The impact of an international healthcare mission experience on healthcare professional students at the University of Northern Iowa

Evelyn Adom-Boateng

University of Northern Iowa

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THE IMPACT OF AN INTERNATIONAL HEALTHCARE MISSION EXPERIENCE
ON HEALTHCARE PROFESSIONAL STUDENTS
AT THE UNIVERSITY OF NORTHERN IOWA

A Dissertation
Submitted
in Partial Fulfillment
of the Requirements for the Degree
Doctor of Education

Approved:

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December 2009
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To everyone who assisted in diverse ways; I am forever grateful.
DEDICATION

A Committed and Visionary Woman

I dedicate this dissertation to my mother

Madam Cecilia Ama Adom

A Home-Maker

Ghana

Your commitment and devotion to your children,

Even when the going was tough and despair stared you in the face

After the passing of our dad, you had seven young lives to nurture and mold

You did not lose hope but you stood firm in your resolve, commitment, and guidance, and with the help of God gave your best to your children.

Here is your Reward, Mom!
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Dr. Rebecca Edmiaston, Committee Co-Chair

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December 2009
ABSTRACT

U.S. Demographic changes have had an impact on health education, care, and promotion. The best health education, promotion, and care can be delivered by culturally sensitive health professionals. The importance of addressing the issue of culture is widely acclaimed by educators from various health disciplines. Participation in an international healthcare mission (IHM) is one means to expand cultural awareness and sensitivity. Little research exists regarding methods for preparing culturally sensitive healthcare professionals. Little published research documents the impact of an IHM experience on the preparation of healthcare professionals.

The purpose of this study was to investigate the impact of an International Healthcare Mission (IHM) experience on the perceived growth of healthcare professional students. The study was specifically designed to examine both the professional and personal benefits of an IHM experience on participating Global Health Corps students at the University of Northern Iowa. Additionally, the study sought to assess the impact of an IHM experience on participants' cultural knowledge, cultural sensitivity, self-confidence, and social relationships.

Methodological Triangulation (including quantitative and qualitative methods) was used in this study. Quantitative data was gathered from 30 participants who responded to a questionnaire framed by Wilson's (1993) IIEM. Results of the survey yielded quantitative data regarding the strength and type of perceived changes that occurred due to students' IHM experiences. In depth interviews with five participants yielded qualitative data describing the impact of IHM experiences.
Results of the study indicated IHM participants grew in their cultural knowledge, cultural sensitivity, self-confidence, and social relationships. The research findings supported Bandura’s theory of self-efficacy and Wilson’s (1993) model. This study also validated Gallagher’s (2004) findings regarding the value of an IHM experience. Participants were found to develop increased sensitivity to people of other cultures and economic status while enhancing provider-patient interactions, multicultural teamwork, and knowledge of factors impacting clients’ receptiveness of health services and health status. This study also suggests that a thoughtfully designed IHM experience should be part of the preparation of healthcare professionals. IHM participants should be given advanced preparation before embarking on an IHM and IHM experiences should be supervised by faculty possessing IHM expertise.
CHAPTER 1

BACKGROUND

World-Wide Migration Patterns Impacting Health Care

Presently, 175 million (approximately 2.9%) people world-wide are living as permanent or temporal international migrants (World Health Organization [WHO] Report, 2003). The United States of America alone hosted 16.7 million immigrants from 1970 to 1995 (U.S. Census Bureau, 2002a). According to U.S. Census Bureau, (2002a) between the 1990 and 2000 census the percentage of foreign-born persons in the U.S. shot up astronomically by a margin of 44% in the U.S. There were 32 million foreign born individuals (almost one in nine) accounting for over 10.4% of the United States population in 2000 (Jasso, Massey, Rosenzweig & Smith, 2004; U.S. Census Bureau, 2002b).

World-wide migration of people today is said to occur mainly through either voluntary or forced means and is considered to be the underlying cause for the swift demographic changes taking place in the U.S. (Kandula, Kersey & Lurie, 2004; WHO Report, 2003). Trends in migration currently show a massive shift toward developed countries as compared to movement of refugees in the past that used to happen, primarily between developing nations (Wayne & Rosenblum, 2005). U.S. demographics thus appear to be moving away from the mostly, white, western European population as a result of these changes. Salimbene (1999) asserts that there will be a reduction of U.S. non-Hispanic whites, from 73.6% in the late 20th century to an estimated 53% of the population by the year 2050.
The distribution patterns of immigrants living in the U.S. tend to be uneven. The western states alone are said to accommodate 39% of the nearly 67% of foreign born individuals, while the southern states play host to 26.8%, with Latin American nations being in the majority (U.S. Census Bureau, 2002b). Approximately 11% resides in the mid-western states, whereas the northeast provides home to almost 23% of immigrants coming to the United States (U.S. Census, 2002b). Migrant populations in the U.S. also are a non- homogeneous group of people (Gomez, Kelsey, Glaser, Lee, & Sidney, 2004). The U.S. Census Bureau (2002b) indicates that Hispanic and Asian populations are the two largest foreign-born people living in the U.S.

Out of the over 28.4 million immigrants in the U.S., the Hispanic population alone comprised more than half (51%), followed by Asian born (25.5%), European born (15.3%) and 8.1% for people from other parts of the world (U.S. Census Bureau, 2002b). In the 1980s the population of Asian born immigrants in the U.S. rose from 19% to 26% of all foreign born individuals in the U.S (U.S. Census Bureau, 2002c). A greater increase of over 35.2% was observed in the Hispanic population in the United States from 1990 to 1998 (U.S. Census Bureau, 2002c).

Researchers agree that one homogenous immigrant group is comprised of several sub-cultures such as the Hispanics (Gomez et al., 2004). For example, an individual of Hispanic origin could hail from Mexico, the Caribbean, or any South or Central American country (Frisbie, Cho & Hummer, 2001); while a person coming from countries such as Korea, India, Vietnam, Philippines, China, and Japan could identify as an Asian (Gomez et al., 2004). The cultural differences noted within and between these
countries vary greatly, thus presenting healthcare professionals with new challenges as a result of the expansion in cultural diversity.

The problem arises particularly when each of these cultural, constituencies uniquely explain illness and health differently (Jasso et al., 2004; Salimbene, 1999). These intercultural interactions are said to be accelerating at a very fast rate and making it harder for healthcare practitioners to offer culturally suitable health promotion and care (Kramer, Ivy & Ying, 1999). These intercultural interactions are also occurring at great frequency in the U.S. attributable to the improvements found in transportation, communication, and immigration (Jasso et al., 2004).

Additional significant factors exerting influences on these intercultural dynamics include economic need, rapid shifts in technology, and political upheaval (WHO Report, 2003). Thus, U.S. changing demographics has affected the practice of healthcare by healthcare professionals. These demographic changes present healthcare professionals today with a greater burden, working with families and individuals coming from different cultural environments (Flynn & Aiken, 2001; Kramer, Ivey, & Ying, 1999). Therefore, healthcare professionals must be educated to have an understanding of the ethical obligation that professionals have toward their discipline and society as a whole.

Obligation of the Healthcare Profession to Society

Most health professions including health educators, physicians, dietitians, nurses, surgeons, occupational therapists, and pharmacists recognize and understand the influence of elements such as environment, economy, society and culture in providing effective care. These healthcare professions including American Occupational Therapy
Association (2000); American Nurses' Association (1995); Coalition of National Health Education Organizations (2000); College of Physicians & Surgeons (2002); Evans (2006), therefore, have enshrined those elements in their codes of ethics.

Healthcare professional students must receive didactic instructions that will help them to develop cultural sensitivity, which includes classroom discussions and assigned readings. They may gain clinical experiences from assignments that require them to care for individuals coming from other cultures (Carrillo, Green, & Betancourt, 1999; Sommer, 2001). In some cases, healthcare professional students gain cultural sensitivity through assigned internet contact (Thomas, Walpin & Tuella, 2001), or clinical experiences by working with clients, team workers, or student peers who come from other cultures and countries. Other healthcare professionals could gain international experience in a healthcare setting (Azad, Power, Dollin & Chery, 2002), which will be discussed in detail in Chapter 2.

Cultural sensitivity hence has currently become an urgent obligation for healthcare professions. Professional healthcare students must experience cultural sensitivity as part of their professional training. Cultural insensitivity on the part of healthcare professionals would have a damaging impact on relationships between caregivers and receivers, as well as the relationship between healthcare professionals, especially when they come from diverse cultures in their collaborative efforts needed for effective care (Carrilo, Green & Betancourt, 1999; Lester, 1998a, 1998b; United States Department of Health & Human Services, 2001).
The U.S. healthcare system has an obligation to cater to the health needs of migrant populations living in the country. The health needs of these newcomers must be met in order for them to have healthy and meaningful lives in their respective host nations (WHO, 2003). This goal can be achieved by raising the cultural sensitivity of health care professionals. Every individual experiences culture differently. Quickfall (2004) asserts that culture exerts great influence on lifestyles and behaviors. Thus, an individual’s affective perception about his or her culture has great influence on his or her lifestyle and behavior. Hence lifestyle differences observed among individuals. An understanding of cultural determinants of health would enable healthcare professionals to comprehend significantly the epidemiology of health and disease states (Corin, 1995). Providing the best form of education and care to clients requires expanding the views of healthcare professionals on cultural sensitivity.

By learning to recognize the interrelationship between health behavior and cultural beliefs, healthcare professionals will be more capable of providing and promoting optimal care. Increasing exposure of healthcare professionals to persons coming from different countries and cultural backgrounds is important. This will compel them to take into account the impact of factors such as the environment, social norms, perceptions regarding health, disease, and culture on behavior and self-efficacy of their clients (Kramer et al., 1999; Yehieli & Gray, 2005).

Culturally Sensitive Healthcare Professional Students

Healthcare professional students are required to gain varied clinical and classroom experiences, a qualification needed to work with clients from the ever-growing diverse
cultural origins (Kramer et al., 1999). Effective health promotions would be better achieved through such caliber of healthcare professionals who have been taught to be culturally sensitive. However, the problem remains whether healthcare professionals are receiving sufficient and affective experiences and motivation to make them culturally sensitive enough to impact their self-efficacy.

Research on methodology regarding the different ways of preparing culturally sensitive healthcare professionals is scant, besides the reality that U.S. demographic changes have altered the practice of healthcare in many respects (Brennan & Schulze, 2004; Kramer et al., 1999). Geiger (2001) posits that what is missing is “evaluation, namely, measures not merely of changes in knowledge and attitudes but also of changes in outcome. We do not yet know ‘what really works’” (p.1700). Consensus does not exist yet to determine the best method among other educational methods for developing cultural sensitivity in healthcare professional students.

International health missions fulfill one means by which cultural awareness could be raised among healthcare professionals (Brennan & Schulze, 2004). There is, however, a paucity of published research, particularly concerning the impact of an International Healthcare Mission (IHM) on participating healthcare professional students. IHM provides opportunities for healthcare professionals going from the developed countries to offer services voluntarily to developing nations including dental, surgical, medical, nursing, health promotion, education, and pharmacotherapy (Gray, Murdock & Stebbins, 2002).
The Purpose of the Study

The purpose of this study was to investigate the impact of an International Healthcare Mission (IHM) experience on the perceived growth of healthcare professional students. This research examined both the professional and personal benefits of an IHM experience on participating professional healthcare/Global Health Corps students at the University of Northern Iowa (UNI). Particular areas of interest included (a) cultural knowledge, (b) cultural sensitivity, (c) self-confidence, and (d) social relationships.

Research Questions

1. To what extent do participants in an international healthcare mission (IHM) improve their cultural knowledge?

2. To what extent do student healthcare professionals who participate in an IHM feel that they are more culturally sensitive to the health beliefs and behaviors of diverse clients?

3. To what extent does an IHM experience enhance the self-confidence of participants in regard to their professional practice?

4. To what extent does an IHM experience affect the social relationships between students and their colleagues, students and their instructors and students and their clients?

Theoretical Framework

The study employed one model and one theory in framing questions. These were obtained from Gallagher (2004), Wilson’s (1993) Impact of an International Experience Model (IEM), and Bandura’s (1986) Theory of Self-Efficacy. Wilson’s (1993, p.16)
model of The Impact of an International Experience was the underlying framework for this research. Two areas of development concerning an individual’s growth due to an international experience are emphasized in this model with each of them having two subdivisions. The first area labeled Developing Self and Relationships, emphasizes a person’s growth in aspects such as “interpersonal” and “personal” growth (Wilson, 1993). Gaining Global Perspective is the second area in which the learner develops in two dimensions, Substantive Knowledge and Perceptual Understanding. Chapter 2 discusses the details of this model.

Bandura’s (1977) Theory of Self-Efficacy as well as his Social Cognitive Theory (1986) perceive “self-efficacy” as a significant construct that plays a major role in the link between culture and health (Bandura, 1996). The concept of self-efficacy was introduced by Bandura in 1977 and modified in 1986 (Bandura, 1986). This concept was developed from a social learning and behavioral standpoint (Stajkovic & Luthans, 1998). It is a component for understanding an individual’s direction of intention, behavior, and strength (Bandura, 1994). Social cognitive theory however, acknowledges the reciprocal interplay that exists between the environment and people (Bandura, 1997). Hence, self-efficacy beliefs are formed through self-reflection, thinking, and behavior.

Self-reflection is considered a significant aspect of the human component of the triad, which comprises the personal, behavioral, and environmental. These factors help in the construction of reality by an individual (Pajares, 2002). Each of these components of the triad of “reciprocal determinism” is influenced by culture, which affects self-efficacy, also affecting action and individual health behavior. Likewise, the personal
career development of an individual is also affected by engaging in self-reflection about one’s professional behavior, role and effectiveness (Bandura, 1986). Bandura, however, propounded the concept of “reciprocal determinism” in social cognitive theory in 1977.

This theory is said to bring harmony in the interactions among the triad factors (Bandura, 1994). Literature explains four main sources of human self-efficacy: mastery experiences, vicarious experiences, social persuasion, and psychological and emotional states (Bandura, 1994). Self-efficacy development is influenced by four additional factors including motivational, affective, cognitive, and selection processes (Bandura, 1996). Discussions on the components that affect self-efficacy are discussed later in Chapter 2.

**Significance of the Study**

Findings from this study will supply knowledge about IHM experiences to advance the cultural knowledge among healthcare professional students. This knowledge will enable these students to recognize and understand the influence of elements such as environment, economic, social and culture in providing effective care (Evans, 2006). Cultivating cultural-sensitivity among healthcare professional students is an important objective for healthcare professions. Providing the best form of education and care requires healthcare professionals to broaden their visions on cultural sensitivity. Findings from this study will supply knowledge regarding experiences gained from IHM, useful for expanding on the cultural sensitivity of healthcare professional students (Gallagher, 2004).

Developing self-confidence among health care professional students is an important objective of healthcare professions. Healthcare professional students must receive
affective experiences and motivation to make them culturally sensitive enough to impact their self-efficacy or self-confidence. This will help them in practice to promote health effectively. Findings from this study will provide data regarding experiences gained from IHM that could assist healthcare professionals to improve their confidence. Developing social relationships and connectivity among healthcare professional students is central to the healthcare profession.

The U.S. population continues to increase in cultural diversity. Healthcare professions understand and recognize the need to improve the social relationships among their professionals to enhance collaborative efforts needed for effective care. Findings from this study will assist both instructors and students alike to achieve this objective. Attaining this goal requires healthcare professional students to receive training on the value of relationships that should exist between students and their colleagues, instructors, and clients from diverse cultural backgrounds and origins (Kramer et al., 1999). Additionally, information obtained from this study will assist other healthcare institutions, seeking ways to increase cultural sensitivity among their professional students in varied ways.

Limitations of the Study

The limitations of the study were as follows:

1. A student’s report regarding perceived changes due to IHM experience may be influenced by what they perceived to be socially acceptable.

2. A reader’s bias could exert influence on the student’s report concerning the impact of their IHM experience to be either over- or under-estimated.
3. A student’s perception may be influenced by the type of experience(s) they had on their IHM.

4. A student’s educational focus within the healthcare discipline could bias their perception toward their IHM experience.

5. The student’s perception about their IHM experience might be influenced by a maturation effect. For example, their experiences over the distance to and from the IHM location, and the student’s current level of study within their healthcare educational program, could impact their responses to the survey-questionnaires.

6. The potential for multiple-treatment interference may exist for interviewed participants. The interviewee’s responses to the survey-questionnaires thus may influence their responses to interview questions, because of their current reflection and recall of their IHM experiences.

Definition of Terms

Cultural Sensitivity Self-Efficacy—Cultural sensitivity self-efficacy refers to “an individual’s perceptions regarding their abilities, enabling them to respond to people from other cultural backgrounds in a manner that is respectful and gives consideration to differing cultural beliefs.” (Gallagher, 2004, p.18)

Global Health Corps—The Global Health Corps at UNI is a specific example of a preparatory program for healthcare professional students. The unit was established in 1996, with the goal to enhance the professional preparation of post-secondary students in the area of cross-cultural community health, through the offering of field-based programs (Global Health Corps, 2001).
Healthcare Professional Student—Healthcare professional student is synonymous to professional healthcare student, a term used interchangeably throughout this study. A healthcare professional student is, therefore, described as a person who is enrolled in an educational program to be prepared for a professional career in any healthcare discipline. These include (a) pharmacist, (b) registered nurse, (c) dentist, (d) both undergraduate and graduate health educator, (e) both undergraduate and graduate health promotion, (f) physician, (g) occupational therapist, (h) physical therapist, (i) dietitian, and (j) physician assistant (Gray, Murdock & Stebbins, 2002).

International Healthcare Mission (IHM)—International health mission includes missions that provide opportunities for healthcare professionals going from the developed countries to offer services voluntarily to people of the developing nations. There are short and long-term missions. Short-term missions could last as long as one week to a month, while long-term missions could last several months. These missions may include dental, surgical, medical, nursing, health promotion, education, and pharmacotherapy (Gray, Murdock & Stebbins, 2002).

Interpersonal Connections (Social Relationships)—Social relationships in this present study are defined as the “continuation and maturation of relationship or communication with persons from a different culture or nation” and is one of the four components of Wilson’s ISEM (Gallagher, 2004, p.19).

Perceptual Understanding (Cultural Sensitivity)—Cultural Sensitivity in this present study is defined as “the integration of facts and broadened perspectives that develop
critical thinking skills” (Gallagher, 2004, p.20). Perceptual understanding is equal to cultural sensitivity and also one of the four components of Wilson’s IIEM.

Personal Growth (Self-Confidence)—Self-Confidence in this present study is defined “as the perceived change within an individual which results in increased self-confidence, a changed personal attitude, or outlook on life, and/or a greater appreciation for personal resources.” It is also one of Wilson’s four components of IIEM (Gallagher, 2004, p.20).

Professional Self-Efficacy—Professional self-efficacy is defined as a person’s perceived capabilities that enable him/her to perform health-discipline tasks and responsibilities in an effective manner (Gallagher, 2004).

Substantive Knowledge (Cultural Knowledge)—Cultural knowledge is referred to as “factual information that adds to an individual’s intellectual development,” which is also one of Wilson’s four components of IIEM (Gallagher, 2004).
CHAPTER 2

LITERATURE REVIEW

The purpose of this study was to investigate the impact of an International Healthcare Mission (IHM) experience on the perceived growth of healthcare professional students. This research will assess both the professional and personal benefits of an IHM experience, on participating professional healthcare/Global Health Corps students at the University of Northern Iowa. Particular areas of interest include: (a) Cultural Knowledge, (b) Cultural Sensitivity, (c) Self-Confidence, and (d) Social Relationships. Progress towards equality in healthcare services and delivery is a much desired goal in healthcare. The United States Department of Health and Human Service (USDHHS; 2002b) believes that if culturally sensitive healthcare personnel are able to (a) provide care for individuals coming from different cultures, (b) empower persons with necessary health information, (c) improve access to health services, and (d) promote safety, it is possible that progress towards equality in health will be achieved.

Culture however, in no small measure has been reported to wield a great deal of influence on individual’s help-seeking behaviors, b) their attitudes toward healthcare providers, and (c) their reception of health information (Denboba, Bragdon, Epstein, Garthright, & Goldman, 1998). Therefore, it is essential that professional healthcare students learn about cultures other than their own. It is obligatory also for healthcare professionals to be prepared to acknowledge and become sensitive to cultural factors that influence as well as hinder a client’s self-efficacy, for example in issues regarding communication. This will enhance further reduction or elimination of health disparities
found among special populations in the U.S. This chapter will examine current and relevant literature supporting the rationale for this proposed study. Thus, the review of related literature focused on these following areas: (a) existing disparities in healthcare for diverse cultural populations in the United States, (b) preparation of healthcare professionals to serve culturally diverse populations in the United States, (c) the impact of international service learning experiences in the preparation of healthcare professionals, and finally (d) literature on the role of self-efficacy in preparing healthcare professionals to serve culturally diverse populations in the United States.

Existing Disparities in Healthcare for Diverse Cultural Populations

In the United States

Decreasing health disparities among vulnerable groups in the U.S is of paramount concern to most healthcare professions. Healthy People 2010, a national health promotion and disease prevention initiative, challenges communities, individuals and professionals to take specific steps to ensure the enjoyment of good health and longevity for all, as put forth by and supported by the United States Department of Health and Human Services (USDHHS, 2002b). This is an objective that the U.S. has to achieve over the first decade in the 21st century.

Health Disparities Defined

The goal-setters and planners for Healthy People 2010 agreed on the notion of decreasing health disparities among vulnerable groups in the U.S (USDHHS, 2002a). These groups consist of low-income earners, individuals with disabilities and some category of racial and ethnic minorities. These special populations have been observed to
experience disease, disabilities and deaths far beyond average (Schlesinger, 2006; National Cancer Institute [NCI], 2003; Texas Department of Health [TDH], 2003). TDH (2003) looked at health disparities in two ways. They first defined health disparities as the “differences in incidences, prevalence, mortality, and burden of diseases that exist among variously defined populations” (p.1). Such outcomes specifically include (a) differences in survival following medical conditions such as cancer, or (b) differences in the incidence of medical conditions such as diabetes.

These disparities actually are said to be a disproportionate disease burden observed within certain ethnic minority groups and races. The second description of health disparities focused on the differences in mortality and morbidity observed among certain groups who are defined in terms of age, gender and geographic location. Factors attributable to health disparities include genetic susceptibility, risk behaviors, socioeconomic factors, cultural mores and attitudes toward prevention (TDH, 2003).

Notable disparities observed in the priority health outcomes were found to be related to healthcare access. TDH (2003) asserts that “improved access to primary healthcare services could promote good health, reduce morbidity, and decrease complications from chronic disease” (p.2). TDH (2003) found that existing disparities among Texans were mainly linked with ‘access to health care,’ which consequently affected their general health and wellbeing. For example, TDH (2003) found the following disparities among various Texan populations:

1. The rate of uninsured for all Texans is 24%, for non-Hispanic whites 16%, for African-Americans 28% and for Hispanics 38%.
2. Almost half the rural residents in Texas have low incomes compared with 36% for urban dwellers.

3. Access to healthcare is a significant issue in border counties where 65% of residents are considered low-income.

4. Twenty-four counties in Texas (9%) have no primary care physicians, 138 counties (54%) have no pediatricians and 158 counties (62%) have no obstetricians/gynecologists (TDH, 2003, p.2).

This study, therefore, called upon planners, public health professionals and legislators to address the issue of “access barriers that impede equitable health care delivery” among various populations.

Disparities Regarding Priority Health-Related Outcomes

Marked disparities also were observed to exist among people in terms of race, ethnicity and geographic origin regarding priority health-related outcomes. For example, in Texas, African-Americans have been found to have much higher incidence rates of cancer than other groups, especially for cervical cancer and colorectal prostate (NCI, 2003; TDH, 2003). These cancers supposedly could be prevented through preventive screenings. NCI (2003) also reported on the lower survival rate among African-American patients with early-stage, non-small-cell lung cancer compared to white patients. The reason attributable to this was largely due to the lower rate of surgical treatment among African-Americans. The study made use of a sample of patients who were 65 years of age and over, comprising 10,124 non-Hispanic whites and 860 African-Americans. Findings from the study indicated that:
1. The rate of surgery was 12.7 percentage points lower for African-American patients than for White patients (64.0 percent versus 76.7).

2. The five-year survival rate was also lower for African-Americans (26.4 versus 34.1 percent).

3. For patients who had surgery, survival rates were similar for the two racial groups.

4. For patients who did not have surgery, survival rates were also similar (NCI, 2003 p.4).

In addition, lung cancer rates were noted to be higher among African-American males than the prevalent rates among both Hispanic groups and non-Hispanic whites (TDH, 2003). African-American females also experienced higher mortality from breast cancer than all other minority groups. The study, however, found they experienced a lower incidence from this disease. Major disparities in early diagnosis, treatment and possible access to care were noted in the study.

TDH found African-Americans in the state of Texas to have experienced the highest mortality rates of heart disease, stroke and diabetes than any other group. HIV/AIDS rates were also notably higher among African-Americas, which reached epidemic levels among the males before 2003 (63 AIDS cases per 100,000; TDH, 2003). Infant health and birth outcomes were also found to be poorest for African-Americans, who had twice the number of infant mortality rates compared to non-Hispanic whites, as well as higher proportion (13%) of low birth-weight babies (Center for Disease Control [CDC], 1999; TDH, 2003).
Hispanics, on the other hand, with the exception of cervical cancer had lower rates of cancer compared with non-Hispanic whites (TDH, 2003). Hispanic females experienced twice the rates of cervical cancer fatality than non-Hispanic whites. Hispanics also experienced significant problems of neural-tube defects especially among those who lived along the Texas-Mexico border. The study again observed that tuberculosis rates were higher for Hispanics and African-Americans compared to other groups in the state of Texas. Hispanic-Texans were found to suffer disproportionately from diabetes mortality, while paradoxically, suffering lower heart disease and cardiovascular mortality than do African-Americans and non-Hispanic whites. Compared to the national average, the study again found that immunization levels were low for the whole Texas population (TDH, 2003). TDH (2003) concluded that to eliminate health disparities in Texas will require commitment from appropriate health authorities, who will identify and address the underlying causes of higher levels of disease in ethnic and racial minority communities.

Healthy People 2000 Goals toward Reduction of Health Disparities

The USDHHS (1992) stated objectives were written specifically to assist in the reduction of identified health disparities among diverse populations. Healthy People 2000 also formulated one of its goals to focus especially on reducing these health disparities found among the special populations (USDHHS, 1992). These following results were obtained by the midcourse review of the Healthy People 2000 objectives. USDHHS (2002a) observed that the Healthy People 2000 made 50% of its goal toward achievement
of its objectives, indicating that 8% of their objectives had reached or surpassed the limits set for the year 2000.

The results also indicated that some progress had been made toward their targets in connection with another 40 percent of their objectives, 18% of data collected indicated a shift away from the targets, mixed results were obtained for 5% of their objectives, while a “no change” result was obtained for 3% of their objectives. Progress made toward over a quarter of the objectives, were not measured for the lack of baseline data. However, the priority areas that showed most progress toward meeting the objectives were stroke, cancer, heart disease and unintentional injuries with more than 65 percent of the objectives in those areas showing progress. USDHHS (2002b) results for this mid-course review indicated a partial achievement toward the Healthy People 2000 goals, aimed at providing health services for these special populations.

Preparation of Healthcare Professionals to Serve Culturally Diverse Populations

In the United States

The influence of societal structure and politics on culture is well noted by USDHHS (2002b). Concepts of culture may include the country of origin, gender, race, age, religion, socioeconomic class and ethnicity (Journal of American College Health [JACH], 2003). Thus, an individual’s health- behavior and health may be impacted by all cultural components (Culley, 1996). Cultural influences could be classified as follows: (a) perceptions of health, illness and disability, (b) attitudes towards healthcare providers and facilities, (c) attitudes toward communication of health information, (d) attitude of help seeking behaviors, (e) preferences for traditional versus non-traditional approaches to
health, and (f) perceptions regarding the role of family in healthcare (Denboba et al., 1998, S-47). Healthcare professionals are therefore required to have an understanding regarding the influence of culture on both health and health behavior, for the optimal delivery of health promotion, care and education.

**Cultural Influences on Healthcare Delivery**

Appreciating the influence that culture has on health and health behavior should compel healthcare professionals to provide health education, promotion and care in an atmosphere of respect, while recognizing the unique practices of minorities, immigrants and persons who come from varied cultures (USDHHS, 2001; Yehieli & Grey, 2005). Liburd, Giles and Mensah (2006) conducted a study with the goal of identifying situations in which socio-cultural factors were not incorporated into the U.S. health care delivery system and how that lead to poorer quality care, specifying the points for intervention as follows:

1. To explore at what level in the process of obtaining care these barriers occurred (health systems level, clinical encounter level, and so on).
2. Identify cultural competence interventions that address these specifically identified socio-cultural barriers (Liburd, Giles, & Mensah, 2006, p.4).
3. Link these interventions to a framework that can be applied to the elimination of racial or ethnic disparities in health and healthcare.

A multilevel analysis of socio-cultural barriers to healthcare identified one major level of healthcare at which a barrier occurs which contributed to racial or ethnic disparity in health and healthcare. For example, an organizational barrier was identified
among other socio-cultural barriers. The authors alleged that healthcare systems and structural processes of care are shaped by the leadership who has the responsibility to design them, as well as the workforce that have to implement them. This constituted one crucial factor identified in the study, which was found to infringe on the acceptability and availability of healthcare provided for minority and racial ethnic group members. This factor was described as the extent to which the U.S. healthcare leadership and workforce reflect the racial/ethnic composition of the general population. Liburd, Giles, and Mensah (2006) assert that though these results may not offer perfect distinction of issues, they could, however, form part of a framework for comprehending the important and complex issue of cultural competence in healthcare.

The authors employed a series of anecdotal evidence to gather data, which indicated the lack of diversity in leadership and workforce in healthcare. Findings from the study also showed that Native Americans, African-Americans, and Latinos make up only 3% of the medical school faculty, fewer than 16% of public health school faculty and only 17% of all city and country health officers, even though minorities comprise 28% of the U.S. population (Liburd et al., 2006). In addition, non-white minority populations represented less that 2% of individuals with senior leadership roles in health care management.

The study results suggested that racial/ethnic diversity in the healthcare workforce has been found to correlate well with the delivery of quality care to a diverse group of people in the U.S. For example, cultural sensitivity has been observed to impact client-provider relationships. Liburd, Giles, and Mensah (2006) and Minnesota Department of Human Service (2004) suggest that when the client-provider's relationship is based on
cultural sensitivity and respect, complying with the recommendation of a healthcare professional for the purpose of improving, maintaining and restoring health to patients from diverse cultural origins, is positively impacted. In contrast, non-adherence to health recommendations could result in poor health and also increase disparity in health, particularly among minorities. Potential negative impact on U.S. immigrants could be a reduction in health self-efficacy, due to uncertainty in the use of the English language, anxiety and lack of prior experience or knowledge about the U.S. health system (Elder, Apodaca, Parra-Medina & Zingia de Nuncio, 1998).

**Coursework for Healthcare Professional Students**

Various clinical methods have been designed for the purpose of developing cultural sensitivity in healthcare professionals. Classroom discussions and assigned readings provide didactic instruction for health care professional students for the development of cultural sensitivity. Azad, Power, Dollin, and Cherry (2002) asserted that some professional healthcare students acquired cultural sensitivity by working with clients, team workers, or student peers who came from various cultures and countries around the world. Cultural sensitivity was also cultivated from other means such as experiences gained through assigned international internet contacts (Thomas et al., 2001).

Gaining experiences in an international health care setting constitute another avenue through which healthcare professionals can increase their cultural sensitivity (Eisenberg & Good, 1978). There is however, no consensus in literature indicating the most effective means for developing cultural sensitivity in healthcare professionals. Geiger (2001) posited that the link between what “is missing” and “is now” is evaluation, which cannot
be described just in terms of knowledge and attitudinal changes alone but also for outcome changes, since "what works" actually has not yet been proven.

However, relevant areas of learning for healthcare professional students have been delineated in literature (Bandura, 1994). Professional healthcare students are required to receive education consisting of experiences obtained from both experiential and didactic courses conducted in the lab, classroom and clinical environments (Bandura, 1996). For example, psychomotor learning domain allows the use of both technical and physical skills in the discipline of health care (Meeks & Heit, 2003).

