obstacles that impair the advancement of nursing are similar to those faced in other countries: supply and demand for nurses, education level of nurses, long hours, working conditions, and low wages (Rashdan, 2007).

Supply and Demand for Nurses

One of the obstacles affecting the nursing workforce is the supply of nurses. "Egypt suffers from a severe shortage in the number of nurses in hospitals and public clinics. There are 276 nurses for every 100,000 people" (United Nations Development Program, and the Institute of National Planning, Egypt, 2005, p. 76). The distribution of nurses is not equal throughout Egypt. Unfortunately, there is a severe shortage in the governorates of Upper Egypt (rural area). The WHO (2006) estimates that approximately 2.36 million health care providers will be needed to deliver health care. Without action from countries addressing the supply and demand, the shortage of health care providers will worsen.

Education Level of Nurses

As we mentioned before, the majority of Egyptian nurses are diploma graduates from the nursing secondary schools (El-Noshokarty, 2004). In addition, they are very young. As a result of the multiple levels of entry into practice and various ages associated with admission to programs, there is a lack of role delineation for each graduate, which creates the mentality of "a nurse is a nurse." It may be beneficial to determine the minimum level of entry into practice. To accomplish this task, there is a need to open channels of communication with all nursing education venues to ensure a sufficient number of nursing faculty possessing advanced degrees and willing to educate the professional nurse (Rashdan, 2007).

Long Working Hours

The research clearly documents staff nurse fatigue and its impact on patient safety (Balas et al., 2004; Rogers et al., 2004). Studies link fatigue to slow reaction times, lapses of attention, and errors of omission that compromise problem-solving ability (Tabone, 2004). In Egypt, nurse fatigue exists due to the shortage of nurses to handle the number of patients and the long hours worked because of the lack of enforcement of labor laws (Rashdan, 2007). The schedule of technical nurses sometimes contains 30 days of night shifts, which can be exhausting.

Working Conditions

Due to the financial constraints that face some hospitals and clinics in Egypt, especially those belonging to the governmental sector, some basic supplies can be unavailable, such as gloves and hygienic products for hand washing, which can lead to a high turnover of nurses (Farag, 2008; Rashdan, 2007).

Low Wages

In 1999, wages stood at 116 Egyptian pounds per month at minimum, with an average of 928 Egyptian pounds per month during 2004/2005. Many foreign companies related to Gulf hospitals offer high wages (10 times more than standard Egyptian wages) to attract workers (American Chamber of Commerce in Egypt, 2008). In some governmental hospitals, nurses who double a shift can get only 90 piasters, which is frustrating (El-Noshokarty, 2004).

After the Egyptian revolution of January 25, 2011, all Egyptian nursing categories have called for salary increases to counter high living expenses. The MOHP is currently responding to the call for improved wages.

A Call for Advancement in Egyptian Nursing

In order to meet the dynamic demands of Egypt's booming population growth, there is a need to increase the number of competent professional nurses that are available to deliver health care. More attention should be paid to educating nurses to allow them to broaden the impact of nursing knowledge in a hospital or clinic, similar to how a pebble ripples across a body of water (Rashdan, 2007).

Regulation of Practice

A clear and specific Nursing Practice Act defining the scope of nursing practice that defines professional nursing is important to advancing the nursing profession in Egypt. Development of a Nursing Practice Act will safeguard the public health by shielding the public from unqualified and unsafe nurses. Creating a Nursing Practice Act will define entry into nursing practice, specify the scope of practice, and establish disciplinary procedures (Rashdan, 2007).

From Syndicate to Nursing Board

After graduation from the nursing secondary schools, technical nursing institutes, or the faculties of nursing, the graduates have to register automatically in the nursing syndicate to legally practice nursing in the hospitals. This syndicate is responsible for providing service of all the nurses all over the country. It provides social activities and workshops—continuing education programs that can help nurses improve their practice. Sometimes ceremonies are held to honor exemplary nurses from around the country. Nurses in Egypt are not required to pass a board exam to practice nursing.

