FACULTY PREPARATION FOR ACCOMPANYING NURSING STUDENTS ON INTERNATIONAL EXPERIENCES: MOVING BEYOND TRIAL-AND-ERROR

by

AMANDA GRACE EGERT

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Abstract

Many Canadian nursing programs offer international experiences (IEs) as educational opportunities for students. While evidence of pre-departure preparation exists for students, little is known about the preparation of faculty who accompany them. In this qualitative study, semi-structured interviews were conducted with nine novice-to-expert nursing faculty to explore faculty preparation for accompanying nursing students on IEs. The interpretive description design was informed by critical inquiry methods which examined preparation alignment with critical global perspectives. Four themes were interpreted including: the overarching theme of *gaining preparation expertise over time,* and three main themes of *learning on-the-job*, *discovering the different responsibilities*, and *learning for-the-job*. In the findings, experience was emphasized over formal preparation. Additionally, preparation was complicated by a lack of global health knowledge and a lack of institutional support. Recommendations include moving beyond learning from trial-and-error and moving towards intentional preparation that better considers the experience, knowledge, skills, and attitudes for preparing nursing faculty for IEs.

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Hope, a flickering light
Sometimes it’s dim
And sometimes it’s bright
Even when I can’t see it or feel it or believe it
It flickers on
In the night
~ Sharon Egert, 1994 – A poem from the suffering, for the suffering.

" . . . good teaching means that faculty, as scholars, are also learners" (Boyer, 1990 p. 24).

Chapter One: Introduction and Background

Globalization in the 21st century has increased diversity within local populations, enhanced interconnectedness between countries, and highlighted issues of inequity and social injustice on a global scale. In response to our globalizing world, and in response to growing interest from students and faculty, the past 30 years have seen many nursing programs in North America implement an international experience (IE) as a curricular approach (Burgess, Reimer-Kirkham, & Astle, 2014; Hoe Harwood, Reimer-Kirkham, Sawatzky, Terblanche, & Van Hofwegen, 2009; Ogilvie, Paul, & Burgess-Pinto, 2007; Reimer-Kirkham, Van Hofwegen, & Pankratz, 2009). A 2007 survey found that 54% of nursing programs in Canada offered IEs as *innovative clinical placements* (Hoe-Harwood et al., 2009; Reimer-Kirkham, Harwood, Terblanche, Van Hofwegen, & Sawatzky, R., 2007). Although these data represent the incidence a decade ago (more recent research data are not available), authors such as Ogilvie et al. (2007) have anticipated increased implementation of IEs in nursing programs. Anecdotal evidence suggests the number may well have grown as programs align with the needs of our globalized world.

From the perspectives of those in sending institutions, IEs have long been celebrated for their benefits to students. Although evidence-based claims are recently emerging, a growing body of knowledge supports that immediate learning in IEs allows students to gain a greater understanding of the socioeconomic influences on health and a heightened social consciousness towards health inequities (Reimer-Kirkham, Van Hofwegen, Pankratz, 2009). Another related, and widely acknowledged, student outcome from IEs is increased cultural competence (Bentley & Ellison, 2007; Kulbok, Mitchell, Glick, & Greiner, 2012; Levine & Perpetua, 2006). This

outcome is of interest because of how some conceptualizations of cultural competence have been connected with narrow approaches to the complexity of diversity and health; how culture is conceptualized has implications in IEs (Culley, 2006). Among the claims of positive outcomes of IEs, there is wide variation of their implementation and "no clear consensus from the literature on what structure, support, and assessments lead to greater student learning" (C.A Browne & Fetherston, 2018, p. 6). Recently, positive student outcomes from IEs have been measured against some unexpected negative outcomes such as safety risks (National League for Nursing [NLN], 2011), ethical risks (Hanson, Harms, & Plamondon, 2011) and risk of potentiating – rather than relieving – root causes of health disparities through cultural voyeurism (Racine & Perron, 2012). These risks suggest that not all IEs are "good all the time" (Riner, 2018 p. 251), therefore encouraging more attention to preparation and implementation.

In nursing programs, the responsibilities for preparing and implementing IEs are often informed by a model where faculty accompany students (NLN, 2011; Mill, Yonge, & Cameron, 2005). Suggested faculty responsibilities for this model include promoting student learning, maintaining a safe and ethical approach, and avoiding Westernizing the IE context (NLN, 2011). Along with these responsibilities for IEs is the nursing mandate for attention to equity and social justice in a global context (Canadian Nurses Association [CNA], 2009). There are also important responsibilities with an educational mandate to maintain what Andreotti (2006) might refer to as a *critical* perspective of global health education. The responsibilities for preparing, implementing, and accompanying IEs suggests that faculty are key players in this educational approach. Little attention, however, has been paid to how faculty are prepared. To address this gap, the purpose of this qualitative study is to explore faculty preparation for accompanying nursing students on IEs. Because of the attention to the global concern of equity, social justice,

and critical perspective for IEs, I explored faculty preparation as it aligns with critical global perspectives.

Background

To begin this exploration, it is important to reflect on the historical context of two influencers on IEs in nursing education: (a) the nursing discipline, globalization, and global health; and (b) nursing's conceptualizations of diversity and culture. First, I considered the nursing discipline, globalization, and global health. Nursing has traditionally been attentive towards those whose health has been negatively affected by marginalization from unjust social disadvantages (Beck, 2010; Mill, Astle, Ogilvie, & Gastaldo, 2010; Reutter & Kushner, 2010). The 19th century Nightingale Era saw a formalization and expansion of these traditions to international contexts (Beck, 2010). Nurses also have a long history of involvement in international missionary work, although the mid-1900s began to see missionary nursing shift to the margins, rather than the center, of nursing practice (Grypma, 2007). As the nursing discipline sought to establish itself in the 20th century as a scientific and theoretical discipline, the focus on health disparities and social justice issues in local and international settings took a proverbial back seat (Falk-Rafael, 2006). A broader integration of global concepts into nursing curricula has had a slow uptake despite calls to action from scholars who urged nurse educators to not forget their social mandate for equity, social justice, and critical global consciousness (Mill et al., 2010; Mill, Astle et al., 2005; Ogilvie, Astle, Mill, & Opare 2005; Thorne, 1997).

Global interconnectedness and interdependence intensified in the late 20th and early 21st centuries. Technological and economical advances have revealed complex social influencers on health, while concurrently intensifying global wealth disparity (Falk-Rafael, 2006; Grootjans & Newman, 2013). In this way, globalization's advancements in travel, migration, and technology

have further exposed how the health and well-being of one country is impacted by the health and well-being of the world; we can no longer act in isolation (Bradbury-Jones, 2009).

With a fresh spotlight on global health disparities, and a growing diversity in local communities, the globalized 21st century has seen the nursing profession re-orient to their roots of addressing issues of inequity and injustice that affect the health populations world-wide (Grootjans & Newman, 2013; Tschudin & Davis, 2008; Villeneuve, 2008). This re-orientation better considers the "social, political, economic, and environmental contexts" (Falk-Rafael, 2006, p. 5) of health and the global burden of disease. Nursing's mandate for equity and social justice in a globalized world also aligns with recent conceptualizations of "global health" (Koplan et al., 2009, p. 1993) that considers health to be borderless and pays greater attention to the root causes of global health inequities. A renewed focus on issues that are important to nursing—equity and social justice—therefore intensified a call for nurses to be *global* health practitioners engaged in these global health concerns (Bradbury-Jones, 2009; CNA, 2009; Jogerst et al., 2015; Thorne, 1997; Villeneuve, 2008).

In the last few decades, select nursing programs have integrated international concepts into curriculum through various ways such as IEs (Ogilvie et al., 2007). In countries such as Canada, 54% of undergraduate nursing programs offered an IE before the formal establishment of global health conceptualization (Hoe Harwood et al., 2009). Accrediting bodies of North American nursing schools have more recently mandated programs to integrate global health concepts into core curriculum (Canadian Association of Schools of Nursing [CASN], 2015; NLN, 2017). While some programs opt to use local settings to teach global health concepts, many continue to implement global health education in the international context through an IE (Simpson, Jakubec, Zawaduk, & Lyall, 2015). It is prudent to acknowledge that not all IEs are

intended as a means to integrate global concepts per se. They have also been used by nursing programs as innovative clinical placements to address a shortage of clinical placements in the local setting and are also sought after by students and faculty (Hoe Harwood et al., 2009; Reimer-Kirkham, Harwood, & Van Hofwegen, 2005b). Several nursing programs also use IEs to meet perceived needs in impoverished areas (Brown, 2017; Christoffersen, 2008) and to meet student learning needs for understanding the health challenges of diverse populations (C.A Browne, Fetherston, & Medigovich 2015; Hoe Harwood et al., 2009; Simpson, 2013).

The second related historical influencer on IEs in nursing education is how the nursing discipline approaches diversity and culture. Nursing's approach to diversity and culture is especially important when considering that many programs use IEs to enhance student learning for working with different cultures (C. A. Browne & Fetherston, 2018; Delpech 2013). Historically, nursing has tended to rely on the construct of culture as a nexus of social identities that emphasizes ethnicity and race and assumes "particular characteristics as inherent to all members of a group of people" (Campesino, 2008, p. 302). Nurse scholars, such as Campesino (2008) and Culley (2006), have critiqued this approach as being culturally essentialist in nature. Even with advances in nursing's understanding of culture over the past several years, widely accepted approaches for nurses working in diverse settings, such as transcultural nursing (Leininger & McFarland, 1995) and cultural competency (Campinha-Bacote, 2002; Purnell, 2002), have been thought to limit critical reflection on the underlying social, political, and historical influences on culture and health. In whatever conceptualization of culture that is used, cultural essentialism within that approach is inadequate for addressing health inequities (A. J. Browne, Varcoe, Smye, Reimer-Kirkham, Lynam, & Wong, 2009; Campesino, 2008; Culley, 2006; Currier, Lucas, & Saint Arnault, 2009; Giddings, 2005; Gustafson, 2005; Harrowing,

Gregory, O'Sullivan, Lee, & Doolittle, 2012; Racine & Perron, 2012). Nursing's re-emerging orientation to broader critical perspectives of culture better recognizes the impact that health disparities have on culture, and the importance of "the social, economic, and political position of certain groups within a society" (Smye & Browne, 2002, p. 46). Critical conceptualizations of culture and diversity should be then be considered when preparing for IEs. See Appendix A for a table of nursing's conceptualization of culture and diversity.

Critical perspectives of culture, such as global consciousness (Thorne, 1997) and cultural safety (J. M Anderson et al., 2003; A. J. Browne et al., 2009; Ramsden, 2002; Smye & Browne, 2002), better align with nursing's mandate to address health equity and social justice in a diverse world. These critical perspectives also align with the re-imagined concept of global health that looks beyond traditional views of culture and health (Gregory, Harrowing, Lee, Doolittle, & O'Sullivan, 2010; Koplan et al., 2009). As the nursing discipline aligns with global health concepts, there is emerging attention to critical global perspectives that expand notions of culture beyond borders. These critical global perspectives include global health competencies (Currier et al., 2009; Jogerst et al., 2015), global citizenship (Mill et al., 2010; Simpson et al., 2015), and critical global citizenship (Andreotti, 2006; Burgess et al., 2014; Chavez, Petter, & Gastaldo, 2008). In response to the globalized 21st century, nursing programs implementing IEs are encouraged to embrace critical global perspectives as a necessary shift towards fostering students' understanding global of concepts of justice, equity, and relationship of power when working in diverse settings (Mill et al., 2010). Critical global perspectives help those involved in IEs to avoid perpetuating neo-colonialist activities which may enhance, rather than reduce, health disparities (Burgess et al., 2014; Crabtree, 2013; Harrowing et al., 2012; Racine & Perron, 2012). The influencers on IEs from the nursing discipline, globalization, and global health, along with

nursing's conceptualization of diversity and culture health, provide context to what we know of IE education today. From this understanding, questions emerged about how faculty are prepared to plan and facilitate these complex learning approaches.

Rationale for the Research

Unlike various international programs in higher education in which faculty more often prepare and implement the IE from a distance, nursing education more often has faculty accompany students to the IE location (Mill, Yonge, & Cameron, 2005; NLN, 2011). Most literature pertaining to an accompaniment model emphasizes the heightened responsibility of faculty for learning and safety in the dynamic foreign setting (Mill, Yonge, & Cameron, 2005; NLN, 2011; Racine & Perron, 2012; Riner, 2011). Some authors have also cautioned that IEs may also result in unintentional oppressive practices in the host communities (Racine & Perron, 2012). Yet, evidence-based guidance for how to implement such IEs remains in its infancy (Riner, 2011). Additionally, there is little evidence-based research on how to prepare faculty for accompanying students on IEs. In fact, little is known about IEs pertaining to faculty at all (Green, Johansson, Rosser, Tengnah, & Segrott, 2008). Anecdotal documents do not deny that faculty should be prepared, on the contrary, faculty preparation is often endorsed as being imperative to the success of IEs. The IE has been thought to be more "rich and powerful if guided by qualified faculty members" (Ryan & Twibwell, 2002, p. 31). The path to preparation, however, remains unknown despite this endorsement (Kohlbry & Daugherty, 2013; Read, 2011; Riner, 2011; Sloand, Bower, & Groves, 2008; Thompson, Boore, & Deeny, 2000). As faculty seek to facilitate IEs that address global health concerns, approach diversity with a critical perspective, and mitigate the potential negative harms, they need to be well-established in their knowledge, skills, and attitudes for these settings.

An anticipated problem lies within the historical progression of global health and critical global perspectives in the nursing discipline. If these concepts are only recently emerging as a focus of nursing curriculum, then many faculty tasked with the responsibility of preparing and implementing IEs may not have received formal global health training in their own nursing education. Crabtree (2013) suggested that faculty on IEs "may not have deep academic preparation in comparative development theory and ideology, cross-cultural communication and psychology, transformational learning theories, and other relevant fields" (p. 60). Lack of academic preparation for global health concepts leads to inconsistencies among faculty's understanding of these concepts (Crabtree, 2013). These inconsistencies can make it challenging for faculty to facilitate students' learning of critical global health perspectives and other theoretical knowledge related to IE education (Crabtree 2013). Blaess, Hollywood and Grant (2012) suggested that positioning students' global competencies before faculty competencies is like placing the proverbial "cart before the horse" (p. 89). If nursing programs continue to implement IEs accompanied by faculty, these faculty should be appropriately prepared for the complex learning environment.

Conceptual Definitions

Throughout this paper various concepts are used. Provided here are the definitions of these concepts as they are understood for this study.

Globalization

Because there is little skepticism to the existence of globalization (Grootjans & Newman, 2013), the descriptors indicated here are included to expand understanding of globalization as it relates to nursing practice and global health education, not to prove its presence. Globalization has been defined as "a constellation of processes by which nations, businesses, and people are

becoming more connected and interdependent via increased economic integration and communication exchange, cultural diffusion (especially of the Western Culture) and travel" (Labonte & Torgerson, 2005, p. 158). Interconnectedness and interdependence have been a "force in shaping the health of populations around the world" (Koplan et al., 2009, p. 1994), therefore legitimizing a response from the nursing discipline. Accelerated globalization in the late 19th century has been attributed with enhancing benevolent contributions to poor countries but is also "synonymous with the works excesses of colonialism" (Falk-Rafael, 2006, p. 3). In this way, globalization has increased our awareness of global disparities by bringing them within closer view, but associated acts of neo-colonialism have also contributed to these more visible disparities (Falk-Rafael, 2006). This study seeks to explore nursing faculty preparation for IEs within this context of "nursing in a globalized world" (Grootjans & Newman, 2013, p. 83).

Global Health

As globalization has evolved, so has our understanding of health work abroad from its origins of *tropical medicine* and *international health,* to new understandings of "global health" (Koplan et al., 2009, p. 1993). Falk-Rafael (2006) challenged the common understanding that global issues are simply "extending national health beyond national borders" (p. 5), instead proposing that the concept of global health must capture the "social, political, economic, and environmental contexts" (p. 5) of the burden of disease. Koplan et al. (2009) offered this re-conceptualization through defining the term *global health* as,

> An area for study, research and practice that places a priority on improving health and achieving equity in health for all people worldwide. Global health emphasizes transnational health issues, determinants, and solutions; involves many disciplines within

> and beyond the health sciences and promotes interdisciplinary collaboration; and is a synthesis of population-based prevention with individual-level clinical care. (p. 1995)

For this study, Koplan et al.'s (2009) definition guides the exploration of faculty preparing for IEs. If faculty prepare in alignment with the concept of global health, they might then be prepared to actually do global health.

Global Health Competencies

A recent document from the Consortium of Universities for Global Health (CUGH) Competency Subcommittee (Jogerst et al., 2015) considers the title "global health practitioners" (p. 241) for those engaging in activities such as IEs. This sub-committee built upon Koplan et al.'s (2009) work to provide a list of interprofessional global health competencies to inform how health practitioners become *global* health practitioners in local and international settings (Jogerst et al., 2015). This sub-committee represented 30 professional organizations and societies including the International Council of Nurses and the NLN (Jogerst et al., 2015). Another sub-committee within the CUGH (2018) developed a toolkit for the application of the competencies in 2017 that was later updated in 2018. In addition, discipline-specific global health competencies have been explored in nursing (Wilson et al., 2012). The creation of global health competencies suggests a positive movement to address global health education's otherwise "fragmentation and inconsistency of current pedagogical approaches" (Arthur, Battat, & Brewer, 2011, p. 348). More recently, host and partner perspectives on desirable competencies for global health practitioners have also been explored (Cherniak et al., 2017). In this study, global health competencies are identified as an aspect of faculty preparation and faculty in IEs are explored as being global health practitioners.

Critical Global Perspectives

An interest for this study is how faculty prepare for IEs in alignment with critical global perspectives of health. This is important because of the desire to ensure IEs cultivate these critical perspectives in students. In this study, critical global perspectives refers to postcolonial approaches to health that challenge the tendency to elevate Western perspectives and the tendency to view impoverished global communities as "helpless" (Andreotti, 2006, p. 43) and in need of external intervention. The prefix "critical" (Andreotti, 2006, p. 40) is important as it challenges discourses which problematize impoverished populations rather than investigating the root causes. The opposing "soft" (Andreotti, 2006, p. 43) approaches to global health may perpetuate colonial attitudes, increase host community dependency on external intervention, and elevate Western perspectives. Postcolonial approaches instead highlight social justice, relationships of power, and social responsibility towards the other (Andreotti, 2006). For this study, *critical global perspectives* includes both Andreotti's (2006) critical framework representing the discipline of education and from the nursing discipline Mill, Astle et al.'s (2005) concepts of global health equity, social justice, and Mill et al.'s (2010) global citizenship.

International Experience

A wide variety of terms have been used to explain the process by which university students engage in cross-border placements. These terms include *international experience, international placement, international exchange, global service learning,* and *study abroad*. IEs are not new or unique to nursing, with many professional university programs participating in cross-border education over several decades (Loh et al., 2015; Matheson, Pfeiffer, Walson, & Holmes, 2014). Strategies for IEs vary widely and include intradisciplinary, interdisciplinary, short term, long term, volunteer, and accredited experiences for both high-income (HIC) and

low-income country (LIC) destinations (Mill, Yonge, & Cameron, 2005; NLN, 2011). Many nursing programs have faculty accompanying students on their IE, although preceptorship models and online models also exist (Chavez, Bender, Hardie, & Gastaldo, 2010; Mill, Yonge, & Cameron, 2005). In the health disciplines, such as nursing, several accounts of IEs are those where countries with economic wealth send students to countries with economic poverty. IEs are also alternative clinical locations such that accompanying faculty would be considered clinical instructors (Hoe Harwood et al., 2009; Reimer-Kirkham et al., 2005b). For the purpose of this study, the term *international experience* (IE) is used instead of the emerging term of *global health experience* to capture the focus on cross-border sites. The term *international* aligns with the current understanding of global health and departs from earlier conceptualizations of international health.