It is important that healthcare professionals acquire the abilities needed for learning and performing that demand technical and physical skills required by the profession (Graber, Pierre & Charlton, 2003). For example, a medical student is expected to perform technical skills such as "arterial puncture" and "proper immunization technique," just as a health educator must be able to instruct a child on proper dental hygiene, bike safety and healthy eating by the use of games (Meeks & Heit, 2003). "Perceived effectiveness by students in this learning domain could impact the magnitude and strength of his or her self-efficacy beliefs as a healthcare professional" (Gallagher, 2004). Kramer et al. (1999) presumed that certain aspects of learning should be integrated into an educationally designed program, so as to qualify either as service or experiential learning. These include: (a) advanced didactic mission preparation, (b) written learning objectives for students, and (c) evaluation of the educational learning experiences of the healthcare mission. An individual's cognitive learning also can be enhanced through an effective
and meaningful experiential learning environment (Carrillo et al., 1999; Kramer, Ivey & Ying, 1999).

Proudman (1995) posited that education of this nature is emotionally fulfilling with the potential to influence individual student’s self-efficacy by means of vicarious and mastery experiences when it is employed as a method. Wallace (1993) defines experiential education as “a planned, effective, individual, and thoughtfully evaluated component of an educational program” (p.3). Experiential learning thus has become the medium through which many healthcare professional institutions offer students the necessary “hands-on” or practical application of discipline-specific knowledge and skills.

Professional healthcare student educators have, therefore, developed many cross-cultural and patient-based-curriculum in order to address issues on culture as well as its impact on health in curriculum (Carrillo et al., 1999). Experiential education in an international environmental setting is believed to supply participating students with rich cultural and specific learning experiences. But the usage of affective domain could also improve further on these international learning experiences for participants in a more effective way that involves self-reflection, while being influenced by both emotional and psychological states. An important means for developing service learning among healthcare professional students combines academic programs with IHMs.

Service Learning for Healthcare Professional Students at UNI

Service learning is a specific example of experiential learning (Anderson, 1998; Bringle & Hatcher, 2007). Bringle and Hatcher (2007) assert that to attain the goal of
service learning, a program must have a combination of structured opportunities and
service tasks, which can lead to self-discovery, self-reflection, as well as the
comprehension and acquisition of content knowledge, skills and values.

Albert (1996) maintained, however, that student learning occurs by means of
immersion in preparatory coursework, work setting and reflection, after experience had
been gained from an educationally designed service-learning program. Numerous
benefits can be derived from service-learning programs, which could serve as a good
source of reinforcement for discipline-specific classroom presentations, ethical
responsibilities and cultural issues.

The application of discipline-specific, cognitive and psychomotor learning, in a
multi-disciplinary and multi-cultural environment, for the purpose of enhancing effective
learning, can be promoted through experiential learning within the context of an
international environment (Albert, 1996). Another benefit of service-learning is the
creation of opportunities leading to mastery experiences that could influence the strength
and magnitude of self-efficacy of the professional healthcare student (Kramer et al.,
1999; Bandura, 1994).

International and Service Learning Opportunities

for Healthcare Students

Health programs are among the several curricula programs offered at UNI in Cedar
Falls, Iowa. These include preparatory health programs purposely designed for both
allied and healthcare professionals. Programs offered span the spectrum from the
Bachelor of Arts, to the Master of Arts. Some of these programs prepare professionals as
school teachers in community schools to address the health education needs of the state of Iowa. Others prepare professionals in health professions who work in hospitals, non-profit health agencies, government and public health departments, worksite health promotion programs, Young Women Christian Associations (YWCA), Young Men Christian Associations (YMCA) as well as commercially operated health clubs (UNI Office of Marketing & Public Relations, 2005). In addition to these programs, the Division of Health Education within the School of Health, Physical Education and Leisure Studies (HPELS) at UNI provides certificate courses in Global Health and Culturally Competent Health Care (UNI Office of Marketing & Public Relations, 2005).

The Global Health Corps at UNI is a specific example of a preparatory program for healthcare professional students. The unit was established in 1996 with the goal to enhance the professional preparation of post-secondary students, in the area of cross-cultural community health, through the offering of a field-based program (Global Health Corps, 2001). Success in the Global Health Corps requires students to undergo four levels of training. The first level demands students to take a specific amount of credit hour academic courses, working towards a concentration area and certificate. The second level provides a short-term mission practicum, while the third and fourth level training provide opportunities for both short and long-term domestic and international health missions.

Each IHM has its objectives and purposes designed by the faculty of the Global Health Corps, which exclude learning objectives for the healthcare professional student. Participating students receive three hours credit for attending a series of pre-departure
meetings to prepare them adequately for the mission, thus ensuring that maximum benefit is derived from both the service and experiential learning (Global Health Corps, 2001). Student participants in an IHM do not receive specific, advanced classroom preparation in connection with mission experiences. Their roles regarding IHM participation, however, are assigned by the director of the unit.

However, for an educationally designed program to qualify as either service or experiential learning, it requires the presence of certain components of learning. These include advanced didactic mission preparation, written learning objectives for students and evaluation of the educational learning experiences of the healthcare mission (Bringle & Hatcher, 1997). Most IHMs do not embody all the components enumerated above, which differentiates mission experiences from experiential and service learning experiences.

The point of interest or issue is that despite the fact that these missions are organized and supervised by faculty, there has not been much intensive study regarding the impact of these IHMs on a student’s perception and self-efficacy, besides debriefing and completion of an assignment upon their return (Global Health Corps, 2001). Little information, therefore, exists on this topic due to the absence of these components indicated above, coupled with the scantiness of research in this area of study.

The Impact of International Experiences in the Preparation of Healthcare Professionals Serving U.S. Culturally Diverse Populations

The impact of an international experience on numerous and different groups of people have been widely researched. Wilson (1993) conducted research for the purpose
of verifying the impact of an international experience on numerous and different groups of people including college and high school students, teachers and returning Peace Corps Volunteers. Wilson thus designed the Impact of International Experience Model (IIEM) to enable individuals to derive meaning out of their international experiences. Wilson’s (1993) study, which captures “The Meaning of International Experience for Schools,” written both in the form of an article and book contains components of this model (1982, 1985, 1986, 1993, 1994, 1998), demonstrating the meaning educators and students in education derived from these cross-cultural and international experiences. These documents also emphasized the worth and uses of such experiences in the setting of the classroom.

Relevance of cross-cultural experiential learning for teachers is noted. Wilson (1982) identified and suggested the following reasons for the need and justification of cross-cultural experiential learning for teachers based on these facts indicating that:

1. Teaching itself is a cross-cultural encounter.
3. Cross-culturally effective persons have the characteristics needed for effective teaching.
4. Cross-cultural experience leads to global perspectives necessary for global education to happen in schools. (p.186)

The author claimed that these same cross-cultural reasons, especially international experiences, must also apply to healthcare professional students since they are required to offer suitable and effective healthcare and promotion. This present research on IHM, therefore, placed particular emphasis on the meaning of an international experience to professional healthcare students in regards to their professional and personal lives.
There are two categories of Wilson’s IIEEM, each of which consists of two subdivisions. The first category, Gaining Global Perspectives has two subdivisions: Substantive Knowledge and Perceptual Understanding. The second, Developing Self and Relationships, also has two subdivisions: Personal Growth and Interpersonal Connections. A diagram of Wilson’s IIEEM model, which provided a framework for this study, is shown in Figure 1 adapted from Gallagher (2004).

*Figure 1.* Wilson Impact of an International Experience Model (Adapted from Gallagher, 2004).
Gaining a Global Perspective

Gaining a Global Perspective is the first category of Wilson's IIEM. It has two subdivisions: Substantive Knowledge and Perceptual Understanding.

Substantive Knowledge. Substantive Knowledge referred to as Cultural Knowledge in this present study, comprises one of the two areas under Global Perspective. It is defined as additional factual information an individual adds onto his or her intellectual development (Wilson, 1993). Wilson indicated that this form of learning for healthcare professional students can occur while embarking on an international experience/mission. For example learning in the specific or substantive / cultural knowledge area could include: (a) gaining knowledge about the culture, (b) encountering health beliefs system in other nations, (c) learning about diseases not common in the U.S., and/or medical terminology in a new language. Wilson (1993) believes that this type of learning is indeed relevant for healthcare professional students because it offers new opportunities and practical application for health education, didactic teaching, technical skills, and theory. Likewise, Substantive Knowledge, obtained from an international experience can improve their effectiveness as health professionals, educators and care givers.

Perceptual Understanding. Perceptual Understanding (Cultural Sensitivity) is the second component of the Global Perspective. It is defined as the integration of facts and broadened perspectives that could assist in the development of critical thinking skills (Wilson, 1993). Perceptual Understanding development enables individuals to be more open-minded, reduce stereotyping and to see others as individuals. It is therefore crucial
to develop perceptual understanding in healthcare professional students, through an IHM experience.

The advantages of increased cultural sensitivity are a broader understanding regarding the impact of a client’s environment, beliefs and control over behavior on the person’s health. Kramer, Ivy and Ying (1999) stressed that this form of learning could improve the healthcare professional student’s ability to individualize healthcare and eventually expand on their health promotion skills. This form of understanding may be beneficial to healthcare professional students by helping to raise their ability to engage in a broader, more in-depth analysis of a problem. Support and consistency exist in research for the perceptual understanding component of Wilson’s model regarding nursing students, who had international exposures and experience (Frisch, 1990; Haloburdo & Thompson, 1998; Zorn, Ponick, & Peck, 1995).

**Development of Self and Relationships**

Development of Self and Relationships is the second category of Wilson’s IHEM. It has two subdivisions: Personal Growth (Self-Confidence) and Interpersonal Connections (Social Relationships).

**Personal Growth.** Individuals are said to confront selves and personal beliefs as they gain global perspectives. Wilson (1993) therefore acknowledged some overlap in the Substantive Knowledge in the Personal Growth component. Besides verification of personal values, other areas of personal growth may include changed personal attitudes or outlooks on life, greater appreciation of resources, and self-confidence. Nonetheless,
much of the growth and change that occur in personal development could overlap as well as facilitate interpersonal relationships (Lester, 1998b).

**Interpersonal Connection.** Interpersonal Connection is the second component of Development of Self and Relationships, which can be referred to as, “the continuation and maturation of a relationship or communication, with persons from another culture or country” (Gallagher, 2004, p.43). This component requires improvement in the ability to make interpersonal connections through increased respect, flexibility, and sensitivity for other people, while being warm and open to cultural differences. Wilson (1993) also noted an overlap in the classifications of this model, meaning that interpersonal connections will demand perceptual understanding about global perspectives. Cultural knowledge and sensitivity, therefore, have been found to be central to the education of healthcare professionals (Loudon, Anderson, Gill, & Greenfield, 1999).

**International Experiential Learning for Healthcare Professional Students**

Thus, educators in the healthcare professions including nursing, pharmacy, and medicine have documented the current need and growing importance of promoting learning experiences that could enhance cultural knowledge and sensitivity in healthcare professionals (Baker, 1997; Berger, 1998; Langston, 2001, Machado, 2001). Loudon et al. (1999) therefore, conducted a meta-analysis of available literature on medical school courses that incorporated cultural diversity and concluded there was limited availability of information. They recommended that multicultural programs be included in the core curriculum for medical students. These authors indicated that the recommendation
appeared to be widely accepted, but the best means to provide optimal cultural learning experiences for healthcare professionals still remains unresolved (Denboba et al., 1998; Geiger, 1996).

In the literature, international experiential learning for students in education and nursing, however, have been found to dominate most published articles related to this study with no discourse on the impact of IHM experience on student participants. Nevertheless, consensus exists among researchers indicating the worth of international experience for participants, irrespective of the student’s discipline as revealed by research described in the following sections.

Impact of International Experiences on Education Students

Research supports the importance of multicultural education for elementary education students. A search for literature produced a study that examined international experiences of students in education. The study conducted by Willard-Holt (2001) assessed the impact of week-long teaching experiences on 22 elementary education student teachers in a bilingual school in Mexico. Triangulated methodology was employed in this research to analyze data from students, journals, field notes, informal interviews and researcher observations. Additional qualitative data was obtained from a ten-item, open response questionnaire administered before and four months after the Mexican experience noted.

Willard-Holt (2001) conducted a one-year post trip interview among participants to assess the long-term impact of the Mexican experience on participating students and found several positive impacts. The study results indicated that the participating
elementary education students recognized the importance of a multicultural education. They specifically realized the importance of accepting, preserving and encouraging, social and cultural differences among students in their own classrooms. These student participants further admitted recognizing broader perspectives due to their international experience. Participants also acknowledged having developed more tolerance for other people thus boosting their self-confidence.

The students vowed on their return to the U.S. to share their new points of view with their own students. Their future teaching characteristics may have altered as the participants perceived that they were better prepared to work with their own students, who come from other cultures and countries. The participants also developed increased sensitivity to the special needs of others, particularly regarding the need to promote understanding with minority students through clear communication.

The students who participated in the Mexican experience reported they felt a sense of maturity in many ways including personal flexibility, patience and professionalism. The participants in the Willard-Holt (2001) study also observed the occurrence of positive personal changes in other areas. The participants in deed, realized an enhanced appreciation for U.S. resources and noted the pervasive ingratitude shown by most U.S. citizens for the many assets they have in their own country.

The students reported two possible personal negative changes. One was in regard to being over-confident by one participating student, and the other was not being able to identify possible classroom situations to apply the Mexican experience to. On the whole, however, this research supported all four of Wilson's HEM components (Willard & Holt,
The author concluded that most of the students who participated in the Mexican experience had integrated the content learnt into their future assigned-teaching, thus giving credence to the participant’s substantive growth in another culture.

Participating students again demonstrated growth in perceptual knowledge, making it possible for them to dispel stereotypical perceptions about another culture or country and actually making use of this knowledge. Improved skills in tolerance, empathy, patience and flexibility, the third component of Wilson’s IIEM, confirmed the student’s personal growth. Willard and Holt (2001) emphasized that Wilson’s fourth component on Interpersonal Connections was supported by those U.S. participating students, who continued to communicate with their Mexican students over time.

Impact of International Experiences on Nursing Students

Relevance of multicultural education to nursing students abounds in literature. Information about international experiences for nursing students was obtained from nine published articles. These articles described international experiences that were components of nursing courses across nine different locations in both the developed and developing countries (Duffy, Harju, Huittinen, & Trayner, 1999; Frisch, 1990). Developed countries included Northern Ireland, England and Finland, while those of the developing countries included Barbados, Jamaica, Nicaragua, Mexico, Ghana and the Dominican Republic. Out of the nine participating schools cited, only two offered international exchange programs. Only one site provided varied levels of clinical experiences for student engagement while working with patients. Participating students for the remaining sites either had observational experiences or worked in the clinics,
hospitals or community settings with local/home faculty supervision (Duffy et al., 1999; Frisch, 1990).

Several researchers employed a variety of methodologies to determine the impact of international experiences on participating nursing students. For example, quantitative measures, such as Epistemological Reflection Measurement (MER) for exploring cognitive development were utilized by some researchers (Frisch, 1990; Zorn et al., 1995). Hadwiger and Hadwiger (1999); Rosenkoetter, Reynolds, Cummings, and Zakutney (1993), and Bond and Jones (1994) examined a student’s perception through course evaluations, written reflections and follow-up surveys. Four authors of research studies utilized qualitative methods including grounded theory to examine the impact of an international experience on participating students (Haloburdo & Thompson, 1998), interviews (Kollar & Ailinger, 2002) and phenomenological methods (Holstege, 2000; Pross, 2000). Lastly, St. Clair and McKenry (1999) employed mixed methodology that utilized the Cultural Self-Efficacy Scale (CSES) and the combination of student’s journals, field notes, and participant’s observation to explore the impact of international experience on students. The researchers noted that in general and regardless of the methodology employed, the findings obtained from these studies, which are described below, were almost the same. The Measurement of Epistemological Reflection (MER) was utilized in two separate studies to measure changes that occurred in the cognitive development of student participants compared to non-participants, in an international experience, in the same nursing program.
Frisch (1990) employed the MER to examine twenty-three senior nursing students. These participants responded twice to this survey in the same semester. The initial response happened in the second week, while the second response took place in the 15th week. Six of these student respondents traveled to Mexico for an international experience program sometime during that same period. Findings from this study indicated that the students who had the Mexican experience, showed significant cognitive development 3.5 times more likely than their non-participating counterparts.

Another researcher, Zorn et al., (1995) utilized similar sampling and methodology to that of Frisch (1990). The sample for this study consisted of eight out of a class of ninety-five senior nursing students, who had participated in an international experience program abroad, in England. Similarly, just like Frisch’s (1990) these eight students together with twenty classmates, randomly selected, had to complete the MER twice in the same semester. The study findings showed that those students who had participated in the international program as measured by the MER, were 3.125 times more likely to realize cognitive development than their non-participating mates. The author noted with interest the differences that existed in cognitive development between the participants with international experience and those without. The researchers further indicated that this finding actually supported the substantive (cultural) knowledge component of Wilson’s model, while reflecting the potential influence of mastery experience on student’s self-efficacy. Frisch (1990) remarked that these quantitative studies however, failed to reflect student’s feelings or thoughts explaining “why” and “how” the results came about.
Researchers, such as Bond and Jones (1994), Hadwiger and Hadwiger (1999), and Rosenkoetter et al. (1993) studied the impact of an international experience on course participants by means of course evaluations, student's reflections and follow-up surveys. In all, nineteen students participated in the research comprising ten first year and nine second-year undergraduates enrolled in a nursing program. All the participants received advance information on Mexican culture, Mexican-Americans in the U.S., cultural variables and assigned readings during the first two weeks of the course. Students individually selected a course project as they identified an area of interest. Weeks three and four were used for the cultural immersion component of the course in Mexico.

Activities for the two-week immersion period included tours of the Mexican hospitals without the provision of any hands-on care. This omission happened because the course faculty strongly believed that students should focus on learning the Mexican culture and not responsibility for nursing care. Activities for the final week consisted of student presentations and course evaluations. The evaluations conducted upon the completion of the course were repeated after one year. Evaluation results indicated overall positive experiences by students, since they had gained empathy and respect for others. Wilson's IIEIM, Aspects of Personal Growth and Interpersonal Connections were also supported by student's reflections, enhanced insights into personal beliefs and values, learning about self and appreciating things that are more essential.

A course designed for program participants to achieve trans-cultural experience in the Philippines was described by Hadwiger and Hadwiger (1999). The sample for this study included eight senior nursing students from the mid-western section of the U.S.
who participated in a study abroad program in the Philippines. Student experiences within the four weeks included acute and critical care rotations, home visits, clinical work, and community health experiences in a leprosarium. On their return to the U.S. the student participants reported substantial growth in their acceptance of people from other cultures, feeling associated with being foreign and in the minority, appreciation of necessities, and the benefit of learning about culture from a-hands-on-experience. These findings are consistent with Wilson’s components of Perceptual Understanding, Personal Growth, and Interpersonal Connections. The value of the Philippine trip served as mastery experience that could impact participating student’s cultural self-efficacy.

A collaborative academic project between universities in Northern Carolina and Barbados focused on the purpose of developing nursing courses. Rosenkoetter et al. (1993) explained the goal was to provide an opportunity for students to learn about the culture and health care system in Barbados. According to Rosenkoetter et al. (1993), the faculty responsible for developing the course realized the need to expand on student’s critical thinking skills while they acquired skills and learned how to care for people from other cultures. Evaluation outcomes indicated that these students had positive experiences during their four week stay in Barbados, thus, strongly advocating for the program continuation. Some of their commendations were as follows: “This has been one of the best, if not the best experience of my life,” “It’s been an experience of a lifetime. I will never forget because of the people and the country in general. My whole outlook on nursing has changed, as well as my outlook on life” (Rosenkoetter et al., 1993, p 532). The participant’s comments were found to be consistent with the impact of an
international experience on the personal and perceptual components of a student’s growth as well as its potential value to enhance self-efficacy.

Haloburdo and Thompson (1998) and Kollar and Ailinger (2002) published two qualitative studies which investigated the thoughts and feelings of students regarding an international experience. Haloburdo and Thompson (1998) employed grounded theory methods to compare international learning experiences among fourteen undergraduate nursing students, who traveled to either developing or developed countries. Haloburdo and Thompson (1998) observed more similarities than dissimilarities in the experiences between these groups of students. These two participating groups of students realized both professional and personal growth, while learning the importance of recording or processing their experience.

The participants also remarked having noted a feeling of increased self-confidence, were not as judgmental, had reduced ethnocentrism, reduced stereotyping of others and increased sensitivity to culture from their international experience. Another dimension indicated by those students who traveled to a developing nation was the “reconnection with caring as the essence of nursing” (Haloburdo & Thompson, 1998, p.19). These researchers thought this reconnection feeling came about as a result of providing care in a developing country, where empathy, connection with clients and using nursing interventions were more readily available methods than typical tools of western technology. Thus, without modern U.S. technology the students rather learned to provide care by using “self.” Findings from the study also indicated that participating students
had acquired knowledge regarding the influences of political and social factors on healthcare, based on their international experience.

Haloburdo and Thompson (1998) posited that this type of learning provides empirical insight into population-based health problems, hence creating the opportunity for comparison between the health systems of other countries and that of the U.S. The study results also indicated that international experience could support the value of an experiential learning to enhance didactic teaching and lend support also to the belief in mastery experience and physiological states being sources for self-efficacy. This would grant further support to the value of an international experience for gaining substantive or cultural knowledge and perceptual understanding and cultural sensitivity. The long-term impact of an international experience on graduate nurses was also explored (Kollar & Ailinger, 2002).

Researchers interviewed twelve nursing alumni about their two-week working experiences in a developing nation. Graduate and undergraduate nursing students had a yearly opportunity to participate in an international nursing experience in Nicaragua. Over the course of two weeks, these students provided hands-on care in a barrio community-setting. Graduate students had the dual responsibilities of working in the clinics as well as in the barrio, as well as working with the undergraduates. Advanced practicing nurses worked in the barrio in addition to gaining experiences in the local hospital too. Student comments regarding their experiences during the six years that the program was offered was summed as “both remarkable personal and professional experiences for them” (Kollar & Ailinger, 2002, p.29). Examples given by these
interviewees in relation to how their Nicaragua experience affected their personal and professional lives follows (Wilson’s IIEM provided organizational framework for arranging the data from the interviews).

Specifically, noted was the increased self-confidence and autonomy observed among the participants. Kollar and Ailinger (2002) revealed that the interviewees report concerning the substantive or cultural knowledge category indicated: (a) a broader understanding in regard to the needs of clients from other cultures, (b) changed perceptions about public health patients, and (c) increased cultural awareness and comfort with international patients. The researchers, therefore, found support from Wilson’s IIEM along with evidence showing the long lasting effects of an international experience on these participants.

The participants of the Kollar and Ailinger (2002) research also recalled applying classroom concepts more readily because of the Nicaraguan experience, as well as having the feeling of enhanced knowledge of: (a) the Spanish language, (b) Hispanic culture, and (c) medical terminology in the category of perceptual understanding or cultural sensitivity. In the category of personal growth or developing self-confidence, the interviewees noted career changes because of the Nicaraguan experience. Thus, some of the students chose to work more directly with Hispanics, the poor, or in a health division. The fourth category in Wilson’s IIEM, which is Interpersonal Connections or Social Relationships were also supported as follows: (a) increased respect for health professionals in developing countries, especially in relation to the quality of care
provided with few resources, (b) awareness of the differences between countries, and (c) appreciating and loving life as it is.

A doctoral dissertation and one master’s thesis utilized qualitative methods to assess the impact of international experiences in nursing (Holstege, 2000; Pross, 2000). Holstege’s (2000) thesis explored the lived experiences of students, who provided health care in Nicaragua three months following the October 1998 hurricane, using phenomenological methodology. The researcher, who was also a participant on this mission trip, described this type of learning experience to be a close approximation to that of an IHM experience reported in research.

Four focal meanings associated with the Nicaraguan mission experience were indicated, which are recorded in the following sequence: culture shock, (b) adjustments, (c) lessons learned, and (d) memories (Holstege, 2000). The researcher explained the focal meaning ‘cultural shock’ with themes which are similar to Wilson’s (1993) “Gaining Global Perspectives.” These include: (a) the roles within the Nicaraguan families, (b) male dominance, (c) surreal conditions and the impact of the environment, and (d) economy and government on healthcare and health needs.

Holstege (2000) expanded on the second focal meaning, “Adjustments” also with themes such as: (a) feeling unprepared for the trip, (b) living an emotional roller coaster, (c) adapting to new living conditions, and (d) group dynamics. Themes such as personal stamina, gratitude, and provision of medical treatments with limited resources emerged for the third focal meaning titled, “Lesson Learned.” According to the researcher, the themes for the second and third focal meanings support Haloburdo and Thompson’s
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(1998) research. These findings are linked to personal and professional growth, as well as the influence of mastery experiences and physiological states on self-efficacy.

The findings from Holstege (2000) were also found to be consistent with the personal growth category for Wilson's (1993) IIEM. "Memories" which forms the title for the fourth and final focal meaning from Holstege (2000) included themes such as, friendships, generosity, and long-term effects. These themes however, support the "Developing Self and Relationships" category of Wilson's (1993), in addition, to Willard-Holt's (2001) study, which reported on personal growth or self-confidence from the student's international experience.

Pross (2000) used undergraduate nursing student's international education experiences as a basis for a phenomenological qualitative doctoral dissertation. The study's participants differed widely on their length of stay, nursing experiences and travel destinations. Their nursing responsibilities ranged from hands-on-care, to observation and to no nursing experience at all. The researcher also noted that not all participant's responsibilities were related to their nursing courses. The study made use of interviews (n = 11) and mailed surveys with open-ended questions (16) to obtain data for the study. The major themes that emerged from the study were as follows: (a) preparing, (b) adjusting, (c) caring, and (d) transforming.

"Preparing" being one of the emerging themes from this study supposedly began prior to student's departure from their country of origin. Planning for the trip was, therefore, influenced by shared feelings of excitement for their chosen adventure, friends, finances and school responsibilities. Student's concerns were found to revolve around
"matching personal values and beliefs with experience" (Pross, 2000, p.113). The participants for this study prepared in advance toward their impending international experience, by studying the culture and language of their intended destination or country.

Some students actually benefited from this advanced preparation, regarding their adjustment in the course of their international experience. Conversely, two students could not find sufficient time to prepare adequately. They blamed the challenges and frustration they faced in adjusting to their host countries to inadequate preparation. Pross (2000) equated the insufficient preparation time to experiences of volunteers on an IHM as opposed to a service or experiential learning situation. In service or experiential learning, participating students are usually given advanced knowledge about the culture, language and other conditions in host nations.

The second theme addressed by Pross (2000), “Adjusting,” which evidently, started when participant’s excitement toward the culture and country of their intended destination decreased. Important characterization for this theme included shock, coping and appreciation. These students prepared in anticipation by looking at pictures of a developing nation. However, this could not adequately prepare them for the untold poverty they encountered during their mission-trip. Thus, the word “shock” was used by participants to describe the deplorable living conditions and extreme poverty that existed in those countries. According to Pross (2000) coping became the only option left for the students, which, in the view of the researcher “was also a part of adjusting described as reassuring self of inner strength” (p.120).
Some researchers agree that the category characteristic "inner strength" be linked with increased self-efficacy and confidence observed in other studies (Haloburdo & Thompson, 1998; Kollar & Ailinger, 2002). Coping, again for some of these participants, meant shunning their U.S. peers, who could not accept the environment of the host country, thus describing them as embarrassing. Finally, "appreciation" being the third experiential structure of "adjusting" was an outcome of participant's adaptation to the culture and country of their destination as they compared self, culture and country to their host nation. Willard-Holt's (2001) research with education students and Hadwiger Hadwiger's (1999) study with nursing students supported this notion of appreciation for U.S. resources.

"Caring" was the third emerging theme for Pross (2000). This theme is said to involve the awakening of enhanced feelings of caring for and relating to others on a human level (Gallagher, 2004, p.55). In the Pross (2000) study, caring was described as requiring nothing in return and being non-judgemental. Wilson's IIEEM category of Developing Self and Relationships support these behaviors. The caring theme was found consistent with the findings of researchers such as St. Clair and McKenry (1999) and Haloburdo and Thompson (1998). This theme can potentially support the physiological states of healthcare professionals, emotions that could impact self-efficacy.

Results from the Pross (2000) study suggested that ethics, culture and value had influenced participant's perception regarding international experiences. The participants, however, were challenged by this experience to re-evaluate their worldviews. These student participants commented on the strength of human spirit in regard to those people
living in poverty. The student participants apparently began to initiate change, as they witnessed the existence of this huge poverty elsewhere or in their host countries.

"Transformation" which was the fourth theme to emerge from Pross' (2000) work was found to be consistent with the views of several authors on personal growth or self-confidence (Haloburdo & Thompson, 1998; Holstege, 2000; Rosenkoetter et al., 1993). The transformation theme also aligned with Wilson's IEM personal growth category, which undoubtedly overlaps in the development of global perspective and cultural awareness or perceptual understanding. Another research was conducted by St Clair & McKenry (1999) using triangulation methodology to examine the relationship between international experience, cultural competence and cultural self-efficacy in nursing students.

Participants of the study completed the Cultural Self-Efficacy Scale (CSES). This included senior nursing students who took part as well as those who did not participate in the international experience. Qualitative data was collected while utilizing field notes, participant's observations and daily journal entries done over the course of their international experience. Quantitative data was gathered through the use of CSES, which was administered to students in order to measure their cultural self-efficacy, at three different periods in the study.

The first data collection was concluded at the start of participant's senior year and before they embarked on their international experience. The second phase occurred at the start of the spring semester, while the final collection was collected just prior to their graduation. Findings from this triangulation study supported the previously discussed
studies (St Clair & McKenry, 1999), which granted a holistic picture of the relationship that exists between cultural self-efficacy and cultural competence in nursing with an international experience. The coefficient levels that ranged from 0.88 to 0.94 were obtained quantitatively from a descriptive, correlation study design. The result showed significant improvement for all the 200 nursing students who participated in the study, particularly among those who participated in the nursing international experience.

The qualitative data for the study also gave credence to student’s increased CSES scores. This gave support to the impact of mastery experience on cultural self-efficacy. Student’s writings indicated, specifically the influence this experience had on their perspectives, beliefs and values. The students reported that their knowledge about “selves” increased, as well as their sensitivity for minorities. This assisted them in realizing their prejudices, ethnocentrism and presumptions. The researcher’s observations regarding journal entries by students showed improvement in collegial relationships, growth in professional skills and interdisciplinary teamwork. This study therefore supported the usage of triangulation. In conclusion, St. Clair and McKenry (1999) emphasized that the international experience “made the difference in the student’s ability to sustain the transformational process in their practice long after their return from foreign countries” (p.233). Their work demonstrated that past students who had taken part in this international program were also continuously in contact with their faculty mentors, while affirming that they have become “better listeners, more patient, more giving, more flexible, and overall better nurses” (p.234) as a result of their experiences gained in foreign nations.
Reactions of Individual Professional Healthcare Students to IHM Opportunities

According to Bandura (1994) individuals often react differently in similar teaching contexts. Hence, self-efficacy beliefs might motivate an individual to take advantage of environmental challenge, by perceiving the challenge as a growing opportunity. Other persons may regard these same stimuli as threats to their capabilities. Bringle and Hatcher (1997) observed that people develop self-efficacy beliefs through experience.

Thus, IHM opportunities can influence individual students positively or negatively and vice versa. Students may also exert the same influence on existing IHM opportunities (Scholze, Dona, Sud & Schwarzer, 2001). For example, results obtained from a triangulated methodological study, confirmed that participants expanded their perceptual understanding concerning the impact of their service-learning experiences (McKenna & Rizzo, 1999). A measure of how a service-learning experience influenced the student’s academic motivations and understandings of course concepts were provided by the qualitative data. No significant differences were found between student experiences, location and either motivation or understanding of course concepts irrespective of the service learning placement or site.

The study also illustrated how students integrated their service experience with course concepts by the use of qualitative data. The data comprised of journal entries, subjective feelings and thoughts. These included data which could not be revealed by objective measures in quantitative methods. The McKenna and Rizzo (1999) study found an unanticipated impact of service work on student participant in relation to “learning
about self," which was shown by both quantitative and qualitative methods. The study findings indicated that students were able to rate their "expected" and "actual learning" about self and others through the questionnaire. Findings of the study also indicated that many of the participating students initially had expected to learn more about others than they intended to learn about "themselves."

Even though the actual learning-rating about self was higher than they anticipated from the start, entries in student journals offered additional, and more specific qualitative data that supported the quantitative findings. Students were able to write about their learning concerning personal strengths, weakness, heterogeneous groups and adaptability to challenging situations. Findings from the Mckenna and Rizzo (1999) study also found that both methods complemented each other, in the research of the civic impact of service learning on student participants. The study findings indicated that about 30% of students volunteered beyond twenty hours. Those who intended, and are more likely to perform future community service, were those students who perceived a greater contribution at their service location. Student’s journal entries also produced qualitative data, which emphasized student’s increased awareness about the need for volunteers in the community.