Encouraging the Egyptian Nursing Syndicate to adopt an agency mission is very important. However, the nursing board needs to be responsible regarding all nursing practice–related issues in Egypt. This can offer protection to the citizens of Egypt and promote their welfare by ensuring that each person practicing as a nurse in the country is competent to practice safely. Moreover, the Egyptian Nursing Syndicate should adopt and enforce rules that regulate the practice of professional nursing, establish standards of professional conduct for those nurses who practice nursing in Egypt, and determine the health activities constituting the practice of professional nursing. The nursing board should delineate the scope of practice for each level of professional nursing (Rashdan, 2007).

Advancement and Growth of Continuing Education Programs

On successful completion of the nursing exam conducted by the MOHP in Egypt, nurses hold a lifetime license to practice. Consider a paradigm shift in the practice of nursing whereby continuing education is a requirement to maintain and continue practicing as a nurse within Egypt. Continuing education can be required, thereby to assure the public that

each nurse has current and updated knowledge of nursing science and the skills necessary for protecting the safety of patients receiving nursing care. Education is the most powerful weapon we have for changing the world (Rashdan, 2007).

Foster Curriculum Changes in Nursing Education Programs

Nurses are trained as generalists with little time spent in specialty areas. Curriculum changes will be required. Education should be learner-focused rather than teacher-centered. Curriculum changes need to incorporate the subspecialty areas—for example, oncology nursing, pediatric nursing, and neonatal intensive care nursing (Rashdan, 2007).

Perform Needs Assessment in Current Nursing Education Programs

It is important to perform an assessment of academic institutions to assess the number of graduates per year and their anticipated capacity of students. A needs assessment should be completed to analyze the fundamental needs of nurses and the locales of learning institutions. Educational programs are not meant to teach everything to students but rather to provide them with the skills to learn how to find information through problem-solving accomplished with simulation laboratories, clinical decision modules, critical thinking scenarios, and integration of evidenced-based practice (Rashdan, 2007).

Improve the Image of Nursing in Egypt

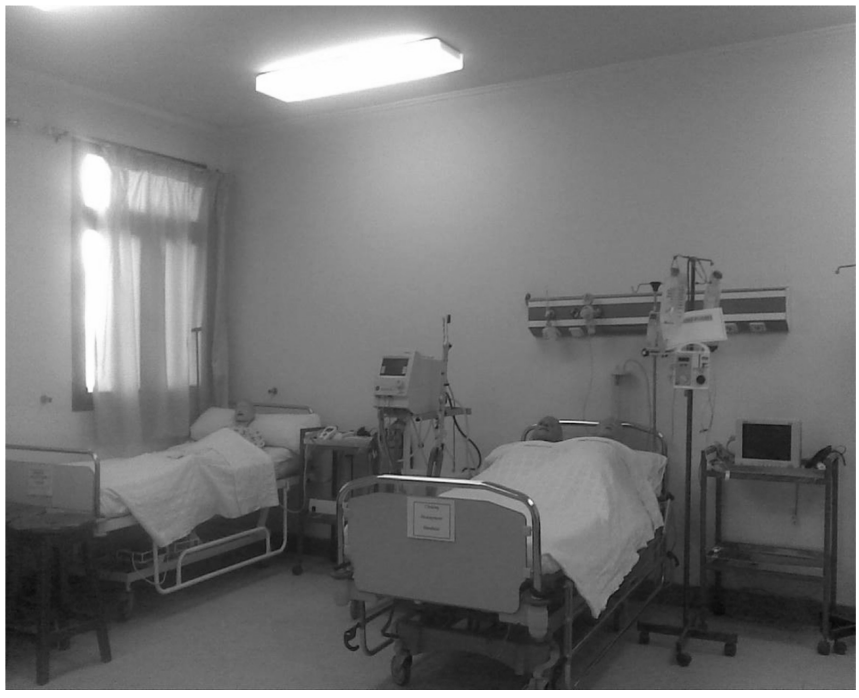
Nurses must continue to improve the image of nursing in Egypt by demonstrating to the public the professionalism of nurses there. Positive media coverage of events could make use of newspapers, magazines, television, or other forms of media. Nurses must seize the opportunity to highlight their contributions by writing letters to the editor to discuss what nurses do and how important nurses are to the delivery of health care for the people of Egypt. Nurses must position themselves at strategic levels of policy decision making to help develop policy and legislation to benefit the image of nursing and impact the delivery of health care (Rashdan, 2007).

