Global health predeparture training for physiotherapy placements in low income countries: comparing current and best practices

ABSTRACT

Purpose: To identify: 1) Predeparture training (PDT) best practices for physiotherapy students participating in a global health experience (GHE) in low income countries, 2) current practices in Canadian physiotherapy programs, and 3) to compare best and current practices.

Methods: This study employed a mixed method approach. A scoping review was performed to identify PDT best practices discussed in scientific and grey literature. An online questionnaire surveyed Canadian physiotherapy academic coordinators about their current training practices (questions covered student selection, PDT, on-site training and supervision and debriefing). Qualitative and quantitative analysis were performed for both phases of the study; best practices were compared to current practices.

Results: Best practices included recommendations about the content and format of PDT, the organization of GHEs (e.g. focus on sustainability), the student selection process and the support offered to students before, during and after the GHE. Canadian universities have varying practices in terms of content, training format and duration. All universities having GHE have mandatory PDT and an established student selection process; half of them have mandatory debriefing.

Conclusion: Discrepancies between current and best practices exist. Next steps should focus on reviewing PDT based on best practices and evaluating impacts on students, universities and partners.

Key Words: global health, predeparture training, physiotherapy, low income countries

INTRODUCTION

Global health is an increasingly important area of study and practice for physiotherapists and a growing number of Canadian physiotherapy students participate in a global health experience (GHE) during their studies.[1-4] *Global health* refers to problems, issues, and concerns that transcend national boundaries, and may be influenced by circumstances in other countries.[5] It encompasses political, economic and social dynamics and diseases that impact substantially on the health of Canadians and citizens of all countries.[5] As such, GHEs may be performed in local (e.g. with marginalized groups) or international settings. Formal GHEs can contribute positively to a student's personal and professional development.[2] They can lead to increased cultural sensitivity, enhanced community, social and public health awareness and improved clinical, problem-solving, evidence-based medicine and communication skills.[2-3] GHEs help students acquire knowledge and skills relevant to appreciating patients' cultural differences, global health disparities, the multi-factorial influence on health and challenges within health care systems.[2,3] Moreover, GHEs have been linked with future practice patterns, including work in public health, multi-cultural settings and underserviced areas within local communities.[6] Along with the positive impacts of GHEs, it is becoming increasingly recognized that inherent risks also exist.[3] Students may be in a situation where they are asked to practice beyond their scope of knowledge.[3,7] A lack of focus on sustainability and the tendency to focus on student learning rather than community needs may have a negative effect on the host community.[8] GHEs may divert clinical resources away from direct care to provide support to students who will only be present in the host country for a short period of time.[8] Moreover, local supervisors may become frustrated if they feel more of a tour guide than a clinical supervisor.[1] Finally, challenges have been reported with students lacking knowledge of the local culture or language influencing their

ability to offer an adequate and efficient care plan.[1]

In light of these moral hazards, a growing consensus seems to emerge that universities have a responsibility to train students before a GHE.[1,3,5] Yet, little research exists that discusses the actual training itself. This raises the question - how should we and do we train students for a GHE? In this study, we were thus interested by PDT, defined as any preparation that students complete before taking part in a GHE that has as its goal building trainees' competencies and skills necessary to maximize learning while also minimizing harm to themselves and the communities in which they study.[9] The purposes of our study were therefore to: 1) identify global health PDT best practices for physiotherapy students participating in a global health experience, 2) identify current practices in Canadian physiotherapy programs, and 3) to compare best and current practices with regards to physiotherapy students' preparation and support before, during and after a GHE.

METHODS

Our study used a mixed method approach with two overlapping phases. Ethics approval was obtained from our University's Research Ethics Board. This study was part of a broader research project exploring practices for undergraduate medical, physiotherapy and occupational therapy students participating in GHEs in high income countries, low middle income countries (LMIC) and Canadian indigenous communities. This paper focuses specifically on Canadian physiotherapy placements in LMIC due to the increased participation of Canadian physiotherapy students in these placements and the fact most of the PDT literature focuses on training for GHEs in LMIC.