Students sometimes may also choose to seek out a particular form of mission experience, with the aim of enhancing their educational/professional strength or individual interest. In other instances, they may either decline or welcome an opportunity to go on an IHM (Pajares, 2002). Bandura’s concept of reciprocal determinism is found to be consistent with this notion, whereby reciprocal interaction occurs between the triad
factors (Bandura, 1994). However, at the core of reciprocal determinism lie beliefs of self-efficacy. Individual’s responses to environmental factors thus appeared to be dependent upon and influenced by the individual’s perception about his/her capabilities.

Bringle and Hatcher (1997) observed that people develop self-efficacy beliefs through experience. It is therefore important to assess the impact of participation and perceptual changes on behalf of healthcare professional students regarding IHMs. Students, who volunteer for these missions usually may not receive advance preparation or guided reflection after acquiring their experiences. This has led to limited or no information regarding the impact of IHM on volunteering, participating healthcare professional students. Elaboration on the usage of Bandura’s TSE in research will be discussed in Chapter 3. Meanwhile, further discussion on Bandura’s TSE follows.

The Role of Self-Efficacy in the Preparation of Healthcare Professionals: Serving Culturally Diverse Populations in the U.S.

The concept of self-efficacy was introduced by Bandura in 1977, and modified in 1986 (Bandura, 1986). This concept was developed from a social learning and behavioral standpoint, propounded by Albert Bandura (Stajkovic & Luthans, 1998). As a component of social learning, self-efficacy purposely was formulated to give insight into an individual’s direction of intention, behavior and strength (Bandura, 1994). This construct found within the broader context of Social Cognitive Theory (SCT) and human agency, however, advanced to the Theory of Self-Efficacy (TSE) in a more present time.

Self-efficacy has been found to be an important variable in the effort aimed at reducing health disparities and at the same time promoting positive health behaviors.
Self-efficacy, however, is said to develop from individual’s reflections regarding their abilities to perform certain tasks. Culley (1996) among others claimed that it is critical that healthcare professionals focus on the reduction of health disparity among minority populations and provide the type of environment that can promote those influential factors on individual’s health behavior self-efficacy, and discard ignorance and prejudice about other cultures (Baker, 1997; Denboba et al., 1998; Geiger, 1996, 2001; Gostin, L., 1996; Langston, 2001; Laviola & Twomey, 2002, Loudon et al., 1999; Machado, 2001; Rafuse, 1994; & Vance, 1999). The need for healthcare professionals to improve on their Perceived Self-Efficacy will be discussed next.

Perceived Self Efficacy and Professional Healthcare Students

Perceived Self-Efficacy describes “people’s beliefs about their capabilities, to produce designated levels of performance that exercise influence over events affecting their lives” (Bandura, 1994, p.1). Personal beliefs of self-efficacy comprise both (a) an individual and a social construct, and (b) the key factor of human agency (Bandura, 1997; Pajares, 2002). Bandura’s broader social cognitive theory also acknowledges the reciprocal interplay that exit between the environment and people. Hence TSE provides an organized approach for this study to explore perceptions and the potential influences affecting self-efficacy of professional healthcare students.

A person’s feelings, thoughts, behavior and enthusiasm are directed by his/her self-efficacy (Bandura, 1994). For example, an individual who has a high-perceived self-efficacy would consider a difficult task as a challenge that must be overcome. This individual’s interest in the activity is enhanced, due to his or her motivation, to succeed
under the circumstance. According to Bandura (1994) a person with a strong sense of self-efficacy tends to attribute failure to deficient abilities, effort or skills. In Bandura's view, all these are achievable over time with persistence.

But the opposite is true for an individual possessing a low sense of self-efficacy. Such a person is usually observed to shy away from difficult tasks and views failures as personal threats, which eventually may cause the individual to lose focus on a job and to continuously evade threats (Bandura, 1996). Bandura (1994) also stated that individuals who have a low sense of self-efficacy, are usually found to be most susceptible to depression and stress. The reverse, however, applies in the case of persons with a high-perceived self-efficacy. Bandura (1997), thus explained the difference between self-efficacy and self-esteem.

Self-efficacy is a psychological process that is driven by self-reflection, but self-esteem is a global construct (Bandura, 1997). Self-esteem is also deemed to be more stable and reflective of the individual's evaluation, of his/her self-worth and personal characteristics, but self-efficacy is dynamic, task specific and changing across time, as experience and knowledge increase. This same author defined self-efficacy as the actual measure of a person's reflective belief in his or her capability, but not in relation to a lower or higher self-esteem.

Self-Efficacy Dimensions

The three main dimensions of self-efficacy include magnitude or level, strength and generality (Lorsbach & Jenks, 1999). Bandura (1997) defined magnitude or level of efficacy belief as the degree of complexity involved in a task. In literature, a broad range
of tasks efficacy has been observed to exist, even though these same authors believe that a simple task does not require high performance abilities to bring about a successful outcome. Hence, it is the responsibility of individuals to decide whether they possess the requisite skills or not to perform a difficult task at a specific level, by reflecting on their perceived capabilities for that function.

The second dimension of self-efficacy, which is strength, is described as the conviction that individuals have the capability to successfully complete a task at a specific level (Bandura, 1997). An individual’s rating on a measured scale (not a “yes-no” response), therefore, could indicate one’s actual ability to perform a particular task. Generality represents the third dimension of self-efficacy, which specifies “the individual’s perceived capabilities for a specific task across similar domains or in other situations” (Gallagher, 2004, p. 27). Due to limited research, there seems to be scarcity of information regarding this third dimension of self-efficacy.

Generally, self-efficacy perceptions usually occur in a relatively limited area or field. Pajares (2002) espoused that self-efficacy belief gained in an area can be useful for other dissimilar tasks. Bandura (1994) pointed out that this third dimension or generality apparatus depends mostly on how the individual’s self-efficacy beliefs enable him or her to adapt to varied situations or impact resilience. Hence individuals tend to explore a wider range of positive self-efficacy beliefs when they are challenged to adapt to new situations (Scholze, Dona, Sud & Schwarzer, 2001). Bandura (1994) acknowledges four sources of influences on self-efficacy including mastery experiences, vicarious experiences, social persuasion and psychological and emotional states. Discussion on
each follows, together with examples as well as discussion of their impact on healthcare professionals and patient’s self-efficacy.

Factors that Influence Self-Efficacy

The individual’s perception about him or herself is believed to be the most influential component among the four sources affecting self-efficacy (Bandura, 1997; Pajares, 2002). Experiential learning (already discussed), is said to be an educational method, mostly employed to prepare healthcare professionals. Reflection, which entails self-evaluation, is expected to follow after participating in an activity. A successful or positive self-evaluation supposedly elevates the student’s self-efficacy, but on the contrary, the learner whose self-evaluation turns up negative, would have a lower self-efficacy, in respect to a specific area of competency (Bandura, 1994). Additional experience and academic grades will then be required in such circumstances, to further reinforce the self-efficacy of the affected student. But a student who has high self-efficacy would increase his or her efficacy beliefs, while the reverse would happen in the case of the learner with negative or unsuccessful experience.

This student with an unsuccessful experience will then be challenged to strive harder to put in extra effort, to gain prerequisite knowledge or skills needed for improvement. In regards to client’s health behavior, Lorsbach and Jenks (1999) indicated that persons with high self-efficacy will be challenged to master new knowledge and skills in order to control the progression of a health problem. But a low self-efficacy patient would have no motivation whatsoever to learn new skills and knowledge that will help control the progression of a disease. Such patients are usually branded as non-compliant. A greater
challenge for a foreign born client with a different cultural background could be how to have positive mastery experiences that involve cultural, gender, language and other barriers. Factors that should not be taken for granted when attempts are being made to improve on the self-efficacy of these patients (Kramer et al., 1999).

Vicarious experiences or models can also influence self-efficacy beliefs (Bandura, 1997; Lorsbach & Jenks, 1999; Pajares, 2002). It is a type of experience that refers to the personal performance accomplishment, acquired through observation of others performing tasks. Bandura, (1997) asserted that this form of experience is important not just for its contributing role of influencing self-efficacy, but also because of its influence on the observer’s beliefs in relation to his or her own abilities. For instance, a graduate health educator witnessing a colleague successfully instructing a fitness class or clients on cardiovascular endurance through aerobic exercise, would enhance his belief regarding his own capability to deliver or instruct a similar class.

Vicarious experiences are usually strong in instances where the observer identifies with particular attributes of a model person, an individual whose success becomes a basis of measure for her own success (Bandura, 1994). Gallagher (2004) cites an example where a pre-medical student could increase her self-efficacy beliefs, when she observes a friend graduating from medical school. Another example cited is the case of an admired orthopedic surgeon, who inspires a medical student to look for residency in that same area of practice. But, from a patient education perspective, Gallagher (2004) posits that a female patient, considering the possibility of under-going a radiation therapy for breast cancer, could benefit from the successful completion of treatment by a friend or relative.
Thus, the patient’s current beliefs in her own ability to successfully complete the treatment, may increase through the recall of information about the treatment, and the handling of side effects by the previous patient or woman.

Influences such as stress, anxiety, moods/emotional states and somatic states, referred to as physical wellbeing and energy level, can affect self-efficacy (Bandura, 1994; Pajares, 2002). People’s perception and interpretation of such influencing factors play a role to a greater extent in self-efficacy, than the intensity of the somatic or emotional state (Bandura, 1994; Stajkovic & Luthans, 1998). Both the physiological and emotional reactions to a pending task could greatly influence a person’s self-efficacy. For instance, being confident, non-stressed, or in a good mood, can affect self-efficacy beliefs positively, in just the same way as fear, nervousness and a bad or depressed mood can weaken a person’s self-efficacy beliefs (Bandura, 1994; Stajkovic & Luthans, 1998).

The issue is that people who normally possess high-efficacy beliefs tend to characterize somatic arousal as a source of energy. But individuals with low self-efficacy, on the contrary, perceive this same condition as debilitating (Stajkovic & Luthans, 1998). Thus a healthcare professional, who possesses a high cultural-self efficacy belief, would be better prepared to recognize potential problematic, physiological and emotional states in immigrants, than another health professional lacking in this same quality. Immigrants are found to be overwhelmed with their inability to access the U.S. healthcare system. They are thus considered to be at a higher risk for a low health self-efficacy that can lead to a greater risk for illness.
Social persuasion is another factor observed to have great influence on self-efficacy beliefs. This aspect of social efficacy focuses attention on individual’s perceived capabilities (Bandura, 1994), rather than raising or improving their levels of abilities. Verbal persuasion for instance, is said to strengthen a person’s beliefs in relation to skills one possesses or could acquire, which are needed for the completion of a specific work. Hence, social persuasion can assist in the sustenance of effort aimed at gaining mastery of a task despite the odds.

Bandura (1994) asserted that the greatest impact of this aspect of self-efficacy is mostly felt by people who believe they have the potential to achieve a specific end, by means of personal action. In contrast, individuals having low self-efficacy often devalue the positive assessment of them by others. Hence, they are not impacted wholly by verbal persuasion, and have no desire to increase their self-efficacy as compared to persons with high self-efficacy (Stajkovic & Luthans, 1998). According to Bandura (1994) it is important however, to understand that unsupported persuasion can cause failure, which could lead to a reduction in self-efficacy beliefs, and in addition, have a damaging effect on the credibility of the advisors.

As already indicated, social persuasion is an important tool for healthcare professionals who have the ability to provide culturally sensitive health promotion and care, to improve the compliance and understanding of their clients (Liburd, Giles & Mensah, 2006; Minnesota Department of Human Service, 2004). But, from the perspective of the client, the effective usage of social persuasion by a healthcare professional (who is also culturally sensitive in the provision of care and health
promotion), could decrease the stress that patients experience in the family and healthcare setting. Liburd, Giles, and Mensah (2006) affirm that self-efficacy and motivation needed for the maintenance and attainment of positive health can thus be developed through social-persuasion.

**Summary**

Working towards equality in healthcare is a national priority (USDHHS, 2002b). Health disparities exist among culturally diverse populations in the U.S. (USDHHS, Healthy People 2010). Healthy People 2010, a national health promotion and disease prevention initiative, calls upon communities, individuals and professionals to take specific steps to ensure the enjoyment of good health and longevity for all. Most healthcare professions agree on the notion of decreasing health disparities among special populations in the U.S. These special populations have been observed to experience disease, disabilities and deaths far beyond average (Schlesinger, 2006).

The influence of culture on health and healthcare is recognized by academicians and health care professionals. It has become increasingly crucial for healthcare professionals to be prepared in a way that will enable them to develop cultural sensitivity and also recognize the numerous factors acting as influences on health and health behaviors. This will ensure the optimal delivery of health promotion, education, and care. USDHHS (2002b) believes that if culturally sensitive healthcare personnel are able to provide care for individuals coming from different cultures, empower persons with necessary health information, improve access to health services and promote safety, it is possible that
progress towards equality in health will be achieved. Goals are, therefore, set by the Healthy People 2010 planners, in order to decrease health disparities in healthcare.

Related literature reveals the positive impact of international academic nursing experiences, while there is no available literature related to non-nursing, health professional disciplines. Thus, this research will be important and timely for these reasons:

1. To understand the impact of an IHM experience on other healthcare professional students.

2. To consider the value of an international experience for participating students in the practice of health care in a changing patient-population and work environment.

Wilson’s IHEM was employed in framing questions, while Bandura’s TSE guided the questionnaire development in this study.
CHAPTER 3

METHODOLOGY

The purpose of this study was to investigate the impact of an International Healthcare Mission (IHM) experience on the perceived growth of healthcare professional students. This research examined both the professional and personal benefits of an IHM experience on participating professional healthcare/Global Health Corps students at the University of Northern Iowa. Particular areas of interest include: (a) cultural knowledge, (b) cultural sensitivity, (c) self-confidence, and (d) social relationships. The study focused on the following four research questions:

1. To what extent do participants in an IHM improve their cultural knowledge?
2. To what extent do student healthcare professionals who participate in an IHM feel that they are more culturally sensitive to the health beliefs and behaviors of diverse clients?
3. To what extent does an IHM experience enhance the self-confidence of participants in regard to their professional practice?
4. To what extent does an IHM experience affect the social relationships between students and their colleagues, students and their instructors, and students and their clients?

This chapter expounded on the methods used to conduct this study, which included the following: (a) Research Design, (b) Subject Selection, (c) Data Collection Procedures, (d) Instrument Development, (e) Establishing Validity and Reliability, and (f) Data Analysis.
Research Design

Between Methods Triangulation

Answering the research questions with the best approach is essential to this study. Methodological triangulation offers the best comprehensive research method for examining the impact international healthcare mission (IHM) experiences have on participating healthcare professional students. In literature, the between-method approach of inquiry can permit the use of qualitative data to comprehend the experience of an IHM from the perspective of a professional healthcare student (Gallagher, 2004). The usage of quantitative data provided measurable results, which were used to assess the strength and type of perceived changes that occurred due to the student’s IHM experience. Previous findings on the impact of an international experience on both the cultural and professional lives of nursing and education students could be validated by either of these two forms of data.

Sandelowski (2000) contended that mixed-method or methodological triangulation studies are fundamentally controversial, since each method has a different model. Thus, research which utilizes both a quantitative and qualitative research traditional methods usually is not considered a true methods combination, but rather an “explicit framing of inquiry” (p. 247). The framing of this present study was done by employing data from qualitative interviews to understand student’s IHM experience. Verification of the qualitative information, previous research on international experiences, as well as measurement of the student’s perceived level of change on varied aspects of their IHM experiences, was done from responses obtained from a quantitative questionnaire.
These two methods combined, augmented each other to increase understanding concerning the experiences of participating healthcare professional students. The need for appropriate philosophy to inform a qualitative study is vital. Thus, interpretive or hermeneutic phenomenology was the specific form of qualitative research employed in this study. The researcher is required to become the instrument for data collection in this type of research (Eisner, 1998). Heidegger's philosophy has been found to be fitting for this type of study, since the researcher's IHM experiences must be considered in regard to their potential influence on their interpretation of meanings (Johnson, 2001).

As previously stated, Wilson's (1993) IIEF was utilized in the framing of the quantitative data collection instrument, which is a self-completed questionnaire. Bandura's TSE guided questionnaire development obtained information on participant's perceived changes in their capabilities and self-efficacy that could occur in relation to their mission experience. Further discussion on each component of this mixed, between-method, within-subject research follows.

Phenomenology could be classified in two ways, as a methodology and a qualitative method. Van der Zalm and Bergum (2000) explained that it could have descriptive and interpretive components if used as a qualitative research method (Creswell, 2003; Speziale & Carpenter, 2003). Morse and Field (1995) agree that phenomenology provide a description of events, since it accepts experience as it exists in the individual's consciousness. The interpretive aspects of phenomenology is said to stem from the researcher, who "identifies the 'essence' of human experiences concerning a phenomenon, as described by participants in a study" (Creswell, 2003, p.15). Interview
data could offer insight into the student’s IHM experiences, as the participants describe significant events and their perceived impact on them.

The researcher’s data collection and analysis supposedly should also be guided by the same philosophy that directs this type of phenomenology. Hermeneutic or interpretive phenomenology, which is entrenched in Heidegger’s philosophy, tend to place emphasis on comprehending the phenomenon under study, while at the same time being cognizant of the researcher’s experiences that are brought to the study (Johnson, 2009).

Heideggerian philosophy states that “experiences can only be understood in terms of one’s background… and the social context of the experience” (Draucker, 1999, p.361). Since the researcher’s background helps in understanding the phenomenon under study, the Heideggerian philosophy stresses the role of the researcher’s presupposition, which needs to be known but not categorized and marginalized (Draucker, 1999). Therefore, the researcher ideally should self-disclose information in order to increase awareness of any possible subjectivity that could taint the data.

**Researcher Disclosure**

My journey as an educator began when I obtained a teacher’s certificate “A” (four year) at the end of my secondary school education. I taught for eight years in the K-6 elementary schools in three regions in Ghana. I went for further studies at a Teacher’s Specialist Training College to obtain a Diploma in Physical Education in 1987. I taught for five years in two different high schools also in Ghana. I again embarked on attaining a bachelor’s degree at the University of Cape Coast in Ghana. In 1997 I successfully completed my degree for the Bachelor of Education in Physical Education (BE.D in P.E.)
program. I taught P.E. in a high school in Ghana for a few months thereafter, before proceeding to the United States to pursue advance studies for the Master of Arts in Health Education at UNI—School of Health, Physical Education and Leisure Studies (HPELS) in 1998, which I obtained in 2003.

Through this program, I was able to work as a graduate assistant and project manager at the UNI Global Health Corps Unit. Clinical and classroom experiences formed part of the job specification for a graduate assistant. As a Global Health Corps project manager, I had the responsibility to arrange sites for presenting health information to varied clients, supervising and training the junior members of the Corps to provide culturally sensitive health education to underserved populations both at local and international locations.

My course work also enabled me to share information on various health topics at different health care facilities within the community. These included settings such as hospitals, schools, churches, and resettlement homes for the aged. My doctoral program offered me further opportunity to present on various health topics to diverse audiences at various conferences in the U.S. I am currently working on my dissertation in the Department of Curriculum and Instruction in the College of Education. I hope to work as a college professor in the College of Education upon graduation.

I have worked with health education team members who were being prepared through didactic learning and training to become effective in their professional practice. These professional healthcare students were able to provide sound and preventive health education to the communities both at domestic and international locales, particularly to
the underserved communities. In so doing, I became exposed to clients/patients who could live healthier lives than they presently do by altering their lifestyles. Thanks to these experiences and working for the Global Health Corps, I have come to appreciate these health care team-members, as well as the timely and safe care, provided in very hygienic conditions with readily available equipment in the U.S. hospitals. I noticed also that all patients who present themselves at most hospitals in the U.S. were given appropriate healthcare treatment regardless of their ability to pay by law; a requirement of U.S. health system (Gallagher, 2004).

Coming from a developing country and having been a volunteer on a UNI health mission to Ghana (my original home country) gave me the opportunity to realize the grim difference in the health system between these two nations. Because of the high level of poverty and the inability to pay for medical bills, people in Ghana, as in most developing nations, usually respond readily to health missions of any kind that arrive in the country from international shores.

In Ghana, for example, patients or clients queue for many hours to be attended to freely by IHM teams because it is hard to pay for medical care and treatment supplies from the public clinics and hospitals. Similarly, a team of Global Health Corps members (including me) were well received when we arrived in Ghana in 1999 to offer health talks on various preventive health topics. An impressive durbar, comprised of local chiefs together with residents from the whole town, assembled to receive the team, and accord us a befitting welcome, and listen to our presentation.
Other problems I have observed afflicting the health systems in developing countries such as Ghana are the working conditions for either the patients or workers. Often times the working conditions existing at the IHM health facilities appear safer, with readily available supplies of basic equipment than in those of the local hospitals and clinics. Thus, things like running water, a working bathroom, and continuous electricity supply are not taken for granted. Hospitals and clinics are not found in most villages and in hinterlands, while clinics, which are not common, contain few types of equipment as well as limited staffing. People have to make painstaking trips in order to obtain health care. I have therefore learned to greatly appreciate the U.S. health resources due to my IHM experiences.

Members of my family and I have enjoyed excellent healthcare services since our arrival in the U.S. These range from personal medical issues through physicals, optometric care, gynecology, childbirth, pediatric, surgery, dental services and others. We have also encountered some difficulties in gaining access to and utilizing some aspects of U.S. healthcare services due to our inability to purchase high premium, comprehensive insurance, and given our financial constraints. On other occasions we had to wait in the consulting room for over thirty minutes to see the doctor. These experiences were not supposed to occur within the U.S. health care system according to law (Gallagher, 2004).

My continuous education at UNI has afforded me the opportunity also to interact with many immigrants/refugees and international students from diverse cultural backgrounds and origins. From these acquaintances I was able to gain first-hand information regarding their experiences with the U.S healthcare system. These foreign
students and immigrants comprised of both women and men either shared with me their intimate feelings or allowed me to be part of their effort to seek solutions to their perceived problems in dealing with the U.S. health system. Specific examples of difficulties regard the insensitivity and lack of understanding on the part of health care personnel, who could not relate properly to their health problems in order to provide suitable care. They also complained about cultural inappropriateness of services provided in the sense of not incorporating their beliefs and values in services provided to them as well as the modes of delivery.

For example, an immigrant female student who gave birth recently narrated her story regarding the difficulty she encountered during the delivery of her first baby. She recounted her story amidst sobs for the treatment she received from the personnel of this labor ward. She perceived the cause of her mistreatment to be a lack of regard for her personally. Another foreign female student, who also gave birth a few years ago, told her story about her ordeal of neglect at the hospital that resulted in the loss of her baby.

A doctoral male student who just finished defending his dissertation recently fell ill suddenly. He lived in one of the traditional married houses all alone, found it hard to obtain transportation to the hospital, but finally when the ambulance arrived, the health care personnel were unprepared to attend to him. Other immigrants complain about the counseling services available, which do not meet their needs because of financial and cultural differences. This is an issue of acceptance of health services. Similar situations arose when on some occasions I had to prepare food for some of these patients on admission for various ailments, just because they could not eat the food provided for
them at the hospitals. These emphasize the need for training in cultural sensitivity for healthcare professional students.

I have been exposed to theories of health behavior, information about international health programs and problems, and the effect of environment on health during my coursework in the health education program. My understanding concerning health and healthcare in other countries has improved greatly because of all these experiences, which exceeds those of most healthcare professionals who do not have similar experiences. For example, my personal experiences of knowing and experiencing the damaging effect of limited healthcare and infrastructure in my country, lack of safe water, sanitation, food insecurity and lack of knowledge and tools to promote health, have greatly influenced my perceptions regarding the health system in the U.S.

My experiences as an international student coming from a developing country, in addition to my coursework, have greatly influenced the manner in which I provide health education to diverse individuals. I believe that I am more open-minded and try to understand how an individual’s beliefs, environment, finance, education, resources and lifestyle can affect their health. I am presently more highly aware of the effect of cultural beliefs and environment on health than before gaining IHM experiences. I have also learned to appreciate the expanding cultural diversity among health care professionals in the U.S. As a strong patient/client advocate, I am also a believer in personal responsibility and cost effective health promotion. Acknowledging these suppositions must not, however, obstruct the interview and the proper analysis of qualitative data in this study.
Subject Selection

Participants for this study were selected using purposeful sampling techniques. Research reports on similar terms for purposive sampling include criterion-based, judgmental, or purposive selection (Maxwell, 1996; Polit & Hungler, 1999; Speziale & Carpenter, 2003). The usage of any of these terms permits purposeful sampling and choosing informants intentionally to supply first-hand experience information on the study phenomenon. All the participants for this study possessed IHM experiences that qualified them as samples for between-method subject statistical evaluations. Thus, participants for this study included professional healthcare/Global Health Corps students at the University of Northern Iowa, who had volunteered for and lived the experience under study. Hence, participants comprised students, who usually and voluntarily took personal or break time to undertake mission service independently, away from their academic requirements, to gain IHM experiences.

Appropriate participants for qualitative research has been reported in research that is linked to the principle of sampling, Creswell (1998), Maxwell (1996), Morse and Field, (1995), and Speziale and Carpenter (2003). Thus, in purposeful sampling the participants, who are selected should have lived the experience under study. Conversely random selection, which is the opposite of purposeful sampling, is deemed to be an ineffective technique for qualitative data collection on specific events, since the informants may not possess the needed experience for the topic under investigation.

In literature the use of random selection in qualitative research becomes a potential source of invalidity (Morse & Field, 1995). Therefore in this study, experienced IHM
participants will be solicited to reveal their: (a) feelings, (b) personal thoughts, and (c) reflections regarding their IHM experiences. Thus, the goal for using criteria for the purposive sampling in this research was to maximize the use of these informants, who have had personal experiences from an IHM, and had not been previously influenced by both academic pre-experience preparation and/or post-experience reflection.

**Inclusion Criteria for Research Participants**

1. A volunteer on an IHM
2. Participated in an IHM
3. Spoke, read, and wrote in English

**Exclusion criteria**

1. Received an academic pre-experience preparation
2. Academic reflection specifically on their mission experience

**Sample Size**

Determining adequate sample sizes for Between-Method Triangulation is a challenge (Gallagher, 2004). Between-Method Triangulation is said to be a type of research that makes use of both quantitative and qualitative methods, which usually poses a challenge for determination of sample size or “n” sufficient enough. Data collected of course should be sufficient in quantity and quality to ensure that findings are interpreted accurately. Research indicates that in mixed quantitative and qualitative study it is important to meet the appropriate method-related standards for determining an adequate sample size or suitable number of participants (Speziale & Carpenter, 2003). In view of
the above stated guidelines for stipulating an adequate sample size, the following considerations will be made in this present study.

**Quantitative Sampling**

Guidelines for quantitative studies usually suggest the use of a larger “n” than qualitative studies. Sample estimates for quantitative studies include: (a) time, (b) desired effect size, (c) number of variables in questionnaire, (d) availability of representative participants, and (e) power analysis (Gallagher, 2004). Hence, consideration for “n” in this study depended on the following criteria: Personal experience from an IHM, healthcare personnel who had volunteered for IHM, and the homogeneity of the sample population.

In literature small numbers of samples are suitable when: (a) independent and dependent variables are strongly connected, (b) the population is homogeneous in relation to the variables under study (Polit & Hungler, 1999). These authors indicate that a study with many variables could make use of a larger sample size; thus twenty to thirty participants are recommended for each independent variable (Polit & Hungler, 1999). This might be very unlikely for such a specialized sample target for this study. This study, however, focuses on only one primary independent variable, which is IHM Participation. Gallagher (2004) stresses further that larger samples of participants could be possible, only if additional independent variables are considered, such as age, past history, and number of past missions participation. Other variables may include ethnicity, gender, religious affiliation, knowledge and use of foreign language, and previous travel
experiences. But the author also posits that information regarding these variables could be collected as demographics.

**Qualitative Sampling**

Generally, qualitative research has been found to employ small numbers of participants, though some researchers allege that there are no specific rules regarding the number of participants employed in a qualitative study (Polit & Hungler, 1999; Wiersma, 2000). Other researchers, however, hinted that it is impossible to predetermine the number of participants required (Specziale & Carpenter, 2003). A sample size of 8 to 10 students would, therefore, be appropriate for the qualitative component of this present research. Gallagher (2004) claimed that consideration for determination of this number range was based on time constraint and feasibility for a research on data collection and analysis, which was found to be consistent with (Polit & Hungler, 1999), indicating that the sample size for phenomenological studies usually tend to be less than ten. Polit and Hungler (1999) asserted that sampling in qualitative studies should yield data that will be relevant to the rationale and purposes of the research. Potential representative informants from the past and present Global Health Corps IHM participants were invited for interview. Sufficient volunteers, who met the inclusion criteria, were interviewed until no new themes emerged or the data got saturated. The qualitative data collection process was then completed.

**Data Collection Procedures**

All past and present UNI Global Health Corps students possessing IHM experiences were invited to participate in this study. These students were contacted by letter
requesting them to participate in the research study. The content of the letter included a lay summary of my study and definitive roles of participants in the study. A follow-up phone call was made after the dispatch of the letter to confirm participation in the research and also to answer questions related to the study (see Appendix D).

**Quantitative Procedures**

Participants were recruited through e-mail contacts to participate in the survey. Cover letters and survey questionnaires were mailed to participants to independently complete and return them to the researcher by mail. It took approximately twenty minutes for students to complete PIHMQ. All demographics and questionnaire responses were confidential, since participants were not required to personally identify themselves on the paperwork. Participants gave their consent to participate in the study by completing the questionnaire.

**Quantitative instrumentation.** An ex post facto self-evaluation questionnaire was designed to elicit participant’s perceptions regarding their experiences obtained from the IHM. The title of the survey was the “Perceptions of an International Healthcare Mission Questionnaire” (PIHMQ) obtained from Gallagher (2004). The survey comprised of sixty-five survey questions, and thirteen demographic questions. The complete survey instrument can be found in appendix A. The PIHMQ was designed following Wilson’s IHEM framework.

The questions for the survey were framed using qualitative themes from previous research on student international experiences in just the same way as information from focus groups is utilized. The survey questionnaire also explored Wilson’s four
components and experiences that potentially can influence the healthcare professional student’s self-efficacy while embarking on an IHM.

The outcome variable measures in the questionnaire focused on the student’s perceptions about the four components of Wilson’s model including: (a) Substantive (Cultural) Knowledge, (b) Perceptual Understanding (Cultural Sensitivity), (c) Personal Growth (Self-Confidence), and (d) Interpersonal Connections (Social Relationships). The use of Likert-type response scale enabled students to rate their perceptions regarding their mission experiences and any possible impact on their growth or self-efficacy.

Wilson’s IIEM Operationalized. There are two components of Wilson’s IIEM (1993), and each has two subdivisions. The first component, Gaining Global Perspectives, includes subdivisions titled Substantive Knowledge and Perceptual Understanding. The second component, titled Developing Self and Relationships, includes subdivisions Personal Growth and Interpersonal Connections (Wilson, 1993). In this present study these sub-theme headings have been applied and articulated as follows:

1. Cultural Knowledge (Wilson’s Substantive Knowledge)
2. Cultural Sensitivity (Wilson’s Perceptual Understanding)
3. Self-Confidence (Wilson’s Personal Growth)

The four components of Wilson’s IIEM, comprising Substantive Knowledge, Perceptual Understanding, Personal Growth and Interpersonal Connections, were utilized as outcome variables obtained from an IHM, (Gallagher, 2004). The development of questions on each of Wilson’s four categories was based on findings from previously
cited research. These questions were designed in such a way that permitted the appropriate exploration of the healthcare professional student’s experiences within each of Wilson’s four categories. For example, in the area of Substantive Knowledge (Cultural knowledge) category, Williad-Holt (2000), Haloburdo and Thompson (1998), Pross (2000), St. Clair and McKenry (1999) uncovered themes that suggested “learning about another culture or country.”