Advance Gender Roles in Nursing

Nursing in Egypt is primarily a female occupation, and very few men are admitted to nursing programs in the university sector. In 2007, the Egyptian military sector graduated its first class of male subofficers, with a graduating class of 60 nurses. The employment of male nurses represents a positive advance in gender roles for Egypt (Rashdan, 2007). Male nursing students joined university nursing education in 2004. This has helped nursing become a more gender-balanced profession. Females continue to dominate the profession, and male nursing students display a lack of desire and enthusiasm attributable to the image of nursing in Egypt and a general feeling that nursing is a female job. From our experience with our nursing students, it was difficult for a male to become a nurse, taking on what is considered a female job. In the beginning, male students felt ashamed to tell others that they would be nurses, but after the first group of students graduated and entered the workforce, this image began to change, and male students are now more positive about the profession.

Challenges to Egyptian Health Care Within the Context of Culture

There are many challenges within any health care system, and cultural context always plays a role regardless of country. In Egypt some of the factors influencing health and the nursing profession include:



Critical care nursing training lab in the Faculty of Nursing, Alexandria University. *Credit*: N. Elcokany

- Female patients prefer to be examined by a female physician, especially for gynecological or obstetric purposes. Women feel shy and embarrassed talking about private issues like sexual issues with a male physician, so they prefer female doctors.
- Egyptian patients like to hear good news about their health, but if they have a serious illness, it is better to report the seriousness of illness and its consequences to a selected member of the family.
- Most Egyptian people don't seek medical care unless they are in need. They don't like routine checkups, lest they discover a disease—though the educated people have regular checkups.
- Herbal medicine use is a common precursor to seeking medical advice.

THE DREAM: STUDYING NURSING ABROAD

In light of the challenges to nursing in Egypt, as a nursing educator, I was looking for new information that I could apply in my field. I wanted to develop my career, expand my nursing skills, and learn more about conducting nursing research. My story began 5 years ago when I started to think of studying nursing abroad. These years were spent comparing nursing in my country (Egypt) and nursing in Western countries. I had many ideas about nursing abroad from the media as I watched the television series *Grey's Anatomy* and *ER*. They motivated me to practice nursing in my country and I noticed in these series that the nurse has an important role in the medical team. Essentially, the media and Internet were the instigators of my search.

AWARENESS AND SEARCH FOR INTERNATIONAL PROGRAMS OF STUDY

My first problem was to find a university for study. To do this, I contacted many universities to find a professor who matched my area of research. A second problem was to find a way (grant or scholarship) to cover my study and living expenses. The Internet was the only way

to look for a professor who matched my specialty in critical care nursing with an emphasis on pulmonary problems. In Egypt, I was a student in the PhD program at the University of Alexandria and had completed the coursework and data collection for my dissertation. The studies I envisioned would add to what I had learned and enable me to take this information back to my country.

I contacted many schools of nursing in the United States, and each school suggested another school for me. I was surprised to find that they read e-mails from people abroad. I felt that the nursing professors were helpful and willing to attract international students and help them succeed. After I found a professor (Dr. Leslie Hoffman) at the University of Pittsburgh, I was in contact with her for more than 18 months before receiving my scholarship. My dream then was not just to come to the United States as a visiting scholar, but to earn a degree in the United States. The value and quality of studying in the United States is well known and includes exposure to advanced technology in research, teaching, and nursing practice.

At our university, located in Alexandria, Egypt, we usually receive many announcements about scholarships, grants, and exchange programs between our university and other universities. The scholarship that I applied for was offered by the mission sector, which was managed by the ministry of higher education and scientific research. Major requirements for receiving support included being an assistant lecturer at the university, being younger than 30 years old, obtaining professor acceptance from a foreign university, having an acceptable TOEFL score, and completing the PhD coursework, along with other requirements. I learned that prior successful applicants were primarily from the medical field and other majors, such as engineering, agriculture, and veterinary medicine. Undeterred, I submitted my application. I was finally accepted during the revolution of January 25, 2011, 10 months after I applied. The scholarship provided me a small stipend to cover my living expenses.

Next came the process of obtaining a visa, and for that, I needed to journey to Cairo from my hometown of Alexandria, a 135-mile trip (3 hours by car or train). I had to leave at 5 a.m. each morning to arrive at the visa office at 8 a.m., but I persisted through all the paperwork and the required interview process.