Faculty

Nursing programs vary in how educators are classified in their teaching position. This includes terms such as *faculty*, *professor*, *educator*, or *instructor* to name a few. The term *faculty* can sometimes have the connotation of tenure and permanence. For the purpose of this study, however, the term *faculty* refers to any nurse educator who is hired by a nursing program to facilitate the learning of students while accompanying them on an IE.

Faculty Preparation

Currently, a standard conceptualization of *faculty preparation* does not exist, although various understandings of how faculty are prepared for their teaching duties are accepted in several disciplines. Merriam-Webster's (2019) dictionary defines preparation as "the action or process of making something ready for use, or service, or of getting ready for some occasion, test, or duty; the state of being prepared; a preparatory act or measure" (para 1). In higher

education, Boyer's (1990) widely embraced model of scholarship connects well to Merriam-Webster's (2019) definition such that scholarship enhances the process, development, and delivery of teaching. Glassick, Huber, Maeroff and Boyer (1997) emphasized faculty preparation as an important element for the scholarship of teaching because it readies faculty with the appropriate knowledge, skills, and resources for teaching in their respective fields. For the purposes of this study, the term faculty preparation is used when exploring any activity to ready faculty for their IE role. At times, there is differentiation between *formal* and *informal* preparation such that "a formal experience is designed to prepare faculty for the IE role, while an informal experience coincidentally provides knowledge that faculty might be able to use in the role" (Goode, 2008, p. 157).

Purpose and Research Questions

The purpose of this research is to explore nursing faculty preparation for accompanying nursing students on IEs by addressing the following questions:

1. How are nursing faculty prepared to teach nursing students in IEs? What assumptions underlie approaches to faculty preparation for IEs?

2. What are the qualities that prepare or qualify faculty for IEs, in other words, "Who is the IE educator?"

3. What are the implications for faculty preparation for IEs?

4. What recommendations are given to prepare faculty to teach IEs?

Research Method

An inductive qualitative methodology was chosen because little is known about faculty preparation for IEs. Specifically, Thorne's (2016) qualitative interpretive description (ID) methodology allowed for meaningful exploration of this complex issue in its beginning stages of

discovery. For the research purpose and questions, the ID study design was also informed by methods of critical inquiry that highlight the postcolonial global health concern of equity, justice, and relationships of power. Data for this study was collected through nine semi structured interviews with nursing educators across Canada who have experience in accompanying students internationally. Follow up interviews were also conducted with seven of these participants to extend preliminary findings. All interviews were audio-recorded and transcribed. Data analysis was supported by QSR International's NVivo™ 12 software. True to the methodology of ID, data were analyzed until identified themes extrapolated meaningful findings representative of the data as a whole while aligning with the discipline of nursing education.

Outline of Thesis

This thesis is organized in to six chapters. Chapter One has introduced the rationale for the study, conceptual definitions, purpose, research questions, and method. Chapter Two provides details of a literature review that identified relevant evidence for this research study, as well as supported the need for this research study. The research methods and study design are then identified in Chapter Three, which includes sampling strategies, data collection, data analysis, and scientific quality along with ethical considerations and limitations of the study. The study's findings are then presented in Chapter Four and these findings are connected back to current knowledge in Chapter Five's discussion. Finally, Chapter Six outlines recommendations for use of the study's findings in various domains of the nursing discipline and will also conclude the study.

Chapter Two: Literature Review

To substantiate the need for this ID study, a literature review was conducted to examine "what is known and not known" (Thorne, 2016, p. 63) of how faculty are prepared for accompanying nursing students on IEs. In this literature review, I synthesize existing evidence to address the following objectives: (a) how are nursing faculty prepared to accompany students on IEs, (b) what factors are considered for faculty preparation for IEs, and, (c) how are critical global perspectives used in preparing faculty for IEs.

In this chapter, I first describe the search and retrieval strategies for the literature review and then presents the findings of the review in four sections. The first section provides descriptive findings of the literature including the date of publication, location of the IEs, level of evidence, and general overview of the documents. Second are the synthesized findings related to nursing faculty preparation for accompanying nursing students on IEs—the focus of this study. The third section synthesized findings of how faculty prepare IEs. Although preparation of IEs was not the focus of this study, this section of the literature review provides context and background to the dearth of information for faculty being prepared themselves. In the last section of the review, literature was assessed for how preparation aligned with critical global perspectives using Andreotti's (2006) critical global framework and Mill and Astle et al.'s (2005) critical concepts of global health equity and social justice. Andreotti's (2006) framework was developed from the discipline of education, whereas, Mill and Astle et al.'s (2005) work is from the discipline from nursing, offering discipline-specific and comprehensive insights into health equity and social justice.

Search and Retrieval Strategies for the Literature Review

The literature review process involved three phases: (a) preliminary literature search, (b)

secondary literature search, and (c) final literature search. Each phase used databases of Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medical Literature Analysis and Retrieval System (MedLine), Education Resource Information Center (ERIC), and Google Scholar databases to explore intersecting concepts of nursing education, IEs, and faculty preparedness. See Appendix B for figure of intersecting concepts.

Preliminary Literature Search

The preliminary literature review was completed during a graduate degree directed study under the guidance of Dr. Sheryl Reimer-Kirkham. For the preliminary literature search, an academic librarian provided initial guidance for searching key words using Boolean operators, such as "AND", and "OR", along with controlled vocabulary such as "nursing", "faculty OR educator", and "preparation OR development". Additional terms such as "international service learning," "experiential learning," "immersion experience," and "global health experience" were influenced by key documents and included in the search. This search strategy resulted in 167 documents. Initial inclusion criteria called for evidence-based peer reviewed documents; however, the preliminary literature search resulted in some documents that were anecdotal and related to the research questions, whereas the evidence-based documents did not relate to the research questions. As a result, in consultation with the thesis supervisory team and the academic librarian, adjustments were made to the research strategy to include evidence-based and anecdotal (non-evidenced-based) peer-reviewed documents.

Secondary Literature Search

The secondary literature search applied the same Boolean operators and keywords; however, because of the minimal documents with a clear connection to the research questions, this updated search strategy set aside the concept of "preparation OR development" to be

screened manually by the researcher so as not to miss any embedded detail in the text. This search yielded 567 documents. After 132 duplicate documents were removed, a total of 435 document titles and abstracts were screened for eligibility. See Appendix C for the PRISMA chart. The inclusion criteria for this review included both evidence-based and anecdotal English-language peer-reviewed documents. All documents needed to include nursing faculty preparation for travelling internationally with students for an accredited course. Because of the minimal data related to the topic of interest, there were no publication dates limitations to allow for a wide net to capture early attention to the topic. Highlighting the *international* component was important to differentiate from local placements that are also connected to global health education (Jogerst et al., 2015). Documents with a primary focus on students, with no mention of faculty preparation, were excluded. Student perceptions of faculty preparation, or preparation of nurse volunteers for IEs, were also excluded. The inclusion and exclusion criteria were applied to an initial screening of title and abstracts of the documents.

This initial screening revealed that many documents identified qualifications, attributes, and faculty roles for IEs rather than specific activities for faculty preparation. Furthermore, it became apparent that the documents had a significant focus on how faculty prepare IEs, such as guidelines to prepare curriculum, prepare students, and prepare course logistics. There was comparatively less on how faculty themselves are prepared such as professional development and training. Therefore, two additional decisions were made in consultation with the thesis supervisory team. The first was to include documents that addressed how faculty were selected or qualified for the teaching position, the personal attributes of the faculty accompanying students, and the specific identified roles of faculty accompanying students on IEs. The second decision was to include documents identifying preparation of IEs for the initial inclusion

screening of title and abstracts, and then, in the full-text review, to only include documents if faculty preparation was also addressed in the primary text. Although documents that met these criteria were included even if their focus was how faculty prepare IEs, it is important to note that this review was not intended to explore resources for preparing IEs, but to find evidence of how faculty are prepared. This secondary literature search used the eligibility criteria to screen 435 titles and abstracts which yielded 98 full-text documents for review.

A backward search through reference lists, and forward search through Google Scholar, were also conducted, resulting in 15 additional documents for review. After searching references and seeking recommendations from experts in the field, three grey-literature documents were also included because of their direct relevance to the topic of interest. Thorne (2016) identified that such "non-traditional sources" (p. 57) are important to consider in ID as it promotes situating the phenomenon in the context of what is known. The first grey literature was *Faculty Preparation for Global Experiences Toolkit* by the NLN (2011), the second was a chapter in *Globalization in Nursing* by Chavez et al. (2008), and the last was a resource guide and workshop put on by Evert et al. (2019) *Faculty Development Workshop* for global placements. With this expansion of original eligibility criteria, other grey literature such as toolkits and books were also considered; however, no other documents were found directly linked to how nursing faculty are prepared for IEs with students. University course syllabi and other conference proceedings were not included.

Final Literature Search

Search strategies were initiated in November 2017 and repeated in August 2019 for an addition of seven documents to be considered for the literature review. The dearth of data related to the topic created interest for how other disciplines prepare faculty to accompany students on

IEs. However, using the same search strategy applied to CINAHL, ERIC, and MedLine, with the removal of the concept of *nursing* revealed not only this same dearth, but, in fact, no evidence-based documents related to non-nursing faculty preparation for accompanying students on IEs. Although relevant anecdotal documents exist, a decision was made, in consultation with the thesis supervisory team, for this to remain focused on the nursing discipline, and to integrate relevant anecdotal information from other disciplines, where relevant into Chapter Five. Upon full-text review, a total of 31 documents were considered eligible for the literature review. See Appendix D for table of documents used in the literature review.

Strategies for Data Extraction and Analysis

This literature review included an extensive data extraction and analysis process informed by scoping methods of "charting the data" and "collating, summarizing, and reporting the results" (Colquhoun et al., 2014, p. 1293). Garrard's (2017) matrix method was used to capture data extraction for elements such as the purpose, method, findings, and recommendations of each document. Matrix charting also reflected an iterative process where new questions simultaneously emerged from and were posed back to the literature to guide the review. Data related to these extraction questions populated an excel document to form a descriptive map of the entire data set that later informed the synthesized findings.

Descriptive Findings of the Literature Review

The 31 documents eligible for the review ranged from 1992–2019 with the majority published in the past 10 years (n=17). In 25 documents that specified location of the sending and destination countries for the IE, the sending institute included the USA (n=19), North America (n=4), Canada (n=1), and Australia (n=1). Other documents did not focus on a specific trip and instead provided general discussion about IEs. Over 38 destination countries were represented

from the documents. The countries have been organized using The World Bank's (2018) Country Classification that showed that all documents represented a HIC sending to a LIC for IEs. See Appendix E for table of countries represented in the literature review. No documents represented a LIC to LIC experience, or a LIC to HIC experience. A variety of student to faculty ratios for the accompaniment model were reported ranging from three students and one faculty (Chavez et al., 2008) to twenty students and two faculty (Brown, 2017; Wright, 2010). Both private and public institutions were represented with various levels of nursing programs including Associate Degrees (AD), Bachelor of Science of Nursing (BSN), Master of Science (MSN), and Doctor of Philosophy Degree (PhD).

Description of Evidence-Based Findings for Faculty Preparation

Both evidence-based and non-evidence-based approaches were represented in the 31 documents included in this literature review. In total, six documents implemented evidence-based methods and were categorized as Level IV Evidence: "well-designed non-experimental observational studies" (Registered Nurses' Association of Ontario [RNAO], n.d., para 4). Validity was assessed using a Rapid Critical Appraisal Tool (Fineout-Overholt & Melnyk, as cited in Fineout-Overholt, Melnyk, Stillwell, & Williamson, 2010). See Appendix F for an example of the Rapid Appraisal Tool.

Only one article implemented evidence-based methods with a primary purpose of exploring faculty preparation, although, the focus was on preparation for one element of IEs – reciprocity (Miller-Young et al., 2015). The authors used Pace and Middendorf's (as cited in Miller-Young et al., 2015) qualitative research framework of decoding the disciplines to explore a collaborative and self-study approach to determine how faculty learn about "reciprocity" (p.32) in international and local service learning. Seven participants, including two nurse educators,

were involved in this study. Findings highlighted Mezirow's (as cited in Miller-Young et al., 2015) transformative learning as foundational to faculty learning reciprocity in service learning. Transformative learning occurred through the decoding research process, multidisciplinary self-study, external interviewers, critical friends, and facing embedded norms (Miller-Young et al., 2015). Faculty in this group "struggled to let go of their conviction that they were already fully enacting reciprocity" (Miller-Young et al., 2015 p. 40) in service learning, when it was found in the data that there was more to learn and expand their understanding of reciprocity.

The remaining five evidence-based documents had minimal focus on faculty and more focus on logistics of IEs or on students involved in IEs. Haloburdo and Thompson's (1998) qualitative grounded theory study explored 14 senior level nursing students' experience in "developed and developing countries" (p. 13) for their IEs. This resulted in a model for international nursing education where the "faculty role" (p. 20) included planning the IE and debriefing with students. Faculty attributes included previous experience in international work. In another evidence-based document, Leffers and Mitchell (2011) similarly identified the role of faculty in their grounded theory study. The resultant model for partnership and sustainability in global health placements highlighted faculty attributes for success in IEs such as,

> Willingness to live in less than comfortable conditions; openness to the perspective of others; flexibility; willingness to share or give leadership to the host partners; and energy to take personal risks to advocate for social justice and achieve morally sound outcomes. In addition, . . . awareness of self and other personal biases to identify how power, privilege, and ethnocentric values will impact the partnership process. (p. 95)

Their model was developed from interviews with "thirteen nurse-experts from the United States with a range of 3–30 years of both short-term and long-term global health experience" (p. 93). Eight of these participants were nurse educators with expertise in leading students on IEs.

In Reimer-Kirkham, Harwood, and Van Hofwegen's (2005a) interpretive description, alternative clinical placements, such as IEs, were examined as a student learning opportunity. Participants included clinical educators, and authors found that student learning was supported by faculty attributes of a "vision for excellence in community nursing and social justice" (p. 268). Another evidence-based document combined literature review methods with author expertise to develop a framework for globally engaged nursing education (Riner, 2011). This framework included a component called "securing qualified faculty" (p. 313), and the "role of faculty in facilitating the onsite experience" (p. 313), although instruction for these elements was not included. The final evidence-based article in this literature review was C.A Browne and Fetherston's (2018) content analysis of a survey of 18 undergraduate nursing programs in Australia to outline "the structure, aims and learning outcomes associated with international clinical placement opportunities" (p. 1). Although details of the survey were not provided, the findings included a section called "preceptorship and facilitation to enhance student learning outcomes" (C.A Browne & Fetherston, 2018, p. 5), which identified educator attributes of adaptability, language skills, and comfort with the living condition.

Description of Non-Evidence-Based Findings for Faculty Preparation

The remaining documents were anecdotal discussion papers (n=22), or grey literature documents (n=3) assessed at Level V on the hierarchy of evidence as "expert opinion, and/or clinical experiences of respected authorities" (RNAO, n.d.). Of these anecdotal documents, only two had the purpose of addressing faculty preparation for accompanying nursing students on IEs;

both were grey literature. The first was the NLN (2011) *Faculty Preparation for Global Experiences Toolkit* created by a joint task force of the NLN who compiled "decades of personal and professional cross-cultural experiences" (NLN, 2011, p. 7) to recommend faculty preparation for IEs. The five sections of the toolkit include guidelines and resources for practical considerations, logistical considerations, safety considerations, considerations upon arrival, and planning for return. Notably, a backward search of the reference list for the NLN (2011) toolkit revealed minimal data addressing preparation of faculty versus the preparation of IEs.

The second grey literature directly addressing faculty preparation for IEs was Evert et al.'s (2019) *Faculty Development Workshop* for global placements. This interdisciplinary workshop was a collaborative workshop from leaders in global health education, international education, higher education, community engagement, and experiential learning. The workshop integrated presenters' expertise in global health and IEs to prepare nursing and non-nursing participants for international and local global health experiences. Participants were oriented to the definition of global health, the global burden of disease, and the CUGH global health competencies (Jogerst et al., 2015). The workshop also provided a networking opportunity for nursing faculty with other disciplines involved in IEs.

Other anecdotal documents also had a focus on faculty preparation, namely, faculty attributes and roles for accompanying students on IEs. For instance, McKinnon and Fealy (2011) identified faculty attributes of "compassion, curiosity, courage, collaboration, creativity, capacity building, and competence" (p. 95) although the authors did not address how faculty would prepare for these factors. Kohlbry and Daugherty's (2013) document also presented faculty roles of "initiator, facilitator, collaborator, and advocate" (p. 165) although, again, there was little direction for how faculty prepare for these roles.

There were six other anecdotal documents included in this review that had a section of the text dedicated to faculty preparation, attributes, and roles; however, the overall purpose of these documents was guidance or description of preparation of an IE. Lachat and Zerbe's (1992) anecdotal document had a section dedicated to "faculty selection" (p. 54) and "the role of faculty" (p. 54), which included recommendations like making time in the schedule, being prepared for unexpected emergencies, and embodying roles of a "professional colleague, compatriot, and a parent figure" (p. 55). These recommendations were based off of the authors' own experience. In another article based on the author's experience, Christoffersen (2008) narrated her first experience of preparing for accompanying students to Nicaragua and included a section in which she reflects on her decision to accept the teaching position.

Memmott et al.'s (2010) article about their IE also included author recommendations for "selecting and developing faculty" (p. 299). In this section the authors described the importance of faculty year-round commitment for the "heavy workloads, and periods of time away from home" (p. 299). Recommendations included self-selecting to the IE teaching role based on factors such as previous experience in the international context, interest, clinical expertise, language expertise, and professional contacts. Memmott et al. (2010) recommended faculty self-assess their adaptability and ability to tolerate students "24 hours a day" (p. 300) since interactions between students and faculty may "evolve into a more personal level" (p. 300). Wittman-Price, Anselmi, and Espinal (2010) included the headings "faculty preparation time" (p. 91) and "personal travel preparations" (p. 92), which identified the extensive time and effort, necessary language skills, and personal travel preparation for faculty. In another document, Hegedus et al.'s (2013) included a section titled "faculty" (p. 28) which included criteria for faculty selection such as clinical expertise and prior experience in the international context. For

Hegedus et al. (2013), if these two factors were not possible, then faculty were selected based on interest in new experiences and comfort with "cultural diversity" (p. 29). They described how faculty were compensated with incentives to commit to IEs considering the significant responsibilities they had for teaching theory, supervising clinical, facilitating discussions, and teaching about cultural differences.

Finally, Palmer, Wing, Miles, Heaston and de la Cruz (2013) described how they recruited volunteer alumni and graduate students to be faculty to address a shortage of qualified university faculty for IEs. In a section "preparing affiliate faculty" (p. 199), Palmer et al. (2013) emphasized how these volunteers were oriented to roles and expectations, course outcomes and syllabus, and the mission and vision of the university and school of nursing through e-mails, phone calls, and optional preparatory classes with students that were later recommended to be mandatory. The remaining documents in this review had some, although less, attention on faculty preparation, qualifications, attributes or roles when describing planning for IEs. Together, all 31 documents were assessed for how they addressed faculty preparation.

