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MONOGRAPH

A Homestay Model for Global Health and Medical Education in Resource-Limited Settings

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Abstract International health electives often overlook important aspects of cultural competency, psychosocial support, and bidirectional exchange. In order to address these shortcomings, we adapted the homestay model to an elective in Kampala, Uganda. Host families consist of local faculty selected based on experience with international students and involvement in medical education. Host families provide accommodations, meals, psychosocial support, counseling, and an informal curriculum of local language, culture, and politics. Participants are encouraged to find ways to give back to their host communities. This well-structured model enhances the experience of all involved by focusing on cultural immersion, social support, and mutual partnership.

Keywords Global health · Medical education

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Introduction

Globalization has opened a floodgate of connectivity among nations, allowing people and pathogens to traverse borders more easily than ever. The increasing diversity of communities has begun to require the proper training of even local medical personnel to treat ailments from around the globe, along with increased cultural awareness, understanding, and sensitivity [1]. Leading medical institutions, including the American Board of Internal Medicine, American College of Physicians, American Society of Internal Medicine, European Federation of Internal Medicine, and Canadian Medical Association, have recognized these growing challenges, stating that addressing healthcare inequities both nationally and beyond is a fundamental principle of physician professionalism [2].

One approach to preparing the next generation of healthcare professionals for a more globalized world is the inclusion of global health experiences within medical education. Many studies have shown that trainees who have participated in global health electives are more likely equipped with many positive attributes. Specifically, these students have broader differential diagnoses, are more adept at the physical exam, are less reliant on expensive diagnostic testing, have a higher capacity for cultural competence and communication, and are more committed to serving the underserved [3, 4]. In response, US and Canadian medical student participation in international health electives has doubled to approximately one in five students over the past 20 years [5].

Despite the increased participation, overseas electives are often troubled by unclear goals, ill-defined objectives, and discordant definitions of what global health competencies should encompass [6, 7]. Furthermore, though an ideal global health program would form partnerships between home and host institutions with the goal of building a sustainable, equitable, and bidirectional global network, the present literature

on global health electives pertains mainly to developing programs in the global South to serve members of the global North, completely neglecting the reverse. And yet, many programs currently in place in the global South are tenuous and unstructured, particularly lacking in infrastructure for psychosocial support for participants. As a result, trainees are commonly underprepared medically and culturally while inadequately supported psychosocially, creating an avenue for the programs to degenerate into "medical tourism" [8]. Moreover, participants in global health typically stay in accommodations isolated from the local community, limiting the unique cultural opportunities available during an international health elective.

The challenges of better integrating students into a foreign culture and mitigating the effects of "culture shock" are not new. High school and university study abroad programs, the Peace Corps, and others have long addressed these challenges by student participation in a homestay experience in which they live with a local family embedded in the host's culture and family life. However, few such programs have been adapted to global health and medical education. Taking into account the unique emotional challenges of confronting medical practice in a foreign and resource-limited setting, a homestay model designed to support such an experience may require different considerations.

In order to address the shortcomings of current international health electives, we have adapted the host family concept to global health in medical education in order to achieve true immersion and cultural understanding, while simultaneously enabling a system of social support and mutual exchange. The unique element of our particular model is that it utilizes a structured approach with clear expectations for all involved in order to ensure that programmatic objectives are met in a transparent and open manner.

The Host Family Concept and Global Health

Since 2013, Western Connecticut Health Network (WCHN), University of Vermont College of Medicine (UVCOM), and Makerere University College of Health Sciences (MUCHS) have embarked on a collaboration in global health and medical education. At that time, a thorough review of the literature was undertaken during the establishment of an international health elective site at Mulago Hospital in Kampala, Uganda, in order to provide an informed approach to this initiative. Based on this review, careful selection of participants, predeparture orientation, and reentry transition programs have all been well described as key components to a successful global health program [9–15]. However, it was noted that presently, there are few reported global health programs in medical education (and none in the published literature) that utilize host families as a part of their international health electives, despite its longstanding history as a feature of study abroad experiences in high schools and universities.