For example, item 1a solicited information regarding knowledge of a new country, “From participating in an IHM, how much new knowledge did you learn about a different country?” Responses by participants ranged from one (none) to five (tremendous) obtained from Gallagher (2004). Each of the four IIEM categories as well as the findings from previous research was adapted for use in similar fashion in the questionnaire. Table 1 shows the various categories along with the supporting themes that operationalizes each category item as found in Gallagher (2004).
Table 1

Previous Research Themes that Support Wilson’s International Impact Experience Model (IEM) Adapted from Gallagher (2004)

<table>
<thead>
<tr>
<th>Research Themes</th>
<th>Supporting Themes</th>
<th>Researcher(s)</th>
<th>Survey Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural Knowledge</td>
<td>learning about another culture/country</td>
<td>Willard-Holt, Haloburdo &amp; Thompson; Pross</td>
<td>1:1-5</td>
</tr>
<tr>
<td></td>
<td>enhanced cognitive development</td>
<td>St. Clair &amp; McKenny</td>
<td></td>
</tr>
<tr>
<td>Cultural Sensitivity</td>
<td>appreciation for U.S. resources</td>
<td>Willard-Holt, Haloburdo &amp; Thompson; Pross</td>
<td>3:1, 2, 3, 4, 5, 6</td>
</tr>
<tr>
<td></td>
<td>increased professionalism</td>
<td>Holstege; Hadwiger &amp; Hadwiger</td>
<td></td>
</tr>
<tr>
<td></td>
<td>broadened perspectives</td>
<td>Willard-Holt</td>
<td>5:1-7</td>
</tr>
<tr>
<td></td>
<td>dispel stereotypical preconceptions</td>
<td>Willard-Holt, Haloburdo &amp; Thompson; St. Clair &amp; McKenny</td>
<td>2:3, 5, 12; 6: 1-7</td>
</tr>
<tr>
<td>Self Confidence</td>
<td>increased sensitivity/empathy</td>
<td>Willard-Holt; Bond &amp; Jones; Hadwiger &amp; Hadwiger;</td>
<td>7: 1-3, 8:4</td>
</tr>
<tr>
<td></td>
<td>Increased patience/tolerance</td>
<td>Rosenkoetter, Reynolds, Cummings &amp; Zakutney;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Personal flexibility</td>
<td>Willard-Holt; St. Clair &amp; McKenny</td>
<td>7: 4-5</td>
</tr>
<tr>
<td></td>
<td>Improved self-confidence</td>
<td>Willard-Holt; St. Clair &amp; McKenny, Holstege;</td>
<td>7: 6</td>
</tr>
<tr>
<td></td>
<td>Enhanced insight into personal beliefs and values, learning about self</td>
<td>Willard-Holt, Haloburdo &amp; Thompson; Kollar &amp; Ailinger; Pross</td>
<td>4:1-6</td>
</tr>
<tr>
<td></td>
<td>reconnecting with “caring” in professional practice</td>
<td>Bond &amp; Jones; Hadwiger &amp; Hadwiger; Rosenkoetter, Reynolds, Cummings &amp; Zakutney; Pross; St. Clair &amp; McKenny;</td>
<td>8: 1, 2, 8: 3, 4</td>
</tr>
<tr>
<td>Social Relationship</td>
<td>better prepared to work with others</td>
<td>Willard-Holt, St. Clair &amp; McKenny</td>
<td>5: 8-11, 6:9</td>
</tr>
<tr>
<td></td>
<td>continued/maintained communication with persons from another culture/country</td>
<td>Willard-Holt</td>
<td></td>
</tr>
<tr>
<td></td>
<td>gained respect for others</td>
<td>Bond &amp; Jones; Hadwiger &amp; Hadwiger; Rosenkoetter, Reynolds, Cummings &amp; Zakutney;</td>
<td>8: 5-10</td>
</tr>
</tbody>
</table>

Validity and Reliability of Quantitative Instrument

Validity of Perception of International Health Model Questionnaire (PIHMQ). The quantitative instrument employed for data collection for the impact of mission experiences on healthcare professional student participants was the PIHMQ. The PIHMQ questionnaire had been previously validated by a team of healthcare professionals who had IHM experiences. Gallagher (2004) posits that this seven panel of experts comprised four physicians, two pharmacies, and one nurse who all together had forty IHM
experiences. Upon the completion of the review process of the questionnaire by these experts regarding content validity, review, and acceptance, the required editorial changes were made. The same author indicated that changes made focused primarily on improving clarity through editing and altering the wording of question distracters or stems. In one case, a group of questions were changed to make them more precise in eliciting data about perceived changes in specific professional skills in relation to IHM experiences.

Gallagher (2004) explained that the PIHMQ was evaluated in relation to construct validity for its measure of the four categories of Wilson’s (1993) IIEM model. Thus, recommendations made by Dr. Wilson were reviewed among the experts and discussed via e-mail. This resulted in three additional items, which strengthened the ability of the data collection apparatus to obtain information regarding the participant’s realizing the need to "act as a cultural mediator, or an individual who would intervene to assist people from another culture or to help people from different cultures understand one another" (Gallagher, 2004 p.75).

Through personal communication Dr. Wilson confirmed that the questionnaire possessed construct validity, in respect to the Impact of an International Experience Model (Gallagher, 2004). This author claimed that the PIHMQ was evaluated for the measures of its overall construction and self-efficacy by Dr. Timothy Jordan. Gallagher (2004) again conducted a pilot study with former students who had volunteered for various missions. The purpose of the pilot study was to test the internal consistency of the survey items, in addition to exploring the stability and reliability of the questionnaire.
Reliability Testing. The statistical test, Cronbach’s alpha, which is a numerical coefficient of consistency or reliability, was used to evaluate internal consistency of the questionnaire. In literature it was observed that the higher the alpha coefficient, the more reliable is the scale. However, a lower level of 0.70 is deemed acceptable for grouped items, being assessed as a scale (Cronk, 2004; Gallagher, 2004). Gallagher (2004) employed thirteen and thirty-two students for her pilot study and dissertation samples respectively. This author calculated Cronbach’s alpha on each of Wilson’s model categories in order to estimate the internal consistency of the items within the subscales labeled: Substantive Knowledge, Perceptual Understanding, Personal Growth (renamed as Growing as an Individual), and Interpersonal Connections. Scores obtained from the test of internal consistency ranged from 0.7923 to 0.9287 for the pilot study, while scores obtained for the dissertation sample ranged from 0.8589 to 0.9478. However, the researcher using 0.70 as the minimum acceptable Cronbach’s alpha for the PIHMO scales found all the subscales testing Wilson’s IHM categories to be reliable or internally consistent.

Gallagher (2004) again calculated Cronbach’s alpha on three scales that explored factors influencing self-efficacy: (a) Mastery experience, (b) Cognitive processes, and (c) Affective processes. The complete results of testing for internal consistency for each subscale of the PIHMQ, is indicated in Table 2. Cronbach’s alpha scores obtained for these three scales also ranged between 0.8974 and 0.9287 for her pilot sample, while the scores obtained for her dissertation sample ranged from 0.9137 to 0.9646. These subscales for the influences on self-efficacy measured on the PIHMQ were also found
reliable or internally consistent using the minimum acceptable Cronbach’s alpha of 0.70.

Analysis of reliability of the survey instrument can be found in Table 2.

Table 2
Reliability Analysis of Survey Instrument Subscale
(Gallagher, 2004)

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Questions</th>
<th>Internal Consistency</th>
<th>Test-Retest Stability</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Pilot n=13</td>
<td>Research n=32</td>
</tr>
<tr>
<td></td>
<td></td>
<td>.7984 .8166</td>
<td>.7276 .6060</td>
</tr>
<tr>
<td>Substantive Knowledge</td>
<td></td>
<td>.7923 .8340</td>
<td>.7196</td>
</tr>
<tr>
<td>New country/culture</td>
<td>1a-c</td>
<td>9259 .8641</td>
<td>.6912</td>
</tr>
<tr>
<td>Enhance cognitive development</td>
<td>2a,b,d,f-k</td>
<td>.8468 .8074</td>
<td>.7206 .6497</td>
</tr>
<tr>
<td>Subscale</td>
<td>.8092 .8589</td>
<td></td>
<td>.7241</td>
</tr>
<tr>
<td>Perceptual Understanding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appreciation US resources</td>
<td>3a, br,c,dr,e,f</td>
<td>.7923 .8340</td>
<td>.6912</td>
</tr>
<tr>
<td>Professional behavior</td>
<td>5a-g</td>
<td>9259 .8641</td>
<td>.6912</td>
</tr>
<tr>
<td>Broadened perspectives</td>
<td>2c,e,l,;6a-h</td>
<td>.8542 .8553</td>
<td>.6497</td>
</tr>
<tr>
<td>Subscale</td>
<td>.8858 .8650</td>
<td></td>
<td>.6489</td>
</tr>
<tr>
<td>Personal Growth/Growing as an individual</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased sensitivity/empathy</td>
<td>7a-c</td>
<td>9176 .9303</td>
<td>.7196</td>
</tr>
<tr>
<td>Increased patience/tolerance</td>
<td>7d,e }</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal flexibility</td>
<td>7f</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved self-confidence</td>
<td>4a-f</td>
<td>.7814 .8585</td>
<td>.6498</td>
</tr>
<tr>
<td>Insight into beliefs</td>
<td>8a,b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Connecting” in practice</td>
<td>8c,d}</td>
<td>.8434 .8234</td>
<td>.6927</td>
</tr>
<tr>
<td>Subscale</td>
<td>.7923 .9478</td>
<td></td>
<td>.6873</td>
</tr>
<tr>
<td>Interpersonal Connections</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working with others</td>
<td>5h-k,6l</td>
<td>.7186 .7622</td>
<td>.7092</td>
</tr>
<tr>
<td>Gain respect for others</td>
<td>8e-j</td>
<td>.8984 .9267</td>
<td>.7225</td>
</tr>
<tr>
<td>Subscale</td>
<td>.8967 .9250</td>
<td></td>
<td>.7158</td>
</tr>
<tr>
<td>Mastery experiences</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional practice</td>
<td>5a-e,4a,b,e</td>
<td>.9128 .8368</td>
<td>.7148</td>
</tr>
<tr>
<td>Cultural encounters</td>
<td>4c,d,f,5-h-k</td>
<td>.8022 .9009</td>
<td>.7456</td>
</tr>
<tr>
<td>Subscale</td>
<td>.9159 .9137</td>
<td></td>
<td>.7292</td>
</tr>
<tr>
<td>Cognitive process</td>
<td>1a-e, 2a-l,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subscale</td>
<td>6a, c-g }</td>
<td>.8974 .9150</td>
<td>.6962</td>
</tr>
<tr>
<td>Affective processes</td>
<td>7 a-f</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subscale</td>
<td>82-c, e-j}</td>
<td>.9287 .9646</td>
<td>.7028</td>
</tr>
</tbody>
</table>
Qualitative Procedures

The study commenced with the face-to-face, taped interview which offered the benefits of hearing vocal intonations, while observing non-verbal cues regarding the participant’s emotions. These procedures yielded rich cultural/specific data that further validated the spoken word. Clarification on shared information was sought through additional questions. Research volunteers were interviewed twice (Van Manem, 1990).

Interviews lasted between thirty minutes and one hour. A search for the meaning of the IHM experience related by the professional healthcare student was collected during the first phase. The second stage occurred a few weeks later reflecting on the meaning of IHM experience with research participants (Van Manem, 1990). This second phase occurred specifically after transcribing, reading and re-reading of the audiotape of the first interview after it had been completed, with the full meaning of the shared experience being fully understood. The interval between the first and second interview allowed time for further reflection on the meaning of the IHM experience.

Qualitative Instrumentation

Questions such as, “What was the IHM experience like for you?” are usually asked by phenomenological studies (Van Manem, 1990). In order to prevent any bias or leading the interviewee’s thoughts the following interview questions were employed, to elicit individual participant’s perceptions concerning the nature of the IHM experiences.

1. What was the experience of an international health mission or medical mission like for you?
2. What do you feel you brought back from your mission experience as a healthcare professional student both culturally and professionally?

3. Was there any particular occurrence from or related to the mission trip that was particularly meaningful to you personally and professionally? Will you please share the experience, and the reason why it meant so much for you?

Data Analysis

Quantitative Component

Descriptive statistics were used to indicate the student's perception regarding the impact of IHM experiences. Mean scores on student responses for each item of the PIHMQ were reported. The mean for each item was reported according to the following categories corresponding to the research questions: (a) Cultural Knowledge, (b) Cultural Sensitivity, (c) Self-Confidence, and (d) Social Relationships (see Table 1). Corresponding items for the four research questions (see Appendix A) were analyzed to obtain the overall mean score, which included those for perceptual change for the IHM categories. This process enabled complete description of the impact of an IHM experience on students.

Qualitative Component

Phenomenology is said to be a process for understanding human experience, which presently does not have a single accepted approach for its method (Gallagher, 2004). Thus, for this research, Van Manem’s (1990) six interacting activities of methodological interpretation were used to understand the phenomenon under study including: (a) delving into the phenomenon of interest, (b) exploring lived experience rather than
conceptualizing the experience, (c) pondering the vital themes characterizing the experience, (d) recounting the lived-experience of another through writing and re-writing, (e) preserving a strong focus on the phenomenon of study, and (f) balancing the narrow focus of the phenomenon and considering the whole.

Thus, analysis of qualitative data was based on the information contained in the interview transcripts. Van Manem’s (1990) activities and method demands the understanding of the phenomenon of interest. The following steps were used when conducting interviews:

Step 1: Delve into the topic. This interactive procedure allowed not only questioning from the interviewer alone but also from the interviewee. This enhanced the understanding of questions that were asked and validated responses, while collaboratively collecting data about the IHM experience.

Step 2: Search for meaning. Searching for meaning regarding an IHM phenomenon was done through a second contact with the interviewee that occurred when the researcher’s interpretation of the student’s experience had been shared and validated with interviewee (Gallagher, 2004).

Step 3: Impact description: Collectively, all data from the interview described the impact of IHM experience on the student participants. Reflecting, further on the themes and meanings of their experiences, permitted the actual interpretation of their experiences.
Findings from the qualitative component of this study shed more light on the essence of healthcare professional student’s IHM experience, while the quantitative data results in turn filled in the void existing in current research on this topic.

Summary

This chapter explained in detail the methodology and procedures used in gathering both quantitative and qualitative data on the IHM experiences of professional healthcare student participants. The PIHMQ was the instrument used for the quantitative data collection for this study. Descriptive statistics and Cronbach’s alpha was utilized to explore the quantitative data obtained from the PIHMQ.

The qualitative aspects of the study made use of audio-tape interviews and employed phenomenological methodology which was guided by Heidegger’s methodology for obtaining qualitative data (Johnson, 2009). Van Manem’s (1990) phenomenological method served as a basis for the qualitative data analysis. This involved examining perceptions and deriving meaning from IHM experiences by healthcare professional students. The researcher’s information disclosure in an earlier chapter revealed the awareness of her past experiences that impacted the understanding of the studied phenomenon.
CHAPTER 4

RESULTS OF THE STUDY

The purpose of this study was to investigate the impact of an International Healthcare Mission (IHM) experience on the perceived growth of healthcare professional students. This research examined both the professional and personal benefits of an IHM experience on participating professional healthcare/Global Health Corps students at the University of Northern Iowa. Particular areas of interest include: (a) Cultural Knowledge, (b) Cultural Sensitivity, (c) Self-Confidence, and (d) Social Relationships. The study focused on the following four research questions:

1. To what extent do participants in an IHM improve their cultural knowledge?

2. To what extent do student healthcare professionals who participate in an IHM feel that they are more culturally sensitive to the health beliefs and behaviors of diverse clients?

3. To what extent does an IHM experience enhance the self-confidence of participants in regard to their professional practice?

4. To what extent does an IHM experience affect the social relationships between students and their colleagues, students and their instructors, and students and their clients?
Review of Research Procedures

Quantitative Procedures

In order to identify participants for the study, a list of IHM past participants was obtained from the Global health Corps office at the UNI Wellness and Recreation Center. Other sources included the UNI Registrar’s office as well as staff and past UNIGHC members. A search for e-mail addresses for participants was done through Google and Yahoo personal search websites. Some e-mail addresses were obtained from the UNI directory website.

When prospective participants had been identified, an invitation letter including a statement of informed consent and the quantitative questionnaire were electronically mailed to participants inviting them to participate in the study (Appendix A-D). Those who agreed to participate completed and returned the questionnaire. The quantitative data collection period lasted for one month. Overall sixty-three questionnaires were sent out with thirty (46%) returned. Data analysis was done using SPSS version 15.

Qualitative Procedures

A convenience-sample of five was selected from among the thirty survey participants to take part in follow-up interviews. These participants displayed the characteristics showing they were willing to participate, by responding to my letter of invitation. The participants were asked to sign a second informed consent form prior to the commencement of the recording process, to obtain their permission to tape record the interviews. The interview process began with a face-to-face, taped interview which offered the benefits of hearing vocal intonations, while observing non-verbal cues of the
participant’s emotions. Transcribing the interviews was beneficial, thus yielding rich culturally specific data that further validated the spoken word.

To clarify information shared in the initial interviews, a second follow-up interview was scheduled with each of the five participants. Thus, participants were interviewed twice. The length of interviews ranged from thirty minutes to one hour. During the first interview, questions focused on the meaning of the IHM experience for the professional healthcare student. The second or follow-up interview occurred three to five weeks later when initial interview transcriptions had been completed. Consistent with the qualitative research methodology of Van Manen (1990), the second interview focused on clarifying and elaborating on ideas and experiences discussed in the first interview.

This chapter presents both quantitative results and qualitative findings obtained from this mixed-method study. Results of the survey provided measures pertaining to type and strength of personal and professional changes IHM student participants experienced as a result of their mission participation. These changes were explored by examining the four themes which provide the focus of this study. The follow-up interviews further explored the four themes which provided the focus for this study. The results of this study will therefore be presented as follows: (a) demographic characteristics of participants, (b) results from the PIHMQ survey, and (c) results from initial and follow-up interviews.

Survey Participant Demographic Information

The last page of the survey requested participant demographic information (see Appendix A). Out of the 30 IHM participants who responded to the survey, 36.7% were male and 63.3% female. The ages of participants ranged between 18 and 48 years old. A
majority (17) of the participants were Caucasian (53.3%), 26.7% were African-American, and 20.0% were Hispanic. The ages of participants were categorized as follows: (a) 18 to 27 (33.3%), (b) 28 to 37 (43.3%), (c) 38 to 47 (16.7%), and (d) 48 (6.7%). A sizeable percentage of research participants had short-term mission experience (43.3%) while 23.3% had long term-mission experience, and 33.3% had experiences in both short and long term missions. The majority of the participants had domestic experience before embarking on an IHM (80%) while (20%) had no local experience before their IHM. Regarding the time of their last IHM participation, 73.3% indicated their last IHM experience occurred more than a year before, 23.3% indicated 12 months prior to completing the survey, and 3.3% indicated within a month prior to completing the survey.

The results of the study also showed that over half (53.3%) of the research participants had previously taken part in one IHM, while 26.7% had taken part in two IHMs, and 20.0% had participated in three or more previous IHM experiences. On the survey, 60.0% indicated they had previously participated in international travel while 40% had no previous international travel experience.

Participants responding to the survey reported academic training in the following health disciplines: undergraduate Health Education (13.3%), (b) graduate Health Education (33.3%), (c) undergraduate Health Promotion (10.0%), (d) graduate Health Promotion (23.3%), (e) Pre-Med (3.3%), and (f) Other e.g. Youth & Leisure Studies (16.7%).
Characteristics of Interviewed Participants

Five students who participated in the survey were interviewed to gather information for the qualitative data. However, for the purpose of anonymity and confidentiality these interviewees were re-named as participant 1, 2, 3, 4, and 5 in the study. Heidegger’s philosophy has been found to befit this type of study (Johnson, 2009). According to this author, the participant’s backgrounds and experiences must be considered due to the potential influences they might have on their responses and meanings they give to their experiences. Heideggerian philosophy states that “experiences can only be understood in terms of one’s background... and the social context of the experience” (Draucker, 1999, p.361). The following paragraphs reveal information about the five interviewees.

Participant 1 is originally from Rwanda (Africa) but is now a naturalized American. She came to the United States with her three siblings after the genocide. She was hosted by an American family who assumed the role of “parents” to her and her siblings. Thereafter, she embarked on her undergraduate degree in Health Education, specifically Community Health Education. She was one of the founding members of the UNI GHC together with one other student and the directors of the unit in 1996. She has since traveled to Israel, St. Lucia in the Caribbean and China on IHM missions. She then pursued her MA in Health Education, specifically in Community Health Education, graduating in 2001. During that year she got married to an African who was studying for a doctor of Education (Ed.D) in Youth and Leisure Studies, which he obtained at UNI in 2008. He also was a member of the UNI GHC in his graduate study years. Participant 1 founded and became the director of the BrightMove Network for Cedar Falls and
Waterloo local area in 2003. She and her husband have four children and currently live in Texas. They moved after my first interview with her.

Participant 2, an African-American, was a pre-med student at UNI and a member of the GHC. She traveled with the group to Ghana about a year prior to the interview. She is currently enrolled in one of the nursing institutions in Waterloo to be trained as a Registered Nurse. She is single and has a five-year old daughter.

Participant 3 is Caucasian and is a native of Iowa. She was a Health Promotion major for her undergraduate study. She became a member of the UNI GHC during the time of her study. She took a class with GHC and enjoyed it so much that she felt she might as well consider a career in global health promotion. She traveled with the group to St. Lucia in the Caribbean in 1994, which was an 'eye opener' for her because it was her first international travel away from home and her first solo trip. She has since completed her program and now works as a Health Educator at UNI Wellness and Recreation Center.

Participant 4 is an African-American and an undergraduate majoring in Youth and Human Service Administration. She is single and has three teenage daughters. She traveled on a mission with the UNI GHC to Nicaragua for two weeks during one of her summer holidays. She is interested in establishing an organization that will cater to the needs of people of differing cultural backgrounds upon graduation.

Participant 5 is a naturalized American but originally came from Rwanda after the genocide. She is married to a professor from the Department of English and Literature at UNI, who also originally came from Rwanda but is now a naturalized American. They
have three teenage children. She did her undergraduate degree in Public Administration and Public Policy. She is currently pursuing a Master of Arts in Community Health Education. She is also a member of the GHC at UNI. She traveled with the group to Mexico. More importantly she and her family were at the fore-front of the presidential campaign for Barack Obama in their voting precinct and she was a guest at the Oprah show at the latter part of last year (2008).

**Survey Results**

Data obtained from the PIHMQ survey (see Appendix A) was used to determine levels of perceptual change of IHM participants for each of the four themes providing the focus for this study. Survey items were selected from each of the eight main sections of the survey to correspond to the four themes on which this study focused. These selections are found on Table 3.
Table 3
Previous Research Themes that Support Wilson’s International Impact Experience Model (IIEM) Adapted from Gallagher (2004)

<table>
<thead>
<tr>
<th>Research Themes</th>
<th>Supporting Themes</th>
<th>Researcher(s)</th>
<th>Survey Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural Knowledge</td>
<td>learning about another culture/country</td>
<td>Willard-Holt, Haloburdo &amp; Thompson; Pross; St. Clair &amp; McKenry</td>
<td>1:1-5</td>
</tr>
<tr>
<td></td>
<td>enhanced cognitive development</td>
<td>Frisch; Zorn, Ponick &amp; Peck</td>
<td>2:1, 2, 4-6, 7-11</td>
</tr>
<tr>
<td>Cultural Sensitivity</td>
<td>appreciation for U.S. resources</td>
<td>Willard-Holt, Haloburdo &amp; Thompson; Pross; Holstege; Hadwiger &amp; Hadwiger</td>
<td>3:1, 2, 3-4, 5, 6</td>
</tr>
<tr>
<td></td>
<td>increased professionalism</td>
<td>Willard-Holt</td>
<td>5:1-7</td>
</tr>
<tr>
<td></td>
<td>broadened perspectives</td>
<td>Willard-Holt, Haloburdo &amp; Thompson; St. Clair 2:3, 5, 12; 6: 1-7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>dispel stereotypical preconceptions</td>
<td>Willard-Holt</td>
<td>6:8</td>
</tr>
<tr>
<td>Self Confidence</td>
<td>increased sensitivity/empathy</td>
<td>Willard-Holt; Bond &amp; Jones; Hadwiger &amp; Hadwiger; Rosenkoetter, Reynolds, Cummings &amp; Zakutney; Haloburdo &amp; Thompson; St. Clair &amp; McKenry</td>
<td>7:1-3, 8:4</td>
</tr>
<tr>
<td></td>
<td>Increased patience/tolerance</td>
<td>Willard-Holt; St. Clair &amp; McKenry</td>
<td>7:4-5</td>
</tr>
<tr>
<td></td>
<td>Personal flexibility</td>
<td>Willard-Holt; St. Clair &amp; McKenry; Holstege; Willard-Holt, Haloburdo &amp; Thompson; St. Clair &amp; McKenry</td>
<td>7:6</td>
</tr>
<tr>
<td></td>
<td>Improved self-confidence</td>
<td>Willard-Holt</td>
<td>4:1-6</td>
</tr>
<tr>
<td></td>
<td>Enhanced insight into personal beliefs</td>
<td>Bond &amp; Jones; Hadwiger &amp; Hadwiger; Rosenkoetter, Reynolds, Cummings &amp; Zakutney; Pross; St. Clair &amp; McKenry</td>
<td>8:1, 2</td>
</tr>
<tr>
<td></td>
<td>values; learning about self</td>
<td>Haloburdo &amp; Thompson; Pross</td>
<td>8:3, 4</td>
</tr>
<tr>
<td></td>
<td>reconnecting with “caring” in professional practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Relationship</td>
<td>better prepared to work with others</td>
<td>Willard-Holt; St. Clair &amp; McKenry</td>
<td>5:8-11, 6:9</td>
</tr>
<tr>
<td></td>
<td>continued/maintained communication with persons from another culture/country</td>
<td>Willard-Holt</td>
<td></td>
</tr>
<tr>
<td></td>
<td>gained respect for others</td>
<td>Bond &amp; Jones; Hadwiger &amp; Hadwiger; Rosenkoetter, Reynolds, Cummings &amp; Zakutney</td>
<td>8:5-10</td>
</tr>
</tbody>
</table>

Survey results are presented as follows and are organized around the four research questions.

**Research Question 1:** To What Extent Do Participants in an IHM Improve Their Cultural Knowledge?

Table 4 reports the complete set of descriptive statistics examined to answer this research question. The highest mean perception of change within the cultural knowledge subscale was found for item 1:3 asking students about their learning regarding a different
culture (M = 4.20, SD = .71). The second highest mean was found in connection with the item 1:1, learning about a different country (M = 4.17, SD = .87). The third highest perception was in regard to item 1:2, learning about healthcare in another country (M = 3.83, SD = .87). The least perceptual change was found on item 2:2, collecting pertinent information about the patient’s environment (M = 2.10, SD = .95). The student’s mean perception for the cultural knowledge subscale was (M = 2.96, SD = .64) which indicates that overall, the participants perceived minimal to moderate improvement on their cultural knowledge.
Table 4

Student Perception Change after Participation in an IHM: Cultural Knowledge Subscale

<table>
<thead>
<tr>
<th>No.</th>
<th>Item</th>
<th>Mean Score</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:1</td>
<td>A different country</td>
<td>4.17</td>
<td>.65</td>
</tr>
<tr>
<td>1:2</td>
<td>A different healthcare system</td>
<td>3.83</td>
<td>.87</td>
</tr>
<tr>
<td>1:3</td>
<td>A different culture</td>
<td>4.20</td>
<td>.71</td>
</tr>
<tr>
<td>1:4</td>
<td>Health beliefs in another culture</td>
<td>3.50</td>
<td>1.04</td>
</tr>
<tr>
<td>1:5</td>
<td>Healthcare professionals in another country</td>
<td>3.47</td>
<td>.90</td>
</tr>
<tr>
<td>2:1</td>
<td>Gathering patient health history information</td>
<td>2.27</td>
<td>1.05</td>
</tr>
<tr>
<td>2:2</td>
<td>Collecting pertinent information about patient’s environment</td>
<td>2.10</td>
<td>.96</td>
</tr>
<tr>
<td>2:4</td>
<td>Gathering information about the patient’s support system</td>
<td>2.27</td>
<td>1.11</td>
</tr>
<tr>
<td>2:6</td>
<td>Ease of using previously learned physical assessment skills</td>
<td>2.47</td>
<td>1.11</td>
</tr>
<tr>
<td>2:7</td>
<td>New uses for learned physical assessment skills</td>
<td>2.33</td>
<td>.80</td>
</tr>
<tr>
<td>2:8</td>
<td>Learning about the strengths of other healthcare disciplines</td>
<td>2.50</td>
<td>1.14</td>
</tr>
<tr>
<td>2:9</td>
<td>Learning your health discipline’s role on the healthcare team</td>
<td>3.03</td>
<td>1.45</td>
</tr>
<tr>
<td>2:10</td>
<td>Learning about diseases not typically found in the U.S.</td>
<td>3.10</td>
<td>1.27</td>
</tr>
<tr>
<td>2:11</td>
<td>Learning about treatments on typically considered in the U.S.</td>
<td>3.17</td>
<td>1.46</td>
</tr>
</tbody>
</table>

Subscale: Cultural Knowledge perceived change 2.96 .64

N=30
Research Question 2: To What Extent Do Student Healthcare Professionals Who Participate in an IHM Feel They Are More Culturally Sensitive to the Health Beliefs and Behaviors of Diverse Clients?

Table 5 provides the complete set of descriptive statistics examined to answer this research question. Responses obtained for the cultural sensitivity scale reveal that participating students perceived a change in their cultural sensitivity. The highest mean for this scale was found for the item 2:3, considering information about a patient's economic status (M = 4.33, SD = .66). The second highest mean for perception change was found for item 3:1, my views of U.S. healthcare resources became more positive (M = 4.20, SD = .71). The third highest occurred in connection with the item 6:1, inquiring about the culture of a different country (M = 4.17, SD = .65). The least perceptual change occurred on an item 3:2, my views of U.S. healthcare quality became more negative (M = 1.77, SD = .50). The mean perceptual change for cultural sensitivity subscale was (M = 2.99, SD = .46), implying that participants perceived a minimal to moderate change in cultural sensitivity.
Table 5
*Student Perception Change after Participation in an IHM: Cultural Sensitivity Subscale*

<table>
<thead>
<tr>
<th>No.</th>
<th>Item</th>
<th>Mean Score</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>2:3</td>
<td>Considering information about a patient’s economic status</td>
<td>2.43</td>
<td>1.14</td>
</tr>
<tr>
<td>2:5</td>
<td>Considering other resources available to the Patient</td>
<td>2.60</td>
<td>1.10</td>
</tr>
<tr>
<td>2:12</td>
<td>Considering alternatives to Western medical care</td>
<td>2.90</td>
<td>1.24</td>
</tr>
<tr>
<td>3:1</td>
<td>My views about U.S. healthcare resources became more positive</td>
<td>4.20</td>
<td>.76</td>
</tr>
<tr>
<td>3:2</td>
<td>My views of U.S. healthcare quality became more negative</td>
<td>1.77</td>
<td>.50</td>
</tr>
<tr>
<td>3:3</td>
<td>My views of U.S. healthcare availability became more positive</td>
<td>3.57</td>
<td>1.07</td>
</tr>
<tr>
<td>3:4</td>
<td>My views about healthcare availability for the indigent in the U.S. became more negative</td>
<td>2.53</td>
<td>.94</td>
</tr>
<tr>
<td>3:5</td>
<td>My opinion of U.S. healthcare services for a non-U.S. citizen became more positive</td>
<td>3.03</td>
<td>1.07</td>
</tr>
<tr>
<td>3:6</td>
<td>I believe people from another culture / country in the U.S. receive quality healthcare</td>
<td>3.37</td>
<td>.72</td>
</tr>
<tr>
<td>5:1</td>
<td>Assess patient health problems</td>
<td>2.27</td>
<td>1.23</td>
</tr>
<tr>
<td>5:2</td>
<td>Assess patient needs</td>
<td>2.40</td>
<td>1.28</td>
</tr>
<tr>
<td>5:3</td>
<td>Plan patient treatment</td>
<td>1.83</td>
<td>.91</td>
</tr>
<tr>
<td>5:4</td>
<td>Provide patient education</td>
<td>2.80</td>
<td>1.56</td>
</tr>
<tr>
<td>5:5</td>
<td>Provide patient treatments</td>
<td>1.83</td>
<td>.91</td>
</tr>
<tr>
<td>5:6</td>
<td>Evaluate plan for care/treatment</td>
<td>1.80</td>
<td>.81</td>
</tr>
<tr>
<td>5:7</td>
<td>Evaluate results of patient education</td>
<td>1.93</td>
<td>1.02</td>
</tr>
<tr>
<td>6:1</td>
<td>culture awareness of a different country</td>
<td>4.17</td>
<td>.65</td>
</tr>
<tr>
<td>6:2</td>
<td>A different type of healthcare</td>
<td>3.53</td>
<td>1.17</td>
</tr>
<tr>
<td>6:3</td>
<td>Influence of culture on health</td>
<td>4.10</td>
<td>.76</td>
</tr>
<tr>
<td>6:4</td>
<td>Influence of environment on health</td>
<td>3.87</td>
<td>.73</td>
</tr>
<tr>
<td>6:5</td>
<td>The influence of individual beliefs on health</td>
<td>3.53</td>
<td>.82</td>
</tr>
<tr>
<td>6:6</td>
<td>The influence of economic status on health</td>
<td>4.33</td>
<td>.66</td>
</tr>
<tr>
<td>6:7</td>
<td>The influence of support systems on health</td>
<td>3.73</td>
<td>.91</td>
</tr>
<tr>
<td>6:8</td>
<td>My pre-conceptions of individuals from another country</td>
<td>3.13</td>
<td>1.20</td>
</tr>
<tr>
<td>Subscale: Cultural Sensitivity perceived change</td>
<td>2.99</td>
<td>.46</td>
<td></td>
</tr>
</tbody>
</table>

* N = 30
Research Question 3: To What Extent Does an IHM Experience Enhance the Self-Confidence of Participants in Regard to Their Professional Practice?