Synthesized Findings: Faculty Preparation

Although there was limited evidence pertaining to the study's purpose of faculty preparation for IEs, data from all the documents in this literature review were integrated into a synthesis. In doing so, this synthesis highlights the central finding of this review that differentiates how *faculty* themselves are prepared from how *IEs* are prepared. The first section describes three key themes of faculty preparation including professional and personal preparation of faculty, the qualifications and attributes of faculty who participate in these experiences, and the unique faculty roles necessary for leading these experiences.

Faculty Professional and Personal Preparation

Overall, there was little evidence identified regarding the informal and formal activities for faculty preparation. Within this limited data, the most commonly identified activities included orientation, mentorship, and self-reflection (Bentley & Ellison, 2007; Brown, 2017; Christoffersen, 2008; Delpech, 2013; Doyle, 2004; Hegedus et al., 2013; Kohlbry & Daugherty, 2013; Mason & Anderson, 2007; Memmott et al., 2010; Mill, Yonge, & Cameron., 2005; Palmer et al., 2013; Visovsky, McGhee, Jordan, Dominic, & Morrison-Beedy, 2016; Wittmann-Price et al., 2010; Wright, 2010). Institutional support was considered to be important, but it was not always fully enacted. Support from this systems perspective included release from other duties, financial support for travel and accommodation, and personnel support in the form of co-instructors and mentors (Brown, 2017; Delpech, 2013, Doyle, 2004; Hegedus et al., 2013; Kohlbry & Daugherty, 2013; Lachat & Zerbe, 1992; Memmott et al., 2010; Palmer et al., 2013; Visovsky et al., 2016; Wright, 2010). Hegedus et al. (2013) provided an example of strong institutional support for faculty preparation for their IE program by integrating an internship coordinator, resident assistant, and a study abroad committee that supported faculty through mentorship and resources. More recently, Noone, Kohan, Hernandez, Tibbetts and Richmond (2019) identified the importance of institutional "buy-in" (p. 238) to support faculty preparation and preparation of IEs.

In the literature, faculty preparation included a multiday orientation in the destination country (Hegedus et al., 2013; Memmott et al., 2010; Wright, 2010), pre-departure sessions (Brown, 2017; Hegedus et al., 2013), e-mail or phone call orientation (Palmer et al., 2013), self-guided pre-departure orientation (Doyle, 2004), and participation with students in preparatory classes (Delpech, 2013; Doyle, 2004; Mason & Anderson, 2007; Palmer et al., 2013, Visovsky et

al., 2016). Little detail about orientation content was provided, although specified inclusion of policies and procedures of the institution (Brown, 2017; Doyle, 2004; Palmer et al., 2013); orientation to health, safety, and liability (Bentley & Ellison, 2007, Doyle, 2004); handling student emergencies (Lachat & Zerbe, 1992); orientation to the health care system of the host country (Delpech, 2013); and orientation to language and cultural learning (Riner, 2011).

Mentorship was also identified by some authors as an element of faculty preparation (Brown, 2017; Hegedus et al., 2013; Kostovich & Bermele, 2011; Palmer et al., 2013). Brown (2017) identified a model of co-instructorship in which experienced faculty mentored novice faculty during an IE. Hegedus et al. (2013) described dedicated roles in their nursing department responsible for mentoring and orienting new faculty both before and during IEs. Other documents highlighted personal preparation for faculty such as self-reflective activities (Christoffersen, 2008; Doyle, 2004; Leffers & Mitchell, 2011; Memmott et al., 2010; Mill, Yonge, & Cameron, 2005). Mill, Astle et al. (2005) identified that prior to IEs, "it is critical for students *and* [emphasis added] faculty members to become aware of their own health beliefs and practices" (p. 6). This was echoed by Leffers and Mitchell's (2011) conceptual model which encouraged faculty reflection of personal biases including the influence of power, privilege, and ethnocentric values. In a narrative of her first experience, Christoffersen (2008) reflected on her fear of leading the course. Others encouraged faculty to reflect on potential personal impacts of the trip (Memmott et al., 2010; Palmer et al., 2013).

Faculty Qualifications and Attributes

Differing from activities that prepared nursing faculty for IEs with students, there was indication that faculty should be qualified or otherwise have specific personal attributes for accompanying students on IEs. Some authors identified a program director who selected

qualified faculty and others identified faculty self-selecting for the teaching position (Hegedus et al., 2013; Memmott et al., 2010). Previous experience in the international setting was the most commonly listed qualification (Brown, 2017; Christoffersen, 2008; Hegedus et al., 2013; Mason & Anderson, 2007; Memmott et al., 2010; Noone et al., 2019; Palmer et al., 2013). The NLN (2011) *Faculty Preparation for Global Experiences Toolkit* recommended faculty having some travel experience although it was not considered to be essential. C. A Browne and Fetherston (2018) noted how first time facilitators reported apprehension for their role in IEs based on lack of experience, knowledge, and skill.

In situations where programs were unable to secure qualified faculty, some authors indicated *interest* as a reasonable substitute for experience (Hegedus et al., 2013; Mason & Anderson, 2007; Memmott et al., 2010; Palmer et al., 2013). Other substitutes for experience included cultural skills (Palmer et al., 2013), relevant clinical expertise (Hegedus et al., 2013; Mason & Anderson, 2007; Memmott et al., 2010; Palmer et al., 2013), access to professional contacts (Memmott et al., 2010), and language skills (Memmott et al., 2010; Noone et al., 2019; Palmer et al., 2013). In one case, an author worried her lack of experience and clinical expertise would disqualify her from facilitating an IE and she was surprised to be recruited for the position (Christoffersen, 2008).

Other qualifying attributes for faculty accompanying students on IEs included flexibility and adaptability (Brown, 2017; Kohlbry & Daugherty, 2013; Leffers & Mitchell, 2011; Mason & Anderson, 2007; Mill, Yonge, & Cameron, 2005; NLN, 2011; Sloand et al., 2008; Visovsky et al., 2016). Additionally, having interest and enthusiasm in international work (Bentley & Ellison, 2007; Bosworth et al., 2006; Chavez et al., 2008; Doyle, 2004; Kohlbry & Daugherty, 2013; Levine & Perpetua, 2006; Mason & Anderson, 2007; Noone et al., 2019; Sloand et al., 2008),

being open to new and challenging roles and experiences (Kohlbry & Daugherty, 2013; Leffers & Mitchell, 2011; NLN, 2011), and being self-aware and respectful (NLN, 2011, p. 16). Hegedus et al. (2013) also highlighted faculty attributes of "courage, grace, caring and persistence" (p. 31), and Reimer-Kirkham et al. (2005a) recommended faculty have a "passion for social justice" (p. 269).

Faculty knowledge was also highlighted as an important attribute. The NLN (2011) identified that "US [United States] nurses are viewed as the most educated leaders of the profession and as such are expected to demonstrate the highest level of nursing knowledge when consulting and practicing abroad" (p. 12). This includes knowledge of the country's cultural values, cultural beliefs, history, political climate, socioeconomic status, health systems, and common health issues (NLN, 2011). Chavez et al. (2008) highlighted knowledge as an important attribute for faculty and advocated that "those teaching global health have to articulate principles coherently" (p. 184). Along with the attribute of knowledge was the need to be willing to learn (Leffers & Mitchell, 2011; NLN, 2011; Visovsky et al., 2016).

Commitment and sacrifice were also important faculty attributes. For instance, faculty accompanying students sacrifice personal comfort (Christoffersen, 2008; Leffers & Mitchell, 2011) and personal finances (Levine & Perpetua, 2006; Palmer et al., 2013). Several documents noted the enormous amount of time, effort, and personal resources required to prepare and implement these courses (Bentley & Ellison, 2007; Delpech, 2013; Kohlbry & Daugherty, 2013; Lachat & Zerbe, 1992; Leffers & Mitchell, 2011; Memmott et al., 2010; Noone et al., 2019; Palmer et al., 2013; Reimer-Kirkham et al., 2005a; Sloand et al., 2008; Wittmann-Price et al., 2010). Some authors reported the challenge of needing to volunteer the intensive preparatory work without financial support from the institute (Brown, 2017; Levine & Perpetual, 2006;

Wittmann-Price et al., 2010). Intensive pre trip planning began from months to one year before the experience (Brown, 2017; Lachat & Zerbe, 1992; Memmott et al., 2010, Palmer et al., 2013), and some programs also implemented a pre course onsite visit varying from two days to one week, contributing to this resource intensive process (Doyle, 2004; Hegedus et al., 2013; Noone et al., 2019; Reimer-Kirkham et al., 2005a; Sloand et al., 2008; Wittman-Price et al., 2010). Wittman-Price et al. (2010) highlighted "faculty need to be ready to invest significant time in the trip planning and preparation" (p. 92).

Faculty Roles and Responsibilities

Faculty roles and responsibilities for accompanying students on IEs were also identified in numerous documents. An accompanying description for how to prepare for these roles was, however, absent. Two documents dedicated to identifying faculty roles were mentioned earlier including McKinnon and Fealy's (2011) faculty roles of "compassion, curiosity, courage, collaboration, creativity, capacity building, and competence" (p. 95), and Kohlbry and Daugherty's (2013) roles of "initiator, facilitator, collaborator, and advocate" (p. 95). Other identified faculty roles included teacher and facilitator (Lachat & Zerbe, 1992; Maginnis & Anderson, 2017; Mill, Yonge, & Cameron, 2005; Riner, 2011), and mentor, advisor, nurse, and parent figure (Lachat & Zerbe, 1992; Mill, Yonge, & Cameron, 2005). Faculty leading IEs also had the role of preparing the course and the students (Brown 2017; Haloburdo & Thompson, 1998). They also ran "on the ground operations" (Hegedus et al., 2013, p. 28), supported students through culture shock (Nicholas, Corless, Fulmer & Meedzan, 2012; Maginnis & Anderson, 2017; Mill, Yonge, & Cameron, 2005; Wittmann-Price et al., 2010), and acted as role models (Wittmann-Price et al., 2010). The NLN (2011) also emphasized numerous faculty responsibilities including preparing the experience, preparing students, facilitating safe travel,

debriefing students, and initiating collaborative relationships within the host community. C. A Browne and Fetherston (2018) summarized faculty should be prepared for the "complex" (p. 5) roles of accompany students on IEs.

This section of the literature review synthesized information from evidence-based and non-evidence-based documents related to the research questions of how faculty are prepared for accompanying students on IEs. Three themes of preparation were identified and included professional and personal preparation, qualifications and attributes, and faculty roles and responsibilities. The next section of this literature review provides a synthesis of data related to preparation of IEs.

Synthesized Findings: International Experience Preparation

As identified in the previous section, one of the faculty roles and responsibilities for accompanying students on IEs includes preparing the IE which is represented in this synthesis. Although preparing IEs was not a focus of this research study, the interconnectedness between preparing faculty and preparing IEs situates the research questions in the context of what is known about faculty preparation. For this literature review, documents related to preparing IEs were only eligible if they also addressed faculty preparation as per the requirements of eligibility. Therefore, this section is not a comprehensive synthesis of how to prepare IEs, but rather it is included to provide a background for faculty preparation for which there was significantly less evidence. Synthesized themes for preparing IEs included preparing with institutional support along with preparing curricular components, students, safety, relationships, and logistics.

Preparing with Institutional Support

Even though not a prominent theme in the documents, institutional support was identified as important for planning IEs. Those who did not have institutional support highlighted the

financial and work burden on faculty to sustain the IE program. Kohlbry and Daugherty (2013) suggested that when there is institutional alignment and financial support, "international service–learning project is easy to implement" (p. 166). Institutional support included global committees (Doyle, 2004; Hegedus et al., 2013; Wright, 2010), advisory councils (Delpech, 2013; Memmott et al., 2010; Wright, 2010), supporting offices (Hegedus et al., 2013; Palmer et al., 2013; Visovsky et al., 2016), and ad-hoc working groups (Doyle, 2004). Reimer-Kirkham et al. (2005a) identified the "intensive administrative coordination" (p. 267) required for IEs. Noone et al. (2019) emphasized the need to align preparation with the policies of the institution's travel offices. Others identified how institutional alignment with the curriculum helped to sustain IEs (Delpech, 2013; Hegedus et al., 2013; Kohlbry & Daugherty, 2013; Levine & Perpetua, 2006; Memmott et al., 2010; Mill, Yonge, & Cameron, 2005).

Preparing Curricular Components

Every document in this review identified components of curricular preparation for IEs. This included preparing course theories and philosophies, purpose and outcomes, focus population and destination, and assignment and schedule. Some authors identified teaching and learning theories that guided planning such as experiential learning theory (Delpech, 2013), transformative learning theory (Reimer-Kirkham et al., 2005a), and new science leadership theory (Wheatley, as cited in Doyle, 2004). Faculty also planned IEs based on philosophies and concepts such as Chavez et al.'s (2008) focus on primary health care principles as well as postcolonial feminism and global citizenship. In this literature review, the most common concepts identified for IE course curriculum were Purnell (2002) and Campinha-Bacote's (2002) cultural competency, and Leininger and McFarland's (1995) transcultural nursing (Bentley & Ellison, 2007; Brown, 2017; Delpech, 2013; Kohlbry & Daugherty, 2013; Levine, & Perpetua,

2006; Mason & Anderson, 2007; McKinnon & Fealy, 2011). Other courses were informed by principles of service-learning and public health nursing (Brown, 2017; Delpech, 2013; Kohlbry & Daugherty, 2013; McKinnon & Fealy, 2011).

Identifying the IE purpose, outcomes, focus population, and destination was another component to curricular preparation. Many authors suggested that for IEs, the purpose and outcomes should align with the philosophy and commitment of the institute (Lachat & Zerbe, 1992; Mason & Anderson, 2007; Memmott et al., 2010; Reimer-Kirkham et al., 2005a), and should be relevant to similar clinical experiences at home (Nicholas et al., 2012; Noone et al., 2019). In some cases, the focus population was determined by partnering organizations such as non-governmental organizations (Delpech, 2013; Levine & Perpetua, 2006; Wright, 2010). Other strategies for selecting a focus population or destination included proximity to the sending institute (Kohlbry & Daugherty, 2013), safe political climate and pre-existing relationships (Delpech, 2013; Lachat & Zerbe, 1992; NLN, 2011), faculty interests (Sloand et al., 2008; Wright, 2010), previous faculty experiences (Wright, 2010), and access to clinical placements and housing (Lachat & Zerbe, 1992; Levine & Perpetua, 2006; Sloand et al., 2008).

The primary identified purpose of IEs was for student learning which included clinical learning in diverse settings (C. A. Browne, Fetherston & Medigovich, 2015), learning from strong health care systems (Palmer et al., 2013), and increasing understanding of poverty (Bosworth et al., 2006). Few documents identified the needs of the host communities although many highlighted hosts as beneficial to IEs because hosts helped to identify learning opportunities and course content (Bentley & Ellison, 2007; Brown, 2017), provided pre trip orientation (Bentley & Ellison, 2007; Haloburdo & Thompson, 1998; McKinnon & Fealy, 2011), and were an important factor in arranging logistics and establishing safety for the participants

(Doyle, 2004). Reimer-Kirkham et al. (2005a) noted, “where strong partnerships existed with host healthcare agencies, the work of setting up the placements was diminished, and ensuing student learning was enhanced” (p. 269). Some authors highlighted the purpose of IEs was to address health concerns in impoverished areas through service learning although host consultation was not identified (Brown, 2017; Christoffersen, 2008). Several authors described how IEs offered host communities capacity building and empowerment (Leffers & Mitchell, 2011; Mason & Anderson, 2007; McKinnon & Fealy, 2011), along with reciprocity (Miller-Young et al., 2015). Some authors suggested memorandums of understanding to establish collaboration between the host and sending institution (Noone et al., 2019; Visovsky et al., 2016; Wright, 2010). Founded on principles of global citizenship and postcolonial feminism, Chavez et al.’s (2008) IE program was initiated after a host community requested involvement from this Canadian institute. Chavez et al. (2008) completed a needs assessment before engaging in the IE and attended to host feedback to take MSN students instead of BSN students. Likewise, Leffers and Mitchell’s (2011) conceptual model for partnership and sustainability in global health identified a “process for partnership” (p. 95) that includes steps of mutual goal building. The NLN (2011) emphasized host benefits from IEs included access to the latest developments in nursing from well-regarded Western nurses, opportunities for host faculty to participate in international education, promotion of the home institution, and integration the host community into the global nursing community.

Preparing IEs also included preparing assignments and schedules (Bosworth et al., 2006; Brown, 2017; Chavez et al., 2008; Christoffersen, 2008; Delpech, 2013; Doyle, 2004; Kohlbry & Daugherty, 2013; Memmott et al., 2010; Nicholas et al., 2012; Reimer-Kirkham et al., 2005a; Riner, 2011; Sloand et al., 2008; Visovsky et al., 2016; Wittmann-Price et al., 2010; Wright,

2010). IEs ranged from 1-week (Sloand et al., 2008) to 14-weeks (Hegedus et al., 2013). Faculty also planned and facilitated debriefing to enhance students' learning and personal growth (C. A. Browne & Fetherston, 2018; Chavez et al., 2008; Christoffersen, 2008; Delpech, 2013; Haloburdo & Thompson, 1998; Hegedus et al., 2013; Levine & Perpetua, 2006; Mason & Anderson, 2007; Nicholas et al., 2012; NLN, 2011; Riner, 2011; Reimer-Kirkham et al., 2005a).

Preparing Students

Although evidence on how faculty are prepared was minimal, there was significant emphasis on preparing students for IEs. Authors emphasized students' preparation as being as "one of the most important" (Nicholas et al., 2012, p. 369) or the "the most crucial" (Reimer-Kirkham et al., 2005a, p. 268) factor for successful IEs. Even though student preparation was widely accepted as an important element, its implementation varied greatly. Some students were prepared online (Christoffersen, 2008), whereas others received face-to-face sessions (Chavez et al., 2008; Doyle, 2004; Riner, 2011; Sloand et al., 2008). Student preparation occurred either in their free time or in a preparatory course for credits. Two courses offered unique pre trip simulation experiences of a low resource setting (Bentley & Ellison, 2007) or a simulated international home visit (Visovsky et al., 2016). The content of student preparation also varied, and included orientation to political, economic, cultural, religious, health, and social issues in the host country (Bosworth et al., 2006; Mill, Yonge, & Cameron, 2005; Nicholas et al., 2012; Noone et al., 2019). Faculty were also encouraged to clearly, and repetitively, orient students to anticipated health, safety, and liability expectations (Lachat & Zerbe, 1992; Mill, Yonge, & Cameron, 2005; Reimer-Kirkham et al., 2005a), as well as expectations of being a guest in a different community (Lachat and Zerbe, 1992; NLN, 2011). Chavez et al. (2008) emphasized critical global perspectives in their pre-departure classes. This included post-colonial feminism,

globalization, social justice, human rights anti-oppression, cultural competence, and health and safety abroad. Preparing students also included recruitment, screening, and selection of students for IEs. (Delpech, 2013; Hegedus et al., 2013; Kohlbry & Daugherty, 2013; Lachat & Zerbe, 1992; Memmott et al., 2010; Mill, Yonge, & Cameron, 2005; Noone et al., 2019; Reimer-Kirkham et al., 2005a; Riner, 2011; Sloand et al., 2008; Wittmann-Price et al., 2010).