Phase 1: Scoping review to identify best practices

Scoping reviews are an increasingly popular research approach enabling researchers to generate a "map" of the breadth and depth of knowledge in a field.[10] Our research question *"How do we train students for a GHE?"* was explored using two databases (Ebsco and Ovid). We searched these databases with a combination of keywords such as global health, physiotherapy and placements (see online appendix 1 for the complete list of keywords). Inclusion criteria were: scientific articles (accessible through our University databases) or grey literature written in French or English published between January 2000 and February 2014, and having clear guidelines for PDT for physiotherapy, medical and occupational therapy students. The database search found 2154 articles; titles and abstracts were screened to check for eligibility. Two team members (XX; XY) screened the first 50 articles; disagreements regarding whether or not a document should be included for full review was discussed until consensus was reached about the specific article and to ensure validity in the selection process. The rest of the articles were screened by XX.

Following the screening process, 115 articles remained to be read in full. An additional 95 articles were excluded (19 were unavailable through our University and 56 did not meet our inclusion criteria). Other articles and grey literature were obtained through a snowballing method consisting in inviting 28 known global health experts to send us articles based on the above inclusion criteria; 52 articles were received and 13 new articles were retained. We therefore included 20 articles from the database searched and 13 from the snowball, for a total of 33 articles in the overall study. Nine articles included recommendations for physiotherapy students and were thus retained for the purpose of this manuscript.

A data extraction chart drafted by XX and XY was used to extract data related to the training content, format and outcomes. After independently completing the data extraction for 3 articles, XX and XY met to review the data charting form and to ensure consistency in how the information was extracted. Consensus was achieved on the data extracted for these articles and the data extraction form was reviewed to include information on factors influencing the GHE. XX completed the data extraction for the other 6 articles.

A numerical and qualitative analysis was performed of the extracted data. The numerical analysis was performed to identify information such as article types (e.g. qualitative studies). As for the qualitative analysis, XX reviewed the data from the 9 articles, identified major themes and discussed it with XY to validate the interpretation.

Phase 2: Survey to identify current practices

An internet-based survey was developed in Fall 2014 based on the preliminary results (i.e. key components of PDT emerging) from the scoping review. Three experienced faculty members from our institution piloted the survey. Changes were then made to reduce its length and focus on the training process – removing sections concerning the placements themselves. The final version of the survey included 24 close-ended questions and 18 open ended-questions exploring mandatory and optional PDT and debriefing, on-site supervision and training, as well as student selection criteria (see online appendix 2 for a copy of the survey).

We invited the 15 Canadian physiotherapy academic coordinators to be our key respondents because of their knowledge about their programs' clinical placements. An initial email invitation,

including the consent form and survey link, was sent out in March 2015. Two follow-up invitations were sent out at one-month intervals. The close-ended data were analyzed with SPSS software and short open-ended elements were qualitatively analyzed using a thematic analysis[11] to identify themes.

RESULTS

Scoping review

Out of the 9 articles analyzed, 2 were expert opinions, 1 evaluated a global health course and 6 were qualitative studies exploring topics related to GHEs. Nine articles made recommendations for PDT and 3 for the debriefing. No articles discussed recommendations about on-site training, but 7 discussed factors influencing the GHE. No article evaluated the impact of the training on students' competencies or on the host institution. The key concepts that emerged from the scoping review are presented in Table 1.

[Insert Table 1 about here]

Themes to be covered in the predeparture training

Authors suggested that an in-depth PDT requires students to learn about (1) general global health knowledge and (2) the local setting.

General global health knowledge to be covered included exploring direct and indirect global health determinants[1,2,12] (e.g. international economic policies) and discussing global health

roles[1,4,13,14] such as advocacy, teaching and health promotion and prevention. Allowing students to develop critical thinking for ethical practice[1,3,4,13,15] by reflecting on one's motivations and professional limits and on the potential harms of foreign involvement was also recommended. Authors expressed the importance of developing a sense of cultural humility, defined as being humble about one's own culture and limited knowledge of other cultures and understanding the impacts of our values on our actions and perceptions.[1] Preparing students for culture shock,[2,13] helping them to identify specific learning goals[1,2,13] and covering safety related issues[2,3,4,16] such as security, prophylactic and on-site health precautions were suggested.