Table 6 above shows the complete set of descriptive statistics examined to answer this research question. The highest mean perception change for this scale was found on the item 8:1, to learn about myself (M = 4.00, SD = .87). The second highest was found in connection with the item 8:3, learning to connect with the emotions of caring for and comforting individuals (M = 3.83, SD = 1.37). The third highest reported mean was for item 7:1, empathy toward others (M = 3.77, SD = 1.10). The lowest perception change was found regarding the item 4:2, working on multi-disciplinary health team (M = 3.07, SD = 1.04). The overall mean perception change for Self-Confidence subscale was (M = 3.46, SD = .72), indicating that participants perceived moderate to significant change in their self-confidence.
<table>
<thead>
<tr>
<th>No.</th>
<th>Item</th>
<th>Mean Score</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>4:2</td>
<td>Working on a multi-disciplinary health team</td>
<td>3.07</td>
<td>1.04</td>
</tr>
<tr>
<td>4:3</td>
<td>Working on a multi-cultural health team</td>
<td>3.43</td>
<td>.90</td>
</tr>
<tr>
<td>4:4</td>
<td>Working with families from cultures</td>
<td>3.73</td>
<td>.45</td>
</tr>
<tr>
<td>4:5</td>
<td>Working in my health profession</td>
<td>3.13</td>
<td>1.11</td>
</tr>
<tr>
<td>4:6</td>
<td>Help others work with people from other cultures</td>
<td>3.30</td>
<td>.79</td>
</tr>
<tr>
<td>7:1</td>
<td>Empathy towards others</td>
<td>3.77</td>
<td>1.10</td>
</tr>
<tr>
<td>7:2</td>
<td>Ability to be sensitive to the needs of those</td>
<td>3.33</td>
<td>1.42</td>
</tr>
<tr>
<td></td>
<td>from different cultures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7:3</td>
<td>Ability to be sensitive to the needs of those</td>
<td>3.63</td>
<td>1.06</td>
</tr>
<tr>
<td></td>
<td>from a different country</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7:4</td>
<td>To be patient with non-U.S. citizens</td>
<td>3.10</td>
<td>1.62</td>
</tr>
<tr>
<td>7:5</td>
<td>Tolerance toward beliefs other than my own</td>
<td>3.23</td>
<td>1.22</td>
</tr>
<tr>
<td>7:6</td>
<td>Adapt in different culture</td>
<td>3.50</td>
<td>1.17</td>
</tr>
<tr>
<td>8:1</td>
<td>To learn about self</td>
<td>4.00</td>
<td>.87</td>
</tr>
<tr>
<td>8:2</td>
<td>To reflect on my beliefs</td>
<td>3.63</td>
<td>.96</td>
</tr>
<tr>
<td>8:3</td>
<td>Connect with emotions of caring and comforting</td>
<td>3.83</td>
<td>1.37</td>
</tr>
<tr>
<td>8:4</td>
<td>Recognize patients as unique individuals</td>
<td>3.13</td>
<td>1.38</td>
</tr>
<tr>
<td></td>
<td><strong>Subscale: Self-Confidence perceived change</strong></td>
<td><strong>3.46</strong></td>
<td><strong>.73</strong></td>
</tr>
</tbody>
</table>

*N = 30*
Research Question 4: To What Extent Does an IHM Experience Affect the Social Relationships between Students and Their Colleagues, Student and Their Instructors and Students and Their Clients?

Table 7 shows the complete set of descriptive statistics examined to answer this research question. Survey results show that participants perceived a change in their social relationships. The highest perception mean change occurred regarding the item 8:9, gain respect for people from other religions (M = 3.57, SD = 1.22). The second highest occurred on item 5:10, work with patients/families from cultures other than my own (M = 3.50, SD = .73). The third highest was found for the item 8:5, gain respect for other healthcare team members (M = 3.47, SD = 1.20). The lowest perception mean score was found in relation to the item 5:11, help co-workers understand the needs of patients/people from other cultures (M = 3.03, SD = .93). The overall perception mean change score for social relationship subscale was (M = 3.67, SD = .63) implied that IHM research participants perceived moderate to significant change in their social relationships. The highest overall perception change mean score among the four focus areas was found for the social relationship subscale (M = 3.67, SD = .63), while the least or minimal overall perception change mean score among the four subscales occurred in the cultural sensitivity subscale (M = 1.77, SD = .50).
Table 7  
*Student Perception Change after Participation in an IHM: Social Relationship Subscale*

<table>
<thead>
<tr>
<th>No.</th>
<th>Item</th>
<th>Mean Score</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>5:8</td>
<td>Effectively work on a multi-discipline team</td>
<td>3.07</td>
<td>1.04</td>
</tr>
<tr>
<td>5:9</td>
<td>Effectively work on a multi-cultural team</td>
<td>3.37</td>
<td>.99</td>
</tr>
<tr>
<td>5:10</td>
<td>Work with patients /families</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>from cultures other than my own</td>
<td>3.50</td>
<td>.73</td>
</tr>
<tr>
<td>5:11</td>
<td>Help co-workers understand needs of patients/</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>people from other cultures</td>
<td>3.03</td>
<td>.93</td>
</tr>
<tr>
<td>6:9</td>
<td>Need to mediate for individuals from another</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Culture in the U.S.</td>
<td>3.30</td>
<td>.95</td>
</tr>
<tr>
<td>8:5</td>
<td>Gain respect for other healthcare team members</td>
<td>3.47</td>
<td>1.20</td>
</tr>
<tr>
<td>8:6</td>
<td>Gain respect for peers</td>
<td>3.10</td>
<td>1.10</td>
</tr>
<tr>
<td>8:7</td>
<td>Gain respect for patients / clients</td>
<td>3.33</td>
<td>1.27</td>
</tr>
<tr>
<td>8:8</td>
<td>Gain respect for people from other cultures</td>
<td>3.27</td>
<td>1.30</td>
</tr>
<tr>
<td>8:9</td>
<td>Gain respect for people from other religion</td>
<td>3.57</td>
<td>1.22</td>
</tr>
<tr>
<td>8:10</td>
<td>Gain respect for people of other economic classes</td>
<td>3.17</td>
<td>1.26</td>
</tr>
</tbody>
</table>

Subscale: Social Relationship perceived change 3.67 .63

*N = 30*
Summary of Quantitative Findings

General findings from the survey regarding student’s perception of change showed that those who participated in an IHM believed they improved in both their personal and professional lives in terms of knowledge, skills, and attitudes. The highest overall perception change (mean score) among the four focus areas was found for the social relationship focus area, while the least or minimal overall perception change (mean score) among the four focus areas occurred in the cultural sensitivity subscale.

Quantitative data analysis revealed overall, a minimal to moderate improvement in the cultural knowledge of participants. The highest mean perception change within the cultural knowledge subscale was found for the item asking students about their learning regarding a different culture. The second highest mean was found in connection with the item, learning about a different country. The third highest mean perception change occurred with regard to the item, learning about healthcare in another country. The least perceptual change was found for the item, collecting pertinent information about the patient’s environment.

The cultural sensitivity subscale indicated a minimal to moderate perception change for participants. The highest mean for this scale was found for the item, considering information about a patient’s economic status. The second highest mean perception change was found for the item, my views of U.S. healthcare resources became more positive. The third highest mean perception change occurred in connection with the item inquiring about the culture of a different country. The least perceptual change occurred on the item, my views of U.S. healthcare quality became more negative.
Findings obtained from the self-confidence subscale show a moderate to significant perception change for survey participants. The highest mean score for perception change for this scale was found on the item, to learn about myself. The second highest was found in connection with the item, learning to connect with the emotions of caring for and comforting individuals or non-technological aspects of care. The third highest reported mean score for perception change occurred in the item, empathy toward others. The lowest perception change was found regarding the item, working on multi-disciplinary health team.

The quantitative data analysis also indicated that survey participants perceived a moderate to significant change in their social relationships. The highest mean score for perception change occurred regarding the item, gain respect for people from other religions. The second highest occurred on the item, work with patients/families from cultures other than my own. The third highest was found for the item, gain respect for other healthcare team members. The lowest perception mean score was found in relation to the item, effectively work on a multidisciplinary team.

Interview Results

Qualitative Themes

Four major themes with subheadings were uncovered from the analysis of interview data as follows: Cultural Knowledge, Cultural Sensitivity, Self-Confidence and Social Relationship. These themes, in general, entailed gaining new knowledge as well as acquisition of new skills; thus, the modified theme from Gallagher’s (2004) model most befitting is “The Evolving Process of a Globally Aware Person and Healthcare
Professional.” The four themes uncovered under different subheadings, indirectly supported Wilson’s four categories of IEM Model and further expanded on the professional and personal growth components found in the earlier study of Gallagher (2004).

There are two components of Wilson’s IEM (1993), and each has two subdivisions. The first component, Gaining Global Perspectives, includes subdivisions titled Substantive Knowledge and Perceptual Understanding. The second component, titled Developing Self and Relationships, includes subdivisions Personal Growth and Interpersonal Connections (Wilson, 1993). In this present study, these sub-theme headings have been applied and articulated as follows:

1. Cultural Knowledge (Wilson’s Substantive Knowledge)
2. Cultural Sensitivity (Wilson’s Perceptual Understanding)
3. Self-Confidence (Wilson’s Personal Growth)

In addition, the personal and professional impact of IHM experiences would be explored just as in Gallagher (2004). Figure 2 illustrates the relationship between the four research questions. In this present study, the international experiences studied differed in sample and location from those studied in Gallagher (2004). This enabled the participants to be interviewed without pre-set boundaries. Emerging themes from the interview provided data that were similar to Wilson’s (1993) categories and Gallagher’s (2004) two distinct kinds of experiences occurring within the two sub-categories as shown in Figure 2.
Figure 2. The Evolving Process of a Globally Aware Person and Healthcare Professional (adapted from Gallagher, 2004)
Cultural Knowledge

In 1993, Wilson utilized the cultural (Substantive) knowledge theme to describe the increased specific knowledge and cognitive development that occurred among participants on an international experience. In this present study IHM participants shared two categories of new and varied knowledge that also could be classified as “personal” and “professional” components of the cultural knowledge. Gallagher (2004) used these two terms in her previous research. The themes uncovered under the “personal” aspects of cultural knowledge stem from access to information that expanded student’s knowledge of another culture, language, environment and people of the various host nations different from their own. These two (professional and personal) aspects of the cultural knowledge provided a plethora of ideas for comparing and contrasting healthcare, people, economies, cultures and environs of respective host countries and that of the U.S.

In the Cultural Knowledge focus area, learning experiences are summarized in the following areas: (a) learning about people from various countries, (b) various cultures and countries, and (c) other languages. Professional learning and knowledge gain occurred in the area of skills acquisition and learning about different healthcare systems. Findings from the interview are reported and discussed in the following sections.

Cultural knowledge: People from various countries. The international health mission provided participants with exclusive and unique learning opportunities to interact and talk with people from various countries. This, otherwise, could not have been possible for other international travelers visiting any resort or recreational center
(Gallagher, 2004). Thus, participant 5 was glad to share her experiences and knowledge gained from the people she saw and interacted with on her IHM and even pointing out the similarities between Mexicans and Africans (Africa is the place of her origin).

But actually, the people, the Mexican people were very receptive and nice people, in going there for instance what I found was that the people there, they tend to share too much, yes, share, they give; that is African—they give, they give. We ate like anything— everybody want to give, but being so wrong even forgetting to think that I am full. So I had a bit of a problem with my weight. For me um! Historically, you know the people who moved to Mexico and the Caribbean, these are Africans. There is a long history of the connection. The similarities you’ll see also in the climate and the herbs I saw there were the same I saw back in Africa. (IHMp5)

The following quotes also illustrate the experiences and feelings of participants, regarding the nature of the people they met and interacted with. Participant 2 recounted her experience regarding the race of the people she met during her IHM. She felt very happy because of the resemblance she had with them, “... everyone was welcoming, but living in Iowa you don’t always see lot of black people and as soon as the plane touched down at the airport (laughs) I saw lots of people that looked like me, and my family and friends and stuff, and so it was just like I felt okay to be there” (IHMp2).

Participant 3 talked about her experience with the people she interacted with, and the surprise, disbelieving the willingness of the people to disclose health information about themselves and their families to a stranger.

To be honest Evelyn, I don’t remember any specific stories from individuals. I can just remember that many of them shared about maybe their parents or siblings having had short lives because of a disease they might have died from; and they were just very open about talking about the health concerns and problems that they had in their lives. (IHMp3)
The following quotations also revealed participant's sentiments supporting the theme. Participant 4 also commented on her experiences and the mixed emotions she felt, while interacting with the people of her IHM. The people were poor with lots of sicknesses yet they kept their spirits alive with smiles.

My IHM experience was inspiring as well as sadness too, because of the poverty and disease. But the people above that they experience love, unity and community and you know, no matter what the obstacle or poverty issue they are having they still believe in family and always keep a smile on their faces, while everyday all they do is live in turmoil, devastation, you know, hunger and starvation... (IHMp4)

Participant 1 recounted her experience with the people she interacted with during her IHM, indicating the bonding, learning and the effect they had on her: “Yes! That one I said about the people, living close to the people, learning from them. They taught me more about myself, they taught me more about who I am... The people! In every trip I went to, that is what impacted me most” (IHMp1). The next quotation explains her feelings and experience in detail.

The people were very warm; they provided me with food and orientation for the first few weeks, and also in the weekend they invited me to the worship center with them. They also invited me for dinners at their homes and took me around for sight-seeing. When I was leaving they made sure I had a ride to the airport, while others gave me gift of necklaces, hugs and kisses on the cheek. Some taught me about how to be happy in life; they were very generous with little and happy. That says a lot! (IHMp1)

A student participant describes the people she interacted with in terms of: (a) the closeness (b) warmth and (c) hugs received, and the communal form of living as opposed to individualism found in the U.S.

The people are still in my heart; Again, I think I will say the people, the closeness and how they come up and hug you— you don’t get that in the U.S. People are
individualistic you know... this is my family and that is your family... take care of your family and I take care of mine... Once we grow older, we get married we get separated from our families still, you know, they like family life. The mom and when her children are old enough and she becomes grandma too, have them still live in the same row from generation to generation... I have a warm feeling when they come up and just hug me, they don’t even know me, you know— They weren’t looking at the color of my skin you know, they just hug me for want of nothing... just the warmth! (IHMp4)

Cultural knowledge: Cultures and countries. The participants recounted learning experiences about other cultures and countries different from their own. This happened because of the unique experiences created by the mission, to bring balance in their exposure to both the rural, urban and mountainous regions of the developing nations. The participants learned about the people and their cultural practices, in terms of the houses they lived in both in towns and villages, food, religion, schools and socio-economic impact on people’s lives.

The following responses illustrate participant’s feelings and experiences that support this theme. Participant 2 talked regarding the culture of her IHM host country, especially regarding the open market negotiation of prices and mode of carrying babies, she comments, “but those things like carrying the baby on the back; yeah like someone taught me how to do that, it is easier, like your hands are more free and it is better on your back; so those are some of the things I picked from the culture” (IHMp2).

Participant 2, however, in her narrative had complained about the improper education or preparation they received on the culture of the host country before embarking on their mission. She complained specifically about the fact that they did not
have adequate preparation, which she felt, was very important to contribute to the achievement of the mission’s goal. The following quote illustrates this frustration:

So, before we go over there, some education about Ghanaian culture and like the food they eat, how they dress. ....See we never really get to understand the culture before we went and I wish we had, because one of the chaperones that we went with had already been there...I don’t even know if she even knew the culture before we went. You know, just because you go to another country doesn’t mean like you end up or come back understanding the culture. So, before we go over there some education about Ghanaian culture and like the food they eat, how they dress ... you know! Simple stuff like that if they let you know before we go there would be very helpful. (IHMp2)

The participants spoke about their learning experiences in terms of housing in their IHM host countries, which they found quite interesting and different from what prevails in the U.S. For example, in the quote below participant 2 described the houses she found in the townships she saw, and the proximity that existed between the houses in the small villages.

We have some of that now in America but it was kind of different, because you know how they lived in the little areas, I guess, we call it neighborhood but is like all of the township or whatever you may call it...And when we went to the little villages it was kind of neat to see how close knit the villagers are. I saw the student who did his masters here at UNI; Yes... Dr. Ogah Joseph! We went to his house and saw how he lived in a nice house. (IHMp2)

Participant 4 was very surprised to see the disconnection among components of houses she found in her IHM towns as described in the following comment:

And just the fact that there were three-little houses, the kitchen was not connected with the home. The whole home wasn’t connected totally different from the way I am used to living, so everything was—there was one little house right here where the beds were and where we slept and there is another little house next to that where the lady that was the host, her grand children lived in that. They stayed in that one and
slept there, and then a third one right next to that, so there are three little homes next to one another. The third one was the kitchen area. (IHMp4)

Participant 3 was very surprised as she noted the contrast that marked living areas for the affluent and the poor in her response:

We were able to take some time to see the Island itself and it was very eye opening to see the area that we were sort of living in perfect time and the poverty that was there … and that also we spent a day where we got to see the resort; where may be a lot of honeymoon couples were coming, you know, to celebrate their honeymoon; and it was just devastating to see on such a small island that there were very distinct areas where people were living. (IHMp3)

Participant 4 related first-hand experiences and learning about the type of ovens she saw being used for cooking, and also observing the typical day of the people both in the city and the remote regions of the IHM country. She described these elements vividly in the quote below:

I was in both the city, rural, and mountain areas. Okay! I will say they will wake up early in the morning like three in the morning and I guess they will attend to the animals they have like cows and there will be breakfast, which will be served in the morning so that will be fresh food, I mean cut up on, and prepared over like a brick you know, it was just created from—not like they got it from the store but created from what they have. Like brick and mud and what they have on the outside was wood. And so it was like a big shift oven, like a wooden oven...And the children, the grandchildren will actually help with these chores. Behind the home our host grew cocoa beans, that was her livelihood and so her grand children will help her with that...Let see they had a tree which is not inside the building which was outside so, I assume they had to take care of that and make sure is clean and little things like that. (IHMp4)

Participants talked about seeing and learning different types of dances and music regarding the culture of another country during their IHM:

There were also a group of young people that we met they invited us to go with them to a local hall, where they were having like a dance in someone’s house. So we get
to go and experience the dance so, we heard about different types of music, and saw lots of different types of dancing that we won’t be accustom to here; so that is another thing I will recall that was interesting. (IHMp3)

Participant 4 experienced the impact of religion on the people’s lives as expressed in her own words, stressing “hospitality” as a way of life for the people.

I will say that religion was actually embraced or it was just kind of their lifestyle because of how they treated people with hospitality, and I know basic belief by any faith really is to treat people well and being good...they were very humble people, their worship was very humble. Yes...I believe they appreciate what they have even though they did not have a lot, you know they appreciate because we worshipped...it was just a dirt floor—They built a house...a big building made out of wood, no glass, you know you don’t see stained glass like a lot of these Catholic church buildings...You don’t have to worry about getting dirty, I guess, so they were just appreciative to God for what they have, and they just Bless God! (IHMp4)

These IHM participants relayed their experiences regarding the schools and educational institutions they saw and visited during their IHM (IHMp2, IHMp3, IHMp4 & IHMp5). For example, participant 4 remarked, “Yes! They go to school which was quite a distance. I don’t know if they have transportation or there was a little bus that picks them up, but they were walking quite a distance, maybe like three miles from school” (IHMp4).

The school was much like an open - classrooms where, when we were presenting in one classroom, you could hear someone else presenting just at the other side of the wall. The students were all dressed in uniforms...I remember. And from my perception it will seem most of the students had never seen a Caucasian person before based on the way they looked at us. I just remember a large blackboard at the front of their desk. Not a lot or anything on the walls, just very simple. But you could tell the kids were very eager for the knowledge that we had to share. (IHMp3)

The next quotation describes a different view on the schools. Participant 2 observed during her IHM:
Yes! They have a lot of kids in one classroom, with two teachers. But it was so hot, no air and everyone has a uniform in the school; that was so nice. The class that I went to, I think they had from two to five little kids with big kids and sometime it got chaotic. Little boy hits this boy and a little girl hits this girl but they learned (laughs)...And so that was different experience for me. (IHMp2)

Other participants shared their experiences vividly on food they tasted or saw in their host countries (IHMp2, IHMp3, IHMp4, & IHMp5). Participant 3 spoke about visiting a store to see the different kinds of food produce that was sold there and interestingly, to see people selling cooked or fried chicken at the side of the road. One could buy this food to eat for lunch, which to her, did not seem sanitary. “We did try some of their food, it was different, yah! Whether it was different spices, textures, or what not it was different from what you are used to” (IHMp3). Participant 2, beaming with a smile, commented on her experience with food in a different country and culture. “I had no problem with food; I brought a lot of my own snacks but I tried other dishes too like ‘fufu.’ We went to restaurants to eat, mainly, and one of the professors cooked a dinner for us too. But no, we were fine”— laughing! (IHMp2)

Participant 4 was most grateful for the food she ate during the IHM. She commented thus:

I would say it was the most-healthiest times of my life where I had healthy food every day, I mean the food was good...We ate a lot of fruits right off the top of the tree, fruits that was blended and made into juice, very delicious and healthy. I felt good and my system was functioning well filled with good food. Like, we ate rice and beans everyday and by maybe the third day of the second week, I got tired of eating rice and beans...I have no problem with rice and beans, but like every side dish was everything else. The chicken was delicious, beef, and everything was something good— the fruit, with fresh vegetables. (IHMp4)
Participant 5 was happy also because she had a good host who provided her with good nourishment and care.

When we were there we were hosted by a professor who teaches at the University of Morrero. She was a nutritionist so we were fed well ... we ate mainly rice and chicken and taco. The food was good—I guess why my experience was different was because the professor, who hosted us, I won’t lie to you she is someone who is well off. So there was no problem, not really. (IHMp5)

Participant 3, however, had a contrary view about her experience with food from another culture and country compared to what others had to share.

No, for the most part we ate in the hospital so it was the hospital staff that prepared our meals; and so there wasn’t, I don’t remember having a lot of fresh fruits particularly in the hospital...One thing I remember, for example, is we had baked beans with little hot dogs in it. I thought that was strange for being in St. Lucia, but that is what we had to eat. (IHMp3)

IHM participants also spoke of learning about various natural environments and climates of other countries. Participants 3 and 4 shared their thoughts concerning the weather at the time of their IHM. “It was quite warm similar to our summers...to be honest, I don’t even remember, I think it was during the summer, I think it was in July” (IHMp3). Participant 4 spoke on the weather she experienced during her IHM.

Well, the weather was the same as here in the summer time when we had our real hot summers. There was a difference. Just it was extremely hot in the U.S. In Iowa, we have extremely hot days, too. So there was no difference there; but going up the mountains that’s where it shocked me! It was much colder. It was comfortable weather. (IHMp4)

Cultural knowledge: Other languages. Mission participants expressed feeling regarding knowledge gained while learning new words, speaking in another language they already knew as well as learning a new language (IHMp2, IHMp3, IHMp5) similar
to findings in (Gallagher, 2004). They also shared on gaining knowledge on the proper communication of health information to a target audience. Participant 5 shared her delight for her ability to use a foreign language she learned prior to her IHM. She commented, “I always had tried to communicate, which, is to use the only Spanish I had and once they saw that I could speak a little Spanish that really, really made them trust me more” (IHMp5).

English can sound very different sometimes, which led to participant 3’s frustration. Her frustration was because she did not hear English spoken in her IHM host country. She said that the native people spoke English with an accent, which to her was not English because when she was asked whether the natives spoke English she responded, “Yes! Yes, but they have accent … you hear their native language, and it sort of pushes you outside of your box, because you are not hearing English everywhere” (IHMp3).

Participant 2 complained about not learning much in terms of language because of the short duration of the mission. She proceeded to Gambia after her IHM in Ghana, where she claimed she was able to speak the language more than she did in Ghana. She however, was proud of learning a couple of words but was only able to say one word in the new Ghanaian language, “Akua” meaning girl born on Wednesday. She then indicated that, “in Ghana, not so much because I was only there for a limited time, of course, I learned a couple of words to say but in Gambia I was able to speak more than I could speak out there” (IHMp2). As a result she was able to compare her IHM and internship experiences in both countries;

The other trip was through minority health research, through Iowa City-University of Iowa. That one was actually an internship, but we still were able to go out into the
community you know and we were on our own, so we had to learn... how to speak some of the language and you had to know how to get around the city and so it was exciting and it was a better experience for me. I mean, my Ghanaian experience I won’t forget it. But it wasn’t as exciting as it was in Gambia. (IHMp2)

Participant 2 spoke in terms of differences she observed in languages between the U.S. and other developing countries and especially people being required to use the language of their IHM.

Don’t be offended if someone tells you “you have an accent,” because I know most Americans from the south have accents. So, when I meet someone from the south, I usually ask “where are you from?” ha-ha-ha—laughs! Oh! I think I asked you “where you are from?” and you said you were from Ghana, and that’s how I told you I was going to Ghana. When I went to Ghana people asked me “why do I talk like that?” I told them I am an American, and people speak differently. But now people who go on international missions have to learn the local language. (IHMp2)

The students also talked about learning the appropriate means of communicating health information to their target audiences (IHMp5 & IHMp1).

It opened my eyes in terms of, you have to be able to communicate with your clients, your patients especially, if you are dealing with eh...the people we were looking even in Mexico did not even speak that much of English; we were not speaking English. So, to see how he was really able to, trying at least to understand us, that is something I took from there. That’s the way I can apply. (IHMp5)

Participant 1 commented, “I learned how to appropriately communicate health information such as using articles in the paper, poster presentations, radio messages, power-point presentations, word of mouth, using facilities where people gather” (IHMp1).

Cultural knowledge: A different healthcare system. Participating students gained an increased awareness concerning the numerous resources available in the U.S. and the impact of culture and environmental influence on people’s health. They, as a result,
became more aware of their "previous lack of appreciation for the vast resources, and the
general ingratitude by many U.S. citizens and patients" (Gallagher, 2004, p.111). A
participant noted, "even though many people here in America believe that our healthcare
system could be better, if they take time to travel overseas to see what others have, they
will feel much more appreciative" (IHMp3). Participants spoke about their learning
regarding a different type of healthcare in other nations. They commented in terms of
availability of healthcare and in support of this theme. Participant 4 shared her
experiences in the following quote;

Epilepsy, which one of the ladies had, and she had an episode when she fell out.
And so you know if it were in the States or I guess I don’t know anywhere else in
the world; but here, immediately an ambulance would have been called. You
don’t pick her up and sit her down and check to see if she was okay. They just left
her to recover by herself, no medication was administered you know, like you get
prescription from the doctor, things like that—not a bag. That just indicated to me
that healthcare was a problem; and it was up in the mountains so I didn’t know if
they had a facility in the mountains. But if they did in the city, in Managua it will
be several hours before help will arrive. (IHMp4)

Participants gained knowledge regarding a different system and delivery of
healthcare. Participant 2 expressed her personal thoughts and observation in regard to
how people gained access to health information, services and immunization, showing the
differences in the services that were provided to the people of her IHM in terms of
equipment and how babies were weighed, and where and how birth certificates were
issued.

But is like all of the township or whatever you call it, and you go round and you tell
them we are here...and they come and gather in a central area; and then the nurses
gave them a health talk about immunization and why it is important... Like I said
before resources—the way that the babies are weighed, they put them in a little
contraption, I don’t know what it is, and then scale and the way that immunizations are given, and birth certificates are given like you don’t get them at the hospital or in the—what do you call them? Midwives; you have to wait until the nurses come or the person that does the birth certificate comes to the village to give that, so those are some different experiences. (IHMp2)

Participant 5 shared how joyful she was to learn that there were other options of healing besides Western Medicine. "To me it is always good to know that as you treat people from different background, someone asks me, ‘is there other medicine besides that?’ Yes! We have to be opened to other options. Going to Mexico shows that they have something that can heal the sick" (IHMp5). These IHM participants recounted their experiences regarding new medical terminologies they learned in relation to a different type of healthcare.

A student gave this account, “Yes we did travel to the mountains and they have this garden at the backyard so they could show us and pull out the leaf and look at them. For me, unfortunately, I know the names in my language and they were saying the names in Spanish. But I said to myself, I know this leaf; I have seen it before back in my country” (IHMp5). Participants also shared on the nature and type of diseases they saw during their IHM. Participant 2 talked about her experiences with malaria in Ghana. Participant 4 gained knowledge about the disease known as “epilepsy” in her IHM host nation.

In the quote below, participant 5 shared her experience regarding the types of diseases that the Quarandiros or traditional healers are able to treat;

The Quarandiros or traditional healers do heal people with “edema” that people probably call “chicken pox” over here in America. They also heal headaches or stomach aches. Most of the herbs they use for stomach aches or instant diseases. In fact, when we were there I remember seeing a very poor and very sick woman holding her stomach and the man mixed up some kinds of herbs and got the juice
and gave her to drink, and she drank it and she left. And we were asking how long was it going to take for her to start feeling well? And the man said “in fact by tomorrow morning she will be feeling well...” (IHMp5)

The participants spoke on how they learned more about how the traditional healers are able to monitor workings of traditional medicine, especially after a person receives treatment and has been sent home. How long was it going to take for the medication to work? The students understood that people who go to the traditional healers for treatment when sick, live within close proximity. Thus participant 5 remarked:

These are the people who live near-by so, they will come back tomorrow morning or if he is able to travel there, he will travel to check on them and ask them, how are you feeling? Do you need more? I don’t think they just have to stay home. If you can’t come back they will bring it to you. They are just like doctors so they know how the medicine works. (IHMp5)

**Cultural knowledge: Skills acquisition.** The IHM student participants explained how comfortable they felt in utilizing the skills of assessing, planning, implementing and evaluating health promotion/education programs over the course of their IHM. The participants shared their experiences in support of this theme. Participant 1 talked about her experiences regarding assessing and planning saying, “Oh! Well we did an assessment before we did. You learn like the country’s profile, you learn about the health issues that particular country has, and look at the more prevalent problem there, and then you plan based on that” (IHMp1). This same participant further elaborated on her experience:

It prepared me at that time to really love that area of study and it made my theories in class more meaningful and then it prepared me for what I’m doing now. The skills I learned then like planning, implementing, evaluating...they helped me right now as a health educator, it shaped me in a different way; I learned by doing; so it meant my learning style. (IHMP1)
Participant 3 spoke about her experiences with the mission work which helped her to acquire the needed skill in healthcare.

As far as some of the missions we did, while we were there, we did a lot of blood pressure screenings; where we were just set-up outside the hospital where people will come in and take their blood pressures or we will just go or travel to one of the towns and just be along the street and take pressures. That was just interesting to me how the people, many of them called us doctors and wanted us to take their blood pressures doctor, that was me—so that was very interesting eye opening experience. We also talked about diabetes and cholesterol, education—those are some of the main things that I remember. (IHMp3)

Cultural knowledge: Summary. Participant’s experiences related to culture revealed knowledge about various people in different geographical settings in the developing world. People they encountered were rich, poor, humble, generous, receptive, giving, religious, educated and uneducated. The people were mostly black and some of mixed race. The interview data also revealed experiences regarding learning about cultural practices of countries and people. For example, “female circumcision” practiced among the Gambian people in some parts of Africa was unfamiliar to IHM participants for the most part.

Other IHM experiences were in relation to food, dress, perception about time, housing, religious impact on the people’s lives, traditions, natural environments, conduct and interactions, and receptivity to people of different cultural origins. The participants also shared experiences of learning about different systems and delivery of healthcare in their IHM countries. Thus, they were able to learn about available resources and medical supplies of their host nations, new medical terminologies, diseases, traditional medicine
and various healthcare workers and traditional healers. They also shared about how the IHM improved their skills in healthcare delivery, education and promotion including assessing, planning, developing, implementing and evaluating of patient education results and treatment. Through “hands-on” application of classroom discussions and theories during their IHMs, the participants expanded their cultural knowledge.

**Cultural Sensitivity**

Participating healthcare professional students talked about the opportunities that the mission experiences afforded them to gain a deeper understanding of the world and to become more adaptable (Gallagher, 2004). The cultural Sensitivity focus area revealed gains in personal understanding through greater awareness of differences among nations, while findings in professional understanding were related to experiences of learning about (a) a different healthcare system, (b) considering alternative treatment, (c) assessing patient’s health problems, (d) providing patient education, (e) providing patient treatment, and (f) evaluating results of patient education. Analysis of findings from the interviews for cultural sensitivity focus area, are reported in the sections that follow.