Preparing Safety

A crucial element of preparing IEs is preparing for the safety of everyone involved (Hegedus et al., 2013; Kohlbry & Daugherty, 2013; Lachat & Zerbe, 1992; Levine & Perpetua, 2006; Mill, Yonge, & Cameron, 2005; NLN, 2011; Sloand et al., 2008; Visovsky et al., 2016; Wittmann-Price et al., 2010). The most emphasized concern for safety was regarding student safety and related institutional liability. Examples of health, safety, and liability preparation included collecting immunization records (Bentley & Ellison, 2007; Christoffersen, 2008; Memmott et al., 2010; Mill, Yonge, & Cameron, 2005; NLN, 2011; Wittmann-Price et al., 2010), preparing for emergencies (Bentley & Ellison, 2007; Brown, 2017; Nicholas et al., 2012; NLN, 2011; Palmer et al., 2013; Riner, 2011; Visovsky et al., 2016; Wittmann-Price et al., 2010; Wright, 2010), studying international travel advisories (Kohlbry & Daugherty, 2013; Mill, Yonge, & Cameron, 2005; Nicholas et al., 2012, Noone et al., 2019; Reimer-Kirkham et al., 2005a; Visovsky et al., 2016; Wittmann-Price et al., 2010), and choosing safe destinations (Memmott et al., 2010; Mill, Yonge, & Cameron, 2005; NLN, 2011; Visovsky et al., 2016; Wittmann-Price et al., 2010). Haloburdo and Thompson's (1998) grounded theory study found that more preparation for safety was needed in developing countries than in developed countries. Personal safety was encouraged through avoiding dangerous behaviors (Mill, Yonge, & Cameron, 2005, Wittmann-Price et al., 2010), being aware of cultural expectations (Nicholas et

al., 2012; Reimer-Kirkham et al, 2005a), and refraining from discussing religion and politics (NLN, 2011).

Patient and host community safety was not as highly emphasized, although for those who did, clarity on scope of practice was an important consideration for safe care of patients (NLN, 2011; Visovsky et al., 2016; Wittmann-Price et al., 2010). Some authors emphasized preparing for the legal requirements of the host and the sending countries and agencies (Doyle, 2004; Kohlbry & Daugherty, 2013; Nicholas et al., 2012; Noone et al., 2019; Riner, 2011; Visovsky et al., 2016; Wright, 2010) and suggested students should also be aware of their professional roles and responsibility in a new setting (Mill, Yonge, & Cameron, 2005; Reimer-Kirkham et al., 2005a). The NLN (2011) encouraged faculty to consider the ethics of imposing Western nursing theories, specifically considering if it is "ethically or culturally appropriate to impose what is perceived to be right in developed countries onto the developing countries" (p. 10). Other authors echoed the importance for ethical practice in an unfamiliar setting (Brown, 2017; Mill, Yonge, & Cameron, 2005; Nicholas et al., 2012; NLN, 2011; Palmer et al., 2013; Reimer-Kirkham et al., 2005a; Riner, 2011). McKinnon and Fealy (2011) suggested that program who "insinuate themselves into a community, provide a service, and then leave that community" (p. 98) act unethically.

Preparing Relationships

Many authors also highlighted relationships within the host communities as crucial to the success of the international experience (Bosworth et al., 2006; Brown, 2017; Delpech, 2013; Leffers & Mitchell, 2011; Nicholas et al., 2012; NLN, 2011; Reimer-Kirkham et al., 2005a; Visovsky et al., 2016). Included in relationships, some authors identified the importance of preparing "partnerships" (Bosworth et al., 2006; Leffers & Mitchell, 2011; McKinnon & Fealy,

2011; Reimer-Kirkham et al., 2005a). Others used language such as contacts and connections (Doyle, 2004; Sloand et al., 2008). A variety of strategies for preparing and sustaining relationships were suggested. Relationships were beneficial if they were pre-established by the faculty (Delpech, 2013; Lachat and Zerbe, 1992). Interdisciplinary relationships were also encouraged (Brown, 2017; Christoffersen, 2008; Delpech, 2013; Hegedus et al., 2013, Mason & Anderson, 2007; Nicholas et al., 2012). Important contacts within the host communities included religious missions and non-governmental organizations (Bentley & Ellison, 2007; Bosworth et al., 2006; Delpech, 2013; Sloand et al., 2008) as well as schools of nursing, the ministries of health, nursing leaders, and government agencies (Bosworth et al., 2006; Delpech, 2013; Hegedus et al., 2013; Mason & Anderson, 2007; Memmott et al., 2010; Wright, 2010).

Relationships were highlighted as a challenging factor in planning IEs because of the time and effort to build and maintain trust with host communities (Bosworth et al., 2006; Leffers & Mitchell, 2011; Visovsky et al., 2016), the difficulty of managing differing expectations and communication styles (Brown, 2017; Doyle, 2004; Leffers & Mitchell, 2011; Sloand et al., 2008; Visovsky et al., 2016). Some authors identified that several years were required to establish partnerships (Bosworth et al., 2006; Mason & Anderson, 2007) and that preparatory visits to the host country were used to establish relationships (Bosworth et al., 2006; Hegedus et al., 2013; Mason & Anderson, 2007; Palmer et al., 2013; Reimer-Kirkham et al., 2005a; Sloand et al., 2008; Visovsky et al., 2016; Wittman-Price et al., 2010; Wright, 2010). Leffers and Mitchell's (2011) grounded theory provided a conceptual model for partnership and sustainability in global health which identified program factors for sustainability, processes for sustainability, and outcomes for sustainability.

Preparing Logistics

The final factor for preparing IEs was preparing logistics such as travel and finances. Many faculty involved in IEs were also responsible to plan the travel and accommodation (Christoffersen, 2008; Delpech, 2013; Haloburdo & Thompson, 1998; Mason & Anderson, 2007; Memmott et al., 2010; Nicholas et al., 2012; Palmer et al., 2013; Riner, 2011; Sloand et al., 2008; Visovsky et al., 2016, Wittmann-Price et al., 2010, Wright, 2010). This included arranging passports and visas (Bentley & Ellison, 2007; Nicholas et al., 2012, NLN, 2011), transportation (Reimer-Kirkham et al., 2005a), and accommodation (Christoffersen, 2008; Delpech, 2013; Haloburdo & Thompson, 1998; Reimer-Kirkham et al., 2005a). Logistical preparation also included financial planning. IEs carried significant financial costs for students and faculty related to tuition, flights, accommodation, transportation, and fees for faculty and support staff (Mill, Yonge, & Cameron, 2005; Palmer et al., 2013). Faculty implemented strategies to prepare for this financial burden by using closer destinations (Delpech, 2013; Kohlbry & Daugherty, 2013), applying for grants (Bentley & Ellison, 2007; Mason & Anderson, 2007), incorporating fundraising strategies (Levine & Perpetua, 2006; Mason & Anderson, 2007; Riner, 2011), and encouraging students to apply for scholarships (Nicholas et al., 2012). One author volunteered her participation in several IEs so she could offer the course free of tuition (Levine & Perpetua, 2006). Palmer et al. (2013) recruited unpaid affiliate faculty volunteers, such as graduate students and alumni, to mitigate costs. In summary of the synthesized findings related to preparation of IEs, each component of IEs—institutional support, curricular components, students, safety, relationships, and logistics—was significant because it highlighted faculty's responsibility to be fully ready for IEs.

Global Perspectives in the Literature Review

The purpose of this literature review was to explore what is known of faculty preparation for IEs. Of particular interest was how faculty preparation is aligned with critical global perspectives including the global health concern of equity and social justice. To assess for this alignment, a threshold concept approach was applied to a word search and data extraction for each document in this literature review. Meyer and Land (2003) described threshold concepts as "opening up a new and previously inaccessible way of thinking about something" (p. 1). In this way, threshold concepts support common ways of thinking and talking that align knowledge and understanding within specific disciplines (Land, Meyer, & Flanagan, 2016). For instance, in Andreotti's (2006) critical educational framework, and Mill, Astle et al.'s (2005) nursing approach to global health equity and social justice, common concepts include *in/equity, in/justice, disparity/ies, determinants of health, social, political, colonial, and power.* Supported by my thesis supervisors, I chose these words as threshold concepts to search each document in this literature review for alignment with critical global perspectives.

Critical Global Perspectives in the Literature Review

There were few documents connecting faculty preparation to what Andreotti (2006) might consider to be *critical* global perspectives. To provide a historical trajectory, documents addressing threshold concepts of critical global perspectives are identified in order of date, starting first with a focus on how these concepts were linked with faculty preparation, and then later with preparation of IEs. Starting with Reimer-Kirkham et al.'s (2005a) interpretive description, they identified how faculty attributes of "passion for social justice" (p. 269) supported student learning outcomes of increased awareness of social determinants of health, inequities, and structural influencers on disparity. Mason and Anderson's (2007) anecdotal report

of recommendations also suggested an orientation to threshold critical concepts, noting that "many issues of cultural influence, disparity, prejudice, and racism go unrecognized and unattended by students and faculty" (p. 35), and encouraged faculty to reflect on their personal biases, to learn about historical and political influencers, and to identify their "cultural threads" (p. 40). Critical perspectives of global citizenship and global health were strongly emphasized throughout Chavez et al.'s (2008) entire document. Their course was founded on critical theories and postcolonial feminism in a way that sought to address power, privilege, and inequalities and tried to "encourage the examination of the complex layered nature of health issues" (Chavez et al., 2008, p. 177). Faculty commitment and knowledge of critical global health principles facilitated students' understanding of the intersections between health and power, race/ethnicity, gender, social class, and nationality (Chavez et al., 2008).

Even though much of the NLN (2011) toolkit emphasized cultural competence, it also used critical concepts to encourage faculty to consider "power differentials" (p. 9) as well as to learn about political, social, and historical issues prior to engaging in IEs. Leffers and Mitchell's (2011) grounded theory conceptual model for partnership and sustainability in global health identified critical concepts when suggesting that faculty preparing for IEs should reflect on "how power, privilege, and ethnocentric values will impact the partnership process" (p. 95). In Miller-Young et al.'s (2015) research, self-reflection was also encouraged for faculty to acknowledge assumptions about the concept of reciprocity in IEs as supported by Andreotti's (2006) critical global framework with an emphasis challenging presuppositions, and acknowledging positions of power and privilege, as well as the importance of self-awareness and challenging pre-suppositions about host communities. Finally, Evert et al.'s (2019) workshop for preparing faculty for IEs incorporated critical concepts of global citizenship and global health in training

faculty to reflect on positions of power when engaging with host communities.

In this literature review, there were also documents that highlighted critical threshold concepts for when planning IEs. Concepts of colonialism and social justice were emphasized throughout Mill, Yonge, and Cameron's (2005) article describing challenges and successes in planning IEs. IEs should not Westernize the host community but should consider the "cultural fit and ethical issues related to importing theories, models, clinical practices and learning models into countries other than their own" (Mill, Yonge, & Cameron, 2005, p. 7). Riner's (2011) framework for globally engaged nursing education also embedded critical perspectives such as social consciousness, social justice, and social determinants of health for planning IEs. Critical concepts were also found in Nicholas et al.'s (2012) article that encouraged preparing students for the impact of disparities on health and "historical and political issues of the host partners" (p. 370). An IE model from Hegedus et al. (2013) showed how global committee members were hired from the sending and host country to build partnership and capacity with the community. Student were suggested to include enhanced "cultural, social, political, and economic systems that mold the beliefs, attitudes, and practices of the local people" (Hegedus et al., 2013, p. 28). In an approach to planning an IE, Brown (2017) integrated public health nursing principles, including the critical concepts of "social justice activities" (p. 488). These activities included donating money and resources, incorporating cultural foods in teaching, building capacity, and addressing health related inequities. Finally, Noone et al. (2019) identified critical concepts for their student learning objectives of enhanced "awareness of community as client, social determinants of health, impact of policy on community health, public health ethics including social justice, and nursing in an international context" (p. 327).

Soft Global Perspectives in the Literature Review

Several documents in this review did not include any threshold concepts of critical global citizenship or global health equity and justice. Conversely, some documents used threshold concepts of critical global perspectives without connection to described action. Andreotti (2006) might consider these approaches to IEs as having *soft* global perspectives. For instance, Wittman-Price et al.'s (2010) anecdotal report identified their student outcomes as having exposure to "social issues such as social justice" (p. 96) in their introductory statement; however, there was no further mention of these concepts. Some documents in the review emphasized more narrow essentialist perspectives that highlight cultural difference, poverty, and helplessness; this is compared to critical perspectives that highlight issues of unjust social, political, and historical influences on health. For instance, in a narrative describing her first experience with students on an IE, Christoffersen (2008) had students read a book "full of hair raising stories of home remedies one may encounter in remote villages" (p. 240), and she reflected how the trip showed her "a great deal of help we can provide with our first world training and resources" (p. 246). She narrated how she debriefed with students about the filth of the clinic and "reminded [students] that we could just wash our own hands with the waterless antibacterial cleanser we hauled down there" (Christoffersen, 2008, p. 245). Others claimed students learned global concepts yet did not provide explicit definitions of these concepts. For example, in Visovsky et al. (2016) article, "Planning and Executing a Global Health Experience for Undergraduate Nursing Students: A Comprehensive Guide to Creating Global Citizens", authors provided no definition or conceptualization of global citizenship. C. A. Browne and Fetherston's (2018) survey of Australian universities implementing IEs had minimal findings

related critical global perspectives other than one university suggesting students learn how to "apply principles of cultural safety" (p. 4).

Discussion of the Current State of Knowledge

The primary discourse of data included in this literature review was how IEs are prepared. Contrastingly, there was minimal literature on the topic of interest for this literature review: how faculty, themselves, are prepared. Although this review was not intended to provide a comprehensive summary of all resources available for preparing IEs, there were numerous suggested guidelines for developing an IE course, including institutional support, curricular components, students, safety, relationships, and logistics. The wide variation in program recommendations presents a challenge for those seeking guidance on how to prepare, and how to translate knowledge to practice. Including data about IEs preparation contextualized what faculty need to be prepared for, such that faculty need to be "prepared to prepare" (Blaess et al., 2012, p. 88). An assumption that emerged from this literature review is the notion that all faculty who prepare IEs are–themselves–prepared.

Critical global perspectives for faculty preparation were also minimal in this literature included in this review. Reviewing the evidence as it was presented, few authors identified threshold concepts of critical global perspectives. This is meaningful because the presence (or absence) of critical language in education is important to the contexts from which particular narratives develop (Kincheloe, McLaren, Steinberg, & Monzo, 2017). The minimal presence of critical global perspectives is not reflective of the momentum that nursing education has seen in the past 15 years (Astle, Barton, Johnson, & Mill, 2019). A concern is how a lack of critical global perspectives (i.e. global citizenship, global health equity, and social justice) in preparing IEs may perpetuate nonintentional acts of colonialism and neglect nursing's social mandate to

address health disparity (J. M. Anderson et al. 2009; CNA, 2009; Currier et al., 2009; Gregory et al., 2010). Perhaps a greater concern to the minimal evidence on faculty preparation, was the minimal evidence that faculty preparation aligned with a "faculty commitment to a critical perspective" (Thorne, 1997, p. 440). In summary, the lack of evidence-based research on how faculty are prepared, along with even less evidence that faculty preparation aligns with critical global perspectives, supports an exploratory study on faculty preparation for accompanying students on IEs.

Chapter Summary

In this chapter, a literature review using CINAHL, MedLine, and ERIC databases was conducted to explore faculty preparation for accompanying students on IEs by addressing the following: (a) in what ways do nursing faculty prepare to accompany students on IEs, (b) what factors are considered for faculty preparation of IEs, and, (c) how are critical global perspectives used in preparing faculty for IEs. Because of the wide variety of approaches in evidence-based and non-evidence-based methods, the findings of the literature review were presented in a description and a synthesis. Descriptive findings for faculty preparation included a distinction between preparation of IEs and preparation of faculty themselves with the latter having the least amount of evidence. This finding suggests an assumption that preparing the IEs is sufficient to ready faculty to accompany students. Seemingly, however, the literature supports that other elements are considered for preparing faculty including professional and personal preparation, qualifications, and attributes, and preparing for specific roles and responsibilities. Another finding suggested along with the little that is known about faculty preparation is the even less that is known about how faculty prepare in alignment with critical global perspectives. What the literature confirmed is that IEs continue to be implemented despite the little that is known about

how faculty are prepared. This supports the pursuit of exploring faculty preparation for accompanying students on IEs.

Chapter Three: Research Methods

The purpose of this study was to explore faculty preparation for accompanying nursing students on IEs. Chapter One provided a background into the little that is understood about this topic and Chapter Two confirmed the minimal existing evidence and further supported the progression of this research. To complete the study's "theoretical scaffolding" (Thorne, 2016, p. 54) Chapter Three will describe the research process used to address the following research questions:

1. How are nursing faculty prepared to teach nursing students in IEs? What assumptions underlie approaches to faculty preparation for IEs?

2. What are the qualities that prepare or qualify faculty for IEs, in other words, "Who is the IE educator?"

3. What are the implications for faculty preparation for IEs?

4. What recommendations are given to prepare faculty to teach IEs?

Sections of this chapter include description of the research design and methodology, sampling strategies and sample description, and procedures of data collection and analysis. The chapter will conclude with a description of how this research design accounted for scientific quality and credibility, including limitations of the study and fulfillments of ethical considerations.

Research Design and Methodology

As was outlined in Chapter Two, little is known about the phenomenon of faculty preparation for accompanying students on IEs. Therefore, the research questions warranted an exploratory qualitative approach to broadly address the complex, contextual, and interrelated

elements of the phenomenon (Streubert & Carpenter, 2011). After discussion with my thesis supervisory team, it was determined to use Thorne's (2016) qualitative interpretive description (ID). It was also determined the ID design should be informed by critical inquiry to highlight the global health concerns of equity, social justice, and relationships of power and their link to faculty preparation.

Interpretive Description

IEs continue to be implemented by nursing programs despite the little that is known about faculty preparation. Because of this, it was important that this study both enhanced understanding of faculty preparation for IEs while simultaneously offering practical application for nurse educators implementing IEs. Commonly accepted qualitative methods of ethnography, phenomenology, and grounded theory have been historically used in exploratory nursing research; however, these methods have been challenged with producing findings applicable to practice settings (Thorne, 2016). In comparison, the ID design is a comprehensive applied qualitative method (Thorne, Reimer-Kirkham & MacDonald-Emes, 1997). Although the ID method was developed for clinical settings, it is applicable to faculty facilitating IEs because of the link between nursing education and human health. Faculty accompanying students have a direct impact on the "lives of real people" (Thorne, 2016, p. 37) because IEs are considered to be clinical practice in a foreign context. Building on a practice goal for enhanced faculty preparation, the ID approach supported this study design to see beyond the obvious, to deconstruct prior knowledge, and to generate new insights for the phenomenon (Thorne, 2016). With the little existing evidence on how faculty are prepared, the study explored the unknown within the historical context, the current state of faculty preparation, and the individual contexts of the participants therefore shedding some light on what influenced the findings (Thorne, 2016).

The little that is known about faculty in IEs initially suggested that there was little to deconstruct of embedded preconceived notions. The proverbial blank slate, however, only reinforced the responsibility to search beyond the obvious to address the "complexity and interrelatedness" (Thorne et al., 1997, p. 173) of faculty preparation.

As a qualitative method, ID finds its origins in constructivist and naturalist philosophies of the social sciences. Both philosophies are relevant in nursing's philosophical orientation to humanism by embracing the "subjective, contextual, and dynamic factors influencing the human experience" (Streubert & Carpenter, 2011, p. 12). In this study, the ID approach acknowledged the constructed and contextual individual experiences of the participants, while also allowing for shared realities of the phenomenon between the participants (Thorne et al., 1997). Thorne (2016) also attributed the epistemological underpinnings of ID to Lincoln and Guba (as cited in Thorne, 2016), who acknowledged realities as located in the natural setting, influenced by multiple factors on the persons within the setting. The constructivist and naturalist paradigms of ID further supported its use for this project in two ways. Firstly, the participants' experience was acknowledged as being subjective, contextual, and dynamic, such as was seen with participants' varying years of expertise in nursing, education, and travel, as well as with the variance between IE locations. Secondly, these paradigms are essential to the nursing discipline, which the participants of this study would be established in; therefore, their experience is likely situated in these discipline-specific understandings.