Site-specific knowledge included understanding the host institution's expectations.[1] Authors recommended that students develop cultural competency[2,13,14,15,16] - that is to understand a culture and behave in ways that allow an individual to respectfully interact within that culture.[15] This entails learning about historical, sociocultural and political aspects of the host country[1,4,13,14,16] and societal norms and behaviours deemed acceptable.[3,4,16] Learning local verbal[1,2,13,16] and non-verbal[1,13] communication skills and learning how to use an interpreter[1,2] was said to be essential to identify health beliefs[1] and assets and barriers to care, as well as establish, explain and negotiate a culturally acceptable care plan.[14]

Training format for the predeparture training

Authors described various training formats for PDT including different active learning techniques within workshops,[13] courses,[1,2,4,12,13] interest groups,[13] and personal or directed self-learning activities.[14] Specifically, multiple training activities were named by authors: discussions,[14] role-playing,[14] simulations,[14] presentations,[4,14] case studies,[12,14] reflective

activities, papers and readings,[2,4,14] journaling,[4,14] individual research,[1] speaking with experienced individuals[2] and values clarification exercises.[14] No proof that one format was better was found; the choice of one format over another might be influenced by a multitude of factors, including the themes of the PDT. For instance, to develop cultural competencies, APTA suggested students' immersion and active learning as an ideal training format.[14] They suggested students be supported by facilitators providing them the theories, principles, ideas, and reflections on practices to go beyond knowledge and develop attitudes, and skills.[14] Assessing knowledge, attitudes and skills was perceived as an integral part of the education process to develop cultural competency.[14]

Outcomes of predeparture training

One article officially evaluated a global health course.[12] An appreciation survey and a student focus group were used. Students appreciated learning about varied global health topics from experienced speakers and having small discussion groups. They recommended changing discussion groups regularly and having a course synopsis emailed to them before class. No further evaluation was performed on student learning for GHEs.

PDT outcomes perceived by authors (i.e. based on authors' opinion and not on an empirical study) included diminishing moral hazards,[3] promoting ethical practice,[16] increasing the positive impact on students and the local population[1] and minimizing weaknesses and threats[13] such as lack of experience, unrealistic expectations and cultural and language barriers. Other authors suggested that the integration of global health themes in the general curriculum could allow students to develop a deeper appreciation of their global health role and help diminish health

disparities.[13,14]

Barriers to the implantation of predeparture training

Barriers to the implantation of PDT included schedule conflicts, high attrition rates and lack of faculty involvement.[12] Suggested solutions were to offer faculty course recognition and to recruit student volunteers for course planning.[12]

Factors influencing the global health experience

Beyond providing students with a good quality PDT, many organizational factors seem to influence the students' experience in the GHE. How physiotherapy programs develop partnerships and ensure the sustainability of their placements appeared as an important factor.[1,2,3,4,16] Furthermore, an established partnership allowed the university to better ascertain the quality and safety of the placement for their students.[2] Authors mentioned that recognizing and compensating the host's time and resources[4,16] and having an established mechanism for conflict resolution contributed to maintaining a good relationship with the host partner.[16] They recommended that the university and host institution collaborate in identifying GHE goals that are specific, mutually beneficial and based on host community needs.[1,3,4,16] Also, they suggested officially, periodically and collaboratively reassessing these goals as well as GHE outcomes.[4,16] Clarifying the student's role and limits[1,3,4,16], having ongoing faculty involvement at the host site[1,3,4,16] and a committed faculty member[4] and implanting the GHE at an optimal time for the host institution[3,4] with sufficient duration (avoiding short stays and clinical rotations) seemed to be important and contribute to the overall GHE for students.[1,4]