**Cultural sensitivity: Greater awareness of differences among nations.** Participants shared their experiences regarding differences they found in cultural practices, housing, infrastructure, and environmental sanitation. This quote below was shared by a participant, who spoke of her experience with the cultural practice of ‘female circumcision,’ which she observed in two nations, Ghana and Gambia.

Yes, because we are required to do a research paper when you come back—and so you had to pick something and research; and I researched female circumcision ... Yeah! In Ghana, no, I didn’t even know about that... I heard about it but not the
extent of what it was ... They practice it a lot in Gambia. Because they are 99% Moslem and I think it is a bigger Christian-base in Ghana. Well, they think Christians do it too, but I think if you have the Moslem background where it said in the Koran then you do it ... Yeah! They practice it a lot there even though it is illegal they still do it ... (IHMp2)

In her remark, participant 2 emphasized the role that both men and women play to uphold this cultural ritual and why most of the women agree to it.

How, when I talked to the lady there she pretty much put down women even in her culture, those, who did not practice that she called them Westerners/Europeans. So like that kind of expectation; I guess mentality and how women have to deal with that, and I am like I don't do this but am certainly repelled as an outsider. But do they know how hard it is for anybody to live with this? ... A lot of them did it because they want to be married. Some men if they kind of aware that you are not circumcised, they then divorce you. (IHMp2)

Participants observed differences in student housing and amenities. Participant 2 shared her experience regarding differences she found in dormitory conditions between the U.S and those in her IHM mission country in support of this theme.

Well, from the time that I spent there we lived in the dormitory and it was very different compared to the dormitory that I stayed in; I thought the dormitories (laughs) here in America that I lived in were like run-down. You know, but it made me like appreciate what I had here because half the time I was there it was very difficult for me; I was never able to take a shower or take a bath. And the water was in a big garbage pail (a plastic bucket) I don't know how you call it. And then you see all the students carrying water on their head just to go take a shower and stuff like that; and the electricity was limited so we had to do certain things between time frame; so that is it for the dorm. (IHMp2)

Differences in infrastructure between the IHM countries and the U.S. were noted. In the quote below, participant 3 recounted her feelings and experience regarding the nature of roads and transportation in her IHM country.
I remember seeing a lot of vans ... I think more drivers that were hired; I don’t remember people having a lot of their own cars. But I just remember that the drivers drove very fast ... They were van-based, like our taxis... and the roads were very hard to travel on. They weren’t well kept and very bumpy as the roads seem to be the drivers still went very fast ... Nothing like what we have over here. (IHMp3)

Environmental sanitation in the host nations was certainly a point of interest for these IHM participants. Participant’s comments indicated the unhygienic conditions prevailing in some IHM nations and the role of government to enforce laws that will deter people from littering the environment. A participant expressed this sentiment;

I think economic and political like there are laws against trash and stuff; they need to be enforced because of malaria. Like you have a lot of pools of water standing which breed a lot of mosquito larvae. Also, there is a lot of trash thrown everywhere...I mean that was just simple answer, obviously it is not easy to do but it needs to be done...So, I think if the laws are enforced you know pick up your trash and make sure the puddle of water like, be careful with them or cover them up or something because that increases the chances of sickness. (IHMp2)

Environmental influences on healthcare and other social services were also addressed by participants. Participant 4 shared her learning experiences regarding the impact of environmental influence on health, thus supporting this theme, as stated in her comment:

When people are not satisfied with those in power it is the poor people they mainly, yeah! They rise up because of the lack of healthcare and all the other issues. I believe that the president in power now is trying to make a change, a difference—He was in power before and they re-elected him and so it seems like he had epiphany, I guess, and now he wants to change his ways and bring more money into Nicaragua. So it helps poor people to establish and also establish social services that were; and bring money into those social services that will help people in the rural area and in the cities; you know, as far as educating the farmers and bringing in more money into the country. (IHMp4)
**Cultural Sensitivity: A different kind of healthcare.** Students recognized the differences that existed between the healthcare system and delivery in some developing countries than that of the U.S. Participant 2 spoke about the differences, especially referring to the way babies are weighed and how immunizations are conducted in the U.S. and the host nation. This same participant talked about her experiences indicating that whereas these procedures are done in the hospital in the United States, they were carried out in the open and by few health workers in the host nation. She emphasized, nevertheless, that the mothers in those countries knew they had to take their children for immunization and that failure to take their children for immunization would not be due to ignorance but for a different reason. This is what the participant said:

Yeah! Like the way the measurement system, the scale when they weigh the babies like a harness and the big (laughs) brown jacket. That was cute, a lot of babies didn’t like it though, and they cried— because you got “a little dangling!” Also the way immunizations are carried out, like we go to the hospital but they do it outside. I mean it is not a big deal; though it might take you forever because you will have about two, three workers but at least you know you’ve got to take your baby for immunization... and if you don’t go then it is your choice. (IHMp2)

Participant 3 spoke about the only difference she perceived between the U.S. healthcare and her IHM host country lies in the healthcare system itself, which she described briefly.

The only differences that I saw was in terms of healthcare that was offered, that people had to wait for a very long time before getting to see a doctor ... So, the main difference to me was the healthcare system itself— people coming from many miles still on foot, waiting for hours to see a doctor and some are very sick. It just was very difficult to see they had to wait for so long. (IHMp3)

Participant 2 focused on the scarcity of resources in the IHM countries, compelling healthcare professionals to resort to the use of radio for event announcements as indicated
in her response: “So, just like how do they know what immunizations their child needs, because a lot of people don’t have phones and I doubt even the healthcare workers have telephone themselves” (IHMp2). Participant 3 commented, “I’m sure in terms of the equipment there will be differences. I didn’t see a lot of that myself, and I didn’t get actually to see a lot of or examination of that nature” (IHMp3). This same student in her interview compared how much easier it is to obtain medication in the U.S. than in her IHM host country.

In comparing what we have done as an American is to realize how opportune I thought I felt, especially growing up in rural Iowa to see the kinds of things that people in St. Lucia were dealing with, with their health compared to things that we deal with over here, how easier it seems to get the medication that we need quickly, to be able to just go down the street to a doctor, or say some of them had to walk on foot for miles to get to the hospital and then wait for hours to receive care. (IHMp3)

Participant 5 shared similar feelings on the availability of traditional healthcare professionals in her IHM host nation saying;

Well, I can’t speak for the whole Mexico, but where we were up in the mountain, not many; it’s just like any other culture, when they get old they pass on. There is no one to take over. They were just two; they weren’t that many where we went …. Given the remoteness of the specific area that we were, which was about two hours drive from Mexico City, I think they tried to do the best given what they did...The best that they can do is to equip the people or write down the names of this medicine they are using so when they’re gone this can be used. But given what they have they tried their best. But apparently, there is no documentation. (IHMp5)

Cultural Sensitivity: Considering alternative treatment. The IHM experience provided opportunity for participating healthcare professionals to learn about other forms of healthcare available in various countries. They learned about traditional or alternative
medicine. Participant 1 spoke specifically about her experience regarding the negative and positive impact of traditional medicine on women’s health.

My experience in Ghana, I learned about how traditional practices can impact people’s health and health decisions. When I was in Ghana I was interested in looking at the impact of traditional practices on women’s health, I found out that sometimes, they may use local remedies to take care of some health concerns, this was positive, but also it could be negative as it could lead to the delay of new approaches of addressing health problems. (IHMp1)

Participant 5 recounted her experience with traditional medicine in Mexico, emphasizing that there are other forms of healing that healthcare professionals can explore. She expressed her views thus:

It meant the healing we are used to go to when we get sick, and we know that diversity is increasing here in the U.S. So there are alternative medicines that actually I was looking for— being a health professional in healthcare, there are other alternatives using traditional medicine. To me it is always good to know that as you treat people from different background, someone asks me “is there other medicine besides that” Yes! We have to be opened to other options. Going to Mexico shows that they have something that can heal the sick. If you want to see its work face to face, “yes”. So if you want specifically, to learn about the alternate medicine, “yes” Mexico is not far from us, from the States. And we have people from Latin America, African – I mean though, traditional medicines in Latin-America are not different from traditional medicines from Mexico. So! I guess learning about those traditional medicines will be interesting. (IHMp5)

Cost of healthcare and geographical location determined people’s choice between Western and Traditional medicine. The same participant was able to observe the traditional medicine in Mexico first-hand. She talked about the reasons behind people’s choice for healthcare, the connection between health providers and patients, payment flexibility and how providers perceive their patients (IHMp5). She talked at length in support of this theme.
We were told that most of the people prefer the Quarandiros or traditional medicine than the Western medicine. And we were told that because they trust this Quarandiros. They’ve known them long time, perhaps this Quarandiros treated all parents and relatives. So they go to the Western medicine (for lack of a better word) if it is really, really something worse, or they have tried everything with the traditional medicine, and nothing is working; that will be their last option... But also I think it depends on where they live. Those people in the cities (we went to the village), I am sure those who lived in the cities and have more money will go to the hospital first. But those at the country side may be it is closer to them and also maybe in terms of the cost. This Quarandiros are not charging a whole bunch of money, I don’t even know if they charge them. If you are willing to give me medicine and I pay tomorrow or whenever I can afford, is better than going to the doctor and then they give you prescription and then they give a bill. (IHMp5)

Participant 5 again talked about the way plants or herbs were processed for medicinal purposes both in her host and native country of origin, since people in the remote regions relied mostly on alternate medicine instead of Western medicines for their health needs.

The way they prepare medicine was the same, for instance, you go out there, they know the herbs and their names, what to pick, they gather the herbs they bring home. Some may be need to be prepared fresh. They wash them and they mix them and get the juice out. Some of them may be need to be dried and eventually extract the juice. As they were preparing the medicine, I could see my mother mixing them out using mortar and pestle to extract the juice. Those were the similarities. Again, I grew up in the village those who grew up in the city may have a different take on it, but ah! (IHMp5)

Students spoke about their learning concerning the availability of healthcare professionals in other countries. Participant 2 related her experience, while comparing healthcare accessibility in the U.S. and the host country, a very important aspect of healthcare; “Also the way immunizations are carried out, like we go to the hospital but they do it outside. I mean it is not a big deal; though it might take you forever because
you will have about two, three workers” (IHMp2). In the quote below she emphasized her disappoint in the lack of access to healthcare by some marginalized groups in the United States.

It was kind of neat to see how close knit the villagers were; the people living in the villages, how the nurses went out to give information to them because we have a sad situation here (U.S.) that people are unable to get certain information because of transportation, so it would be helpful if we have like programs that went out into the community, more programs actually run by the community health educators. (IHMp2)

Cultural Sensitivity: Providing patient’s education. These students shared their thoughts and feelings as to why the patient’s health needs should be assessed before planning the patient’s education. Patients health needs can vary based on who they are in terms of, for example, culture, socio-economic status, gender and language spoken. The cultures of the target audience are important factors that could influence planning for and educating patients. Participant 1 disclosed her experiences regarding working with diverse audiences. “For example, in St. Lucia we educated women from the health clinics and men from where they were fishing, I learned to meet them where they are. In Ghana, I learned how to work with the local leaders in order to get things done” (IHMp1).

Participant 2 gained experience in proper communication and open-mindedness, working with people of different countries and cultures;

Yeah! Before I thought I was a diverse person but now I don’t think, I kind of looked at what about if I have a patient from another country and there is a language barrier, how am I, going to get around it. But I understand now that not everybody is going to be able to speak English, and everybody is not going to think the way I think that I think you know, so! Just be open and try to communicate as much as you can. (IHMp2)
Need assessment is an important skill in health promotion and education that helps the
health-provider to offer effective services to their clients or patients. Participant 1 spoke
about her mission experiences relating to this theme.

It taught us to assess and make sure you’re meeting the right need, and working with
people that you are trying to change never even a good idea to just go ahead, without
finding out and try to plan for people when you did not even talk to them. You can’t
pretend you are super and tend to ignore, (laughs) if you want to work with people
assess their needs, talk to them one-on-one first and have their suggestions and come
up with a plan that you think would be more meaningful. (IHMp1)

Participating healthcare professional students learned why they needed to understand
their patients and clients before they provided education. “I feel like it is very important
to understand a patient no matter what background they come from, you know, you have
to understand the way they think in order to educate them on health issues” (IHMp2).
This same participant spoke about skills that aided her in her work during her IHM,
which she thought would be proper for educating culturally diverse populations in the
U.S.

E-e-eh! I think I said this before, like just be open to other cultures and like kind of
know where they are coming from because if you are open to them you are able to
communicate more effectively like if you know someone and their culture they don’t
do this practice that we usually do here in America then you have to improvise. Is
giving the same information that you will give to an American but in a way that they
can understand, and then like explain it to them okay, that like “you might do it this
way in your culture, but if you do it this way here is the benefit okay”. But you just
have to compromise somewhere. (IHMp2)

Participant 3 also talked about how important it is to listen and communicate
effectively when trying to educate culturally diverse populations. She noted that
Americans are fast in speaking and need to slow down in attempting to educate culturally diverse people. She commented thus;

I think just taking the time to listen and after explaining something to take the time to say ‘does this make sense to you?’ If they may have a puzzled look on their faces to try and find different ways to communicate to them; a different way to get the message across to them. I think in America we are often very quick at communication, we speak very quickly and just remembering to slow down in speech, but also to verify that the information is understood, and if it is not, to make sure that you take the time with each individual person that they understand what you said and if not to say it in a different way. (IHMp3)

Participant 2 stressed the importance of learning about different cultures, being diverse in thinking and having an open mind before attempting to educate culturally diverse populations.

You have to understand different cultures- you know; because your patients are going to come from different backgrounds...so you have to be open-minded, be diverse and you know about different cultures and that will help on the communication. Like the Latino-Americans, they might need a different education than African-Americans or American-Indians...I mean you don’t have to overwhelm yourself but little simple things like what do they think about time? Like is time important? That is important, because when we went to Africa time is not all that important and that is a reason that’s important you have to know. Why is time not important? Because sometimes you have to travel ways to go visit your relative, and so you might spend hours and hours there and what they have planned before might not be important. But just knowing what is offensive and what is healthful information for your patients might be good. (IHMp2)

Participant 3 felt her clients were not well-informed enough to know the difference between a health educator and physician. She was convinced that knowing these differences could guide them on the type of questions they could ask a physician and not a health educator.
I think it definitely made me more aware of different cultural backgrounds, different health upbringing that maybe our international students had. Thinking of different ways to explain why we take our blood pressure for example, what we are looking for because it seems like we can provide very basic information there. And it seems like they did not have a lot of detailed questions, whereas you know if you are working with someone that is very educated and knows a lot about something particular with their health they may ask more detailed questions of the health educator that would make more sense to ask their physician. But they just think you know the answers, but we don’t – laughs! (IHMp3)

Participant 4 talked about her experiences from the mission, which she deems very helpful since that is going to assist her in her future career in social work, and to provide culturally appropriate services to people of diverse cultural backgrounds. The following quotations support the theme.

It helps me that when I work with people in diverse population, I would be able to respect them and understand what they are going through and provide services. Because my goal is to have an organization servicing people in every ethnic group and background. It is going to be diverse services that I will provide for people, and I will be able to understand. Because I have been there and I have seen it, so I will be able to provide services that they will look for, for each specific ethnic group. (IHMp4)

Participant 1 talked about the role of visual aids in patient education and utilizing different approaches to health education.

It was very helpful to learn this and as we travelled it helped to see what certain people think on different health approaches … I learned that when you educate people and show them visuals about the consequences of a particular disease, they are more likely to react towards a behavior change, for example when we educated people on dental hygiene in St. Lucia, we used demo to show teeth and we washed out plaques on it which made the kids be able to remember those lessons well. (IHMp1)
Cultural sensitivity: Evaluating results of patient's education. Students talked also about learning how to evaluate results of patient education due to mission experience. “And then it is always good idea to evaluate to make sure if you think you’re making a difference or you have to make a little adjustment and be willing to be flexible; so we learned all those stuff on our trip ... right, even to get suggestions from the locals and your team mates” (IHMp1).

Cultural sensitivity: Plan patient treatment. A student spoke of how comfortable she felt treating patients from another country and culture after her mission experience. “And now that I have gone to other countries, I know there are thousands of other countries that I haven’t gone to but like if I know someone is from West Africa a lot of them like spiced food. So, if they come in with stomach ache, heart-burn; what kind of food have you eaten ha-ha-ha-laugh! You know so! I am able to address that” (IHMp2).

Cultural Sensitivity: Summary. Interview data obtained for the cultural sensitivity focus area indicated greater awareness or sensitivity on different fronts. These included awareness of differences in cultural practices. For example, rituals of “female circumcision” are practiced in some countries in West Africa and not in others. Their experiences also revealed gaining awareness regarding differences in housing and living conditions as observed in towns, villages, and on college campuses throughout their IHM nations and those of the United States.

The data also showed that participants became more aware of the differences in infrastructure regarding roads and transportation in their host countries. They also gained awareness of prevailing environmental influences on healthcare and sanitation in their
IHM countries and the United States. The interview data indicated greater awareness by IHM participants regarding the differences they observed in the delivery of healthcare. Participants gained greater awareness concerning the following: (a) access to health information, (b) resources and locations of programs, (c) cost, (d) health workers, and (e) traditional medicine. IHM participants became more sensitive to different systems for providing patient education and treatment, using skills such as assessing, planning, communicating, listening, using visuals and evaluating patient's education.

Self-Confidence

Participants in an IHM talked about the change that occurred in them individually regarding values and beliefs, due to learning opportunities and experiences offered by the mission. This same finding occurred in Gallagher (2004) indicating that the individual transformation reflected an affective component that impacted both their personal and professional growth. Generally, the IHM participants were pleased with the improvement in their self-confidence following their IHM experience. Interview results revealed both professional and personal growth in participant's self-confidence. Personal growth occurred in areas that included (a) inner satisfaction, (b) insight, (c) learning about self, (d) appreciation for U.S resources, and (e) overcoming challenges. Growth in professional self-confidence was realized in areas regarding (a) feeling for patients, (b) setting standards, (c) future career focus, (d) adaptability in various situations, and (e) sensitivity to the needs of people from various countries.

The healthcare student participants talked about their experiences relating to self-confidence. "Yes! I would agree [laughs] that a student with IHM experience has more
confidence to provide healthcare to diverse people of different cultural origins than individuals who never participated” (IHMp3). Another participant responded positively confirming this belief. “I would say yes! It improved my confidence level in being able to provide services to diverse population” (IHMp4).

**Self-Confidence: Inner satisfaction.** Participants spoke about specific experiences that brought joy and satisfaction to them during their IHM in the developing countries. The students talked about their satisfaction in terms of personal benefits that came along as gratification or individual fulfillment of a need of some sort (Gallagher, 2004).

Participant 2 commented;

> Just being around other college students and having them welcome us, just letting us come into their territory to teach them, and working with them to get health education throughout Ghana was important to me; I really appreciate them opening their arms to us and accepting us. (IHMp2)

Participant 2 again responded “I mean I enjoyed my stay, I mean like I want to go to Ghana and like fully immerse myself in the culture. In Gambia, I had a little of that like I said the mentors over there were very helpful. And then I want to visit other African countries when I have school breaks and have about $3,000.00 [laughs]” (IHMp2).

Participant 5 confirmed earlier assertions by her colleagues saying, “Yes, I was one of the lucky people; she has everything—just like to be here in the U.S. Other people, who stayed with other host families, had different experiences” (IHMp5). For example, participant 1 expressed her satisfaction with the people she met and interacted with in the next quote:

> And to see they’re welcoming, how they love you, they temporarily teach you about their culture, they interact with you, to me was the most meaningful; the people. In
every trip I went to, that’s what I think about most. Remembering you are doing it for people, or you’re doing it for; you are just for being adventurous and traveling and enjoying the plane flight. (IHMp1)

Participant 4 was satisfied with her meals during her IHM especially the impact of these foods on her life and digestive system was expressed;

You know we had the fruits, so, it was very fresh food, the chicken very healthy food. I never felt better in all my life, being there I felt so good on the inside. That was one of the exciting parts of it, one of the best parts, because there were lots of great moments, there were lots of good moments being there. (IHMp4)

Participant 1 spoke about how easy it was for her to integrate into the culture of her IHM host country. She was at home with the culture, she knew what to do when she woke up, what to wear and did not bother about her appearance or her language. She was particularly happy for the people she met and interacted with, thus helping to broaden her perception about the world.

Yeah! If I were somewhere, where the culture and social activities are similar or close to mine, it felt like home I did not rush to come home right away. I was going to church, and I didn’t want to leave them, they were my friends [laughing]. It was like I went to church when I wake up in the morning. Yeah, I know what to do; I am not so conscious about what they will think about me, my clothing, language, hair, that wasn’t an issue. But, you get to know a lot of people and many viewpoints. You will have a good time. (IHMp1)

Participant 4 spoke about the appreciation she had for the people, their genuine faith and worship. She was particularly full of admiration for these people because she felt that they were authentic in their worship without any pretence and took pride in what they had.

You know a lot of times people, they know people are coming from the United States, they are still Americans, [laughs]—then they will be forced to put up elaborate, ‘We have to put up our best, but that is your best.’ God says ‘work with
what you have, that is your best.' You don’t have to put up a show for anybody you
know; and I just enjoyed that. The children everybody participated in the worship;
everybody was active in the service. (IHMp4)

Participant 5 expressed her feeling regarding the opportunity she had to learn first-
hand from the traditional healers, the Quarandiros, who she described as “those who
actually do and know the work.”

I went to Mexico, I think it was 2005. I went with a student. We went to Mexico for
one week. The intent was to learn about traditional medicine. We visited the
Quarandiros— I think they are the traditional healers. I enjoyed it; specifically
coming from Africa, Mexico is no different. However, I was pleased to see that we
are actually learning from people who actually do the work. We went to the region to
see the Quarandiros, they used herbs, they used special herbs and they know their
names. So that is similar to what I am used to; what I grew-up with. It was a good
experience; I liked it and always wanting to go back. But really seeing that the health
system, I think the similarity between what I saw in Mexico and what system we
have back at home; it made me really happy to see that as health professionals the
old men we were able to watch back home, are similar. (IHMp5)

Participant 4 shared her experience of working side by side with people of different
cultures and countries and her admiration for them during her IHM.

Well, a lot to share; I just want to say that I think everyone should have experience
of living, working side by side with people from another, a diverse population or
ethnic group. I just feel all people and countries should if it is feasible (if it isn’t
expensive don’t kind of refuse to do that) to travel, to find out about other cultures.
Don’t be caught into the fact that ‘the media says,’ you know, and then we all come
from somewhere else, and then just experience. I wish that all people are like the
people that I met— just read on open-wide you know. I just wish, that’s my, the
world right now [Laughs]! The peace, the indifference, prejudice, and
discrimination. (IHMp4)

A participant talked about her anxiety as the only black person on the team and
needed to gain the trust of the people who did not even speak English, thus she resorted
to using the limited Spanish she knew and it paid off.
Also another thing since, I was the only black person I didn’t know how they were going to receive me. I had to gain the trust. So, I always had tried to communicate, which, is to use the only Spanish I had and once they saw that I could speak a little Spanish that really, really made them trust me more; the few words of Spanish that I said, that gave me the lead. My experience was again, remember, I am a very patient person… I guess because I was hosted by this professor everything was great. For me I did not experience any hostility. Whatever I learned in Mexico wasn’t really new; it is something I grew up with. (IHMp5)

Participant 2 rather, shared her dissatisfaction concerning the way the mission was organized or supervised. She expressed negative feelings about her overall mission experience, “Yeah! So, I wanted to come home right away; why am I there if I can’t have experience; I traveled all this way and am like I can’t learn anything? That was very upsetting at the time but now I had to get over it” (IHMp2). In the following quotation, she further emphasized her point regarding mission supervision:

It depends on how supervised it is because like the mission in Gambia wasn’t supervised but like it was indirectly supervised. We had someone we can go to, but for two weeks at least ever since we had another guy, we had mentors that were actually from Gambia that we could talk to. Then later another American lady came and she was the overall of us, and made sure everyone was okay and made sure everyone was going to the sites everyday for work. And that was a good experience conducted like for an adult, and if I needed someone to talk to I knew whom to go to. Whereas in Ghana I just felt like I was being rushed over at times and like being told what to do and not to do and not being able to enjoy my stay there. (IHMp2)

Self-confidence: Insight. Participants articulated the insights into their own personal mission experiences in a variety of ways. Some thought they needed extended time in order to acquire more knowledge about people, cultures, and countries. They thought this was necessary for greater skill development that would help in providing better services to culturally diverse people. Participant 2 was particularly worried that her teammates were not accepting the reality of the situation. She feared that this would prevent them
from acquiring the necessary skills for the healthcare profession. She spoke about this in her comment:

When we were in Ghana I felt like eh! My colleagues or those students who visited were kind of reserved and like had certain mentality that they were not willing to open up to the reality of the situation, and that’s not how you supposed to, you know, when you go through that situation of course you are going to have your own thoughts, there’s no argument about it. But once you get into that situation you have to accept that reality; if it is true then it’s true but if it is stereotype and your perception is different—just accept it. I didn’t feel like they were opened and willing to accept it; I thought they were just like ready to go. (IHMp2)

Other participants recounted their experiences, saying why it was important for healthcare professionals to be culturally competent. They emphasized that “immersion” was the best means for learning. For example, participant 3 expressed this sentiment regarding this theme in the quote below:

Being among another culture is a lot different than reading about it in a book or watching a movie; when you’re actually in front of the culture. I think just everything about being immersed in a culture, you experience the food they have to eat, the climate the people live in, you hear their native language, and it sort of pushes you outside of your box, because you are not hearing English everywhere. (IHMp3)

Participant 5 for example, talked about demographic changes taking place in Iowa and the need for healthcare professionals to be culturally competent, exemplified in the next quote:

Seeing that people are trying to teach us is something that I brought back. Also, I guess living in Iowa has its own advantage because Iowa is, like is a “tornado,” is getting more diverse, even within our schools. So going to Mexico to see the culture… I know how I can relate with Hispanic people. I know how I can relate to Latino people because I have seen it. So...as a healthcare professional you have to be
culturally competent...You can read in the book, but when you see it and you are able to work with it, that is more practical. (IHMp5)

Participant 4 commented on time constraints for gaining knowledge during the IHM.

Like, I said two weeks was not enough and the program I went with, Global Health Corps was not tied with lot of that trip. Well they put the trip together. You can get knowledge, I mean, it has more, more of the cultural mores upon you, more being involved that was just great [laughs], I will continue to pursue that. (IHMp4)

Participant 2 gave suggestions to faculty who are responsible for planning regarding the organization of IHMs.

I will just suggest for the faculty that planned the mission trip to be a little bit more organized than my 2007 experience; and like maybe, present some of the stereotypes that are often presented to us as Americans; and then tell the students okay now go over there and see if this is true, you know! And tell the people that you have to be open-minded, and then just try to experience the culture. When foreigners come to America we expect them to speak English and eat our food. So I kind of think that it is important for us if we tell other people that, then we need to do that when we go to other people’s country. (IHMp2)

The response below reflected a participant’s feeling regarding the importance of gaining knowledge as healthcare professionals which would enable them to practice in diverse cultural settings. Participant 5 felt that though differences exist in cultures, there is no superior culture and that all cultures are good and equal. She talked about some of the qualities that helped to make her a leader of her IHM group. Above all, she thought my dissertation would help in advancing diversity in the real world. The following quote illustrates her feelings, while emphasizing the importance of knowledge for healthcare professionals.

I guess there is no limit to health profession. If, for instant they pick you up from here and plant you in Peru you can even serve there as long as there is knowledge. And also, I think here in the United States we tend to think that, “our way is better,
what we know is better.” That is not true. There is no greater culture; all the cultures are fine and very equal. We do really need to think of what we can learn from each other especially in the health profession. We would be dealing with people from different backgrounds so, you may as well be open to their culture. (IHMp5)

Participant 4 spoke concerning the quality of life of the Nicaraguan people, who she had the opportunity to meet and interact with during her mission experience. The impact of governments on the people’s health, not having their needs met, and the seeming epiphany of repenting and doing the right thing for the people.

The quality of life for Nicaraguan people is not too good really, because of the political atmosphere and because of what is going on with every president in office. They govern in a way that wasn’t benefitting the people, not seeing to people’s needs, but “how much money can I pocket and spend and take care of myself and some friends,” and so that plays a very important role in the country’s economic situation and the quality of life itself. But I believe now they are trying to make a turn-around. (IHMp4)

Self-confidence: Learning about self. Participants expressed their feelings and learning about themselves through their mission experiences in their responses. Participant 1 shared her joy for interacting and learning about her strengths and weaknesses from the people she met.

Yes! That one I said about people, living close to people and learning from them. They taught me more about myself and they taught me more about who I am. Through them I could count my strengths and weaknesses and also knowing you are there you want to make an impact. It makes you strive to do the best, you know; to plan a good program. You don’t want to go there and come back like you went to waste time or you took advantage of them so you can learn and get out of the country. You want to give the best to the people, look in their eyes while chatting with them. (IHMp1)

Self-confidence: Appreciation. Healthcare students expressed their feelings of growing personally in areas such as learning to accept oneself more in terms of shape or
color, being grateful for the quality healthcare they receive, and better living conditions they enjoy in the U.S. compared to what they experienced during their IHMs. Participant 3 shared her feelings about learning to appreciate the type of healthcare she has in the U.S. “Even though many people here in America believe that our healthcare system could be better, if they take time to travel overseas to see what others have, they will feel much more appreciative” (IHMp3).

The quote below reflects participant 4’s observations and experience regarding living conditions in the dormitories in the U.S. and those of her IHM host country. She found living conditions in the dormitory to be sub-standard in terms of shower amenities and shortage of electricity which impinged on her ability to take a shower or forced her to do things within a certain time limit.

You know, but it made me like appreciate what I had here because half the time I was there it was very difficult for me; I was never able to take a shower or take a bath. And the water was in a big garbage pail (a plastic bucket) I don’t know how you call it. And then you see all the students carrying water on their heads just to go take a shower and stuff like that; and the electricity was limited so, we had to do certain things between time frames. (IHMp2)

Participant 4 talked about the abundance of food she enjoys in the U.S. compared to what she experienced on the mission. The quote below supports this theme.

For a week, I guess, I got tired of rice and beans but then, I will have a dish but actually we were told not to throw anything away, leftovers, because of scarcity of food you know and so that made me appreciate because we throw a lot of food away here. You know, my grandmother and my mother always used to tell me when I was little, “don’t throw the food away because of other people in the country, yeah!” There were a lot of people who always tell me that. (IHMp4)

Self-confidence: Overcoming a challenge. Participants shared different aspects of their growth in self-confidence which they realized during their IHMs. These included
the ability to take a first international trip without their families, sleeping alone in
different rooms beside what they were used to in college, learning to accept prejudice and
trying to communicate in a different language, specifically testing Spanish skills. For
example, participant 3 talked about her experiential learning in relation to her first
international trip abroad.

Well first of all traveling internationally, I think going to St. Lucia was the first
international trip I've taken. I was still a young college student going without my
family. That was a big step outside my box for me. When we arrived at the location
where we were going to be staying for our time, we actually stayed in the hospital
setting. I had to admit, I was nervous when we first got there and found out that we
each had one room. At first my friends and I weren't sure if we were comfortable
with that, but eventually, it was just fine. (IHMp3)

Participant 5 spoke concerning building self-confidence as result of her interaction
with non-English speaking people and gaining the ability to work with people of diverse
cultures during her IHM.

Yes, going there was helpful because I did not speak Spanish. I have taken Spanish
for one year so, I was also testing my Spanish to see whether I would be able to
understand. Actually, I gained more confidence in working with everybody. I have
worked with Caucasians; I have worked with African-Americans and Africans, and
actually, with Hispanics. But, actually, the Mexican people were very receptive, nice
people. Yes, it gave me confidence. I know now that I can work with everybody.
(IHMp5)

Learning how to accept prejudice was one important lesson that participants had to
learn during their IHM. In the quote below, participant 1 related her experience in support
of the theme;

What I see particularly, of the other side of the coin, for me, I had to learn to accept
some of the prejudices. One example is when a taxi driver got really mad at me for
making his car dirty after a long day working in the mud to help build a house as part
of our project. He got mad at me but not the other student. We were both dirty. This
showed me that there was something that triggered him to be so angry at me. I assumed it was our skin color differences... Like, when I was neutral you could see that they treated me differently than my friends so you need to learn how, actually, they might not be familiar with you. So you can accept who you are and just keep yourself. But towards the end we were hugging and crying [laughs]. We became very close. At the beginning they were a little bit hesitant. (IHMp1)

**Self-confidence: Feeling for patients/clients.** The IHM participants discovered that they had developed a feeling of connectedness with their clients or patients they interacted with, which was beyond their professional growth. This theme is similar to the findings in Gallagher (2004), which is reflected in the following quotes. Participant 3, thus commented, “This really saddened me a lot, it really opened my eyes. And now as an adult, working in a health profession to support people in other countries that don’t have healthcare or healthcare systems that aren’t as good as what we have” (IHMp3).