Critical Inquiry

As discussed in Chapter One, the nature of global health requires commitment to a critical perspective. With this in mind, the thesis supervisory team and I determined it was important to have the ID study design be informed by critical theories that highlight the nursing

concern—and the global health concern—of equity and social justice. A critical approach works well alongside the ID tradition, which calls for researchers to "critically interpret" (Thorne, 2016, p. 36) the meaning of data. Fontana (2004) described critical science as "any research approach that draws on a critical tradition of its theoretical and philosophical framework" (p. 93).

Critical inquiry in nursing scholarship emerged from nursing's social mandate to promote social justice and equity while also seeking to understand—and deconstruct—the complex social, political, and historical construction of the human experience (Fontana, 2004; Reimer-Kirkham & Anderson, 2002; Reimer-Kirkham, Varcoe et al., 2009). To address these complex influences of the human experience, this study draws from the postcolonial frameworks of Andreotti's (2006) critical global citizenship from an education discipline perspective; from a nursing discipline perspective, the study is informed by Mill et al.'s (2010) global citizenship and global health equity. Although common critical inquiry approaches include emancipatory work such as participatory action or feminist research, Fontana (2004) suggested that critical inquiry can reach beyond emancipatory work to inform other methodologies. As such, a critical approach in this study was not intended for emancipation of the nurse educator per se, but to explore the critical orientation for preparation. It was anticipated that some faculty preparation may be more aligned with critical global perspectives and some may be less aligned. Critical inquiry and ID work in harmony to provide critique (deconstruction of the phenomenon) and praxis (envisioning a socially just way forward) for faculty preparation for IEs (Reimer-Kirkham, Varcoe, et al., 2009).

Fontana's (2004) seven foundational elements of critical inquiry were used including context, critique, dialectic analysis, politics, emancipatory intent, democratic structure, and reflexivity. Chapter One of this study situated IEs within a historical context of globalization, global health, and nursing conceptualization of culture. This chapter also provided a critique of

nursing's historical approach to culture and diversity. In critical inquiry approaches, context and critique ensure the phenomenon of faculty preparation was not "examined in isolation" (Fontana, 2004, p. 97). Dialectic analysis was used when asking the question of the data: "why is the way we practice nursing different from the way we wish to practice" (Fontana, 2004, p. 99) and this question emerged when exploring the potential implications for faculty preparation. In regard to the critical inquiry element of politics, emancipatory intent, and democratic structure, this study took a non-neutral stance on the social mandate of nursing to address health disparities and moved beyond narrow cultural essentialist approaches to IEs. However, differing from Fontana's (2004) suggestions for critical inquiry, this study is not an emancipatory project per se. Instead, this study is positioned to provide preliminary exploration into the phenomenon of faculty preparation, which may inform how to better prepare for IEs in ways that promote critical perspective of global health. The remaining critical inquiry elements of reflexivity and democratic structure are addressed later in this chapter.

Sampling Strategies

This study used stratified purposive and snowball sampling to recruit nine nurse educators across Canada who have experience in accompanying students internationally. The Canadian focus allowed for an exploration within the historical context of Canadian nursing education and it also maintained a reasonable scope of the project. In discussion with the thesis supervisory team, we determined eight participants were the minimal sample size necessary to provide rich data and ten participants would be the upper limit as justified by time and resource constraints. This decision aligned with standards for qualitative studies that do not have strict guidelines on sample sizes (Streubert & Carpenter, 2011; Thorne, 2016). Contrary to popular qualitative sampling strategies that determine sample size by "data saturation" (Streubert &

Carpenter, 2011, p. 91), Thorne's (2016) ID suggests the "possibility of infinite experiential variation" (p. 107), which further supports a smaller sample size. For this study, data collection was completed with nine participants, as it was determined that rich data had been captured for analysis. Because a study on this topic has not been done before, ground breaking theory was not the goal of this study and this smaller sample size provided a "meaningful description of a complex problem that is in its beginning stages of exploration in the discipline of nursing" (Thorne, 2016, p. 105).

With the intention of the study to explore how faculty are prepared for IEs, it was important to seek out nurse educators from a variety of programs across Canada who would reflect this variation in IE implementation. Stratified purposive sampling allowed for inclusion of participants with a variety of knowledge of central to the topic (Patton, 2015). Thorne (2016) identified that an important form of purposive sampling is the "strategic identification of 'key informants'" (p. 91). Key informants included nurse educators with expertise in preparing for IEs, participants who were willing to engage in the research, and participants who have "a particular affinity for observing and thinking about the situations within which they found themselves" (Thorne, 2016, p. 91). The working understanding of *expertise* for this sampling strategy is participants who have "technical, process and interpretive knowledge . . . and the character of practical or action knowledge" (Bogner, Littig, & Menz, 2009, p. 55). The "stratification" (Polit & Beck, 2012, p. 518) of the sampling strategy was important to seek variation in gender, expertise, location of the IEs, and perspectives of culture.

From this understanding of key informants, expertise, and stratification, recruitment began using my supervisor's, Dr. Barbara Astle's, known network of contacts from academic institutes. Dr. Astle is active in global health nursing education across Canada with a wide

network of educators also involved in global health. From this network of contacts, Dr. Astle developed a list of 30 nurse educators, who were anticipated to meet the inclusion criteria, to be sent a recruitment notification. Inclusion criteria included nursing faculty in Canada who had current, or prior, experience accompanying nursing students on a minimum of one IE for an accredited course. For the scope of this study, participants were also included if they were English-speaking and accessible for either a face-to-face interview, or an interview by distance through telephone or virtual software such as BlueJeans™. Participants who did not meet this inclusion criteria were excluded from the study. Additional snowball sampling was used to invite contacts to forward my project along to others who meet the inclusion criteria; however, no participants were obtained from this strategy.

After receiving approval from Trinity Western University's Human Research Ethics Board, all 30 nurse educators from Dr. Astle's list were sent an e-mail with a Letter of Information inviting them to participate in the study. See Appendix G for Research Ethics Board approval and Appendix H for the letter of information. Within three weeks of sending recruitment information, eight educators responded and agreed to participate; all of them met inclusion criteria for the study. Recruitment took place during the summer months and my supervisory team agreed that once the Fall semester began, there would be less chance of potential recruitments agreeing to the study. With these time constraints in mind, participants who met inclusion criteria were selected for interview on the basis of whomever responded to the invitation first, while also monitoring for appropriate stratification of the sample. For instance, the first eight participants who were interviewed represented different programs across British Columbia, Alberta, and Saskatchewan, included a wide range of expertise, and consisted of one male participant and seven female participants. After interviews with these eight participants, I

sent a follow up e-mail to the remaining potential recruitments to gain more interest. Three additional nurse educators responded. However, at this time, I re-examined the stratification of my sample and found minimal representation from males, from programs in eastern Canada and the territories, and from participants with a self-identified ethnic heritage other than Canadian, or European. In consultation with my thesis supervisory team, I specifically sought further representation of males and non-Europeans and waited for additional responses. From this, one additional male participant responded and became the ninth—and final—participant for the study. The nine participants will be described in the next section.

Description of the Sample

Nine faculty were included in the study. Participants were given a demographic form to complete prior to the interview, with the option of declaring their self-identified orientation to culture or ethnic heritage, gender, age, years of experience as a nurse, years as an educator, number of IEs, and location of the IEs. See Appendix I for table of participant demographics. Eight participants identified their ethnic heritage as Canadian or European with the European classification further expanded to Scottish, German, English, Irish, and Polish. One participant did not provide ethnic heritage identification.

In total there were two male participants, both of whom were the only participants with a BSN as their highest form of education. Additionally, these males represented younger educators, both under the age of 35; only one other female participant joined them in this age category. The age range was from 27–70, with the majority of participants (n=6) over the age of 50. Three participants had retired from nursing although still did contract or volunteer work with students. Years of experiences as a nurse ranged from 5 to 48 years; five participants had more than 25 years of nursing experience. Participants also ranged in experience as a nurse educator from 2 to

40 years. Many participants were actively involved in IEs with students such that five participants were currently preparing for upcoming IEs within a few months following the interview; one participant had their last IE 10 years ago. Participants had a wide range of the number of times they have accompanied students abroad, with the lowest being one time (n=1), the majority being between four and nine times (n=7), and the most being over 20 times (n=1). All but three participants were involved in the pioneering of the IE program at their institute. Four participants accompanied students to the same location year-after-year, whereas five participants accompanied students to multiple different locations over the years. In total, there were over 17 destination countries represented. These locations varied in World Bank (2018) classification of LIC, low-middle-income countries (LMIC), upper-middle income countries (UMIC), and HIC. Two participants accompanied students on IEs to HIC. In both of these HIC, however, students worked with structurally marginalized and impoverished populations, such as working with Indigenous communities and working with refugees. Participants represented nursing programs in British Columbia, Alberta, Saskatchewan and Ontario. Two participants were from the same school in Alberta and the remainder were from different programs in respective provinces.

In the study's findings, the concept of *expertise* emerged as being important and is discussed further in Chapter Four and Chapter Five. To situate the data within the context of expertise, findings are narrated through participant pseudonyms and classification of participants

as *novice*[1] or *experienced*[2] which are a construct of the researcher. The categories represent the participants' expertise in clinical nursing and education, international travel and work, international experience with students, and academic qualifications at the time of the interviews. These categories are reflective of Benner's (1982) seminal work but do not ascribe value to expertise; instead the categories are used to better understand the context from which the participants were speaking. Notably, the term *novice* does not negate participants as key informants. Additionally, the term *experienced* is used over the term *expert* because the findings later highlighted that being an expert in a foreign country may not be possible, nor is it the goal.

Procedures

In the ID research design, data construction (collection) and data analysis occur concurrently as each informs the other through a dynamic process of constant comparative analysis (Thorne, 2016). This process sets the stage for data to be interpreted through thematic analysis and to be evaluated in relationship to the research questions. This section will describe the procedures for data construction and data analysis following the ID design.

Data Construction

With an emphasis on the researcher's responsibility for the construction of data, Thorne (2016) oriented the ID researcher to the language of data *construction* instead of data collection to highlight this process does not exists outside of the realm of interpretation. A decision was made to do individual semi structured interviews with participants and invite them for a follow

[1] Novice (Josiah & Tim): less than 5 years' experience as an educator and a Registered Nurse, some international travel (personal and/or nursing related); less than three times accompanying nursing students internationally; Bachelor's in Nursing prepared.

[2] Experienced (Janet, Melissa, Sharon, Hilary, Julie, Susan, Bonnie): more than 5 years' experience as an educator and a Registered Nurse, some international travel (personal and/or nursing); at least three or more times accompanying nursing students internationally some IE; Masters or Doctoral prepared.

up interview. Interviews allow for rich and complex data to be shared by participants as they identify their "attitudes and beliefs, that would be difficult to obtain without asking the participant directly" (LoBiondo-Wood, & Haber, 2018, p. 293). The semi structured format allowed participants to discuss the minimally understood topic of faculty preparation with a flow of conversation informed by their unique context, while also remaining in the parameters of the study (Streubert & Carpenter, 2011; Thorne, 2016). Because recruitment was across Canada, it was anticipated that geographical distance may prevent the desired face-to-face interviews; however, I was able to meet in person with two participants located in British Columbia. Face-to-face interviews allowed me to gain trust and build rapport with the participants while visualizing additional data sources, such as the environmental context and nonverbal cues (Streubert, & Carpenter, 2011; Thorne, 2016). Other participants were given the option of virtual interviews through the BlueJeans™ platform, which still allowed for nonverbal nuances to be captured (Streubert & Carpenter, 2011).

I developed interview questions that had suggested revisions from my thesis supervisory team. Together we developed seven main questions to guide the interviews including: "what was your experience taking students on an international experience"; "what went well and what did not go well"; and, "what do you think is important for faculty preparation for IEs with students". See Appendix J for the full interview guide. The interview guide also included planned prompts—such as, "tell me more about that," or "what was that experience like for you"—to help me maintain the natural flow of conversation. After conducting the first interview, I transcribed the interview and consulted with my thesis supervisor to determine if the interview guide appropriately garnered answers to the research questions. At that time, we determined that I would add the question "what are the implications of faculty preparation," to better address this

same research question. I then conducted two additional interviews, transcribed them, and then consulted again. A concern was that participants were focusing on how they prepared the experience, not how they themselves were prepared; this prompted the update to the interview guide to emphasize "what specific elements are necessary for faculty preparation for these types of IEs with students," to refocus participants on how they were prepared, versus how the IE was prepared. Participants' focus on preparing the IE versus preparing themselves was later identified as a key finding.

Another concern after the initial interviews was that several participants were not naturally identifying alignment of faculty preparation to critical perspectives of global health. To address the possibility that this was overlooked in the interview, rather than not considered in preparation, the decision was made that, if the participant did not naturally identify these perspectives, the researcher would add the question, "global health has equity as one of its core dimensions. How can faculty be prepared to teach this"? After the updates, my supervisor encouraged me that even in my novice researcher status, the interviews were providing rich data. The updated questions were later asked to earlier participants in follow up interviews, so that all participants were asked the same questions.

Eight interviews were completed in a 3-week time period during July and August of 2018. Participants were eager to complete interviews prior to commencement of the Fall school semester. The ninth, and final interview, was completed in November 2018. For virtual and telephone interviews, an informed consent form was e-mailed to participants for review one day prior to the interview. See Appendix K for informed consent form. Participants were given the option to sign the form prior to meeting or wait until the time of our meeting and send the signed consent form via mail or email. Participants were also sent a demographic information form to

complete prior to the interview. See Appendix L for demographic information form. In two face-to-face interviews, participants were given forms to complete at the time of the interview. The informed consent form was then reviewed with each participant to acknowledge that the study had no anticipated harm and to remind participants they were allowed to withdraw at any time. They were also encouraged to ask questions during the process. Interviews were audio-recorded.

I only had previous academic relationship with one participant and was, therefore, tasked with building rapport with the others in a short amount of time (Thorne, 2016). Additionally, many participants, being in academia, were expert researchers and supervisors. I was personally challenged with being a neophyte interviewing these experts in the field. While in many cases the researcher positionality of power needs to be held in check, in this case, I was aware that my participants were in a potential position of power over me as a future academic. To gain rapport, I started with sharing some information about who I was, I talked about my interest in global health and asked a few general questions. To make the interviews conversational, I followed the guide carefully but allowed for natural flow of conversations when participants naturally answered questions that were meant for later in the interview (Streubert & Carpenter, 2011). At the end of each interview, the recording was turned off and I provided an opportunity for debriefing. During this time, several participants commented on how comfortable they felt in the interview and positively commented on my interview skills as a novice researcher. The comfort of the participants was further affirmed because eight interviews went well beyond the planned 60-minute length, even though I paused the conversation at the 60-minute mark to give opportunity to end.

Most participants were eager to discuss the topic; one participant even called me afterwards to leave a message on my phone with more of her perspective. Interviews were an

average of 90 minutes in length (n=7), with the range of 45 to 120 minutes. At the end of each interview, I thanked participants for their involvement, provided a short debrief and gave an option to receive a copy of an executive summary of this study upon completion. All participants were invited for an optional follow up interview and seven participants agreed. In ID, follow up interviews are a way to extend initial conceptualizations and confirm representation of experienced realities (Thorne et al., 1997). In consultation with my thesis supervisor, I formulated a follow up interview script of questions to extend the data which included questions related to participants perceiving IEs as different to other educational experiences in nursing. Follow up interviews lasted around 30 minutes. See Appendix M for follow up interview questions.

Additionally, for the data construction process, immediately after each interview (first and follow up), I typed or hand-wrote field notes, an interview summary, and reflexive notes. These notes supported data analysis and provided important commentary on the environment of the interview, immediate thoughts, personal reactions, main ideas, and comments about the interview (Polit & Beck, 2012). In total, data for this study included audio-recorded interviews, transcripts from audio-recorded interviews, and a written demographics sheet. Field notes, interview summaries,, and reflexive journaling supported data analysis.

Data Analysis

Data analysis in ID requires a shift from merely describing or explaining the data to instead seeking the reason for the data. This is done by situating the data contextually and interpreting patterns and relationships (Thorne, 2016). With data construction and analysis occurring concurrently, data analysis began during the first interview through recording my preliminary thoughts and conceptualizations using a reflexive journal and audit trail. While

Thorne (2016) warned against landing on codes and preconception too soon, she also identified that the researcher is always moving back and forth from data construction to data analysis and encouraged preliminary thoughts to be documented.

Data analysis progressed through each subsequent interview. After each interview, I wrote field notes, preliminary thoughts, and reflexive notes. I then immediately listened to the audio-recording and made additional notes. Of the nine main interviews, I transcribed two, and of the seven follow up interviews, I transcribed one. I hired a transcriptionist for the remaining interviews. It was beneficial for me to transcribe the first few interviews so that I could listen and re-listen to the interviews, get a strong sense of the data and make necessary changes to the interview guide. Time between interviews was spent reviewing audio-recordings, available transcripts and supportive field notes, to identify broad insights on the phenomenon by asking "what is going on here" (Thorne et al., 1997, p. 175) and also, "what am I learning about this" (Thorne et al., 1997, p. 175). I added these preliminary insights to a reflexive journal and also made notations and comments in the transcripts. Preliminary insights materialized into what Thorne (2016) refers to as "meaning units" (p. 146). An example of this in data analysis was the use of meaning units such as *prior international volunteer work*, *prior international travel*, and *prior international military work*. Meaning units were developed for the first two transcribed interviews as similarities and differences were discovered within, and across, each interview. These meaning units were then collapsed and organized to create broader codes, for example, collapsing the above meaning units into the code of *prior international experience*. This process eventually formed a preliminary codebook subsequently used to code the entirety of the data. I consulted with my supervisor to evaluate the codebook since the codes provide structure to explain what is happening in the data and are a critical part of data analysis (Streubert &

Carpenter, 2011; Thorne, 2016).

Initial feedback from my supervisor was that my codebook had too many categories, and that some categories were too specific, narrow, and indistinguishable. These are all common challenges for novice researchers (Thorne, 2016). My supervisor then assisted me in developing a codebook with seven primary codes and 31 sub-codes. See Appendix N for the finalized codebook. We validated the codebook by individually coding a transcript and then comparing our coding process. This process showed that we were both using codes similarly and built confidence about the appropriateness of the codebook as it was later applied to all other interviews. QSR International's NVivo™ 12 software was used to manage the evolving conceptualizations and to provide ease of moving in and out of data collection and analysis. After coding the preliminary interviews, I reflected on initial conceptualizations of the data as a whole, such as the importance of *experience gained over time*. In the follow up interviews, I refined the analytic process by sharing initial conceptualizations with the participants. Thorne (1997) suggested this method builds "confidence that the conceptualizations are, indeed, grounded in data and representative of shared realities rather than an artifact of design or instrument (researcher) error" (p. 175). In each of the seven follow up interviews, participants confirmed initial conceptualizations and added further insights.