Appropriate candidate selection was identified as an important component to a successful GHE. Identifying students with strong personal attributes (e.g. adaptability) [2,3,4,13,14] and clinical skills,[2,3,4,13] previous travelling experience[3,13] and specific language skills[3] was suggested. Students need to have realistic goals,[8] demonstrate a desire to learn about the host country[3,4,16] and commit to the project by participating in planning,[16] in PDT,[16] in GHE evaluation[16] and debriefing[16] and in mentoring future students.[3]

Providing support to students throughout all GHE phases was seen as positively influencing the GHE. These may include faculty assistance in organizing logistics (e.g. housing and visas) [2,4] and appropriate clinical supervision[1] (an on-site or remote faculty member and/or a local mentor).

Finally, authors suggested that formal debriefing was essential[16] for GHE and PDT enhancement.[2,4] Moreover it contributed to a student's professional development.[2,4] Students should give feedback on the GHE by identifying strengths and areas for improvement[16] and discuss learning outcomes[2,3] and challenging situations that occurred during their placement.[2,3] Discussed formats were reflective activities and peer presentations.[2]

Survey

Out of the 15 surveys that were sent, 7 participants completed it and 1 responded back by email stating that they did not offer GHEs. Two additional universities did not offer GHEs at the time (this information came from personal contacts at each of the universities). Among the 7 universities that responded to the survey, 6 had placements in LMIC (one university only had placements in high income countries). Of these 6 programs, 2 had specific PDT for students

going on placements in LMIC and 4 had a generic PDT (i.e. by "generic" we mean training incorporating students participating in placements in high income countries, LMIC and in indigenous communities). Table 2 presents the results of the survey, where most answers were not mutually exclusive (multiple-choice answers allowed).

[Insert Table 2 about here]

To select students for a GHE, the academic record was the most frequently strategy used, followed by letters of intent and faculty approval. Submitting resumes, letter of reference, preceptor interviews and demonstrating interest about the country were also reported selection criteria.

Two universities offered on-site training to their students including language courses, discussion groups and cultural visits. All universities had formal supervision for their students; 1 had a university-recruited supervisor (i.e. from the same community than the student), 3 had local supervisors and 2 had local supervision as well as a remote university supervisor.

Three universities had mandatory debriefing, which were generic sessions led by their global health offices. Of these three, one university had additional debriefing given by their program and another from student peers (students teaching students). Debriefing training formats varied from one university to another: 1 integrated their debriefing in a university course, 1 gave a conference, 1 held a workshop, 2 gave reflective assignments and 2 held individual or team meetings with the students. Only one university had an interdisciplinary debriefing session. Mean debriefing length was 7 hours. The three universities covered similar content including

252 reverse culture shock, lessons learned, placement evaluation, competency transfer and general
253 exchanges about the experience.
254
255 **DISCUSSION**
256 This study identified PDT best practices for physiotherapy students participating in a GHE and
257 current practices in Canadian physiotherapy programs. All universities having GHEs in LMIC
258 have formal PDT, which aligns with the belief that universities have the responsibility to provide
259 students with additional training for such placements.[1,3,5] As identified in the scoping review, a
260 majority used a variety of training formats such as workshops, courses or individual readings.
261 Only one university required reflective assignments from their students, yet assessment of
262 knowledge, attitudes and skills is an integral part of the learning process.[14] Adding assessments
263 to PDT may allow universities to offer credit for the training, which may lessen attrition rates.[12]
264
265 Discrepancies are noted when comparing best and current practices with regards to the training
266 content. Themes identified in the literature rarely part of current PDT include the sociocultural,
267 historical and political aspects of the host country; yet, knowledge of the host country is essential
268 to develop cultural competency.[14] Moreover, no university reported covering language skills.
269 Lacking language skills may hinder the student's ability to communicate with the patients and
270 local colleagues;[17] furthermore it may imply the need for an interpreter which requires specific
271 skill sets and the understanding of concepts such as neutrality, power imbalance and biases that
272 may arise when working with an interpreter.[5] Different reasons might explain why no program
273 offered language courses: placements were in English or French speaking countries, universities
274 request students to be fluent as a selection criteria (but this did not emerge when respondents

were asked about selection criteria), language courses were offered but were not considered part of the PDT – or this is really a core component lacking that remains to be integrated, along with working with an interpreter if needed, in PDT.