The Challenges of International Health Electives

Despite the vast educational potential of international health electives, there are many barriers to fulfilling this potential:

1. Stress: Trainees, particularly those who are studying abroad for the first time, can feel strained by a myriad of circumstances from the mundane to the existential. Previously, comfortable routines, such as procuring food, arranging transportation, and managing finances, are often transformed into significant challenges further augmented by language barriers, cultural differences, and safety concerns. Furthermore, global health in resource-limited settings can be an emotionally overwhelming experience given the depth and breadth of need juxtaposed with the relative lack of available staffing, medicines, equipment, and infrastructure the trainees are accustomed to.
2. Cultural divergence and culture shock: Losing touch with their home culture, being unaccustomed with their host culture, being a member of a visible minority, and having inadequate time for emotional preparation before departure can all contribute to the phenomenon of culture shock, "the emotional reactions to the disorientation that occurs when one is immersed in an unfamiliar culture and is deprived of familiar cues" [16]. This can be further exacerbated by the workplace environment, given different approaches to bioethics, physician-patient relationships, health systems, medical education, and traditional healing.
3. Social isolation: As mentioned earlier, language barriers and cultural variances may contribute to a sense of isolation for the trainee. This isolation can be intensified given that trainees often stay in accommodations removed from the local community (e.g., hotels, guesthouses).

The Host Family Concept

Our conception of the host family adapted to global health in medical education evolved out of an attempt to address the aforementioned challenges and thematically revolves around the ideas of cultural immersion and understanding, social support, and mutual exchange.

The host families in our collaboration are faculty members and physicians at Makerere University College of Health Sciences, who have experience in hosting and counseling international students and have long-term involvement in medical education and global health. Many have even spent significant time (6–12 months)

in the USA for clinical fellowships, research training, and/or guest professorships. Once selected, the host families form the foundation of the participants' international health experience. They provide accommodations (including a private bedroom, bathroom, mosquito nets, access to kitchen, and laundry facilities), communal meals (breakfast and dinner), and arrange transportation (airport transfers, contact information for reliable taxi operators, carpool options to and from the hospital). They are financially reimbursed for their contributions.

In terms of cultural immersion, the host family offers a fully embedded experience. The trainee is able to appreciate how people in their new environment live day in and day out. The sharing of meals is a meaningful way to foster a relationship between all parties while encouraging language development and the skills to cope with the challenges participants may face by providing a sense of belonging in the community [17]. During communal meals, the participant is able to experience traditional home-cooking, while the host family is expected to engage the participant in an informal, organic curriculum that includes basic language lessons, instruction on the history, politics, and culture of the host country, and enriching discussions in a safe, open-minded space. Moreover, knowledge and understanding of the host culture reduces the potential for intercultural misunderstandings, assists in ameliorating the risk of culture shock, and provides a context-specific biopsychosocial framework in terms of health, disease, and the patient-physician relationship.

In terms of social support, the host family is a key resource for the participant. The host family streamlines the integration of the trainee into the local community by providing practical on-site advice (e.g., locations of ATMs, Internet cafés, supermarkets, restaurants, and points of interest; cell phones; navigating public transportation; arranging weekend field trips) and invitations to community events (e.g., religious services, weddings, cultural ceremonies, social gatherings). In addition, the host family functions as a support group. During communal meals, the participant and host family have an opportunity to bond, share stories about their day, ask questions, and debrief about their experiences in a judgment-free environment. Given that the host families are composed of members of the academic medical faculty, many of them are uniquely prepared to assist the trainees in processing and assimilating their diverse experiences both in and out of the healthcare setting. These host families not only are a part of the local medical establishment; but, as previously mentioned, many have spent significant time in the USA for clinical fellowships, research training, and/or guest professorships. Thus, they have the benefit of seeing the experiences of the trainees from multiple perspectives and offer valuable advice and insight. Lastly, the host family arrangement provides an invaluable safety net in cases of serious illness, injury, and/or political unrest.

In terms of mutual exchange, the participant is explicitly encouraged to reach out to the host family to ask how they can contribute to the host family and local community in a meaningful way (e.g., volunteering in the community, church, orphanage, or school; teaching English or computer literacy courses to children; etc.). Currently, global health programs are generally unidirectional, whereby trainees are the primary beneficiary of the international health elective while providing nominal benefit to the host country and institution [9]. The purpose of this bidirectional arrangement is to create a more symbiotic relationship that is balanced and mutually beneficial.