After the follow up interviews, I began to move from categories of codes in the initial codebook, to broader categories where codes could be collapsed into themes. This analytical process compelled me to challenge the obvious conceptualizations for deeper interpretations of the data; this process makes sense of individual cases while remaining attentive to common experiences of the data as a whole (Thorne, 2016). An example of this process was moving from a sub-code of *self-selection* to a larger code of *faculty selection process* to the final theme of *how*

I first prepared. As broader themes began to develop, I used concept maps and drawings to conceptualize my thinking while I listened to audio-recordings and read transcripts. I also had a notebook with me at all times, in which I could record my thinking when it happened at unconventional times of the day. This process of "iterative listening, observing, writing, thinking, listening, writing, thinking, and writing again" (Thorne, 2016, p. 197) allowed me to see the shape, patterns, and relationship of the data, drawing me closer to the final conceptualization. From this process I also developed a thematic diagram to represent the findings. The process of data analysis was further supported through meetings with my thesis supervisory team to challenge and confirm my thinking in new ways. This ongoing iterative and dynamic process continued until, as Thorne (2016) put it, I felt that I had "arrived" (p. 153). This sense of arrival resulted in the overarching theme of *gaining preparation expertise over time,* which represented the forward trajectory of the participants' experience. The findings are also represented by three main themes of *how I first prepared: learning on-the-job; why I prepare: discovering the different responsibilities;* and *preparing differently: learning for-the-job.* These themes are described in detail in Chapter Four and are interpreted in Chapter Five. The next section of this chapter will identify how the findings are to be interpreted in light of the context in which they were established, therefore demonstrating the scientific quality of the study.

Scientific Quality and Credibility

Qualitative researchers should enhance scientific quality and rigor of their study in order to accurately represent the phenomenon (Streubert & Carpenter, 2011). Qualitative studies often follow Lincoln and Guba's (1985) qualitative criteria to ensure trustworthiness including credibility, transferability, dependability and confirmability. For the ID methodology, Thorne (2016) expanded these notions of trustworthiness by identifying nine quality considerations that

support the responsible reading, application, and excellence of the findings. These considerations include epistemological integrity, disciplinary relevance, moral defensibility, contextual awareness, analytical logic, interpretive authority, representative credibility, pragmatic obligation, and probable truth (Thorne, 2016). I created a table adapting Thorne's (2016) suggestions to display how each element of credibility has been implemented through this research design. See Appendix O for a table of scientific quality and credibility.

The research questions ground the study design in the understanding that knowledge is a constructed truth, acknowledging the subjective human experience. As such, the findings are presented in light of this understanding, which supports epistemological integrity. The research questions are also contextualized by disciplinary relevance and moral defensibility in which Chapter One and Chapter Two provided explanation to the importance of faculty preparation for IEs in relationships to nursing education in the foreign context. The credibility of the study has also been enhanced through contextual awareness. Contextual awareness acknowledges how the research questions, and the findings, must be considered in current reality, but also as they have been shaped through the history of globalization, global health education, and nursing's approach to culture. Contextual awareness was also addressed through the study's background, the use of a reflexive journal, and an audit trail of decisions made.

The audit trail and reflexive journal also support the credibility of analytical logic by providing evidence of the decision-making process, starting with the inception of the research questions and design, and ending with decisions made for interpretation and knowledge claims of the findings. Analytical logic was further achieved through frequent meetings with the thesis supervisory team to confirm decisions. To further enhance credibility, interpretive authority was accounted for by building in systems in the research design to check my interpretations (Thorne,

2016). These systems included member-checking through follow up interviews that extended initial interpretations and conceptualizations and allowed participants to confirm or expand on the preliminary findings (Thorne, 2016). The audit trail also reflected my openness to receive critiques of my work. The systems to check interpretations also enhanced representative credibility by triangulating between interviews, evidence from the literature review and input from my thesis supervisory team. Triangulation in this way "adds new confidence to the reliability and validity of data" (Streubert & Carpenter, 2011, p. 359).

Finally, credibility of the study was enhanced through the elements of pragmatic obligation and probable truth. This was done by anticipating the application of the findings to nursing practice, while also avoiding sweeping generalizations. For instance, the findings of this study are from Canadian faculty situated in the historical context of nursing education in Canada and might not represent the experience of faculty from other countries. In this way, the findings are presented with caution and humility, and with an understanding that even the most carefully constructed study can result in findings that prove to be untrue in future and differing contexts (Streubert & Carpenter 2011; Thorne, 2016).

Researcher Reflexivity

In the ID research design, credibility is further enhanced through researcher reflexivity of personal philosophies and preconceptions brought to the inquiry by the researcher (Jootun, McGhee, & Marland, 2009; Thorne, 2016;). For instance, my experience as a nurse educator inspired my interest in this topic. I have been a registered nurse for eleven years, and for the past eight years, I have been a full-time faculty member in a BSN program in Western Canada. I have experience in the international context as a child, with my family involved in international health and religious-focused missions, and as an adult, through participation in humanitarian work.

Although I have participated in humanitarian work, my graduate schooling in my MSN program, with a global health stream, has supported new understanding of critical perspectives of global health and intervention into the lives of others. As a white woman of European descent, and with much of my international work bringing me to LIC, this new knowledge has caused me to critically reflect on my past. These experiences, and new knowledge, have fostered a cautious approach to what I consider to be a specialized form of nursing education, such that if the opportunity was presented to take students on an IE, I would respond, "Yes! But how do I do this appropriately"? In my work as a nurse educator I have also participated in faculty development and have also mentored new faculty. From these experiences, I anticipated that faculty preparation has an impact on student learning and host community safety.

Other influences on the study design may be from my thesis supervisory team who are experts in the fields of qualitative research design, critical inquiry, gender equity, social justice, health equity, global citizenship, and global health. They may have used these lenses when guiding and supporting me. To further position myself to the study, I have had minimal experience with qualitative interviews, and this is my first time as a primary researcher. All of my participants were faculty and all but two had MSN degrees or higher. Half of my participants had PhDs and credentials to act as a supervisor to graduate students. I often reflected about my position as a graduate student as I interviewed those whom I considered to be experts and pioneers in the global health field. At times I also had an internal struggle of wanting to represent the participants well and wanting to soften any data that might represent them in a negative way.

Qualitative inquiry acknowledges that, as a researcher, I brought these inherent biases and preconceptions to the study (Jootun et al., 2009). Some scholars suggest these preconceptions should be set aside or "bracketed" (Streubert & Carpenter, 2011, p. 27). Contrary

to this, ID instead "explicitly recognizes and capitalizes on the researcher as instrument" (Thorne, 2016, p. 70). The goal, therefore, is not to bracket biases but rather to disclose them and remain reflexive to their undeniable influence on every aspect of the research process (Thorne et al. 1997). Reflexivity is defined as a "self-critical sympathetic introspection and the self-conscious analytical scrutiny of the self as researcher" (England as cited in Patton, 2015 p. 70). In this study I used a reflexive journal and frequent collaboration to evaluate how my thoughts and beliefs were influencing data collection and analysis (Jootun et al., 2009).

Reflexivity is also a foundational process of Fontana's (2004) critical inquiry that supports the researcher to "identify, acknowledge, and do something" (p. 99) about preconceptions that may constrain the study. Thorne (2016) suggested researchers critically reflect on "how else might I understand this aspect of the data, [and] what might I not be seeing?" (Thorne, 2016, p. 178). For instance, I reflected on my surprise that few participants disclosed alignment of faculty preparation with critical global perspectives. To challenge my own judgement of this data, reflexive journaling helped me interpret the findings in the context of how global health knowledge is recently emerging in the nursing discipline. Because of this reflexivity, I added questions to the interview guide and also interpreted the findings within the historical context of global health education in Canada. This update was then recorded in a decision-making audit trail.

Decision Making Audit Trail

The researcher is held "highly accountable" (Thorne, 2016, p. 134) for data generation and data construction. Thorne (2016) suggested the study's credibility is enhanced through the researcher's commitment to "tracking constructions" (Thorne, 2016, p. 138), which captures the immersive back and forth steps of data analysis that "confirm, test, explore, and expand on the

conceptualizations that begin to form" (Thorne, 2008, p. 99). This tracking is commonly referred to as an *audit trail,* which use note taking and memos of decisions made throughout the process of the research design and implementation (Streubert & Carpenter, 2011; Thorne, 2016). For this study, I kept a written journal and an electronic audit trail to track of decisions made through the research process. An example of this was the process for the literature review in which, over a period of two years, I captured the decision-making for three phases of the search strategies and discussions. Overall, my audit trail provided a transparent process for how the final product was shaped and provided the "eventual audience with sufficient information about the decisional processes . . . made along the way" (Thorne, 2016, p. 138).

Limitations

Although significant efforts were made to ensure scientific quality of this study, there remained some limitations that should be considered prior to applying the findings to other contexts. Thorne, Reimer-Kirkham and O'Flynn-Magee, (2004) identified some common "pitfalls" (p. 8) of ID to which novice researchers are particularly vulnerable. These pitfalls include prematurely closing the analytical process or clinging to preconceived assumptions that can go unnoticed even with a reflexive approach (Thorne et al., 2004). Furthermore, with the reliance on the researcher as the instrument, there is potential for a novice to misrepresent the "unique and distinct" (Thorne, 2016, p. 143) participant stories while attempting to synthesize commonalities. My own position as a novice to research and novice to IE education could contribute to missing cues and themes in the findings. Attempts to mitigate these limitations were made with frequent consultation with my supervisors.

A general limitation of this study is related to the extent that the findings are transferable to other groups and contexts (Polit & Beck, 2012). While the sample size of nine participants

was thought to be appropriate for this study's scope and exploratory purpose, the size should be considered when determining if the findings are transferable. There are four other potential limitations. The first is related to the decisions around who was included as a key informant. The identification of a group of nurse educators with expertise for the sampling strategy was a "construct" (Bogner et al., 2009, p. 50) of myself as the primary researcher. True to the constructivist approach of qualitative research design, findings from any socially constructed group—even those with expertise—requires appropriate "humility and restraint in generalization" (Thorne, 2016, p. 139).

The second potential limitation from the sampling strategy was related to sample stratification. This could have been influenced by only using my supervisor's networks for recruitments and also by the time constraints for obtaining participants. The nine participants represented only four provinces in Canada and none of these were from Eastern Canada or the territories. These participants also represented only eight schools of nursing of a possible 101 across Canada (CASN, 2018a). To apply the findings to other faculty populations would require careful interpretation, for instance, the findings should be cautiously considered for faculty working in other countries outside of the historical context of Canada. Related to gender representation, the sample included seven females and two males with no other gender orientation represented. A stratification of self-identified orientation to ethnic heritage was also lacking since all participants were of European descent, though one participant left this question unanswered. With this study's attention to critical perspectives of global health, it was perhaps a limitation to not have representation from those who might provide a different lens of their understanding of power and privilege and those who might be a visible (or invisible) minority in their communities of practice.

The third potential limitation was discovered during thematic analysis and represented how demographics could have been more clearly obtained. Although a variety of expertise was represented in the sample, it was unclear what expertise participants had prior to their first IE. For instance, one participant indicated she had 20 years of teaching experience at the time of the interview, yet she did not indicate how much teaching experience she had prior to her first IEs with students. This could be a limitation with how the findings are applied, depending on the level of expertise in nursing, education or travel prior to their first IE.

The fourth limitation is related to the research design and procedures. Although ID is an appropriate method for an exploratory study, it is likely that with only eight nursing programs represented of a possible 101 programs, there may be some nursing programs in Canada that better support faculty preparation. Therefore, it is possible that a survey may have better contextualized the ID approach. The ID procedures in this study also only used interviews as a data source. Even though it was beneficial to include follow up interviews, adding focus groups, observations, or open-ended written surveys may have further strengthened the findings. (Streubert & Carpenter, 2011). Despite all of these limitations, the study is supported by ID's commitment that "interpretive description's claims to generalization must be understood as tenuous" (Thorne, 2016, p. 40) and there is always more to know. It is from this philosophical paradigm that Thorne et al. (2004) encouraged a humble interpretation of the findings not as facts but as "constructed truths" (Thorne et al., 2004, p. 6) when considering application to other contexts.

Ethical Considerations

Like all research, it was important for this study to uphold the ethical considerations for qualitative research by prioritizing protection of the participants (Streubert & Carpenter, 2011).

Ethics approval was received from Trinity Western University's Human Research Ethics Board and was not obtained elsewhere because nurse educators function as independent scholars and there was no recruitment through various institutions. See Appendix G for Human Research Ethics Board approval. For this study, each participant was provided with a written consent form to sign prior to each interview. Each point of the consent form was discussed with the participant prior to the interview commencing and included the purpose of the study, permission for the participant to withdraw from the study at any point without negative outcomes, an explanation of the risks and benefits of participation, and an explanation of the procedures used for preserving confidentiality and anonymity. See Appendix K for informed consent form. There were no anticipated risks to the participants or conflicts. One of the participants was known to the researcher although the connection was academic and had no association with positions of power. The anticipated benefits to the participants were being able to talk with another nurse educator about professional practice and insights derived from participating in the study; participants may have also been motivated to consider faculty preparation for future IEs. Although there were no anticipated ethical concerns for this study, I remained alert for unanticipated ethical dilemmas (Streubert & Carpenter, 2011).

Confidentiality and anonymity were preserved through many avenues. A transcriptionist was hired to transcribe audio-recorded interviews verbatim after signing a confidentiality form. Audio files and de-identified transcripts were sent back and forth from myself to the transcriptionist through a secure password protected server. See Appendix P for transcriptionist confidentiality form. Interview transcripts, field notes, and reflexive journals were de-identified with a participant code and uploaded to a secure file on an external server ownCloud™, shared only by me as principal investigator and by my thesis supervisory team. Electronic transcripts,

audio-files, and field notes were kept secured on a password protected computer. Hardcopies of the transcripts, demographics sheet, and field notes were kept in a locked filing cabinet. De-identified working documents were secured in an office. Further protection of participants' information included a plan to shred hardcopies for disposal after five years and to delete electronic copies from my computer hard drive after five years. I recognize that I am responsible for data monitoring, analysis, and disposal.

Chapter Summary

Chapter Three has outlined the study's design including the decision to use ID informed by critical inquiry to explore the little that is known about faculty preparation for IEs. After receiving ethics approval, nine participants were interviewed, and later, seven of these participants engaged in follow up interviews. The audio-recordings were transcribed after each interview and data analysis began while further data collection continued. Through this iterative process, themes were identified to represent the findings as a whole, while also capturing the individual experience. Scientific quality and credibility were upheld through numerous approaches suggested from Thorne's (2016) ID methodology. This included triangulation, an audit trail, and frequent communication with the thesis supervisory team. True to the critical inquiry and ID approach, credibility was also enhanced through reflexive journaling and team consultation. Although efforts were made to enhance the study's credibility, limitations of the sampling strategy, research design, and my novice position as researcher warrant cautious application to new contexts. Ethical considerations support the overall protection of participants as it relates to the study. In Chapter Four, I will present the findings constructed through this process of data collection and analysis.

Chapter Four: Findings

The purpose of this research is to explore nursing faculty preparation for accompanying nursing students on IEs by addressing the following questions:

1. How are nursing faculty prepared to teach nursing students in IEs? What assumptions underlie approaches to faculty preparation for IEs?

2. What are the qualities that prepare or qualify faculty for IEs, in other words, "Who is the IE educator?"

3. What are the implications for faculty preparation for IEs?

4. What recommendations are given to prepare faculty to teach IEs?

One overarching theme and three main themes were interpreted from thematic analysis. The *Overarching Theme*, *Gaining Preparation Expertise Over Time*, captures participants' emerging understanding of preparation from their first–to their latest–IE with students. This theme is interwoven through three main themes of *How I First Prepared: Learning On-the-Job; Why I Prepare: Discovering the Different Responsibilities;* and *Preparing Differently: Learning For-the-Job.* Together these themes depict a narrative of the trajectory of preparation over time, starting with participants' first experiences in the IE teaching role. The overarching theme, main themes, and subthemes are represented with a thematic design in Figure 1.

Theme One, How I First Prepared: Learning On-the-Job, highlights how, for their first IEs, preparation was informal, relied on individual faculty, and occurred in the moment. Participants drew on prior experience, established relationships, interest in international work, and a willing response to be *serendipitously qualified to prepare* for an IE. Without formalized

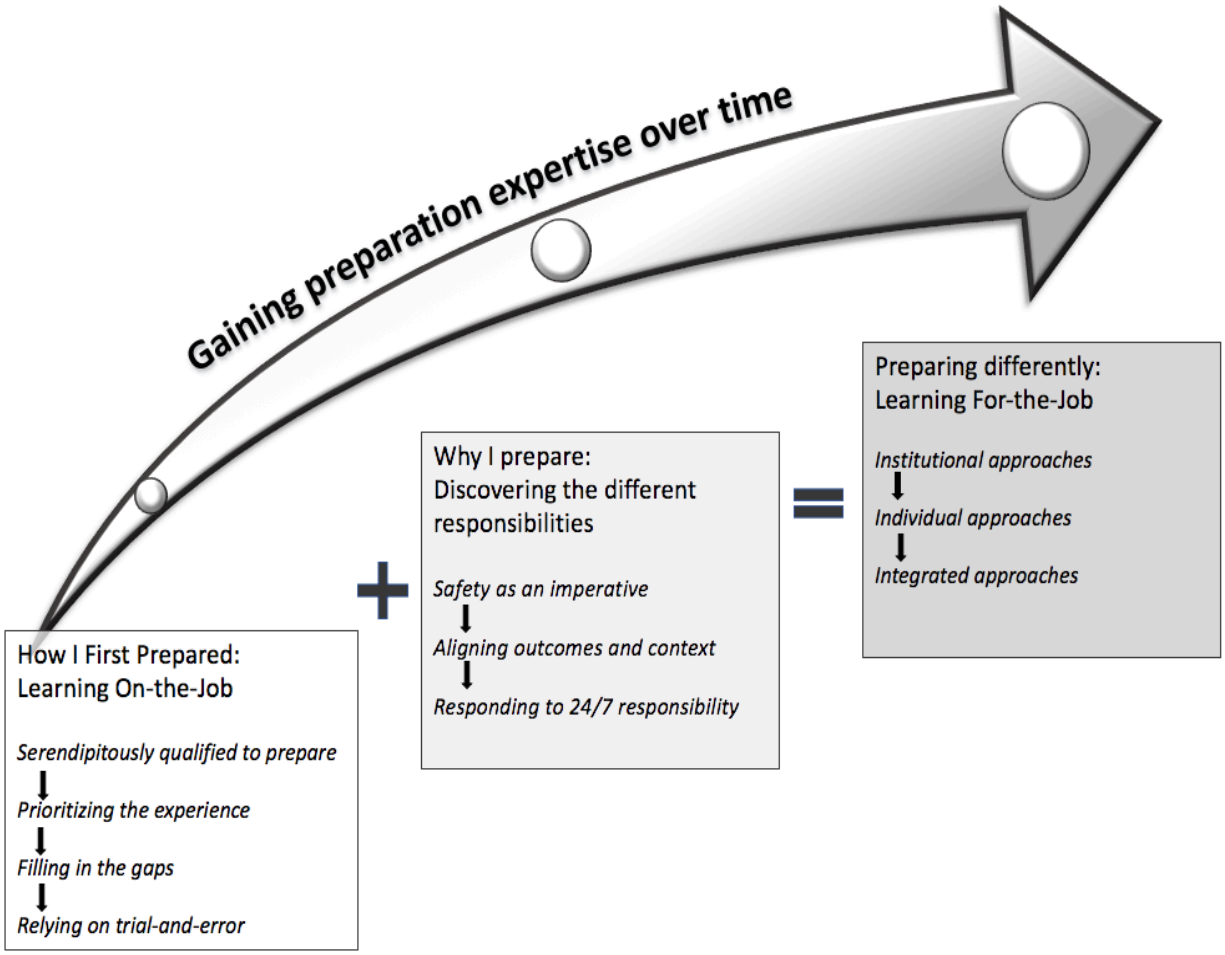

Figure 1. Faculty preparation thematic design.

institutional[3] support, however, faculty were on their own to prepare by *prioritizing the experience* and *filling in the gaps.* Because these preparation approaches were seen as insufficient for the unique IE context, participants prepared by *relying on trial-and-error*. In *Theme Two, Why I Prepare: Discovering the Different Responsibilities,* participants realized that individual and informal activities for learning on-the-job did not comprehensively support the responsibility for *safety as an imperative,* and the responsibility for *aligning outcomes and*

[3] A finding for this study was participants' reliance on themselves for preparation. This was described as receiving little external resource support for preparation from the program, department, managers, and the university. For the sake of this study, the term *institution* will be used to encompass elements of external support outside of the individual participant.

context. To meet these responsibilities, participants prepared for *responding to 24/7 responsibility.*

Discovering the heightened responsibilities inherent to IEs prompted faculty to adapt approaches to preparation that are represented in the final main theme, *Theme Three, Preparing Differently: Learning For-the-Job.* This theme is a culmination of the first two themes in which participants applied learning from their first IEs, along with their new understanding of the responsibilities of IEs, to then identify how they needed to prepare differently. These different approaches to learning for-the-job included *institutional approaches, individual approaches,* and *integrated approaches.* In following with the *Overarching Theme: Gaining Preparation Expertise Over Time,* a cycle of learning on-the-job, discovering the difference, and learning for-the-job repeated as participants gained new understanding of how to prepare with every IE. This ongoing cycle suggested there was always more to learn about how to prepare.