The length of PDT was variable in Canadian universities. No clear recommendations exist for optimal PDT duration, but Edwards suggested that international electives will only meet the requirements of globalization if they are delivered within a comprehensive program of teaching about international health.[18] Alappat and APTA, who suggested the pertinence of integrating global health content into the general curriculum, echoed this idea.[13-14]

This study also identified an overarching theme not previously discussed in the PDT: factors influencing the GHE. PDT aims at preparing the students for their GHE; this study highlights that student training is but one of many factors influencing the students' experience in global health, including how the GHE is developed and sustained. Pechak established a set of ethical guidelines for GHE development.[16] These guidelines recommended that host and sending institutions collaborate in developing a well-structured program to derive mutual and equitable benefits and clarifying goals, expectations and responsibilities. They also suggested that students commit to the placement by planning, implementing and evaluating the placement and demonstrate awareness and respect for the sociocultural, political and historical aspects of the community before and during the placement. All parties involved should be responsible for the success of the GHE.

All universities offering GHEs in LMIC had a selection process focusing mostly on academic standing and not taking into account recommended elements such as a student's motivations and

willingness to commit to the project. Developing and implementing global and inclusive guidelines for student selection could help clarify expectations and ensure a positive GHE with significant benefits for the student and host institution.[3]

All universities had clinical supervision for their students, in most cases by a local therapist. The prevalence of local supervisors emphasizes the need for a mutual understanding of the student's roles and limits. Also, having a local supervisor may facilitate cultural and linguistic translation for the students, but it highlights the importance of recognizing and compensating the time spent on mentoring our students to avoid the potential drain on local resources.[16]

Only half of the universities offered mandatory debriefing – but those who did were in line with best practices covering lessons learned, competency transfer, GHE evaluation and general exchanges about the experience. Additionally, reverse culture shock was covered, which surprisingly was not spoken of in the literature. Addressing reverse culture shock allows the student to reintegrate back home. It also may allow us to identify students who may need further help - who may be isolating themselves and feeling marginalized by the change they see in themselves after their experience.[19] Ultimately, debriefing is an essential step allowing the student to consolidate his learning process, it is therefore essential.

LIMITATIONS

The scoping review allowed us to identify content to teach students before their GHE, but as we did not search for specific "themes" (e.g. cultural competency and global health determinants), we might have missed relevant articles. Likewise, articles published in other fields such as medicine could be relevant to guide the development of PDT in physiotherapy but where not

included in this study. We are however confident that our search strategy allowed to map the current knowledge in physiotherapy PDT.

The survey included very few questions related to other factors influencing the GHE (some questions about placements were removed to increase the feasibility of the study and response rate of the study). Adding these questions would have allowed us to better compare current and best practices related to GHEs in Canadian physiotherapy programs. Variability of practices across programs forced us to keep the survey relatively general, even if it would have been interesting to have more details about the PDT practices. Furthermore, the low response rate limits generalization but certain trends are observed and offer opportunities for reflection about how to improve PDT.