Participant 4 felt a great deal for the people of her IHM after seeing the surrounding poverty and the lack of material wealth. She also expressed similar sentiments regarding this theme:

> It has impact on me in terms of the people and the poverty and how I need to; it got to the core of my heart, because I want to help other people in the best way that I could. It helps me that when I work with people in diverse populations, I would be able to respect them and understand what they are going through and provide services. Because my goal is to have an organization servicing people in every ethnic group and background. It is going to be diverse services that I will provide for people, and I will be able to understand. Because I have been there and I have seen it so, I will be able to provide services that they will look for each specific ethnic group. (IHMp4)

**Self-Confidence: Setting standards.** Participants also spoke about various experiences during their IHM, which they felt had helped to reinforce their understanding of the “does and don’ts” in healthcare for people of diverse cultural origins. These
included doing away with stereotypes, being open-minded, being accepting of other cultures, learning from different cultures and making healthcare more practical. One of the sub-themes which the participants talked about was in regard to inadequate preparation and planning. They, therefore, gave suggestions including more intense future planning for IHMs in terms of conducting proper orientation to be provided by natives of the host country if possible. All IHM participants must participate fully in addition to addressing issues regarding safety (IHM2).

Participant 5 stressed on the need for practicality in healthcare as she responded to an interview question on cultural competency and immersion. She indicated that students by all means must be exposed to the real world after learning the theory. She offered these suggestions regarding how this could be achieved in the case of limited resources.

I am probably not your average person in terms of cultural competence because of coming from and living it since I was a child. Perhaps, I have been over-exposed. Having said that everything is learning! Whether you travel or not you can learn. But the most important thing for me and going through the school, I think it is important to take students from history to the real world. You can learn everything in the book but I think if for example, you are learning about persons, about the healthcare system in South Africa, and if it is too far, if you ever get the theory and it is possible, why can one not take advantage of it? Even if you take one or two students and bring them back and let them present what they saw to the rest of the class, I think in fact, that is one of the ways you can do it. (IHM5)

Participant 2 re-emphasized proper pre-departure orientation of students by natives of host nations for the mission. She presumed that this would provide proper knowledge and adaptation for participating IHM students.

Yeah! More pre-planning; we had meetings every week or two weeks, and were supposed to get our power-point information together. This would prepare us for the team-work project and then how to teach them “how to roll out,” like, teaching
programs like brushing your teeth and washing your hands. And we also had one evening talk about culture. It was like pre-gnosis or orientation, which wasn’t good at all. It would have been helpful if they had someone from Ghana to provide information. (IHMp2)

Students also expressed their feelings and experience in terms of overall organization before and after IHM attendance and how things could be improved for future IHMs. Areas of concern included providing participants with the general outline of activities, daily schedules and allowing for some flexibility in the conduct of the mission. Participant 2 also shared her experience and suggested how students on IHM should be treated.

Like treat me as a student and as an adult at the same time. After we came back they acted like everything was so planned out and we knew what was happening from day to day like we had schedule. We never had schedules when we went over there. It seemed like they were just like going day to day; what’s the activity that we were going to do? And that made me frustrated, I am not like that; I really want to know what I am doing. I don’t like to wait around for people to figure out what is happening and that was what I was being restricted. When I was out in the villages walking around; like they didn’t want us to go around by ourselves and that’s why. But if no one wants to go with me what I am supposed to do? (IHMp2)

Participant 2 spoke about her experience dealing with the stereotyping of people of host nations and beyond, and called for open-mindedness and the need to treat people as individuals.

But there was an incident right after we got off the plane into the van from Accra to Cape Coast, and again I was the only African-American, and the first thing that the girl (she had been there already for three months, I think) said to the other females is “be careful because the Nigerian guys that go to school at Cape Coast; they think that every American is rich and they might try to marry you. That’s not something you want to tell someone this is their first time in Africa, right? That might make them afraid or hesitant to even speak to anyone. Because, how can they tell the
Nigerians from the Ghanaians or the Gambians or any other? They don’t know, so that can make them kind of reserve to even speak to other people. (IHMp2)

Therefore, participant 2 suggested that healthcare professionals should stay open-minded when dealing with people of different races.

Yeah! So you just need to stay open-minded and people exaggerate things. I’m not a Ghanaian, but that hurt my feelings [laughing loudly]. And there was a guy there from Cape Coast and he could, kind of tell that I was upset, so, he pulled me to the side and explained, that it’s not even just white women; is all Americans that they think that all Americans are rich. So, he is like they say stuff like that so, don’t let it get to you. So, I would just suggest that health students who go on missions, wherever country you go to just stay open-minded. I mean you can get suggestions from people, students, if they are already there for whatever reasons, but still understand that you are there for your own experience. And their experience might be different from yours. (IHMp2)

The response below was given by a participant who emphasized the practical aspect of healthcare, acceptability of all cultures and learning from different cultures as an essential cornerstone for caring for people of diverse cultural origins.

I mean, I read from the books, the practical aspect of it. Did I accomplish my goal? As far as the practical aspect of it, yes, because we hung out with the Quarandiros in the remote area. How do we deal with Quarandiros or the traditional health practitioners? As far as in the healthcare profession in America are we learning from what is practiced back home so we can serve other people? I say yes, or as far as diversity goes, given the fact that United States is really going to change in five years from now. You know, I know that it’s not going to be your “typical white community.” I do think that things have to be more practical, not only in Mexico or Africa, everywhere given how the population is changing. Are we really accepting the cultures of other people? So we have to be very, very careful when we call ourselves healthcare professionals. Are we serving one culture or are we serving many cultures? If we do serve many cultures are we learning from these people? (IHMp5)

This participant expressed concern about healthcare professionals learning from Hispanic people so as to better serve them.
When I signed up to go I had two goals: one, I was interested to see how the healthcare system or mainly the traditional medicine from Mexico is different from back home and how or the United States is using what is practiced in Mexico here? Given the fact that Mexico is not far from here, and we have the Hispanics/Latinos people moving into the United States. Are we learning from them so we can better serve our Hispanic population here? (IHMp5)

Self-confidence: Future career focus. These professional healthcare students were able to observe different approaches to teaching health education in different settings. They also observed how to make lessons more practical, to encourage participation and to bring about meaningful student outcomes during their IHMs. For instance, this participant talked about the type of classroom and teaching approach, “It was like training the trainer and it looked as a western kind of institution, but it is run like a laboratory to mimic the real-world. I really liked her teaching” (IHMp5). This same student specifically learned about the conversational or feedback method of teaching which impressed her greatly and promised to employ the method in her own classroom when she returned from the mission. Another student commented, “These trips also provided lots of career openings and possibilities in health promotion both locally and around the world (IHMp1). These quotes reflect this theme;

When we were there we were hosted by a professor who teaches at the University of Morrow. She was a nutritionist so we were fed well. One evening, I think we were in a group of 10 to 12; and I wanted to go to see how she teaches. So, I followed her to school, I sat in her classroom, and also I wanted to compare the teaching there, the teaching here, and the teaching in my country. What! She, really impressed me. When she was teaching nutrition I guess, she had the text book with her. So as she was describing you have minerals, you have proteins, and she had the food in the classroom “cooked and uncooked.” Most of her students because it was an evening class were older, my age and a little bit older. And you could see how they were really eager, interested to touch the food before she was talking or finished with the meat or even the protein. We even ate. So that was really interesting, I liked it. To
me, I think her class was unique; I don’t think there are many of that. She is teaching them the theory and was also teaching the practical way. She is very good at what she does. (IHMP5)

Participant 5 commented on the teaching approach to health education that she observed during her IHM:

Also, another thing I saw basically, she, in her class was really more of a conversational type. She wasn’t lecturing. She wasn’t the one that says “we are learning about so and so. Her way of teaching was really nice to me; that was excellent.” Let them get active; that is something we can do here especially when you are working with immigrants; people from the third-world countries. They have something you can learn from them as much as they can learn from you. So the feedback or conversational type of teaching is good. Oh! Yes, on Saturdays she will bring people (I think people who are registered) to her home to learn how to eat healthy. She has a big kitchen and two refrigerators. Saturdays and Sundays people come to eat in her house. One gentleman, I remember, came and he said he was giving a testimony. I think he used to be big and he said, “Since I have taken this class I have lost about 20lbs.” And he was proud. (IHMp5)

Participant 2, however, expressed dissatisfaction with how the mission was organized, which did not help her to improve much on her professional skills. The next quotation explains the frustration of participant 2, who described the whole mission encounter as unprofessional.

Yeah! Because we had to plan everything before we went over, but there was a problem with the computer downloading the power-point or something so, we had to improvise. But there is nothing other than that I got blamed for. We went together to get the education across and sometimes it was weird because we were broken up in teams. My team put the power-point together but we did not present it. Why didn’t we present the power-point if were familiar with it? There was another girl who presented it, and they weren’t really prepared even though we had meetings before we went…we never had a schedule and that bothered a lot of the students. Like we never knew what was going to happen until the day, and that I think was unprofessional. (IHMp2).
Self-confidence: Adaptability in different situations. A participant shared her experiences adapting to different situations and countries, especially in regard to food and personal care or hygiene. While some participants were able to adapt, others could not. The quotes below illustrate participant’s feelings and experiences. For example, participant 4 spoke about how she had to take a bath under a tree which was quite a new experience for her, compared to other team members who refused to adapt.

And we would see them prepare water for bath. This means the bath is on the outside because you will have your water in a barrel, and you would scoop your water, and you just take a shower you know, under the tree! That was fun (laughs) I just adapt, I had no fears. I had lots of anxiety and excitement but I just prepared myself, exactly, I let myself go. The leader of our group said you know there was one girl; she didn’t go to the bathroom for all the time we were there. She waited, and she got sick. I said, I was not going to do that, I mean a bathroom is a bathroom [laughs]. I’m like no; I am going to experience this and have something to talk about. It was quite an adventure. (IHMp4)

This same participant recounted her experience with food, which she thought was quite satisfactory. This was because she felt comfortable trying and eating the food that was served to them in the course of their IHM. She commented:

Oh! The food was wonderful; we had rice and beans everyday and our leader said “are you okay we eat rice and beans?” I have been eating rice and beans all the time. I guess some of the people I was with had not had rice and beans before. But I have had rice and beans before and I am like ho-o-o! I can eat rice and beans. And every meal that we had was very healthy fresh from the tree, because she actually grows mango and oranges. I think, at the back of her home so, not only cocoa beans. It was fresh from the tree, cut-up vegetables, fruits, and chicken. And so, to keep from having a lot of starch build-up we ate carefully [laughs]. (IHMp4).

Self-confidence: Sensitivity to the needs of people from other countries.

Participating students recounted their professional growth in terms of becoming more aware of the health needs of people of diverse cultural backgrounds. Participant 3, for
example, developed sensitivity to the needs of other people from the experience she
gained working with her IHM people.

Well, something that we focus on a lot here in UNI is especially with our student’s
fairs. The purpose on campus is we have lot of diversity workshops. But when I
think back on my experiences in St. Lucia working with people with diverse
background except for myself. I learned a lot from them, with how their upbringing
was, and it made me more sensitive; for example when I am working with students
that have diverse backgrounds than myself and also how I train my student
employees. (IHMp3)

Participant 4 also recounted her experience from her IHM, which had sensitized her
to the needs of other people. This had helped to focus her attention on the people instead
of the services she would be providing. She expressed this sentiment in the following
quote:

Let’s say making me more sensitive and because I know that people who come here
have their own culture that is different and way of life is different... than mine. So it
helps me to be more understanding or provide services with suggestions from people
that I give services to; diverse group. I won’t be closed-minded. I would be open for
ideas asking “what do you need” because it is about people. It is not about me
having a great organization you know, and I stop thinking that it is about people. I
want people to take ownership of it, they can get their needs met, they can say that
this organization is meeting some of my needs. I can go there, like a melting-pot
being under one roof and that you can come and get services. (IHMp4)

Participant 5 cautioned healthcare personnel not to pretend to “know it all,” but,
rather, should endeavor to understand the physical and emotional ramifications of the
health profession. She spoke of the benefit of doing a good job.

Yeah, being able to listen, ask questions, be opened to whatever they have to say and
don’t go there as “just know-how.” I know everything; I am the nurse; I am the
educator. So when a person trusts you with their health you’ve got to take good care
of it. As healthcare professional we deal with the physical but we also deal with the
emotional. I really do believe that in healthcare spirit if, you do your job as you
supposed to, the person you are helping moves on with what they got to do, I can assure you that they will remember you for the rest of their lives. (IHMp5)

Participant 5, again, stressed the need for effective communication by healthcare professionals based on what she witnessed on her IHM. The Quarandiros made frantic efforts to communicate with them in English, even though the traditional healers were not English speakers.

Also, it opened my eyes in terms of, you have to be able to communicate with your clients, your patients, especially if you are dealing with...the people we were working with in Mexico did not even speak that much of English. We were not speaking English. So, to see how they were really able to, trying at least to understand us, that is something I took from there. That’s the way I can apply. (IHMp5)

Participant 5 also emphasized the need for healthcare professionals to be sensitive to other cultures and show respect for their traditions.

And here, in the U.S., we are used to looking people in the eyes because that is the culture, of course, that’s the way they are raised. Someone from a different culture that might be considered if they are looking away does not mean they don’t want to look at you or they don’t respect; that’s their culture, that’s how they are raised; respect that. Another thing came to me some years was that we always think whatever we know or think is always right, is not true. There’s no good or bad culture; every culture is the same. And another thing as healthcare professionals, I mean we are not dealing with ‘empty pots,’ they may lack being professionals in your field but they are professionals in other fields. Part of this is, as healthcare professionals we have to be sensitive to other cultures. (IHMp3)

Self-confidence: Summary. Participants expressed various emotions regarding self-confidence, ranging from happiness and inspiration to disappointment. The underlying reasons were related to the different IHM experiences and locations involved. The interview results indicated how personal and professional satisfaction with IHM experiences contributed to growth in participant’s self-confidence. They, however, raised
issues regarding time constraints, which did not allow them to develop fully. This level of competence can best be attained through cultural immersion. Cultural sensitivity is enhanced by learning directly from the people, and grounded by introducing practical hands-on experience into the healthcare program. Participants also stressed the need for better organization of the IHM and proper supervision. This would help to improve their personal well being, professionalism, and self-confidence.

Social Relationships

Interview results in the Social Relationship focus area indicated development in both personal and professional relationships. Participants discussed developing social relationships on several fronts: between student and student, student and professor/supervisor, healthcare professionals, families, patients and mission team members (Gallagher, 2004). Social relationship skills developed in the following areas: (a) collegiality, (b) gaining respect for people of different cultural origins, (c) individual preferences and interests, (d) collaborating, (e) dealing with cultural differences, and (e) dealing with stereotypes.

Professional development occurred in areas including: (a) working with patients from other cultures, (b) effectively working on a multicultural team, and (c) effectively working on a multidisciplinary team. They also improved on provider-patient relationships and student-professor relationships. Interview results for this focus area indicated some misgivings on the part of individual participants. These were with regard to some aspects of mission experiences, especially in their relationship with professors and supervisors. They did not feel that directives from supervisors were clearly explained
and supported. The IHM participating students were impacted by the collective effort put in by team members to achieve mission goals. They talked about the benefits offered by the IHM to work in a collegial environment. The following themes reflect participant’s learning and experiences in this focus area.

**Social relationships: Collegiality.** Participants developed social relationships and connections through bonding, collaboration, gaining safety, respect for IHM team members from the U.S. and other participants from various countries. Participants also expressed their feelings regarding knowledge gained, while relating to student participants from other cultures and countries and learning to respect the interdisciplinary responsibilities performed by others. Participants talked about those who helped them to learn, which included patients, other people, team leaders, allied-healthcare professionals and fellow IHM team members, who shared similar values and humanness (Gallagher, 2004). Participant 4 spoke of having learned to respect people from diverse cultures, “Yes it did! I would give respect; I believe it has made me able to give respect to people of diverse cultural background” (IHMp4). Participant 1 reiterated that “It was very meaningful about the human connection we all have despite different cultures and backgrounds. So, I think that was one of the things!” (IHMp1).

**Social relationships: Gaining respect for people of different cultural origins.** Participants learned to transcend racial barriers during their IHM as explained in this quote. “One country I visited and I thought they would not like me because of my color. But when I got there they were very warm. They hugged me, invited me for the food, came over to see me, and took me to social events. I ended up making a lot of friends and
when I was leaving, we all cried for being apart” (IHMp1). Participant 4 was particularly happy for gaining acceptance from colleagues who were of different race. In the next quote, she talked about how her experiences helped her to gain respect for people from other races and gain the understanding needed to interact with them.

Oh Yeah! 15 to 20 people! I think the relationship was good as might be. I lived around white people and survived all my life. I realized of course, yeah! Racism exists, I believe it still exists. But I feel comfortable around Caucasians. Yeah, of course, I stand out. I might speak differently, sound funny to them; some of the things I say much about. I think they more or less accepted me because we will have refreshing time at the end of the day and they culminated. We’ll play a game and there were some questions that go around “what do you not like?” And you ask the question and like I said I don’t like the ‘n’ word, and the next girl would say I don’t like the ‘n’ word. So, I just felt good by being accepted and just being more able to go outside the mere boundary and stay out with the people. Kind of made me feel more accepted, being curious about other people, and the way they live, including myself, because they were friendly towards me, you know. It helped me that when I work with people in diverse population, I would be able to respect them and understand what they are going through and provide services. (IHMp4)

Participant 1 also spoke concerning being able to give respect to her clients while she worked with them, “I learned how to work with the local leaders in order to get things done, it was important to work with the leaders and respect the elderly which is something I cherished” (IHMp1).

Yeah! I grew up with a bunch of neighborhoods different from my race and missionary. So I think a lot of the people I went with there were professors too who are used to people of my race. And the other people I went with or either we went with, who were of different cultural background, everyone actually knew me. The first one she was my classmate, and she was my friend, the second one she was also my classmate, and a girlfriend so, we didn’t have any problem at all as far as socializing. (IHMp1)
Social relationships: Individual preferences and interests. Participant 1 commented on some of the social activities she and her colleagues engaged in outside their mission work, which not only helped them learn about each other's social activities and interests but also helped them get to know each other better.

As far as when we were doing our program, but when we were there, we had different things we were doing. They were used to go skiing, I mean looking at the water stuff where they go. They are more adventurous than I am. Like some of friends they wanted to go for adventure like to swim and I don’t know how to swim so far as socializing we had to do different activities. So, I will choose for example, to go to a church because I don’t know how to swim. “I’m going to sink.” There were differences in our activities outside of our education. Let me give another example, some people who are used to like hiking would want to go to hike other people might go shopping. So, as far as socializing we had different interest. (IHMp1)

Social Relationships: Collaborating. Participant 1 talked about collaborating with one another in order to lessen the stress and do away with social differences, and also to protect each other, “You have to collaborate otherwise you actually get stressed out and remember you don’t have a family there, yeah, working together” (IHMp1). In the quote below, participant 3 talked about how they had to travel together when visiting places due to safety concerns.

Yes, it was in the night, and our leaders all went with us and we all went together as a group, and we all just enjoyed being invited into this local hall. I think the only safety concern was again our leaders told us to stay together and not go anywhere by ourselves; so we always stay with someone. (IHMp3).

Social Relationships: Dealing with cultural differences. Participant 1 stressed how they dealt with cultural differences in order to get things done on their health mission.

“We didn’t quarrel at all, yeah! It was a short time and we were depending on each other, helping each other, you know so we never had any conflict at all, yeah! We were kind of
there actually trying to protect each other” (IHM1). Participant 1 also emphasized their dependency on one another as she shared her feelings in the following quotation:

It didn’t bother me it didn’t bother them. Actually some of them did not, one of my friends didn’t know how to cook so I did all the cooking all the time, so it did not bother me. But she was also more outgoing, but she kind of faced the risks, like when we went to visit places she was more outgoing and was less worried about taking the risk. So we kind of complemented each other that way. She was making me do all the cooking and getting the food ready, I respected her for being outgoing and coming up with different things—you end up believing in each other becoming a team. (IHMp1)

Social Relationships: Dealing with stereotypes. Participant 2 shared views on learning to dispel stereotypes that came up between herself and her peers, which caused some difficulties in their relationships during the IHM.

And then my peers, the girl that was there for three months, like acted as if she knew everything, and I’m sure she was familiar with things, but a lot of the stuff they were saying it was just hard for me like, some people have nice houses. And they say something … like, wow! I wonder how they got them, you know, like they were corrupt people. But there are people in Africa too that can have marriages and services and stuff, they don’t realize that. So when I spoke my mind, I guess, they think that I’m out of line or something. But those are some of the stereotypes that they came over with. (IHMp2)

Social relationships: Working with patients from different cultures. Participants commented on their experience for learning to work with patients from various cultures. One student raised issues concerning her experience in dealing with race, communication, reacting positively to clients or patients, and employing a “give and take approach” in her practice. “Also another thing since, I was the only black person I didn’t know how they were going to receive me. I had to gain the trust. So, I always had tried to communicate, which, is to use the only Spanish I had and once they saw that I could
speak a little Spanish that really, really made them trust me more. The few words of Spanish that I said, gave me the lead” (IHMp5). Specific areas of improvements were found as follows.

Social relationships: Effectively working on a multicultural team. Participants talked about the composition of their IHM team members and their experience working with them. The quotes below support this theme.

Our Mexico group was diverse; we had two professors, one from Allen College and one from UNI. I was the only African and another student who was Hispanic, the rest were Caucasians; yes! We were group of students and I think either the majority of the students were Americans, I was fortunate to be in that group. The other students were learning different things new to them it wasn’t new to me. I guess that’s why I became a leader of the group was because I am also a little older. (IHMp5)

Participant 3 did not have much diversity on her IHM team; she only had one student from a different cultural background. She spoke of her experience of learning to work successfully with this student in the next quote.

We just had one other student on the trip and I’m trying to remember what country she was from, but she was not from America. She was the student that was with us on the trip. So you know, just in general having that kind of personal sharing moment about the culture she came from, and then she may have some kind of different ideas for some of the health education we were offering whether that will be a different activity or just the way she was interacting with the children we were able to see in the schools. And they kind of latched on her accent and asking her different questions about where she was from, how she got to UNI from her country and some of those things. But, I thought as a whole, we did all worked together and worked well as a team. (IHMp3)

Though students spoke positively on this theme, some participants felt things could have been better with proper organization. Participant 2 shared her sentiment in the next quotation:
We kind of had a little clique, you know, because of, and it was mainly the groups we were broken up into groups. I bonded with one of the girls. She was my roommate, because we had roommates while we were there. We became close and talked to each other about some of the issues we had been—and like I said, we did pull together to get things done, because we had several presentations that we had to do and we got those done successfully. I just think that it could have been done a better way. (IHMp2)

Social relationships: Working effectively in a multidiscipline team. Participants relayed experiences regarding working effectively with professionals from different disciplines during their IHM in order to successfully complete mission tasks. Participant 3 expressed her feelings in support of the theme:

We had a van driver and we kind of just had to go with the flow of the group. If the group needed something we will go as a group together rather than individuals for safety concerns; so you really rely on your group members as where you will be going. But the driver was pretty assessable whenever we needed to go somewhere he will make sure that he was there to take us. I think our leaders primarily spoke with the driver or talked with someone at the hospital that tomorrow we will need a ride at 10:00 a.m. and then they will make arrangements for us. (IHMp3)

Social relationships: Provider-patient relationship. The healthcare professional students spoke regarding the opportunity created by the mission that offered them learning experiences from health practitioners. Participants talked about gaining experiences practically from healthcare professionals in differing settings that supported this theme. Some of the participants focused on the provider’s ability to listen, ask questions, spend sufficient time with the patient, and not assume anything about the patient or client (IHMp5, IHMpl, and IHMp2). The quotes below reflect this theme. Participant 2 described the relationship that existed between the nurses and clients she was able to observe on her IHM, saying, “She also scolded them too, because she told
them that they know the day the nurses will come, so we shouldn’t have to go round each
house and told them to come; but should already be gathered” (IHMp2).

This quotation reflects the differences in approach employed by healthcare providers
in terms of time spent interacting with patients. Participant 5 shares her experiences
regarding time flexibility with which the traditional health-providers performed their
work.

Well, when we visited the two, when the patient came in, or the time we were there,
he will he was going to use “African time” “I have two minutes, I have ten minutes,
I am going to pile everything then get done. You’ve got to allow the patient to tell
his or her story; how they feel, what’s wrong with them and you’ve got to be able to
listen. Put aside whatever you know for a minute and listen and then come back to
apply what you have to, after listening. These elder men we saw over there were
very interesting. This is very important if you are going to treat someone from
different culture than you, listen to everything they have to say. Listen and ask
probable questions, if you don’t understand don’t assume, be patient, and allow them
to speak. (IHMp5)

Participant 3 talked about her experiences about learning to give respect to patients
or clients from health practitioners during her IHM:

That it was important to be respectful of everyone no matter what their background
is, and just instilling that in my students. It may not be something they think about,
and I feel like in today’s world, things have gotten better than what they used to be.
But we still have a long way to go. So, I guess, just helping my student employees to
see that importance and why it is important. (IHMp3)

Participant 5 spoke about her experiences from various health practitioners on the
need to build trust between health providers and their clients/patients during her IHM:

We were told that most of the people prefer the Quarandiros or traditional medicine
than the Western medicine. And we were told that because they trust this
Quarandiros. They’ve known them long time, perhaps these Quarandiros treated all
parents and relatives. You could tell that I heard them talking that they treat their
patients like they will treat their own family. In, fact we asked the gentlemen that
how much they pay you when you cure them, then he jumped and said “these are my people, these are my family” if they can get better then we talk about the cost latter. (IHMp5)

Based on her mission experience, participant 2 was able to discuss the differences that exist between the U.S. and her IHM country regarding the type of relationship that doctors have with their patients.

And then like a lot of our doctors they come in they see you and they leave, that’s not how it is over there, like you kind of have a personal relationship with your patient. I have a kind of personal relationship with my doctor only because I have been going to her from the time I was 12 years, so she knows me, my family, she knows all of us. And she is a sweet lady but, all doctors are not like that. And for someone to come from another country, and see them sitting down with the doctor and telling him the whole story you know about what problems they are having and you come over here and you say “hi my name is” you know “what is your problem? Okay!” [laughs] It’s like a skit. (IHMp2)

Participant 5 stressed that healthcare participants should endeavor to learn from their clients/patients since they bring something to the medical encounter.

Learn from them, don’t assume nothing if you didn’t hear them or you don’t understand what they say. Ask them questions or even to step back a bit and say may be this is what I needed for a while. Honestly, I think, there is no environment where you can’t survive. Two things you have to do: One, you have to have something to offer to people; second, you have to believe that those people have something to offer to you. It goes both ways, “give and take” by that I mean if they put you in Peru for instance, it’s a fact that you’ll have language barrier but with time you will learn. All it takes is to have respect toward one another; believing that you are not better than those people or marginalized groups. Um! I think everyone is trainable. I think it is just a matter of understanding one another. It may be you have skills in health in promotion they maybe have skills in something else, you may not care knowing? I guess, I mean, as long as you are willing to learn, and willing to offer, eh! There is no limit as what you can do or learn. (IHMp5)

Social Relationships: Professor-student relationship. Healthcare students shared information regarding their experiences working with professors or supervisors and
leaders of their IHM groups. Some of them spoke concerning positive experiences such as, “our professors of course they are great, they are our mentors, they assist us, they train us, there is nothing better than having a good mentor and a good relationship” (IHMp1).

Participant 2 commented;

I can’t remember exactly but I think one of the professors suggested, that I become a part of the Global Health Corps because ultimately, it will be an expectation, and one of the requirement is to fulfill a mission, and I think that was something important to accomplish, so that was why I decided to join. (IHMp2)

Participants spoke about the good relationship they had with their leaders. For example, participant 5 boasted, particularly about the special relationship she enjoyed with the leader of her group.

The group leader and I had a good relationship contrary to what people say. She whatever she had against—she had never talked to me. We had respect for each other. So in fact, I think she trusted me and will ask me “make sure such and such is okay.” So on that trip specifically nothing was really wrong. So, the trip was o.k. it was fine. (IHMp5)

Participant 1, however, talked about the social differences that she found between her and the leader/mentor during one of her IHMs, which she had to deal with. The quote below explains her feelings:

I went on my own to a country in West Africa, Ghana. The one I went with, about that lady? The lady was really uh! Critical about this country; and that particular one we had a lot of social differences. So, but that was my mentor, she was in the government commission, the (supervisor) of my work, so that’s kind of stuff, Yeah! (IHMp1)

Participant 2 talked about the unpleasant experiences she had with her instructors during her IHM.
The difficulty came in with the instructors. You know they instruct you on how to respect them. We use to respect everyone but they have a different level of respect that you will hope that they will return to you. But whatever they say you have to follow. And so, while we were on the trip, when I was holding the babies, one of the instructors said you have to be careful. Why do I have to be careful? But I respect, am just like whatever. One of the instructors, he gave a speech to some of the students and he lied and said that he recruited or tried to recruit students, African-American students to come and I was the only one that showed up; that’s not true. And when I tried to address him about it he did not say anything to me, he just blew me off. And so that came the difficulty because I just felt I’m here but—And then I have problems with my grades when I came back, they gave me a “B” and I deserved an “A.” They said that I was late in doing the power-point, because I was worried about getting my hair braided (I have asked permission to have my hair braided) than doing my work and that wasn’t true, and so that strain. It started when we were in Ghana and came back over here. (IHMp2)

Participant 2 also shared her experiences regarding misunderstandings between her and the leaders of her IHM groups. She stressed further how the leaders prevented her from taking a closer look at the babies brought for immunization and discouraged her from gaining practical and deeper experience. An experience she did not want to miss. The following quote illustrates her point:

And I kind of felt like the group leaders didn’t understand why I wanted to you know, talk to the people; because when we went out with the nurses to do education, I held babies and stuff; and they were telling me not to do that and I didn’t feel like—if we were health professionals we know how to use precaution and I mean, if you see a baby you can tell they’re sick or not sick you know. So I knew how to protect myself and I didn’t want that experience to pass me by. (IHMp2)

Social relationships: Summary. Interview data for the social relationships focus area indicated both positive and negative experiences. Positive experiences helped students to respect people of diverse cultural backgrounds. These experiences helped students provide services to the people of IHM countries and also prepared them for their future
profession. These experiences helped them to realize the human connection that exists among people of different cultures and backgrounds. Other positive outcomes included learning in a collegial environment, working with mutual respect for one another, collaborating and accepting one another, irrespective of cultural backgrounds. The advantage therefore, was that participants were able to lower their stress levels whilst accomplishing their mission. There was also an indication of a good working relationship between group leaders and students and between professors and students. They also observed a “give and take” approach between healthcare professionals and their clients. IHM participants saw also the trust that existed between doctors and their patients.

Negative experiences described in the interview data included the following:

1. Misunderstandings between group leaders and IHM participants regarding mission goals.
2. Unpleasant experiences which resulted in participants wishing to discontinue the mission experience.
3. Strained relationships between students and supervisors due to lack of respect.
4. Issues related to recruitment of participants, grading and insufficient diversity within the group.
5. Some IHM participants were not able to adjust to conditions in the host nations.

Summary

This chapter described the IHM impact on participating UNI Global Health Corps students. Quantitative and qualitative methods were employed to verify the IHM impact on students. The interview and survey responses presented, enabled all research questions
to be answered. The descriptions of experiences and narratives by participants provided a rich account of the impact of the IHM experience on healthcare professional students. The meanings of participant’s experiences and their narratives were fully uncovered by in-depth analysis of interview transcripts. Surveys, however, yielded measurable results for the impact of IHM experiences. The results consistently showed a perception change by students for all aspects of interview and surveys.
CHAPTER 5

DISCUSSIONS, IMPLICATIONS, AND CONCLUSIONS

The purpose of this study was to investigate the impact of an International Healthcare Mission (IHM) experience on the perceived growth of healthcare professional students. This research examined both the professional and personal benefits of an IHM experience on participating professional healthcare/Global Health Corps students at the University of Northern Iowa. Areas of particular importance included: (a) Cultural Knowledge, (b) Cultural Sensitivity, (c) Self-Confidence, and (d) Social Relationships. The study focused on the following four research questions:

1. To what extent do participants in an international healthcare mission improve their cultural knowledge?

2. To what extent do student healthcare professionals who participate in an IHM feel that they are more culturally sensitive to the health beliefs and behaviors of diverse clients?