To date, our collaboration has had a total of 40 participants over the past 2 years, including 13 attending physicians, 9 resident physicians, 17 students, and 1 program coordinator, across multiple specialties (namely, internal medicine, family medicine, pediatrics, obstetrics/gynecology, and pathology). Based on their experiences, the following qualitative feedback has been extracted from their end-of-rotation evaluations. Consent was obtained from each of the participants in order to share the comments below.

> The [host family] provides a unique lens through which to comprehend an unfamiliar world and culture. Each venture outside the home, through the chaotic streets of Kampala and into the hospital incites a sensory overload and a plethora of questions and unidentifiable feelings. While exciting and eye-opening, these daily ventures can be exhausting and confusing. Returning to the [host family's] safe haven at the end of each day is a relief that washes over you. […] Dinner conversation eases all stresses of the day, whether they be rooted in the sickness of a patient, in a cultural clash or miscommunication, or in your own foreignness. […] Questions are asked and discussed, insecurities are addressed, and stories help place experiences into cultural and historical context. […] The warm kindness and compassion of the family alleviates whatever sense of foreignness, homesickness, and confusion.

> Prior to arriving in Uganda, I knew that […] we would hold daily debriefing sessions about our experiences with our host family. While I expected this would be helpful in adapting to life in a country unfamiliar to me, I initially worried that the sessions might feel overly formal or uncomfortable at times. Yet for me, these conversations were perhaps the most important part of the global health experience. Each night we came together over dinner to exchange stories and discuss everything from Ugandan music, to how to navigate [public buses],

> to understanding perceptions of HIV/AIDS in a Ugandan context. [The host family] often delivered guidance gently, through masterfully woven narrative. […] The [host family] also encouraged us to ask questions (and we asked many!) about any aspect of our rounds at Mulago, our exchanges with locals, or anything we were struggling to process. There were several times when, overwhelmed by an intense day or just general cross-cultural miscommunication, I would not have been able to cope without the guidance and support of this family. […] Staying with the [host family] was perhaps the most essential and memorable part of the program for me, and I am honored to have been welcomed as a guest and extended-family member in their home.

> I really enjoyed joining them for community events, working at [a local orphanage], hosting informal health teaching sessions, […] and attending church. [The host family is] very well connected and well-respected in the community and at the hospital and went out of their way to make sure we were well taken care of and getting everything we could out of the experience.

> Being able to stay [with a host family] while living and working in another country was incredibly valuable. As a coordinator of global heath electives, [the host family was] my go to resource for many of the students and resident questions. These inquires ranged from cultural and history questions to an intense and frank discussion of some of the pressing medical issues the students and residents were observing while on rotations at Mualgo Hospital. Global health is more than rounding on the wards in a different country, it is also interacting and understanding the culture you are practicing medicine in. The homestay model […] grounds the participants within the reality of what it means to be Ugandan and to be seeking medical attention. The homestay model also provides those small but important cultural interactions, which help to provide a holistic experience for the students and residents who are participating in our global health elective.

Furthermore, the host family had the following commentary emphasizing the symbiotic nature of this approach:

> On our side, we find the participants time with us extremely beneficial. [The participants] have delivered several, highly appreciated, health education sessions to the community. The following are some of the topics covered: menopause, cancer of the prostate, cancer of the cervix, cancer of the breast, etc. The participants have also greatly enriched members of our family. For example: they provided a laptop and taught young members of the family how to use the computer and the internet as a tool for their education. [They] taught us new games, […] participated in physical exercises with members of our family, […] and created a fun atmosphere in our home.

Limitations

Though there are many distinct benefits of utilizing this conception of the host family, there are several notable limitations.

Firstly, it may be difficult to identify appropriate and willing host families. Host families must bear many responsibilities, which can be burdensome. Host families in this arrangement must truly operate as surrogate families to the trainees, from supplying room and board to offering psychosocial support. This, in turn, can be trying on the host family, especially given that most international health electives span a 4- to 6-week period. Therefore, it is important that the chosen host families be patient, welcoming, culturally flexible, and accustomed to interacting with people from different backgrounds. Equally important is the proper orientation of the host family to the programmatic objectives. To this end, we have multiple sessions with the host family to discuss the guiding principles of the global health program and their explicit responsibilities. These expectations are, then, clearly documented and a memorandum of understanding agreed upon. In addition, we provide financial assistance to bolster the infrastructure of the host family (e.g., wireless Internet router, library).