This chapter is organized by first describing the *Overarching Theme: Gaining Preparation Expertise Over Time,* and then by exploring the three main themes. A summary of the findings will conclude this chapter. As discussed in Chapter Three, participants were organized into categories of either novice or experienced so as to situate the findings within the expertise they represented at the time of the interviews.

Overarching Theme: Gaining Preparation Expertise Over Time

The *Overarching Theme*: *Gaining Preparation Expertise Over Time* captures how participants acquired the ability to prepare for IEs over a trajectory of time and experience. Prior experience in an international education approach was identified as the most important way that participants came to understand how to prepare. In the words of an experienced participant, faculty “prepare by just their own experiences over time” (Susan). In this understanding, learning

about preparation did not only occur before an IE, but it also occurred during and after each IE because “each experience teaches you something new” (Janet). Most participants felt unprepared for their first IEs because “the first year is the hardest . . . you don’t know what you don’t know” (Susan). With subsequent IEs, preparation “got easier” (Janet). Tim, a novice, reflected on his gained expertise over time; “looking back . . . I was just scratching the surface. With every trip, you feel like you dig your roots deeper . . . you learn more and more and more”. One participant reflected how even after one IE he felt more prepared.

> I’m looking at myself this semester–one year later–and I know the environment well enough now to anticipate what my students need; I’m not always having to play catch-up . . . I’ve noticed a difference in the quality of student that I’m able to produce at the end than from when I first started this journey. (Josiah)

This was echoed by others such as Melissa, who explained how “10 years of teaching” was a significant contributor to her learning how to prepare for IEs.

Preparation expertise had limitations too. Each participant agreed in some way that for IEs with students, “you can never be 100% prepared” (Tim). Even experienced participants identified, “I felt prepared . . . but there is no way I can prepare for everything that might happen” (Bonnie). The reality of the unachievable perfect preparation was in constant tension with a sense of needing to be “absolutely over prepared” (Hilary). Knowing that perfection was not possible, participants instead worked to “become more prepared” (Melissa). The limitations of expertise in preparation was also expressed in novice and experienced participants identifying preparation as an unknown, with its essence being “hard to articulate” (Melissa). Some shared in exasperation when describing preparation “[sigh] I really don’t know how . . . I don’t have the answer!” (Janet). The unknown, however, was also embraced as it paralleled a feature of IEs

where “unexpected things happen all the time” (Hilary). Within these understandings of preparation, this chapter interweaves the *overarching theme*, *gaining preparation expertise over time* into the three main themes in which participants describe their emergent experience of preparation starting with their first IEs and ending with their most recent IEs.

Theme One, How I First Prepared: Learning On-the-Job

Theme One, How I First Prepared: Learning On-The-Job represented participants’ first times preparing for accompanying students on IEs. This theme captured how faculty were left on their own to determine what was needed for preparation. Additionally, preparation was described as a personalized assessment such that “I was prepared” (Sharon) or “I felt prepared” (Julie) and was not dictated by an external other, such as the sending institute, the student participants, or the host community. Few participants felt prepared for their first several IEs. Participants, however, also identified that they could be or feel prepared for some parts of the IE but not for other parts. For instance, with 24-hours-notice before departure, Josiah had no preparation other than his own previous travel experience, being given a plane ticket, and a course outline; he identified how he “felt prepared for the travel” but “the responsibility I wasn’t prepared for”. Without formal guidance about what preparation included, participants drew on a variety of informal resources to learn how to prepare while they were simultaneously attempting to prepare, or as Susan put it, “learning as you develop the program”. The first subtheme of Theme One discusses the informal factors participants used to learn on-the-job for their first IEs. The remaining three subthemes of Theme One describe how participants enacted preparation for their first IEs with students.

Subtheme One: Serendipitously Qualified to Prepare

When participants described their initial times preparing to accompany students on IEs, they first referred to factors that supported how they obtained the teaching position. These informal factors were also described as important for preparing for their first IEs. In this subtheme, *serendipitously qualified to prepare,* all participants had a sense these factors for preparation were unplanned "stepping-stones" (Melissa) that had the fortunate positive outcome of supporting their first times preparing for IEs. Serendipitously, these factors were innate upon arrival to the IE teaching position and explained how preparation began long before pre-departure of their first IEs. These factors allowed the participants to be identified as a fit for the IE teaching position and were often "informal" (Melissa) even when selected by a "program director" (Bonnie). As a program director, Julie reflected on how she selected faculty for IEs,

> When I was in the Global Health Office, we tended to select faculty based on our knowledge of them. We don't have a requirement that faculty has to take a course. We've chosen faculty based on what we know about them, their interests and experiences.

Only Sharon identified an explicit selection process for the teaching position to accompany students on IEs which included joining a global health committee, submitting a formal application, and receiving approval by a workload committee. In other cases, participants just-so-happened to be approved for the teaching position by "myself" (Hilary) or by "a mentor" (Tim). Although the selection process was mostly ambiguous, similar factors were identified by all participants as contributing to a fit for the IE role. This fit includes prior experience, established relationships, and interest towards a perceived need.

Drawing on prior experience. Participants identified prior experience as the most important qualifying factor for the IE teaching position. Prior experience was also the most

important resource for preparing faculty. For several participants, prior experience had a serendipitous–unplanned–link to the teaching position. An example of this was the opportune chain of events described by Bonnie:

> I come by this through a family interest in international things . . . my first experience was as a CUSO volunteer. . . . Then I had a PhD supervisor . . . who had four projects going in different parts of the world. I decided that I was doing an international dissertation. . . . Then, the opportunity came up for a project in [Africa] . . . and we had a group of students go there this year.

All participants felt they had relevant prior experience in an international setting before undertaking the IE role. Past relevant experiences in the international context included "global student practicums" (Melissa), "research work" (Janet), "military work" (Sharon), "nursing practice" (Tim), "missionary volunteering" (Hilary), "vacations" (Susan), and "travel" (Josiah). Several participants also identified prior experiences in Canada that supported their preparation for first times accompanying students on IEs. These local experiences included working with "many different cultural practices" (Melissa), with "underserved Indigenous populations" (Janet), or with "refugee populations" (Bonnie).

Educational experience was also identified as important although academic qualifications were not necessary for all participants. Three participants, Josiah, Melissa, and Tim were selected without graduate degrees. Other participants had graduate or postgraduate education. Some participants were also selected without having prior teaching experience. For instance, Tim had no prior teaching experience in higher education, yet was selected over "ten others" who had teaching and international expertise. Tim was selected because of his "clinical experience" and "global health experience".

Prior experience was also the most "critical" (Bonnie) factor for supporting preparation. Josiah, a novice with some previous travel experience and little prior teaching experience identified, "I probably survived the experience because I had travelled so extensively beforehand, right?" Others, like Sharon with her extensive military experience, appreciated how prior experience contributed to feeling prepared noting,

> I have had a lot of years leading soldiers. Like, paying attention to what objectives are . . . all their logistical support and everything that went with them. I was very comfortable with that piece. That's the piece that I think a lot of our new educators are missing.

These prior experiences were key for participants to obtain the teaching position and also prepare for IEs with students.

Drawing on established relationships. Established relationships were another important qualification and preparation factor for participants' first IEs. For most participants, previous relationships within the host community were foundational to being selected for the teaching position. Susan identified, "if faculty wanted to teach, they often they had contacts in another country, and they were willing to put the work in to getting a memorandum of agreement signed". Melissa was selected because of her established relationships within a host community as she identified "I didn't have any kind of formal global health, international experience . . . but I knew a lot of the players because I had been there for seven months already. I think that's why it worked quite well". Another participant made "connections" (Hilary) with Canadian missionaries in a location where she later took students for an IE. This contact contributed to Hilary's self-selecting for the IE teaching position because the missionaries offered to "facilitate going out to villages" and "connect with people".

Several participants also identified the importance of prior established "friendships" (Susan) with host community members and how these friends contributed to preparation. Tim, a novice, became friends with a local driver during earlier international work. Tim identified the importance of this friendship for an IE where the driver became the "tour guide and also cultural navigator . . . he's my best friend [there]". An experienced participant also highlighted how the dean of the host university in a HIC was her "friend and colleague" (Susan) who helped to create an IE program. Bonnie likewise identified how "the director of the [international program] is a good friend" who allowed her students to gain access to a specific village.

In many cases, established relationships within the Canadian context were also important for preparing faculty for IEs. Melissa described how a "contact" at a Canadian hospital was a catalyst for forming an IE program. Bonnie also identified a Canadian "ally" from her previous international work who became an important asset in a student's medical evacuation. Some participants also drew on the expertise of contacts within the Canadian sending university. For instance, two participants, Melissa and Tim, identified informal mentors (not designated by the program) who were former professors and important relational resources. Tim identified his mentor being his "rock" in the international setting. Melissa shared how the informal mentorship relationship began stating, "I don't even think we had real conversations about that . . . it was, 'come with me and we're going to have a kind of mentorship and I'm going to teach you how to be an instructor". These prior relationships were considered key factors for obtaining the teaching position, and for preparing faculty for their first IEs with students.

Drawing on interest towards a perceived need. In addition to prior experience and prior relationships, qualifying for an IE teaching position was supported by participants' interest towards meeting a perceived need of the program, the students, or the host. For most, this interest

was established well before involvement their first IEs. Josiah stated, “I love culture, I love Medicine, I love Nursing, I love health, and I love all of these things . . . it’s sort of the perfect combination of who I am as a person”. Sharon identified her “love” for international and cultural work adding, “I gravitated towards teaching global health . . . then, when I saw this opportunity to lead students abroad, I said, ‘oh, pick me’!” One participant identified her interest “blossomed” (Janet) through international research prior to an IE. This was similar to Melissa who also did not always have interest in international work but her experience as a student in IEs “completely changed my career trajectory”. Many participants also identified their interest in international work was a key factor for sustaining IEs throughout the trajectory of *gaining preparation expertise over time* because of the workload involved in this teaching role. Passion for international work often outweighed workload such that Melissa stated, “there’s inequities around workload . . . but we all just do it because we’re passionate about it. That’s been always what has carried this program, passion for global health”. Hilary echoed how important passion was to preparation sharing, “it’s a lot of work, but you have to love what you’re doing; there has to be a passion there. I don’t know how people can do it if they don’t have a passion for it”.

Interest in international work motivated participants to respond to the needs of the program and the needs of the students; this response resulted in being selected for an IE position. For instance, a novice, Josiah, was asked to join an IE that was already underway and was given 24-hours-notice prior to departure. His willing response to program needs was a factor in his being selected.

> The associate dean came out of a meeting and looked at me and said, ‘come to my office, close the door’. . . . I thought I was being fired! . . . [She] said, ‘I have students on the ground, and I currently have no instructor there. I need to know if you can go; I need to

> know in the next 24 hours. . . . I don't know if I was chosen because there was something in my curriculum vitae that the dean thought I could do it, if she was going to call me anyways, or if I had just happened to be standing in the wrong spot at the wrong time [laughs], I guess I'll never know. (Josiah)

In other universities, participants' response to a perceived need supported their qualification for the teaching role such that "in our university it used to be you would identify an opportunity and then it would be your placement" (Janet).

Some participants also responded to the perceived needs of the host alongside student learning needs. For instance, Hilary initiated an IE program after discovering students in her program engaged in international volunteer activities, "that were completely unacceptable ethically" because they were practicing out-of-scope such as delivering babies. By starting the IE program, Hilary provided supervised opportunities to "work within their scope of practice" which was important for the safety of the host community. Another faculty was selected because of his clinical expertise to upscale host nurses' clinical practice for a local nursing program supported by the "government and ministry of health" (Tim) which he did alongside an IE.

This subtheme, *serendipitously qualified to prepare,* addressed the factors identified by participants as being important for their fit in the IE teaching position. These factors also contributed to participants feeling prepared for their initial IEs and were by-and-large identified as being fortuitously innate to the participants upon arrival to the teaching position. The factors did not include participants' substantive knowledge about IEs or global health concepts as a core to their qualification. The next three subthemes refer to how participants enacted preparation by *prioritizing the experience,* and *filling in the gaps,* while, ultimately, *relying on trial-and-error.*

Subtheme Two: Prioritizing the Experience

The subtheme *prioritizing the experience* revealed how preparation of IEs, such as students and logistics, was the focus over preparation of the participants themselves. One of the interview questions asked, "what preparation did you, as the nurse educator, have prior to going on these international trips with students?" Most participants first responded with how they prepared logistical factors of the experiences or how they prepared the students; preparing IEs was a key responsibility. Participants' response seemed to conflate preparation *of* the experience with preparation *for* the experience. For instance, Susan, who had no prior international work or volunteer experience, emphasized feeling prepared after she had planned the logistics noting,

> I hadn't experienced the place itself [Pause] I think I was prepared as I possibly could have been . . . I had developed an entire checklist of things that needed to be done prior to pre-departure, immunizations, risk management, visas–that whole application process.

When asked how she, herself, had been prepared for the IE context, Susan added, "I don't know if I really did prepare . . . I guess I was more concerned with other things". All participants agreed that "part of preparation is having students prepared" (Tim). They felt prepared as they readied the experience because they "learned as they've developed the program . . . setting up the country itself" (Susan).

When the interview question about faculty preparation was restated, several participants identified how minimal institutional support (departmental and programmatic support) compelled them to direct time and financial resources to what was deemed more essential activities of preparing (logistics and student). In this sense, participants were not avoiding their own preparation, but instead, had no additional resources "from the top" (Susan) to become prepared. Melissa identified,

> Why we haven't formalized preparation is just workload. If somebody had carved out time for us, if we were compensated for some program development work, I think we would be in a really different position. But in the current state where you only get one teaching credit for this, you're focusing all of it on the students instead of the faculty development. I think that's a big downfall.

Participants reported an overall lack of financial resources for IEs. They were often left on their own to creatively, and sustainably, fund their IE program. The little funding obtained through "research grants" (Janet), campaigning local organizations to "pay for travel expenses" (Melissa), "embedding faculty costs" in student fees (Melissa), or "paying their own ways" (Melissa) was funneled to preparing IEs. Constrained time was also directed to preparing IEs because workload was often "time off the side of our desk" (Melissa) and "it's *way* over and above an ordinary course!" (Susan). One participant shared "we didn't get any extra time to develop the curriculum or technique with the students; we met with the students on Saturdays" (Hilary). The minimal resources meant that when it comes to preparation, "instructors don't get that benefit. The students get that, but the instructors don't" (Sharon) leaving faculty to prepare themselves for IEs.

Subtheme Three: Filling in the Gaps

The requirement to meet their own learning needs for preparation led to a sense of being "on my own" (Janet) which was experienced by all participants–both novice and experts–and persisted through repeated IEs. This is represented in the subtheme, *filling in the gaps,* where without institutional support, participants were left to "take it upon yourself" (Josiah) to fill substantive knowledge gaps for what to teach, and how to teach, in IEs. Being on their own wasn't to say that there was no help from others, such as from colleagues, but was indicative of

having minimal external support and generally bearing the sole responsibility of the IE. Many participants who had their first IEs in the past ten years, identified the difficulty of preparing on their own.

> There's no research to pull up on preparing instructors for these assignments. [sighs and pauses for 8 seconds] I was unable to access the instructor that I was replacing . . . there was no guide . . . no one in my immediate supervisory realm had been [there], ever. I literally went with a 5-page course outline. (Josiah)

After he returned from his first IE with students Josiah added "after I started digging, I found that there's a lot of good nursing research that has been done on global health experiences that I was unaware of until I started looking". Melissa also relied on seeking out resources on her own: "I don't know how I was prepared, other than my own . . . it was nothing formal at all . . . I was pretty naïve". She recalled reflecting how "this is a gap for me" and celebrated her resourcefulness for seeking out "knowledge, networks, people, and just doing my own reading" which evolved into eventually pursuing global health related graduate training to feel more prepared for IEs (Melissa). Three participants, who began IEs in the past ten years, drew from their mentor's expertise. However, even with mentor support, these participants identified a sense of feeling alone in preparation. For instance, after three times accompanying students alongside a mentor, Tim, a novice, still identified "I am usually on my own". One experienced participant had been previously responsible for selecting faculty for the IE teaching position. She identified how there was minimal support for those who were novice to the IE role.

> When I think about the people who've gone on international experiences with students, often it's their own background and their own experience in international settings that

> they're able to draw on, to assist in what preparation needs to happen. . . . There's not a lot of formal training or assistance for a faculty member. (Julie)

Experienced participants who had their first IEs more than ten years ago were faced with a similar, yet tougher reality because there were "no resources" (Susan) even if they went digging. Janet identified "there was nothing to prepare us, nobody there to give you that guidance". She recalled her anxiety for her first-time accompanying students with no preparation stating, "I was very uncomfortable having no knowledge and no real background and nobody to mentor me. I was kind of on my own".

Participants also provided insight into the knowledge gap that resulted from the lack of formal preparation and subsequent reliance on self. This gap related to: (a) *what* to teach, such as the substantive knowledge relating to IEs, global health, and global health equity; and (b) *how* to teach, such as what teaching strategies and logistics were important for IEs. Several participants prepared in a vacuum for their first IEs because, "there is no formalized mechanisms in place that provide everybody a good foundational knowledge to bring students on global health practicums . . . that's a huge gap" (Melissa). The knowledge gap was compounded because in all cases, across decades of IEs, faculty were left to question "how do we teach our students when most educators have never been taught that themselves?" (Sharon). No participants had formal global health training in their own undergraduate nursing education because it "wasn't an option" (Susan) or they "didn't have any . . . global health course at the time" (Melissa). Sharon had expertise in international military work as a nurse, however, she identified a situation in an IE that was unusual to her nursing degree.

> I was there with my students, and a military coup happened . . . I had to do training with them about how to act, how to talk, what to do if a soldier approaches you with a rifle . . . that's not something we learn in nursing school. (Sharon)

Obtaining formalized training for IEs required individual faculty to seek this out through graduate studies. Three participants pursued relevant graduate school education after starting their IE teaching position. Others had graduate school training, and some, like Bonnie and Julie, had international doctoral dissertations they identified as being critical to their preparation.

