Evaluation of an International Trainee Exchange Program Developed by the Global Health Initiative at Henry Ford Health System

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Program/Project Purpose: The Global Health Initiative (GHI) at Henry Ford Health System (HFHS) in Detroit, Michigan is committed to improving health outcomes and infrastructure in resource-limited countries through collaborative capacity-building models. In collaboration with our international partners, GHI developed a medical education and research exchange program whereby international trainees (medical and public health students, residents, and faculty) conduct a one- to two-month observation at HFHS including clinical rotations and lectures, laboratory experience, and engagement in structured global health research training.

Structure/Method/Design: In the published literature, there are few articles that report on the evaluation of similar international exchange programs, and even fewer that include an evaluation of both mentors and trainees, or that focus on multi-country exchange programs. GHI developed surveys to evaluate the experiences of trainees and supervising mentors. The trainee survey includes questions on demographics, prior education, experience and perceptions of the HFHS observation, research training, housing, culture, and logistics. Quantitative and qualitative questions also ask how this experience will have long-term impact on their career and community (i.e. "I feel better equipped to serve the people in my own community"; "How has this experience shaped your educational and career goals?"; "How will you use this new information when you return to your home country?"). The mentor survey includes questions on observation activities, observer strengths and weaknesses, satisfaction with GHI coordination, and how the mentor's department benefitted from the exchange program.

Outcome & Evaluation: To date, GHI has hosted 14 medical and public health students/residents and 5 faculty members from 6 countries (Colombia, Guatemala, Haiti, India, Myanmar and Nepal). Trainees conducted observations in Infectious Diseases, Pathology, Allergy, Nephrology, Dermatology, Neurosurgery, Women's Health, School-Based and Community Health, and Global Health. Evaluation results from trainee and mentor surveys will be presented.

Going Forward: GHI will use these evaluation data to improve the clinical and research capacity training program, enhance mentor experiences, and strengthen collaborative relationships between HFHS and international partners. In the long-term, the exchange program will contribute to the development of global health service providers and improved health outcomes in low-resource settings.

Source of Funding: Internal.

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Strengthened Local Voluntary Membership Networks: Stronger Health Sectors

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Program/Project Purpose: Recognizing the critical role local voluntary membership networks play in the health sectors in low resourced countries, the newly developed and piloted Network Strengthening Program (NSP) is designed specifically for the managers (Board members, Secretariat staff, and actively engaged members) of country-level networks to strengthen their management in five key areas: Membership, Distributed Leadership, Governance, Financial Sustainability, and Communications for Resource Mobilization.

Structure/Method/Design: Implemented over 6 - 12 months, the NSP comprises (1) pre-launch submission of network documents and self-assessment, (2) 2 workshops (3) a results presentation with preparation session, (4) development of short and long term action plans, implementation of one or more short term plans, and (5) development of a network strengthening plan to be implemented in the 12 months following the end of the program.

The NSP supports participating networks to achieve results during the program and develop a road map for further network strengthening in the future. It is based on participatory and experiential as well as adult learning principles and offers practical information and tools.

Outcome & Evaluation: Program evaluation focused on the implementation of action plans and obtaining results, and completing network strengthening plans.

In two pilot offerings of the program in Malawi, the networks achieved short term results related in one case to the composition and criteria for membership, desired and core benefits, and reasonable member contributions and in the other related to mobilizing significant new funding. One of the two networks completed writing a network strengthening plan while the other prepared an elaborated outline.

Since the end of the program, one of the networks has reported increasing its visibility and influence for advocacy among national and international donors (e. g. Global Fund, PEPFAR, World Bank, etc.) by using communications tools offered in the program.

Going Forward: Both networks plan to continue strengthening their networks based on the outcomes of the program and will implement their plans over the next year.

The NSP curriculum is currently being prepared for publication and will be available in early 2017.

Source of Funding: The development and piloting of the program was funded by the United States Agency for International Development through the Leadership, Management and Governance Project managed by Management Sciences for Health.

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Lessons Learned Live: 35 Years' Preparing North American Clinicians for Global & Resource-Limited Settings

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Program/Project Purpose: Before the burgeoning of global health [GH] interest among USA clinicians and students, we identified in 1980 only one US medical school course with a clinical preparation [parasitology] course. Recognizing this need, multidisciplinary Arizona Health Sciences Center faculty in Tucson with "on

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the ground" clinical experience designed the full-time, three-week, case-oriented "Arizona Course," Global Health : Clinical & Community Care, revised and conducted annually since 1982. The evolution of GH education preparing North American clinical professions students for short or career experiences abroad evolved, leading to the 1991 founding meeting in Tucson of the International Health Medical Education Consortium, which became Global Health Education Consortium a decade later, prior to its 2012 merger into CUGH.