EXPECTATIONS AND FEELINGS ASSOCIATED WITH STUDYING NURSING IN THE UNITED STATES

When first arriving in the United States, I had mixed feelings that included happiness and worry. I was happy because it was one of my dreams to go abroad, but at the same time I was worried about the language. In Egypt, we study nursing in English, but we do not use English when speaking with each other. Therefore, we learn a more formal way of speaking that does not include slang or common expressions used with each other. I was worried that I would be misunderstood by the people around me, including my advisor, if I didn't catch the correct meanings of words. In addition, I worried about being away from my family and was concerned about the weather in a different climate. Before traveling to Pittsburgh, I had not been in a country with four distinct seasons, and I had never experienced snow.

REFLECTIONS ON IMMERSION IN A NEW CULTURE

Personal Feelings

I thought that living in a culture totally different from my home culture would be difficult. I was also concerned about communicating with different people. I decided from the start that as long as I was in a different country with a different culture, I must respect new rules, beliefs, and cultural differences. This attitude helped me a lot. At first, I was happy and impressed with the change. However, I did not feel that I truly "fit in." My culture shock was not evident to the people around me, though. I knew my name, where I was living, and

who I was talking to, but at the same time I felt I had some clouds in front of my eyes. I was a little bit confused, but I was also excited by this new experience and new environment. I felt I had finally seen the other half of the world.

I was fortunate that I attended a class in my PhD courses in Egypt about cultural diversity. I remembered what our professor, Dr. Amany Gamal El-Din, said when she explained the concept of culture shock in detail. She had also earned her PhD from the University of Pittsburgh, so she was able to transfer her knowledge and experiences to me. I spoke with her often before leaving, and she gave me the idea of what life would be like in the United States.

In the beginning, I was excited and happy, feeling I had "made it." I did what I was dreaming of: I came to the United States, my dream, but this enthusiastic moment didn't last forever. After all the excitement, enjoyment, and happiness I initially experienced, I felt loneliness, homesickness, frustration, and anxiety and had trouble concentrating and being organized. I started to blame myself and wonder why I had come.

I missed my family and friends. I blamed myself for not reading more about American culture before arriving. The hardest thing for me was to understand what Americans were saying in the street. English is not my native language, and I found American slang extremely difficult. I was no longer able to express myself the way I wanted—this was the hardest adjustment for me.

Everyday life activities were different for me as well, and required significant adjustment. Transportation in the United States is different from in my home country. I solved this problem by trying to get the bus with friends and learning the maps for going from place to place. I found it funny that the people who were using maps included both international students and American citizens. I didn't use a map in my country but found doing so was normal in the United States. When I went food shopping, I could not find what I liked, especially traditional Egyptian food, and I found myself using different units of measurement. I didn't have a conception of an ounce, a pound, or a degree Fahrenheit—we usually use kilograms for weight, centigrade for temperature, and liters or milliliters for volume. The coins were also difficult for me to distinguish. Which coin was higher in value? I couldn't find numbers on coins, so I assumed that the larger in size, the higher the value. Unfortunately, I learned, there is the dime! Over time, though, I learned the differences between coins and at the same time was encouraged by the new things I was learning—I liked the challenge and the new experiences I was having.

Socializing in the United States

There are big differences in social situations in Egypt and the United States. For example, in the United States I found that hand shaking is common when anyone is introduced. In my country, male friends can hug each other. In the United States a man can hug a woman, which is something not allowed in my country. I found that Americans have a very high degree of transparency. For example, on the bus, I can listen to an entire story told by someone speaking with a loud voice. In my country, we keep things private and say little in public.

I also observed that Americans like to have frequent parties in their houses. In addition, they go many places on weekends with others to the nearby park or stores, enjoying their day off. They use their weekend time to the maximum. I also found parks well equipped for many activities, which I found strange at first but now think amazing.