CONCLUSION

The growing participation of Canadian physiotherapy students in GHEs requires universities to train and support their students for these types of experiences, to make sure both students and host institutions benefit from the placements. Our study identified *best practices* related to PDT and to identify other factors influencing the GHE. As some discrepancies exist between best and current practices in Canadian universities, it would be interesting to develop a consensus about the core elements that should be included in PDT. Evaluating and comparing different training programs, with varying themes and formats, could allow us to identify the most (cost) effective way to train students and to formulate clear recommendations that could lead to standardization of PDT within Canadian physiotherapy programs. Integrating global health content into the regular curriculum to prepare all students for intercultural encounters is certainly an interesting

avenue, helping for the "pre" departure training. However, other components of the training will probably remain essential for students going for GHEs (e.g., to learn the specifics about their host institutions before going). As the on-site training, the debriefing and the whole organization of the GHE appear essential to ensure a positive experience, the expression "global health placement training and support" might better reflect the process we are referring too. Finally, as most Canadian universities are going through the same process of developing and improving their global health placements, we have started to connect programs and global health leaders together to share knowledge and resources. We would invite all interested individuals and groups to contact us to work together to optimize GHEs for all students and to evaluate and maximize the impact on local settings, to ensure a positive experience with mutual learning and beneficial goals for all parties involved.

KEY MESSAGES

What Is Already Known on This Subject

Global health experiences can contribute positively to students yet inherent risks exist for them and for the host institution. There is a growing consensus that universities have a responsibility to train their students for such an experience but little is known about best and current practices in physiotherapy.

What This Study Adds

This study identified best and current practices for predeparture training (PDT), and identified some discrepancies (e.g. in the themes covered during PDT). It also identified other factors influencing the global health experience such as the partnerships, student selection, on-site supervision, evaluation and debriefing. As few PDT sessions have been formally evaluated, future research is needed to evaluate different training programs and improve our practices.

REFERENCES

1- Barette, M., Jutras, A., & Côté, M. (2012). *La physiothérapie en pays en voie de développement: recommandations pour la préparation et la réalisation d'un tel projet* (M.Sc en physiothérapie). Université de Montréal.

2- Crawford, E., Biggar, J., Leggett, A., et al. (2010). Examining International Clinical Internships for Canadian Physical Therapy Students from 1997 to 2007. *Physiotherapy Canada*, *62*(3), 261-273.

3- Landry, M., Nixon, S., Raman, S., et al. (2012).). Global Health Experiences (GHEs) in Physical Therapist Education: Balancing Moral imperatives with Inherent Moral Hazard. *Journal Od Physical Therapy Education*, *26*(1), 24-29.

4- Pechak, C., & Thompson, M. (2009). A Conceptual Model of Optimal International Service-Learning and Its Application to Global Health Initiatives in Rehabilitation. *Physical Therapy*, *89*(11), 1192-1204.

5- Anderson, K., & Bocking, N. (2008). *Preparing Medical Students for Electives in Low-Resource Settings: A Template for National Guidelines for Pre-Departure Training* (1st ed.). AFMC Global Health Resource Group and CFMS Global Health Program.

6- Ahluwalia, P., Cameron, D., Cockburn, L., et al. (2014). Analyzing international clinical education practices for Canadian rehabilitation students. *BMC Medical Education*, *14*(1), 187.

7- Elit, L., Hunt, M., Redwood-Campbell, L., et al. (2011). Ethical issues encountered by medical students during international health electives. *Medical Education*, *45*(7), 704-711.

8- Pechak, C., & Cleaver, S. (2009). A call for a critical examination of ethics in global health initiatives in physical therapy education. *HPA Journal*, *9*(2), 9-10.

9- Anderson, K., Slatnik, M., Pereira, I., et al. (2012). Are We There Yet? Preparing Canadian Medical Students for Global Health Electives. *Academic Medicine*, *87*(2), 206-209.

10- Levac, D., Colquhoun, H., & O'Brien, K. (2010). Scoping studies: advancing the methodology. *Implementation Science*, *5*(1), 69.

11- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research In Psychology*, *3*(2), 77-101.

12- Cooper, C. (2012). Global health issues fostering interprofessional collaboration at Queen's University. *Occupational Therapy Now;*, *14*(24-26).

13- Alappat, C., Siu, G., Penfold, A., et al. (2007). Role of Canadian Physical Therapists in Global Health Initiatives: SWOT Analysis. *Physiotherapy Canada*, *59*(4), 272-285.