Secondly, identifying suitable medical student participants may also be difficult. Living with a host family may come with its own challenges such as loss of privacy, unfamiliar living expectations, and a lack of complete autonomy for the trainee. Therefore, home institutions must utilize a careful selection process with which to select participants who exhibit cultural awareness and sensitivity and adept communication skills.

A positive relationship between both participants and host families is crucial to the success of this model and can be difficult to achieve unless particular care is taken with regard to the selection process and orientation of all involved.

Conclusion

Globalization has resulted in unique challenges whereby mature global health programs at academic medical centers will be necessary in order to train future physicians that will be able to address the profound healthcare needs both domestically and internationally. However, the development of successful global health programs has its own inherent barriers that must be overcome. For participants in international health

electives to maximize their experiences, global health programs must be designed in such a way as to ensure that the stresses, cultural divides, and social isolation do not undermine the potential these opportunities have to offer.

The structured homestay model presented above is one solution that not only minimizes these factors but also seeks to foster greater cultural immersion and bidirectionality. Through shared experiences, participants and host families are able to develop personal connections that may continue long after the elective is over and ultimately lead to the lifelong partnerships necessary for the development of a global network for the betterment of health for all. This arrangement creates a more intimate understanding of the challenges associated with living in the host country rendering participants more apt to envision interventions aimed at improving quality of life and capacity building, while instilling them with a greater commitment towards the underserved and a deeper compassion for their struggles.

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Conflict of Interest The authors declare that they have no competing interests.

References

1. Levy D. Shock of the strange, shock of the familiar: learning from study abroad. J Natl Coll Honors Counc. 2000;1:75–83.
2. Brennan T, Blank L, Cohen J. Medical professionalism in the new millennium: a physician charter. Ann Intern Med. 2002;136(3):243–6.
3. Sawatsky AP, Rosenman DJ, Merry SP, Mcdonald FS. Eight years of the Mayo International Health Program: what an international elective adds to resident education. Mayo Clin Proc. 2010;85(8): 734–41.
4. Henry JA, Groen RS, Price RR, Nwomeh BC, Kingham TP, Hardy MA, et al. The benefits of international rotations to resource-limited settings for U.S. surgery residents. Surgery. 2013;153(4):445–54.
5. Izadnegahdar R, Correia S, Ohada B. Global Health in Canadian Medical Education: current practices and opportunities. Acad Med. 2008;83(2):192–8.
6. Battat R, Seidman G, Chadi N. Global Health Competencies and Approaches in Medical Education: a literature review. BMC Med Educ, 2010. 10.
7. Eichbaum Q. The problem with competencies in global health education. Acad Med. 2015;90(4):1–4.
8. Cherniak W, Drain P, Brewer T. Educational objectives for international medical electives: a literature review. Acad Med. 2013;88(11):1778–81.
9. Collier MJ. Cultural and intercultural communication competence: current approaches and future directions for research. Int J Int Relat. 1983;13(3):287–302.
10. Dowell J, Merrylees N. Electives: isn't it time for a change? Med Educ. 2009;43(2):121–6.
11. Saffran L. Dancing through Cape Coast: ethical and practical considerations for health-related service-learning programs. Acad Med. 2013;88(9):1212–4.
12. Gudykunst W, Hammer M. Uncertainty, anxiety, and adaptation. Int J Int Relat. 1984;14(3):301–17.
13. Stephan CW, Stephan WG. Reducing intercultural anxiety through intercultural contact. Int J Int Relat. 1989;16(1):89–106.
14. Adler NJ. Re-entry: managing cross-cultural transitions. Group Organ Manag. 1981;6(3):341–56.
15. Shannon, E. Reflections on the Meaning of Study Abroad. Frontiers: The Interdisciplinary J Study Abroad, 1995. 1.
16. Lewthwaite MA. Study of international students' perspectives on cross-cultural adaptation. Int J Adv Couns. 1996;19(2):167–85.
17. Fruh SM, Fulkerson JA, Mulekar MS. The surprising benefits of the family meal. J Nurse Pract. 2014;7(1):18–22.