Because Egyptian culture is very different from American culture in many ways, in the time I have been in the United States I have also changed internally. I found that in the United States, people do not have time to look at each other or to judge each other, so they can do as they like in the street without any comment or judgment from nearby people. In Egypt, public behavior is judged by others. For example, clothing is different, for many reasons—such as religion, gender, and weather—influencing dress in Egypt. Most of the women in Egypt cover their body completely. If a woman has uncovered any of her body parts, she will be seen as attractive to people in the street, whether male

or female. For some this is in accordance with Islamic doctrine, but Christians also usually cover their bodies. Wearing shorts can be seen as disrespectful even in hot weather, except in some places such as beaches. Finally, another notable difference in social life is dealing with becoming an adult. Egyptian girls and boys are cherished and looked after by their parents until they get married, regardless of age. In the United States, however, it is possible to find many young persons living independently away from their families while unmarried.

Academic Life in the United States

I was shocked when I found that some students refer to their professors by name without using a title such as "doctor"—something not accepted in my country. In Egypt, I use my colleagues' titles when saying their names. This is viewed as respectful to one's senior colleagues. Also, in Egypt as a sign of respect, one does not speak to an older man or woman without adding "uncle" or "aunt" to the name.

Freedom in the classroom is also worlds away from my experience. For example, in Egypt we can't sit in front of the teacher with crossed legs. To do so is considered disrespectful to the teacher—students who do so are considered impolite or thought to have grown up in a poor environment. In the United States, students are free to just sit or to do another activity while attending class. Students may eat in class or engage in other activities while attending the lecture. For example, I attended a class with PhD students and found one of the students knitting while attending the class—and the professor didn't comment, leading me to consider this commonplace. But such students also engage in lecture discussions while doing these things—meaning that they are fully concentrating.

I was eager to gain experience from the United States and to know more about the actual practice of nursing. I asked my mentor to find an undergraduate course I could help teach as a volunteer in the lab or in the hospital. This was a great opportunity for me to learn more about clinical teaching, and my mentor facilitated this as well as other experiences, always offering to help me even without my having asked.

I gained experience in clinical teaching in the hospital by dealing with patients, seeing the hospitals and their many different machines, working with different categories of nurses, and seeing how nurses deal with the patients—and also dealing with different students. One memorable event was hearing the nurses sing to the patients before discharge. My initial impression was that the hospitals are like hotels, they are so advanced and so comfortable. Nurses here are required to do everything for the patients and it seems they have time to provide psychological support as well as physical care. They are talking, singing, smiling, and listening with the patients. I am now assured in my belief that the psychological aspect of care is more important than the physical part and can help in recovery.

Unfortunately, in Egypt nurses have multiple duties and responsibilities. First, we don't have respiratory therapists, so our nurses perform all the pulmonary activities patients need. Second, we have few or, at times, no nursing assistants. Egyptian nurses are also required to care for the mechanical ventilator and the other machines. All these responsibilities add stress to the nurses and can lead to burnout.

Observing and Adjusting to Life in the United States

As part of becoming adjusted to life in the United States, I started to observe everything around me, trying to collect ideas about Americans and American culture. One significant observation that continually amazed me was that I found Americans to always seem happy and positive. Their reaction to different situations is totally different from what I am used to in my country. I'm not sure whether this is a result of the natural environment—with all the green land in Pittsburgh—or whether all Americans behave so.

I also started to find people from other Arab countries, including Egyptians, to help me in my adjustment. Many are immigrants here and gave me hints about the culture and American people. I could see that they were happy, and they were a support to me, helping me realize that I'm not alone here in such a different culture.

After 5 months, I started to adjust. I used my sense of humor to adjust and I found help from others. My American academic advisor gave me a lot of support, guidance, and direction. I felt understood by my advisor. For example, she was driving us somewhere and a male Indian student started to sit beside me in the car, but she asked him to sit in the front seat instead. I can't express the great feeling of happiness that I felt in that situation. I was so happy that my advisor recognized that sitting next to a male student was not considered appropriate in my culture and handled the situation so smoothly.

I also found many of my fellow students here to be totally independent, and so I started to be more independent. I lived for a long time with students from different cultures, including China and Russia, and being with them helped me deal with people in general. We were exchanging cultural differences together. I do find that people in Pittsburgh are friendly and welcoming toward international students.

CONCLUSION

In nursing education, students learn about differences between cultures and religions, so the teachers, students, and classmates probably knew a little bit about my traditions. I remember when I attended a clinical session with the undergraduate students in the simulation center and the teacher gave them many scenarios about different cultures and religions and how to deal with these differences. These activities help nurses deal with humanity with extra care and inspire others to serve without discrimination. I will always remember when I was in my undergraduate class on nursing ethics. The first rule I learned in the code of ethics was to accept the patient as he or she is, regardless of race, religion, and culture.