Structure/Method/Design: Entering our 35th year, University Arizona and distinguished visiting faculty present this intensive 90-hour seminar in "flipped classroom" format, with daily breakouts into three mentor-led clinical/community problem-solving groups of ~8 participants each. Limited to ~ 24 participants, the "Arizona Course" now has 729 "graduates." While we now supply our extensive content via easily-portable "thumb drives," we maintain the real-time interactive dialogue and clinical procedure demonstrations possible only in this live seminar setting. As www.globalhealth.arizona.edu details, this content now forms the core of the College of Medicine's 5-element Global Health Distinction Track.

Outcome & Evaluation: In 1992 and 2009, we surveyed our graduates' careers, supplemented by annual updates on recent graduates' specialty choices and experiences in LMICs. Among the first 700 graduates [1982-2015], 239 [34%] were UArizona senior medical students; another 81 [11.5%] were other Arizona students or clinicians. The other 380 [54%] were from elsewhere, including medical schools in 32 states; 52 came from Canada. Over 60% are women. Of all 543 graduates surveyed in 2009, only 7 could not be located; 16% earned MPH degrees. Among the 322 physicians, 46% had entered family practice, 14% internal medicine and 14% pediatrics. Graduates have subsequently learned and served in 73 LMICs, including several with distinguished careers who return annually as faculty.

Going Forward: We welcome clinical students and faculty to this longest-running USA clinical global health course each October.

Source of Funding: We thank over 40 faculty who, other than the authors, have all been volunteers.

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Cost Recovery and Service Usage in a Community Health Insurance Plan in Rural Uganda

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Background: Without a national health insurance system in Uganda, many areas have developed community health insurance initiatives (CHI). Although several studies examine the increased access to healthcare with CHI's, few studies investigate its sustainability at a hospital level. This study aims to find the differences in cost recovery and service usage between patients paying out of pocket (OOP) and those paying through the Kabale Diocese Community Health Insurance Scheme.

Methods: Accounting data on individual hospital visits from September 2011 to February 2012 was used. Data included services utilized, the department treating the patient, the total bill, and the amount paid. The CHI plan reimbursed the hospital using the flat rate based on the department treating the patient. Net deficits and percentage paid for each hospital visit were calculated and compared between the two patient groups.

Findings: A total of 4,279 hospital visits were recorded (n=3928 for CHI, n=351 for OOP). Two-proportion Z-tests demonstrated that a larger proportion of OOP patient visits used X-rays (19.7% OOP vs. 13.7% CHI, $p<0.05$), were administered medications (99.6% OOP vs. 95.7% CHI, $p<0.05$), involved operations (17.6% OOP vs. 9.1% CHI, $p<0.05$), and deliveries (25.9% OOP vs. 15.7% CHI). A larger percentage of CHI visits used laboratory services (62.7% CHI vs. 53.8% OOP, $p<0.05$). The total bill was larger for OOP visits ($23.77 OOP vs. $19.10 CHI, $p<0.05$). The percentage of the bill that was paid was higher for CHI visits (149.0% for CHI vs. 97.1% for OOP, $p<0.05$). The net deficit for each visit was higher for CHI patients ($1.45 CHI vs. $0.80 for OOP), but this was not significant ($p=0.18$). A 6-month aggregate of payments and costs showed lower cost recovery for CHI visits (84.6% vs 96.6%).

Interpretation: Patients with CHI generally used fewer services per hospital visit, and the total bill was larger for OOP visits. Percentage of bill payment was significantly higher for CHI visits, but there is some data to suggest that the hospital suffers a larger aggregate deficit with CHI patients. This suggests that changes need to be made in the CHI reimbursement schedule to make it more sustainable for the hospital without decreasing access.

Source of Funding: None.

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A Novel Telephone Triage Program for Hiv-Positive Children in Resource Poor Settings: Training Triage Coordinators in Chennai, India

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Background: India is home to the world's third largest HIV-positive population. One particular sub-population- children living with HIV (CLHIV) -requires unique 'HIV triaging' to ensure patients at high risk receive priority interventions and treatment without delay. The International Alliance for the Prevention of AIDS (IAPA), an NGO in Chennai, India, supports 43 CLHIV by offering free once monthly medical visits and packages of nutritional supplements. Between once-a-month visits, all calls from patients are triaged by a single staff member. In Tamil, "uthavi," means help. The UTHAVI Project, a training curriculum and web-based telephone triage database, aims to help IAPA's CLHIV get the treatment they need between monthly visits. Specifically, the UTHAVI project's triage protocol trains community social workers and IAPA staff in triage categorization, evaluating trainees' knowledge and preparedness pre- and post-training.

Methods: In-depth Interviews with staff and physicians were conducted to assess program needs. The triage curriculum, 'The UTHAVI Project,' was adapted from the WHO's Integrated Management of Childhood Illness handbook. Using 25 CLHIV