14- APTA's Committee on Cultural Competence,. (2008). *Blueprint For Teaching Cultural Competence In Physical Therapy Education* (1st ed.). American Physical Therapy Association.

15- Cassady, C., Meru, R., Chan, N., et al. (2014). Physiotherapy beyond Our Borders: Investigating Ideal Competencies for Canadian Physiotherapists Working in Resource-Poor Countries. *Physiotherapy Canada*, *66*(1), 15-23.

16- Pechak, C., & Black, J. (2013). Proposed Guidelines for International Clinical Education in US-Based Physical Therapist Education Programs: Results of a Focus Group and Delphi Study. *Physical Therapy*, *94*(4), 523-533.

17- Pinto, A., & Upshur, R. (2009). Global Health Ethics For Students. *Developing World Bioethics*, *9*(1), 1-10. Sze-Mun Lee, T., Sullivan, G., & Lansbury, G. (2006). Physiotherapists' communication strategies with clients from cultural diverse backgrounds. *Advances In Physiotherapy*, *8*(4), 168-174.

18- Edwards, R., Piachaud, J., Rowson, M., et al. (2004). Understanding global health issues: are international medical electives the answer?. *Med Educ*, *38*(7), 688-690.

19- Bernier, M. (2009). *Travel Abroad: Reverse Culture Shock* (1st ed.). Québec: Student help centre at Université de Laval.

Table 1: Scoping review's key concepts

Themes to covered in PDT	**General global health concepts** - Global health determinants - Global health roles - Critical thinking - Cultural humility - Culture shock - Learning goals - Health and security **Local setting** - Host institution's expectations - Host country's historical, sociocultural and political aspects - Communication skills (verbal, non-verbal and interpreters) - Culturally competent care (establish, explain and negotiate a care plan)

Training formats for PDT	- Active learning techniques (e.g. simulations, discussions and readings) - Assessment of knowledge, attitudes and skills
Factors influencing the GHE	- Established partnership with the host institution - Ongoing faculty involvement - Established mutually beneficial goals - Clarification of student roles - GHE goals and outcomes assessment - Appropriate candidate selection - Adequate on-site supervision - Mandatory debriefing

416

Table 2: Current predeparture (PDT) practices in Canadian physiotherapy programs for students participating in a global health experience (GHE) in a low or middle income country (LMIC)

GHE in LMIC	**N = 6**	
Universities having a selection process	**6 (100%)**	
Universities having mandatory PDT	**6 (100%)**	
	Generic group	***RP specific***
	n = 4	**n = 2**
Who is involved in the training		
The Program	2 (50%)	1 (50%)

Global Health Office	4 (100%)	2 (100%)
Peers (physiotherapy students)	0	0
Other	0	0
PDT has interdisciplinary training activities	3 (75%)	1 (50%)
Length of training	Mean 8.75h (2h to 24h)	Mean 22h (6h to 38h)
Training format		
University courses	2 (50%)	1 (50%)
Conferences	1 (25%)	1 (50%)
Workshops	1 (25%)	2 (100%)
Readings	3 (75%)	1 (50%)
Reflective assignments	0	1 (50%)
Individual / team meetings	3 (75%)	2 (100%)
Other	1 (25%)	0
Training content		
Global health definition	2 (50%)	2 (100%)
Global health ethics	2 (50%)	2 (100%)
Globalisation	1 (25%)	1 (50%)
Culture shock	3 (75%)	2 (100%)
Partner organization	1 (25%)	2 (100%)
Student role during placement	2 (50%)	1 (50%)

Host country culture	1 (25%)	2 (100%)
Host country history and politics	0	1 (50%)
Language classes	0	0
Security and health precautions	3 (75%)	2 (100%)
Luggage (what to bring)	1 (25%)	1 (50%)
Goals and motivations	2 (50%)	2 (100%)
Knowing yourself and the group	1 (25%)	1 (50%)
Reverse culture shock	1 (25%)	1 (50%)
Previous student testimonies	1 (25%)	2 (100%)
Other	1 (25%)	0