I like Americans, and yet I know that during my stay I was touched by only a few sides of America—in particular, academic and professional life. My perspectives are subjective, and I know I cannot uncover everything about the United States during my brief stay of 18 months.

I have seen a number of things I would like to take back with me as goals for change in Egypt:

- An effective board of nursing to control the practice of the nursing profession
- Passage of an exam such as NCLEX as requisite to beginning a nursing career
- Standards of practice for each category of nurses
- Increased funding in support of research
- Websites providing ideas and dialogue about nursing practice

Finally, I'm thinking seriously about how I can be helpful in my country when I return, and about how I will adjust when I go back. Can I be effective in changing something in the curricula? Can I be a factor of change in the nursing profession in general? If so, how? I have a lot of plans and ideas, but I will need strong support from the administrative level and the decision makers in my home institution. I don't know if the people around me will motivate or frustrate me (probably both at times), but I'm hoping I can be a force for change.

REFLECTIVE QUESTIONS

1. What factors do you think would be important to you if you were selecting a nursing program in another country?

2. Think about study abroad for a prolonged period in another country. What challenges do you think you would face? How would you cope?
3. Compare the profession of nursing in Egypt with your country. How is nursing similar? How is it different?

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CASE STUDY 1.3

Developing and Sustaining Partnerships Through Global Health in Local Communities

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CONTEXT: FARMWORKER FAMILY HEALTH PROGRAM, UNITED STATES

Global health practice does not always require a passport. The United States is a remarkably diverse nation, where over 300 languages are spoken. In fact, over 55 million people speak a language other than English at home (Shin & Komanski, 2010). It is essential that health care workers be prepared to work with diverse cultures. This case study describes a "domestic as global" academic–community partnership that has been in existence for longer than 20 years. Clients of this partnership are largely migrant workers and their family members from Mexico, who are not necessarily working in the United States with appropriate documentation. They primarily speak Spanish, but some speak indigenous dialects. These workers harvest fruits and vegetables by hand, grueling work. We ask no questions of clients regarding documentation status during our 2-week summer rotation. However, for the sites where care is provided, migrant status is virtually 100% assured. Federally funded migrant health clinics can only treat clients who meet their definition for migrant status. Because of the fluidity of this population, there is little collaboration between these clinics.

The initial Farmworker Family Health Program (FWFHP) partnership, which began with one small group of undergraduate public health nursing students and one faculty member from a single school who engaged with a single south Georgia farmworker clinic, has evolved to encompass over 100 students and faculty members from five different universities along with community partners. The number of community partners has expanded to include not only the initiating federally funded migrant farm clinic, but also a summer school program, day care centers, two area health education centers (AHECs), businesses, faith communities, and, of course, the farmers and growers. Dental hygiene, nursing, pharmacy, psychology, and physical therapy students, volunteers, and faculty travel to a rural area of a southeastern state as part of a 2-week service learning cultural immersion experience, each adding to the overall scope of services.

PROGRAM OVERVIEW

The FWFHP is a collaboration of the federally funded Ellenton Health Clinic (hereinafter referred to as the Ellenton Clinic), located in Ellenton, Georgia, and five Georgia universities: Emory University (lead university), Georgia State University, Clayton College and State University, Darton College, and the University of Georgia. Other partners include the Colquitt County Health Department, the Colquitt County Board of Education, the Southern Pine Migrant Education Agency, and the owners of farms

and packing houses in the Colquitt County area. Additional budget-relieving in-kind support comes from churches and community organizations in the area. The FWFHP, coordinated by the Lillian Carter Center for Global Health and Social Responsibility in the Nell Hodgson Woodruff School of Nursing at Emory University, has served over 13,000 individuals in its 20-year history. Using students and faculty in the health professions, preventive and episodic health care is delivered over a 2-week period each summer in an intensive outreach setting that also serves as part of the clinical training programs of the universities. Each participating university pays the salaries of its faculty and makes some arrangement with its students regarding housing costs. Although the program is intermittently funded by small grants, no single current funding source covers all program expenses.