3. To what extent does an IHM experience enhance the self-confidence of participants in regard to their professional practice?

4. To what extent does an international healthcare mission (IHM) experience affect the social relationships between students and their colleagues, students and their instructors, and students and their clients?
Discussion: Triangulation of Quantitative and Qualitative Findings

Cultural Knowledge

Both quantitative and qualitative findings showed a perception change in the personal and professional lives of participants. Although the findings regarding the impact of IHM participation on participants proved positive, there were some negative sentiments expressed concerning certain aspects of interviewee’s IHM experiences, which will be addressed accordingly.

Survey findings for the cultural knowledge subscale revealed an overall mean score of approximately moderate improvement in participant’s cultural knowledge. Participants perceived this to be the result of their IHM participation. These findings were also confirmed by the qualitative findings. The particular area worth noting for this subscale is learning about “a different culture.” All the five interview participants commented that participation in an IHM experience brought tremendous improvement in their cultural knowledge pertaining to a different culture. This finding is consistent with the prior research (Baker, 1997; Berger, 1998; Langston, 2001; Machado, 2001) that stressed the current need for advancing the cultural knowledge and sensitivity in healthcare professionals. Zorn et al. (1995) also asserted that nursing students who had international experience increased in cultural knowledge, thus supporting Wilson’s IIEM, substantive knowledge subdivision.

The area with the lowest mean score was “collecting information about patient’s environment.” The mean score representing a “minimal” perception change due to IHM participation was obtained. A number of factors such as time, language, diverse
healthcare fields, and lack of freedom to explore new environs, may have contributed to the minimal improvement. Interview participants were asked to comment on their cultural knowledge gain during their IHM; for example, in the area of language, concerns were raised regarding shortness of mission period and language barriers. Other reasons might be because the participants came from diverse fields in the health professions, which placed varied emphasis on “gathering pertinent information about the patient’s environment.” Freedom to explore was also another reason given by participants for not gaining tremendous knowledge, which they felt resulted from poor supervision strategy and safety concerns. These factors altogether could have limited participant’s ability to improve tremendously in this area.

Cultural Sensitivity

Quantitative and qualitative data analysis indicated that participants perceived their IHM participation to be the source of improvement on their cultural sensitivity. Quantitative results showed a “moderate” improvement for this subscale. The area most worth noting was found to be the item “my views about U.S. healthcare quality became more positive.” Participants realized tremendous improvement for this item as a result of their IHM experiences. Interview results supported the quantitative findings. This result is consistent with the findings from Willard-Holt (2000) that recognized several positive impacts on an elementary education student-sample who had experienced a week-long international mission. These students reported that they had realized the importance of multicultural education as a result of mission attendance.
Willard-Holt (2000) posited that the students, specifically, realized the importance of accepting, preserving and encouraging social and cultural differences among the students in their own classrooms. Furthermore, Willard-Holt’s education sample was reported to have gained an enhanced appreciation for U.S. resources at different levels, which is consistent with findings in Gallagher (2004). Gaining an understanding of the differences among cultures and countries helped the development of cultural sensitivity in participants. In the interviews, participants spoke concerning the relevance of understanding people’s customs and traditions to their professional practice; for example, assessing, planning, implementing and evaluation of patient education and treatment.

Participant’s IHM experiences made it possible for them to compare and contrast healthcare systems in the U.S. and IHM countries in terms of availability, approaches, traditional/alternate medicine, resources and supplies, access and utilization across different settings (remote areas, cities and mountain regions). They also believed that their dealings with patients/clients and healthcare professionals, both in and out of hospital settings, may have contributed to their growth in cultural sensitivity.

They talked about broadened perspectives, and gaining respect for people from different cultures and countries, which they believed that would be an asset to them in their future professional practice as health educators and promoters. They would be more respectful and be capable of understanding what their clients/patients are going through. Similar findings were uncovered by Gallagher (2004) and Rosenkoetter et al. (1993) nursing/medical samples, who talked about changed outlook of life and profession after their international exposures.
The least mean score in the cultural sensitivity subscale, was found in connection with the item, "my views on U.S. health quality became more negative." A minimal to moderate mean score was found for this item, thus indicating only a moderate decline in their views for U.S. health quality. Interview results confirmed these findings. Participant’s comments indicated that their IHM experiences offered them the opportunity to compare and contrast U.S. healthcare across various levels, to that of their IHM nations. They were, thus, able to observe the level of poverty, scarcity of resources, unavailability of healthcare professionals, worsening environmental conditions including economic, political, and cultural influences on the health of the people they found in the IHM countries. On the other hand they found out that some IHM countries had better approaches to some aspects of healthcare than the U.S. These observations may have contributed toward the moderate perception change in this particular instance regarding U.S. healthcare quality.

This finding is consistent with Haloburdo and Thompson (1998), who asserted that this type of learning provides empirical insight into population-based health problems, hence creating the opportunity for a comparison between the health systems other countries and that of the U.S. Hadwiger and Hadwiger (1999) also reported similar results with a team of nursing-student sample who showed immersed appreciation for U.S. resources as a result of their international exposure. The IHM participants, however, expressed some negative feelings regarding some aspects of U.S. healthcare, which was beyond the purview of the PIHMQ. These were linked to healthcare accessibility and utilization by certain minority groups in the U.S. Conditions they found to be better-
managed in some IHM countries than in the U.S. They attributed this failure to lack of transportation (or programs that were out of reach and hard to access) and ignorance about the U.S. healthcare system on the part of some minority groups residing in the U.S.

Self-Confidence

Both the quantitative and qualitative findings indicate that IHM participation aided participants in developing their self-confidence as healthcare professional students. Survey results were interpreted as representing "moderate" to "significant improvement in participant’s self-confidence. A major improvement occurred in the item asking whether IHM experience helped participants "to learn about self." The mean score obtained for this item showed moderate to significant improvement in their self-confidence.

Interview participants correlated with the quantitative findings in this focus area. Personal development occurred in areas including: (a) gaining inner satisfaction, (b) insight, (c) learning about self, (d) gaining appreciation for U.S. resources, and (e) overcoming challenges. Improvement in professional self-confidence occurred in areas such as: (a) feeling for patients/clients, (b) setting standards, (c) future career focus, (d) adaptation to various situations, and (e) sensitivity to the needs of people from different countries. These findings are consistent with previous research on the impact of international experiences on nursing students. For instance Zorn et al. (1995) reported on these benefits that included gaining insights into personal beliefs and values and appreciation for things that are most essential. Willard-Holt (2001) reported an increase in personal gains from international experiences, Haloburdo and Thompson’s (1998)
nursing student sample reported increased self-confidence and sensitivity to other cultures, which also supports Wilson’s (1993) Developing Self and Relationships category.

Learning about “self” through cultural immersion during the IHM, was one of the comments from the interviews, which supported the quantitative results. This notion specified participant’s appreciation for the people they met and interacted with. This is consistent with St. Clair and McKenry (1999) and McKenna and Rizzo (1999). This nursing sample increased their knowledge about self as well as sensitivity for minorities; specifically learning about their personal strengths, weaknesses, and the capability to adapt to challenging situations. When participants of this present study were asked what was most meaningful to them during their IHM experience, they responded “the people.”

Notable comments about “the people” which came out of the interview process included statements like these; “living close to them and interacting with them,” “how they are welcoming and teaching you about their culture,” “warmly embracing, and hugging you, and asking for nothing,” “they taught me about myself in terms of my strengths and weaknesses,” “you want to do your best for the people,” “the people look like me and my family,” and “even teaching me how to be happy in life.” Participants also talked about becoming more sensitive to the needs of people of non-U.S. origin as a result of their IHM experience.

The lowest itemized improvement for the self-confidence subscale was found regarding the item, “working on a multi-disciplinary health team.” The mean score for this item indicated “a moderate” improvement. Despite the low score compared to the
rest of the items on this subscale, the findings from IHM participation still showed a positive impact on participant’s ability to work on a multi-disciplinary health team and all other items in this subscale.

Social Relationships

Quantitative and qualitative results again indicated the participant’s belief that IHM participation helped them to improve their social relationships. The reported mean score from the quantitative data showed a “moderate” to “significant” improvement in participant’s social relationships. Qualitative results confirmed this finding. Generally, both results gave overall impressions that their IHM experiences had a positive impact on their social relationships.

The qualitative findings suggested personal and professional benefits for interpersonal relationships and connections across various levels as follows: those between student and student, student and professor/supervisor, healthcare professionals, families, patients, and mission team members. Professional development occurred in such areas including: (a) working with other culture patients, (b) effectively working on a multicultural team, (c) effectively working on a multidiscipline team, (d) provider-patient relationship, and (e) student-professor relationship. This finding is consistent with McKenna and Rizzo’s (1999) study findings in which they noted that their nursing sample with international experience was able to learn about heterogeneous groups. The findings from this same study noted additional benefits for the nursing students, who realized improvement in collegial relationships, growth in professional skills and inter-discipline teamwork. St. Clair and McKenry (1999) also emphasized that “international
experience made the difference in student’s ability to sustain transformational process in their practice long after their return from foreign nations” (p.233). The results implied that participants gained numerous skills such as tolerance, flexibility and patience, as well as good listening skills and a developing respect for their clients/patients.

A notable area of improvement found in connection with the quantitative results concerned the item, “gain respect for people from other religion.” Qualitative findings indirectly confirmed this since demographic information regarding participant’s religious beliefs was not obtained for this study. Thus, it was difficult to tell whether the religious impact was for a different religious belief separate from participant’s own beliefs (e.g. a different Christian denomination or a belief other that Christianity). This result, however, is consistent with McKenna and Rizzo’s (1999) research, which pointed out that the perspectives of nursing students (with international exposure) were influenced regarding their beliefs and values and sensitivity for minorities, enabling them to realize their ethnocentrism, prejudices and presumptions.

The least area of improvement obtained from the quantitative results was in regards to the item, “help co-workers understand the needs of patients/people from other cultures.” The mean score indicate a “moderate” improvement as a result of IHM participation, which still showed some improvement due to IHM experience. Interview comments revealed some negative experiences by IHM participants in this study. These include comments made regarding participants not benefitting fully from their IHM experience, for example, not gaining a full understanding of the culture, an inability to learn a language, knowing the people better, as well as learning about their environments.
Interview data also suggested that some participants tried to impress upon the rest of the group and their instructors the need for them to gain understanding of people’s traditions. They thought this would help them dispel stereotypes and improve on communication, an essential element for effective patient education.

Yet, Kramer et al. (1999) posit that due to the ever-increasing cultural diversity in the U.S. population, the healthcare professions understand and recognize the value and need to improve the social relationships among their professionals and to enhance collaborative effort needed for effective care. The interview transcripts, however, indicated some negative findings regarding strained relationships among student participants and also between some students and their instructors/group leaders during their IHMs.

**Implications of Findings**


**Wilson’s IIEEM**

Data in this dissertation study supported and expanded on Wilson’s (1993) IIEEM, by investigating the impact of international experience among healthcare professional students. This study replicated Gallagher’s (2004) between-methods triangulation using both quantitative and qualitative methodology, designed specifically for professional healthcare students. Other researchers considering using Wilson’s (1993) four categories to design a questionnaire, would find the survey component very useful.
The educational value of an IHM for student participants was also supported in this research. Participating students specifically benefitted in the areas of gaining global perspectives, developing self-confidence, and their social relationships. The IHM experience impacted participants positively, both professionally and personally. These findings still have implications currently to expand mission experience for healthcare professional students, as well as finding other means to improve and design experiential or service learning opportunities, appropriately in discipline-specific coursework.

Learning about the strengths and value of collaborative teamwork through coursework in an international-setting is essential for healthcare professional students. Cultural sensitivity could also be enhanced through multicultural and multidisciplinary teamwork; important factor for improving provider-patient relationships that can lead to reduction of health-disparities among people of non-U.S. origin and the ever-growing population of newcomers to the U.S., all supported findings from Gallagher (2004).

**Bandura's Theory of Self-Efficacy (TSE)**

Both the quantitative and qualitative findings from this study supported the positive impact of IHM on participant's perceived professional self-efficacy, hence lending support for Gallagher (2004). Making available mission opportunities for healthcare professionals, would enable them to improve their self-confidence through the offering of mastery experiences and vicarious experiences. Providing an opportunity for participants to interact with patients/clients and practitioners was supported in this research, through data triangulation. Other areas that were positively impacted were repetition of technical
skills and gaining clinical knowledge as Bandura (1977) indicated that mastery experience is the strongest predictor of self-efficacy.

Additional support was found regarding affective and cognitive influences on self-efficacy through this study. This study also provided a different dimension of mastery experiences, cognitive, and affective processes on the self-efficacy of healthcare professional students. This is besides that of Gallagher (2004) and other previous researchers. The implication for these findings, therefore, is the re-emphasizing of the benefits of IHM experiences which have been found to enhance professional self-efficacy through mastery experiences and vicarious models, including cognitive and affective influences previously discussed in Gallagher (2004).

**Preparation of Healthcare Professional Students**

This study suggests some positive impact of IHMs on student participants. Healthcare professional student’s education must seriously consider including an IHM experience component. In addition to being an experienced educator and practitioner, an IHM course faculty must also be an IHM volunteer, capable of providing proper leadership and supervision to IHM student volunteers.

The following elements must form an integral part of IHM: (a) advance preparation before students embark on their mission, including proper cultural education by natives and a fore-knowledge of stereotypes applicable to host nations, (b) sufficient time allocation for the mission to allow for adequate knowledge gain and exploration of new environment, (c) supervision strategies that view IHM volunteers as students as well as adults, (d) students should be equipped with the knowledge of activities outlined for the
entire mission period, (e) IHM volunteer students must receive educational direction as well as guidance lasting the duration of the mission, and (f) provision of adequate avenues for sharing, discussion, clarification, and reflection on IHM experiences, also mentioned in the earlier study of Gallagher (2004).

Based on the findings of this study and previous other studies, it is highly recommended that a service-learning course or program for healthcare professional students should be thoughtfully designed, with advance preparation and guidance for students. IHM students must be accompanied by qualified faculty, who possess the above noted expertise.

Implications for Global Health Corps

Suggestions for global health corps IHM participants are premised on the findings of the study.

1. Increase diversity in IHM team composition.
2. Better organization of missions and supervision strategies.
3. Healthcare professionals must adopt varied approaches in health education, care and promotion.
4. Healthcare providers must learn to listen to and learn from their patients.
5. Adapt a “give and take” approach in their practice.
6. Healthcare practitioners must gain the trust of their patients.
7. Gain cultural competency through cultural immersion to increase sensitivity and practicality.
8. Pay attention to issues pertaining to recruitment of participants, grading, and mission goals.

9. Be respectful of everyone no matter their cultural backgrounds.

10. Sponsor more community-based health education, care, and promotion.

11. IHM team members must learn to: (a) accept people from different cultural backgrounds, (b) collaborate with each other, c) team members should depend on each other to get needs met and to accomplish mission goals, (d) be open-minded, (e) understand various cultures, (f) learn about each other’s social preferences and interests, (g) know and complement each other in terms of strength, and weaknesses, and (h) be adaptable.

**Implications for Practice**

Working towards equality is a priority for the U.S. healthcare system. Culturally sensitive healthcare professionals are able to provide health education, care, and delivery in the advent of changing demographics in the U.S. This hopefully will help to reduce/eliminate health disparities existing among special populations in the United States. Implications of these findings support Gallagher (2004) and are consistent with Evans (2006), Kramer et al. (1999), and USDHHS (2002b). Thus, findings from triangulating the data from this study, illustrate the benefits of IHM participation for students who perceive greater knowledge, understanding, sensitivity, and respect for people from other religions, cultures, economic status and countries.

The findings also imply that IHM experiences may be able to: (a) enhance multicultural network, (b) enhance provider-patient interactions, (c) provide opportunities
for experienced IHM healthcare professionals to become cultural mediators, and (d) increase knowledge for healthcare professionals concerning factors that could impact client’s reception of healthcare, education, and services as well as their health status, previously noted in Gallagher (2004).

Implications for Future Research

Future replication is recommended to validate findings of this study. The study could be conducted utilizing a sample of different healthcare professional students from those researched in this present study. This future study might yield comparable results to validate and extend the body of knowledge obtained in this present and earlier research. This could provide other viewpoints to support the generalization of findings for other healthcare professionals, besides those in medicine.

Longitudinal impact of an IHM could be determined by re-surveying and re-interviewing participants after one, two, three years following their mission experience. The long-term effect of IHM on healthcare students could be established by re-interviewing them after they had gained more time and experience in their chosen professional fields.

Conclusions

Both quantitative and qualitative findings showed perception change regarding personal and professional lives of participants. Firstly, participating healthcare professional students in an IHM were positively impacted both professionally and personally in all four categories of Wilson’s (1993) model. They perceived IHM experience to be educational, adventurous, inspirational, enjoyable, and sad, which
helped them to: (a) expand on their cultural knowledge, (b) increase cultural sensitivity, (c) realize growth in self-confidence, and (d) develop social relationships. These results showed overall perception change across the focus areas namely: (a) Cultural Knowledge, (b) Cultural Sensitivity, (c) Self-Confidence, and (d) Social Relationships. Data from the interviews, however, indicated some negative experiences and feelings by participants. These included strain in professor-student, student-student relationships, mission organization, pre-departure orientation-preparation, diversity in team composition, duration, and mission supervision. The following conclusions are premised on the findings of this study.

Both quantitative and qualitative results indicated both personal and professional knowledge gained by participants.

1. Personal knowledge gained in the Cultural Knowledge focus area revealed learning experiences in the following areas: (a) learning about people from various countries, (b) learning about various cultures and countries, and (c) other languages. Professional knowledge gained occurred in areas relating to: (a) skill acquisition, and (b) learning about different healthcare systems.

2. Cultural Sensitivity focus area showed personal understanding and greater awareness of differences among IHM nations, while findings in professional understanding were related to experiences in learning about: (a) a different healthcare system, (b) considering alternative treatment, (c) assessing patient’s health problems, (d) providing patient education, (e) providing patient treatment, and (f) evaluating results of patient education.
3. Both the quantitative and qualitative results indicated both professional and personal growth in participant’s self-confidence. Personal growth occurred in areas that included gaining: (a) inner satisfaction, (b) insight, (c) learning about self, (d) gaining appreciation for U.S resources, and (e) overcoming challenge. Growth in professional self-confidence was realized in areas including: (a) feeling for patients/clients, (b) setting standards, (c) future career focus, (d) adapting to various situations, and (e) sensitivity toward the needs of people from different countries.

4. Both the quantitative and qualitative results in the Social Relationship focus area indicated development in both personal and professional relationships for participants. Personal benefits derived from mission experiences, for interpersonal relationships/connections occurred across various levels, which included those: (a) between student and student, (b) student and professor/supervisor, (c) healthcare professionals, (d) families (e) patients, and (f) mission team members. Professional development occurred in areas including: (a) working with patients from other cultures, (b) working effectively on a multicultural team, (c) working effectively on a multidiscipline team, (d) provider-patient relationship, and (e) student-professor relationship. Interview results for this focus area also showed some misgivings on the part of individual participants regarding some aspects of mission experiences especially in their relationships with professors/supervisors and some team mates.
Secondly, Wilson’s (1993) and Bandura’s TSE was used as a conceptual framework underpinning the design of the PIHMQ, which was found to be a reliable, and valid instrument for investigating IHM experiences of participating healthcare professional students. Both the quantitative and qualitative findings in this research extended and confirmed Bandura’s TSE.

The findings from this study thus validated and extended Wilson’s (1993) model. Wilson’s four categories were especially useful in guiding the design of the questionnaire, and as a result the survey component was particularly useful. The results also lend support to previous findings from Gallagher (2004). There are additional findings exclusive to this present study. For example, participants gained skills regarding a patient’s education, in communicating effectively with patients, and in considering alternative treatment or traditional medicine. It is also worth noting that participants in this present study came from varied health disciplines, different from Gallagher’s (2004) sample comprising medical students. Thus, these findings serve to promote understanding regarding the impact of IHM experience on varied healthcare professionals, besides those in the field of medicine.
REFERENCES


Langston, N (2001). It is indeed a small world after all! *Nursing and Health Care Perspectives, 22*(3), 110.


Rafuse, J. (1994). Students, practicing MDs should be more aware of sexual, cultural influences, committee says. *Canadian Medical Association Journal, 150*(8), 1322.


APPENDIX A

PERCEPTIONS OF AN INTERNATIONAL HEALTHCARE MISSION QUESTIONNAIRE

Directions: Please circle the number that best corresponds to your reply to each question. There is no right or wrong answer. The question response reflects your thoughts and feelings about your experiences as a healthcare professional (HP) student on your International Healthcare Mission (IHM).

1. From participating on the IHM, how much new knowledge did you learn about:

<table>
<thead>
<tr>
<th>Item</th>
<th>None</th>
<th>Minimal</th>
<th>Moderate</th>
<th>Significant</th>
<th>Tremendous</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A different country</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Health care in another country</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. A different culture</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Health beliefs in another culture</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Health care professionals in another country</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Directions: For the next series of questions, please rate the degree of change in your thinking/cognitive skills that you can attribute to your participation in an IHM.

2. From participating in an IHM, how much did your thinking /cognitive skills improve in the areas listed below?

<table>
<thead>
<tr>
<th>Item</th>
<th>No change</th>
<th>Minimal</th>
<th>Moderate</th>
<th>Significant</th>
<th>Tremendous change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Gathering patient health history information</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Collecting pertinent information about the patient’s environment</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Considering information about a patient’s economic status</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Gathering information about the patient’s support system</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Considering other resources available to the patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Ease of using previously learned physical assessment skills</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. “New” uses for learned physical assessment skills</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. Learning about the strengths of other healthcare disciplines</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. Learning your health discipline’s role on the health care team</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. Learning about diseases not typically, found in the U.S.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. Learning about treatments not typically, considered in the U.S.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. Considering alternatives to traditional “Western” medical care</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Directions: For the next series of questions, please rate how much you may have changed your ideas about the United States healthcare system after participating in an IHM.

3. After participating in an IHM...

<table>
<thead>
<tr>
<th>Item</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Not Sure</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My view of the U.S. healthcare resources became more positive.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. My views of U.S. healthcare quality became more negative.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. My opinion of U.S. healthcare availability became more positive.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. My beliefs about healthcare availability for the indigent in the U.S. became more negative.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. My opinion concerning U.S. healthcare services for persons from another country living in the U.S. became more positive.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. I believe people from another culture or country receive quality health care in the U.S.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
**Directions:** For the next series of questions, please rate how your self-confidence may have changed after participating in an IHM.

4. The IHM experience changed my Confidence…

<table>
<thead>
<tr>
<th>Item</th>
<th>Decreased</th>
<th>No</th>
<th>Minimal</th>
<th>Moderate</th>
<th>Significant</th>
<th>Tremendous</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Working with patients</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Working on a multi-disciplinary health team</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Working on a multi-cultural health team</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Working with families from cultures other than mine</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Working in my HP</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Helping others work with people from other cultures</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
**Directions:** Please rate your beliefs about any changes in your abilities to perform various professional tasks after participating in an IHM.

5. The IHM experiences changed my ability to...

<table>
<thead>
<tr>
<th>Item</th>
<th>Decrease</th>
<th>No Change</th>
<th>Minimal</th>
<th>Moderate</th>
<th>Significant</th>
<th>Tremendous improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assess patient health problems</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Assess patient needs</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Plan patient treatment(s)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Provide patient education</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Provide patient treatments</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Evaluate plan for patient care/treatments</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. Evaluate results of patient education</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. Effectively work on a multidisciplinary team</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. Effectively work on multicultural team</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. Work with patients/families from cultures other than my own</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. Help co-workers understand the needs of patients or people from another cultures</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Directions: The following questions ask you about how the IHM may have changed your attitudes. Please rate how the IHM changed your attitudes in each of these areas listed below:

6. **To what degree did participating in an IHM increase my awareness regarding...**

<table>
<thead>
<tr>
<th>Item</th>
<th>No change</th>
<th>Minimal</th>
<th>Moderate</th>
<th>Significant</th>
<th>Tremendous</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The culture of a different country</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. A different type of health care</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. The influence of culture on health</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. The influence of environment on health</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. The influence of individual beliefs on health</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. The influence of economic status on health</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. The influence of support systems on health</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. My pre-conceptions of individuals from another country</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. The need to mediate for individuals of another culture in the U.S.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Directions: Please rate your beliefs about any changes in your abilities to perform various professional tasks after participating in an IHM in the following set of questions.

7. The IHM experiences changed my ability to…….

<table>
<thead>
<tr>
<th>Item</th>
<th>Decrease</th>
<th>No Change</th>
<th>Minimal</th>
<th>Moderate</th>
<th>Significant</th>
<th>Tremendous improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Empathy towards others on return from IHM</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Ability to be sensitive to the needs of those from different cultures</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Ability to be sensitive to the needs of those from a different country</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Ability to be patient with non-U.S. citizens</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Tolerance toward beliefs other than my own</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Adaptability in a different culture</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Directions: The following questions ask about how the IHM may have changed your feelings. Please rate how much the IHM changed your feelings in each of these areas below:

8. To what degree did participating in the IHM help me ...

<table>
<thead>
<tr>
<th>Item</th>
<th>No change</th>
<th>Minimal</th>
<th>Moderate</th>
<th>Significant</th>
<th>Tremendous</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To learn about myself?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. To reflect on my beliefs?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. To connect with the emotions of caring for and comforting</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>individuals or non-technological aspects of care?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. To recognize patients/clients as unique individuals?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Gain respect for other healthcare team members?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Gain respect for your peers?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. Gain respect for patients/clients?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. Gain respect for people?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. Gain respect for people from other cultures?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. Gain respect for people from other religions?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. Gain respect for people from other economic classes?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
## Demographic Information

<table>
<thead>
<tr>
<th>Variable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health discipline</strong></td>
</tr>
<tr>
<td>_Undergraduate Health Educator</td>
</tr>
<tr>
<td>_Graduate Health Educator</td>
</tr>
<tr>
<td>_Graduate Health Promotion</td>
</tr>
<tr>
<td>_Undergraduate health Promotion</td>
</tr>
<tr>
<td>_Pre-Medicine/Nursing</td>
</tr>
<tr>
<td>_Other (specify) __</td>
</tr>
<tr>
<td><strong>Age range</strong></td>
</tr>
<tr>
<td>_18-27</td>
</tr>
<tr>
<td>_28-37</td>
</tr>
<tr>
<td>_38-47</td>
</tr>
<tr>
<td>_&gt;48</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
</tr>
<tr>
<td>_Male</td>
</tr>
<tr>
<td>_Female</td>
</tr>
<tr>
<td><strong>Ethnic Group</strong></td>
</tr>
<tr>
<td>_Asian</td>
</tr>
<tr>
<td>_African/ African American</td>
</tr>
<tr>
<td>_Hispanic</td>
</tr>
<tr>
<td>_Caucasian</td>
</tr>
<tr>
<td><strong>International Travel prior to IHM</strong></td>
</tr>
<tr>
<td>_Yes</td>
</tr>
<tr>
<td>_No</td>
</tr>
<tr>
<td><strong>Number of IHM Trips</strong></td>
</tr>
<tr>
<td>_1</td>
</tr>
<tr>
<td>_2</td>
</tr>
<tr>
<td>_3 or more</td>
</tr>
<tr>
<td><strong>Time since last IHM</strong></td>
</tr>
<tr>
<td>_Within I month</td>
</tr>
<tr>
<td>_1-3 months ago</td>
</tr>
<tr>
<td>_4-6 months ago</td>
</tr>
<tr>
<td>_12 months ago</td>
</tr>
<tr>
<td>_Specify time &gt;1 year __</td>
</tr>
<tr>
<td><strong>Domestic mission experience</strong></td>
</tr>
<tr>
<td>_Yes</td>
</tr>
<tr>
<td>_No</td>
</tr>
<tr>
<td><strong>Short-term IHM</strong></td>
</tr>
<tr>
<td>_Yes</td>
</tr>
<tr>
<td>_No</td>
</tr>
<tr>
<td><strong>Long-term IHM</strong></td>
</tr>
<tr>
<td>_Yes</td>
</tr>
<tr>
<td>_No</td>
</tr>
</tbody>
</table>
APPENDIX B

INFORMED CONSENT: QUESTIONNAIRE PARTICIPANTS ONLY

Researcher: Evelyn Adom-Boateng (M.A. Health Education)
The researcher is an Ed.D Student in the College of Education at the University of Northern Iowa.

Purpose
You are invited to participate in a research study being conducted for the completion of my doctoral dissertation in Curriculum and Instruction entitled: “International Health Mission Impact on Participating Professional Healthcare Students”
The purpose of the study is to gain insight into how professional healthcare students are impacted professionally and personally through their voluntary participation in an international healthcare mission. If you agree to participate in this study you will be asked to complete a questionnaire lasting for 20 minutes. The information you supply will be kept private because you will not be associated with any part of the study. This research is both interpretive and descriptive not a treatment study, hence there will be no benefit or any foreseeable risks to you, for participating, though minimal but not anticipated risk may occur during recall of IHM experiences.
Participation is free without compulsion, you may therefore choose to participate or not, or withdraw your participation anytime. There will be no negative effect for either participating or not, regarding your relationship with the UN I Global Health Corps. You give your consent to participate in the research and again indicating that you are 18 years or older, by completing this questionnaire.

Benefits
Even though, you may not gain or receive any direct benefits personally for participating in this project, you will increase understanding regarding the effects of mission experiences on the healthcare professional students by your cooperation. This understanding will make it possible for efforts to be made toward strengthening the mission experiences and also supporting additional health mission opportunities for professional healthcare students.
Thanks for investing your time to assist in the understanding of your experiences from the mission.

Questions
Feel free to direct any question(s) you may have about your participation in this study to my faculty advisors at the phone numbers: (319)273-7759; (319)273-3250, IRB Administrator: (319)273-6148, or to me.
Evelyn Adom-Boateng
Phone #: (319)222-6048; Email: eveboat@uni.edu

Thanks for investing time to assist in the understanding of the impact of your experiences from the mission.
APPENDIX C

INFORMED CONSENT: INTERVIEW PARTICIPANTS ONLY

Researcher: Evelyn Adom-Boateng (M.A. Health Education)
The researcher is an Ed.D Student in the College of Education at the University of Northern Iowa.

Purpose
You are invited to participate in a research study being conducted for the completion of my doctoral dissertation in Curriculum and Instruction entitled: “International Health Mission Impact on Participating Healthcare Students”. The purpose of the study is to gain insight regarding how professional healthcare students are impacted both professionally and personally through their voluntary participation in an international healthcare mission.

If you agree to participate in this study you will be requested to respond twice and privately to a tape-recorded face-to-face interview questions about your perceptions and experiences from your mission participation at a mutually agreed location. Each interview session may last between 30 minutes and an hour. You will be requested also to review the information as well as the researcher’s interpretation, after the interview tape has been transcribed and analyzed. The audio-tape information will be strictly confidential and coded. Prior written consent will be sought before your identity could be revealed.

The information you supply will be kept private because you will not be associated with any part of the study. Participation is voluntary – you may choose to participate or not, you may also redraw any time from participation. Your relationship with the UNI Global Health Corps will not be affected in any way, whether you choose to participate or not. This research is both interpretive and descriptive not a treatment study, hence there will be no benefit or any foreseeable risks to you, for participating though, minimal and not anticipated risk may occur during recall of IHM experiences.

You give your consent to participate in the research by consenting to participate as well as confirming that you are 18 years or older.

Benefits
Even though, you may not gain or receive any direct benefits personally for participating in this project, you will increase understanding regarding the effects of mission experiences on the healthcare professional students by your cooperation. This understanding will make it possible for efforts to be made toward strengthening the mission experiences and also supporting additional health mission opportunities for professional healthcare students.

Thanks for investing your time to assist in the understanding of your experiences from the mission.

Questions: Feel free to direct any question(s) you may have about your participation in this study to my faculty advisors at the phone numbers: (319)273-7759; (319)273-3250, IRB Administrator: (319)273-6148, or me.

Evelyn Adom-Boateng; Phone #: 219-222-6048; Email: eveboat@uni.edu
APPENDIX D

PHONE CALL SCRIPT TO POTENTIAL STUDY PARTICIPANTS

Hello, this is Evelyn Boateng.

A while ago, I sent you a letter about my doctoral research at UNI. This is a follow up on the letter to see if you have any questions about the study or need any more information on the study.

Will you be able to participate in the study?

Thanks for participating. I would like to arrange an interview date, place, and time with you now. What date and time will work for you?

Where will you like to meet? I suggest a meeting room at Rod Library at UNI as it will be quite and free from interruptions.

I will make a room reservation for us at the library and will confirm the reservation with you. Do you prefer I call or e-mail this information to you?

Thank you so much for your participation. I look forward to our meeting.