The team provides care for farmworker families to live, work, and go to school. In the mornings the team sees children enrolled in a migrant summer program at a local elementary school and day care. In the evenings the team caravans to various locations, including packing sheds, farmworker camps, and local neighborhoods. While the Ellenton Clinic is responsible for communication with and arranging for the various locations for our nightly schedule, the faculty is responsible for making sure students arrive at the farms or service sites together and on time. Participants meet in the parking lot of the hotel where we are housed at a designated time and all leave together for our destination. The leader of the caravan knows the directions to each farm, and a "caboose" faculty car also follows with the directions. Country roads are extremely dark, and the farms and their entrances are spread over four very rural counties. Earlier years without cell phone service posed a challenge, but improvements in technology have helped significantly.

Services provided at the migrant summer school program in the morning are structured around comprehensive physical examinations of children and adolescents. Parental permission is required for a child to be seen. Outreach workers from the Southern Pine Migrant Education Agency work alongside the Colquitt County Board of Education to sign children up for the summer school, and the Ellenton Clinic provides existing charts from their files and makes new charts for children without records. All records are property of the Ellenton Clinic, and all HIPAA regulations are observed. Undergraduate nursing students (BSNs) complete screenings of height, weight (body mass index [BMI]), blood pressure, hemoglobin, vision, and hearing. Nurse practitioner (NP) students do full physical examinations. Developmental assessments are carried out by physical therapy (PT) students. Dental services, including application of sealants and fluoride, are provided by dental hygiene (DH) students. Pharmacy (PharmD) students provide health education in the classrooms. Meanwhile, a small team of students and faculty work at the partnering farmworker clinic seeing patients and preparing the pharmacy. If health-related problems are detected, children who do not have a Medicaid provider listed on their permission form are referred to the Ellenton Clinic for follow-up. Health status letters in both Spanish and English are sent home to the parents of each child seen, whether a referral is necessary or not. Ellenton Clinic outreach workers handle emergent problems on an as-needed basis.

In the evenings BSN students complete height, weight, blood pressure, BMI, hemoglobin, and blood glucose screenings. A foot care station is staffed primarily by BSNs but also with other team members' participation. DH, NP, and PT students have separate stations for their respective practices. The evening focus of care is acute complaints rather than comprehensive examinations. NPs can prescribe with collaborative practice protocols, and PharmD students operate a pharmacy dispensary on site out of the clinic's mobile unit. Patients with chronic conditions are referred to the clinic for follow-up, with on-site clinic outreach workers arranging appointments and transportation. The clinic staff has provided interpretation services subsidized by one of the AHECs at the evening clinics. The need for more interpreters has led to inclusion of an additional team partner, the Emory Volunteer Medical Interpretation Services. This is a student-run organization made up of bilingual students formally trained as medical interpreters. The team starts seeing patients in the

evening clinics before sunset, often staying out past midnight. All members wait until the last patient and provider are done. Then we caravan home together, and in the morning we get up and do it again.

PROGRAM HISTORY OF DEVELOPING TRUST AND A SHARED MISSION

The executive director of the clinic and the lead faculty came to trust each other through a shared vision of improving access to health care for migrant farmworkers and their families. The FWFHP extends the work of the clinic and adds to the numbers of new annual visits they need to continue their federal funding. As the need for additional expertise became obvious, they jointly decided to invite other disciplines to join the nursing students, thus expanding the program's services. The grueling work and conditions of farm labor result in multiple musculoskeletal complaints, and the benefit of having PT students on site became apparent. The nursing faculty reached out to the physical therapy department. A similar situation occurred with psychology, where an identified need carved out a role for an additional discipline.

A good exemplar of dovetailing interests is the example of dental hygiene. Dental disease is among the top five health problems in this population (Lombardi, 2001). Both the clinic executive director and nurses saw a great need for dental services for both the children and the migrant workers. About the same time, many of the dental hygiene programs in the state were transitioning to bachelor-level programs, needing sites for community rotations. These needs allowed for great synergy. Even more importantly, the application of dental sealants and fluoride has probably been the most positive measurable outcome of the program.

Mutual trust and respect has grown over the years. The program's collaboration with the churches each summer has done much to raise community awareness regarding the plight of the farmworker. Because farmworkers are basically an "invisible" population working and living in these outlying rural areas, citizens of the four focal counties rarely see the labor or living conditions of these workers up close.

Two of the individuals who were founding partners have either retired or moved on, but leadership has not been lacking. The strong foundation built by years of work has fostered embedded trust between the involved institutions and has in fact led to a web of new personal relationships that have spun off to additional partnerships in different locations. For example, a member of the FWFHP nursing faculty runs a clinic caring for the uninsured and underinsured population of Atlanta. A member of the PT faculty now brings students to this clinic.

After 20 years of working together, even the site visits have evolved. Initially program faculty drove to the rural area for a day meeting a few months before the annual event. Then all participants (including all students) had a full-day orientation in Atlanta. Communication in preparation for the event now includes e-mails and conference calls and occasional "off-season" site visits. Medical records (the point of which is, after all, good communication) are developed by the Ellenton Clinic to meet their reporting requirements, with interstation transit front sheets developed in collaboration by all partners.

The 20 years together have not been without conflict. Working with partners requires compromise and negotiation. For example, the school system at the partner site determines the dates of the program. These may not always coincide with the best times for academic faculty and students, but as their guests and partners, it is imperative that we work with them based on their needs. In fact, one year the funding for the program was cut, and at the end of the first week we were told the last day would be the following Monday. We took this as an opportunity to look for new partners, which is when we began working with child care centers. This conflict thus turned into a benefit as NP students were able to complete physical examinations on children age 6 months to 3 years at a migrant Headstart program.

An ongoing conflict exists in the broader context of the program. We ask ourselves whether a program that provides care for migrant farmworkers perpetuates the inequities and conditions that put them at risk. Health care is rarely neutral or innocent. Placing

Evening activities from the Farmworker Family Health Program. *Credit:* J. Wold

care in its full context is an important consideration for all health care providers. The act of delivering health care, like providing assistance in complex humanitarian emergencies, isn't that complicated. It's the operational context in which the assistance is provided that is the complicated part. In caring for farmworkers with health problems exacerbated by the working conditions, are we doing all we can to solve the problem? This question is put to students and faculty and provide for self-reflection and ethical discussion. The FWFHP objective is to care for as many people as possible. As we work through this conflict, it may lead to a review of our vision.

The program is evaluated by each student and faculty member every summer. Undergraduate student nurses use this course as the clinical component of their public health nursing course and are evaluated on both didactic and clinical standards used by the Emory School of Nursing. Reflection journals are kept by undergraduate student nurses, and interprofessional reflection groups meet each morning prior to beginning the day covering various questions reflecting on the previous day's experiences. Other students' clinical expertise is evaluated by their respective faculty and credit allocated accordingly. Annual student and faculty evaluations through a questionnaire combining Likert scale and open-ended responses are tallied at Emory School of Nursing. The results are distributed to the other participating schools and considered as a whole by the program faculty. The operations of the program are enriched by suggestions from both seasoned faculty and staff and fresh student participants. We seek continued improvement in the efficacy and efficiency of this important work. Other evaluation comes in the form of thesis or dissertation projects of students from varying disciplines that request use of our anonymous clinical data collected each year on all clients.

Unforeseen collateral benefits include the interprofessional education. Continuity of faculty from year to year fosters faculty role modeling of interprofessional teamwork and partnership. Through the FWFHP, students from the various disciplines collaborate and consult with each other on all sorts of patient conditions. This interprofessional program predates the calls from the World Health Organization (2010) and the Institute of Medicine (Greiner, 2003) for increased interprofessional education.

CONCLUSION

The FWFHP is a unique interprofessional service-learning program that promotes student learning, improves knowledge and skills, and impacts students' attitudes. By partnering with a local clinic to support and expand its capacity at peak harvest season, health care professional students provide care for a vulnerable population. Students learn with, from, and about each other and the community they serve. The FWFHP is an example of a successful academic–community partnership.

REFLECTIVE QUESTIONS

1. Considering that farmworkers are often exploited by their crew bosses, is offering free health care to the workers helping or hindering those workers' cause for just employment and access to health care?
2. Should health care professionals providing health care to migrant workers attempt to lobby for them in the political arena? How do you think this would affect the ongoing development of the partnership?

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