The second gap of preparation knowledge was how to teach in IEs. A common sentiment expressed was participants feeling "novice again" (Tim) or "pretty green" (Melissa) in their teaching role compared to their expertise in clinical practice. Practical knowledge of how to teach for these settings was missing for participants across decades of IEs because "there is no course or workshop or a training module for the kind of things that you need" (Julie). Knowledge was further complicated because some participants had no prior teaching experience. This was challenging for faculty who were also responsible for developing learning objectives for IEs. Sharon identified how each experience, versus formal preparation, contributed to her gaining expertise in how to teach stating, "it got easier as I went along because I had thought through what those objectives were, and I actually created a template for myself . . . but it was a matter of developing that" she added "we didn't have any checklists or anything like that. The university just sent us off; it's a grand adventure" (Sharon). A participant who had extensive prior experience in international work before her first IEs explained the feeling of teaching alone noting, "I was very isolated with [the students]. . . . The first couple of times I was there by myself it was very stressful . . . I didn't have anybody to bounce those ideas off of" (Janet).

Overall, subtheme three revealed how minimal external support left participants to determine how to prepare on their own. This led to participants being coincidentally qualified, prioritizing preparation of the IE, and filling the knowledge gaps on their own. Ultimately, participants were left to rely on learning how to prepare on-the-job through trial-and-error.

Subtheme Four: Relying on Trial-and-Error

Without adequate institutional support participants were left to learn how to prepare by experimenting "in the moment" (Susan). Some identified being "not quite sure of what we're doing" (Hilary) for their first times on IEs. This resultant approach to preparation is represented in the subtheme *relying on trial-and-error*. The *Overarching Theme: Gaining Preparation Expertise Over Time* was meaningful for this finding because those with less prior experience in clinical practice, nursing education, and international work, identified more reliance on trial-and-error for their first IEs with students. Josiah, a novice, reflected on his first IE noting,

> I was not prepared at first. . . . I probably looked like a moth bouncing from lightbulb to lightbulb, just exhausted, and constantly trying to play catch-up, and never really being comfortable . . . or anticipating the needs of my students ahead of time.

Some participants with extensive international work experience felt less reliant on trial-and-error. For instance, prior to her first IE, Bonnie completed an international doctoral dissertation, and had worked as a nurse in a LIC similar to her IE location. She noted, "a lot of things that you could run into, I'd already run into and resolved before so, I didn't have to second-guess" (Bonnie). Furthermore, the overarching theme highlighted the unreachable perfection of preparation such that participants needed to "expect the unexpected" (Bonnie) and perhaps some trial-and-error was inevitable to teaching in the foreign IE context. It was participants' reliance on trial-and-error, however, that seemed to have a different meaning such that this is the way it is

(perhaps inevitable) and conversely this maybe is not such a desirable way to go. Janet expressed discomfort in how she relied on trial-and-error when she was a novice 20 years ago:

> I think some of it was trial-and-error. . . . You can't do it until you just do it. I mean I've read the literature and the postdoc definitely helped me in terms of the cultural side [Sigh]. Geez. [Pause]. I never had a real mentor. Nobody. There was very little literature at that time on how to supervise a student, I mean we're talking almost 20 years. I just think it was trial-and-error and talking to people who were doing it as well. . . . Isn't that a horrible thing to say?

This discomfort of relying on trial-and-error was echoed by Tim, a more recent novice, who stated, "I learned firsthand by doing it, which sounds crazy. . . and now I want to do my master's so that I can learn it properly".

Some participants likened reliance on trial-and-error to learning in the dark. As a novice, Tim noted, "it's like you're going in blind, trying to teach yourself everything before you teach it to your students" (Tim). Hilary, who had more experience, echoed what it felt like to rely on trial-and-error stating, "you're just shooting in the dark; you're hoping that this trip is going to actually be beneficial for both sides". This highlighted a potential negative implication for a trial-and-error approach to perpetuate "doing something that's not satisfying to you or the community" (Janet).

In summary of the first main theme of these findings, in *Theme One, How I First Prepared: Learning On-the-Job,* participants were *serendipitously qualified to prepare* for IEs through factors of prior experience, established relationships, and interest toward a perceived need. Across decades of experiences, participants had minimal institutional support resulting in their enacting preparation by *prioritizing the experience* and *filling in the gaps* of what and how

to teach. Participants were ultimately left to learning how to prepare by *relying on trial-and-error*. The next theme follows the trajectory of participants' learning how to prepare as they discovered the different nature of IEs.

Theme Two, Why I Prepare: Discovering the Different Responsibilities

The second theme–*Theme Two, Why I Prepare: Discovering the Different Responsibilities*–revealed participants' realization of the unique responsibilities inherent to the IE teaching role. Janet compared this discovery to an "epiphany" and both novice and expert participants described this difference as a "higher level of responsibility" (Julie) or a responsibility that is "unique" (Bonnie), "different" (Janet), or "more" (Hilary) compared to teaching in the Canadian context. The responsibilities were also different from independent international travel because "you're not just responsible for yourself" (Josiah). Participants felt responsible to, and for, the student and the host communities because of the risks inherent to IEs such that "the whole experience could be closed down because of things happening, if the students aren't kept safe or you don't prepare that you know what you're doing" (Susan). This section will discuss three discoveries about IEs including: (a) the responsibility for *safety as an imperative,* (b) the responsibility for *aligning outcomes and context,* and (c) the resultant expanded role for *responding to 24/7 responsibility.*

Subtheme One: Safety as an Imperative

One of the most pressing concerns for faculty leading IEs is represented in the subtheme, *"safety as an imperative"* (Janet). While clinical educators in any clinical setting will attest to the safety imperative, the participants in this study articulated how this was intensified in IEs and extended to concerns for life and limb. Faculty discovered, "the safety issues are quite different" (Janet) because "in some cases, we go to these places and we're ignorant about what is

dangerous and what is not" (Hilary). Most participants were faced with unexpected safety events in their first IEs with students. These ranged from "unsafe accommodation" (Melissa), to the "stress and psycho-social challenges that a student might have" (Julie), to a "military coup" (Sharon). It was these safety events which motivated faculty to intensify their "accountability around students going and a little bit better thought processes being put into these things" (Janet). For instance, after a safety event, Janet wondered, "is this going to happen again? How do you keep your students safe?" (Janet).

Although some faculty identified recent institutional "international safety policies" (Melissa), the responsibility for safety remained largely on individual faculty "to know how to respond if a student gets sick or gets missing or something happens" (Julie). In some cases, universities "didn't have the mechanisms" (Janet) for safety which left participants on their own for mitigating and managing safety events. For instance, some participants had to arrange for urgent transportation such as "evacuation" (Bonnie) even when students had travel insurance. Safety concerns persisted through each IE. An experienced participant, Bonnie, emphasized the persistence of her responsibility to safety;

> What would you do if there was a car accident and your students were killed or severely injured? . . . How do you handle that? How do you handle dealing with the other students? How do you handle dealing with the healthcare system or dealing with the faculty and the parents back home? There are other things that could happen; they could be bitten by a snake! They could get malaria! It's a safety issue. What if there's a coup, or a terrorist attack?

Ensuring student safety was challenged with student agency as "adult learners" (Bonnie) because "it's really hard to control other parts of what [students] are doing. Then they break

barriers and things happen" (Janet). Bonnie recalled the high stakes of her IE context when students reported concerns of contracting HIV after choosing "local sexual partners" in a country known for high incidence. She also managed the challenge of students going missing while travelling in their free time. Other safety concerns included legal action from the host community because "the last thing we want is for [students] to do something that they wouldn't think twice about it in Canada; but if you do in another country you could end up in jail" (Sharon). Regardless of students' unsafe decisions, faculty remained responsible to their safety:

> We even had students who got mugged and were threatened with a machete because they didn't follow the rules. They didn't come home when it was dark, but it doesn't matter [Pause]. It doesn't matter that they didn't follow it, I still have a responsibility to their safety. (Janet)

After first emphasizing student safety, some participants highlighted their responsibility for the host's safety to ensure, "not only that the students were safe, but that they hadn't done anything clinically to jeopardize a patient" (Sharon). The context of the IE contributed to the concern for patient safety because students are, "working in a clinical setting that they're not familiar with . . . you don't want them to make errors" (Julie). Participants needed to be aware of the temptation for students to work beyond scope of practice. Bonnie shared how one student had come to her with a request to do circumcisions;

> [The student] spent the day with the nurse doing circumcisions and she came home and said the nurse had told her that the next day, the nurse would help, and the student could do them. And I said, 'Oh, no, you can't.' The last thing in the world we needed was a student to mess up a circumcision! And, no, the students could not do things that they were not covered to do here.

Few participants identified concern with their own safety. A practiced participant, Hilary, identified emotional safety of needing to prepare to "manage my own rollercoaster of emotions". Others concerned with their own safety, did so to emphasize the impact on the safety of their students. For instance, when she was the only faculty on an IE, Melissa reflected, "If I get sick, what are we going to do? . . . That's not safe. I need somebody to take care of me, but I need somebody also to take care of them, too". Safety was the priority responsibility for faculty in IEs. The next priority focused on outcomes in the IE context.

Subtheme Two: Aligning Outcomes and Context

While fulfilling the responsibility to keep students, patients, and themselves safe, participants were also faced with the heightened responsibility for successful student learning outcomes. This responsibility is represented in the subtheme *aligning outcomes and context.* Different from the Canadian context, the IE locations were found to be "difficult foreign environments" (Josiah) for teaching in both HIC and LIC. Participants were challenged with the difference from their familiar Canadian contexts because "every component of that clinical practice changes; the policies of the hospital, the community, the political background, even the disease and the illness that you find in people is different" (Sharon).

The first difference in context were the living conditions for both LIC and HIC. For instance, in LIC, the different living conditions for sleep, diet, and daily living could impact student learning. Some participants had to factor in teaching students "life skills" (Sharon) such as washing clothes by hand and cooking, alongside teaching nursing curriculum. Hilary identified how the living condition impacted learning "in this setting, if we didn't have any protein for supper these guys are going to be really hungry! . . . You are 24 hours a day thinking

'life' around this course". For those in HIC, participants needed to also support students' "culture shock" (Susan) in the new environment.

A second contextual difference was the learning conditions related to healthcare systems and policies within which students had their clinical practice. Susan identified the challenges of working with "different hospital policies" in a HIC. Another participant, Sharon, adapted her students' clinical schedule in a LIC because of the hospital schedule where the nurses left in the middle of the day. She did this because "this is just not good to have my students and I here running the hospital" (Sharon). The different health systems also added complexity to how to address various health problems as they were situated in these unfamiliar contexts.

> Here [in Canada], you have lots of resources or you have police. There, things are not as smooth to activate . . . and you're not as familiar with them. Here, if a child came in in child abuse, we'd know what to do. There, you do nothing. (Janet)

A third contextual difference for student learning was related to health conditions and burden of disease in the IE settings. For instance, in the LIC setting, "there is more time for things to go wrong . . . the weather and environment can change the whole experience. The rains increase tuberculosis, pneumonia, malaria, trauma from mudslides; you don't see that in Canada" (Tim). Some participants highlighted commonalities in the learning context between the IE settings to the Canadian settings such as "social justice issues and health care inequities in Canada" (Josiah) with Indigenous, homeless, and refugee populations. Despite some similarities, for their first IEs, many participants expressed an overall unfamiliarity to the "extreme" (Bonnie) health disparities which were "magnified much more outside of our borders" (Josiah).

In their first IEs with students, participants discovered their responsibility to align student learning outcomes to these foreign living conditions, health systems, and health problems. In

most cases, this alignment was dependent on individual faculty. A novice, Josiah, discovered this responsibility after his first IE stating, “it’s one thing to just show up into a foreign country; but it’s another thing to show up into a foreign country and be responsible for university students’ curriculum”. He added, “you have to take it upon yourself to educate yourself well enough to be able to meet that objective, whatever that may be” (Josiah). An experienced participant, Melissa, also identified, “we’re trying to provide [students] with a layered experience . . . but that’s up to you, as the instructor, to organize all of that”.

Another common finding was participants’ discovery of their responsibility to “globalize” (Sharon) and integrate the Canadian nursing program objectives to their IE. Sharon identified “pulling all that together myself was pretty overwhelming. . . . My biggest fear was, ‘Am I meeting my objectives?’” She added how she was unable to have students meet the undergraduate learning objectives of starting intravenous access on patients because of the safety risk related to the high prevalence of HIV in her IE location. It was Sharon’s responsibility to later find these learning opportunities for students when they returned “back in Canada”. Fewer participants identified the learning outcomes that were specific to the IE setting outside of the learning outcomes that they adapted from the Canadian nursing curriculum. Those that did identify these outcomes included a desire for students “to be able to connect what happens locally and globally” (Janet) and not just come as a “health care tourist” (Hilary) or “voyeur” (Janet). Some participants also integrated perceived host needs into the purpose of the IE.

> We had a Cholera outbreak. That was the day that we were supposed to be going and doing some observation in some other place, but the Cholera outbreak was the most pressing necessity. . . . People have to be aware of what are the communities’ needs, not necessarily the exact learning needs within that particular agenda. (Janet)

There were challenges participants faced in this midst of aligning learning outcomes to the different living and learning contexts. This included needing to adapt learning outcomes at a moment's notice because "in international place, we are not as routinized; we're often called to do sort of other things that might not have been planned" (Janet). Melissa highlighted how the variability within the IE meant needing to capitalize on unplanned moments for teaching in the "day-to-day" and "debriefing time". This was challenging when she was stretched in multiple directions and "tired" (Melissa) from the intensive IE. In their first IEs, several participants were challenged with being the "conduit" (Hilary) of learning when they had little substantive knowledge about the context. Tim shared what this responsibility felt like in the midst of his knowledge gap,

> I really wish I knew more about the diseases . . . because, the second year, I could focus my teaching a lot better because I knew what diseases and illnesses and surgical procedures that they do there, I feel like that that could have been really handy.

Another challenge of aligning learning outcomes with the IE context was participants' own unfamiliarity with the ethical and socioeconomic contexts. Participants who had limited prior experience in the international setting and limited experience with teaching emphasized the challenge of facilitating student learning related to ethics and socioeconomic disparities. After one experience with students, Josiah discovered "it's not the raw medicine that the students come over there and struggle with; the students come over there and struggle with the socio-economic disparities". He expressed how his unfamiliarity with poverty and human rights in his IE setting impacted his ability to align student learning and the learning context as he noted, "[sighs] I tripped over my words a few times . . . I'm still learning myself how to navigate those difficult conversations and not bring more trauma to the student with ill-chosen words". An experienced

participant, Melissa, identified feeling comfortable navigating these conversations only after numerous IEs with students, graduate level education, and a global health coalition mentorship network. She felt better able to help students connect their learning to a "critical social lens" (Melissa) and address root cause of disparities.

In summary, this subtheme explored how participants first IEs with students resulted in their discovery of the responsibility to align learning outcomes with the complex foreign context of the IE. This realization further highlighted gaps in knowledge for the participants as they had to determine how to navigate the dynamic learning contexts. The next section follows the journey of participants' discovery of the responsibilities for IEs as they identified the roles they needed to enact to achieve safety and learning in IEs.

Subtheme Three: Responding to 24/7 Responsibility

To the participants, fulfilling the responsibilities for safety from subtheme one and the responsibility for learning in subtheme two, required a new approach "beyond a typical educator role" (Sharon). This new approach is described here in this subtheme, *responding to 24/7 responsibility.* Participants discovered they needed to wear "many hats" (Tim) and be "on 24/7" (Hilary) with nonstop attention to fulfil the responsibility required for the IE context. In this way, the weight of responsibility extended to "all aspects of [students] lives, not just their nursing clinical aspect, because you're the one they come to if they've got an issue" (Julie).

Two categorical roles were discovered for the IE teaching position. The first was the role of the educator to safely meet learning outcomes. This included the essential role of preparing IEs. While this role itself included similarities to the Canadian context for being a "facilitator" (Susan), "academic support person" (Julie), and "coach" (Julie), the pathway to this role was identified as distinctive and included unfamiliar elements. The educator roles unique to IEs

included “student selection” (Julie), “tour-guide” (Tim), “logistical liaison” (Hilary), and “cultural liaison” (Josiah). Josiah, who had one IE with students, described, “you can’t just go over and be a nursing instructor. You have to immerse yourself. You have to know the culture, or your students are going to suffer”. Participants also found that the responsibilities for managing the logistics of the IE were different from their educational role in Canada where logistical administrative support was more readily provided. Sharon, an experienced participant, summarized, “there are a lot of logistics; there are a lot of roles that you wouldn't think of as a typical educator role; it’s not just being in the hospital”. Melissa expanded how the educator role also included preparing students such as for the “socio-political influences” and also “the day-to-day logistics . . . and getting them to think about what they’re going to pack”.

The second categorical role of the IE teaching position was that of a caregiver. This included the responsibilities to care for students and care for patients. Participants, like Sharon, connected their professional nursing role of interprofessional communication, decision-making, and critical thinking to IEs:

> What do you do if somebody’s raped? What do you do if somebody breaks a leg? How do you care for that, to start with? . . . With us, it’s innate; you know what to do. We’re very good at communicating because that is a huge piece of our training. If we have to counsel someone, or if something bad has happened, we can do that.

The caregiver role was also emphasized because participants were often the only trained health care professionals on the IE team.

> You are generally responsible for the students 24/7. In one situation, I had a student whose doctor told her to take three times the amount of anti-malarial medication as was required, and she started developing neurological symptoms. (Hilary)

While the nursing professional role was seen as an asset to meet the responsibilities of providing care within the IE, several participants also felt the need to be "more than a good nurse" (Josiah). This was to meet the care needs of the students such as "being the cook" and personal roles of being students' "emotional supporter" (Bonnie) and "friend" (Tim). For many, this also meant a parental role of "father" (Josiah), "dad" (Tim), "mother" (Sharon), "house-mother" (Susan), or "harassing mother" (Janet). One participant, Bonnie, had a different approach to caregiving for students in IEs noting that "as nurses, we often go overboard in not valuing the autonomy of the individual, and we mother" and suggested being more "hands off".

For some participants, the caregiver role also extended to a sense of responsibility towards patients in the host communities because "you have to look after your students; and, ultimately, you have to look after the patients that they're looking after" (Susan). In some cases, participants distanced themselves from patient care as they were "very conscious that I wasn't licensed" (Bonnie) which meant doing "very little nursing instruction" (Julie). Other participants became more involved with patient care than when in the Canadian context. One participant identified, "[expels breath] I delivered babies–not in my scope of practice here in Canada–but the nurses left the hospital and the baby was either going to fall on the floor with the rats, or I was going to catch the baby" (Sharon).

The educator and caregiver roles were "often blurred roles" (Julie) when facilitating learning in the IE context. Tim, a novice, shared his experience with this role tension:

> It's a grey line. You're the clinical instructor but you're also the tour guide; you're there with them all the time. No clinical instructor would ever go to meals with you after every clinical shift. So, it's this weird dynamic and they saw me as both. The students aren't going to respond to you after a full month of 'I'm your teacher, and only your teacher'.

Julie, an expert, agreed, that “more than just an educator, you’re often a mother, a coach, a supporter . . . They would often come to me because I had been to [the country] several times”. Because of the blurring of roles, some participants needed to advocate to their institutional leadership to “re-evaluate this role because I’m not just a nursing instructor over here; I am a mother, I am a father; I am a tour guide; I am a cultural liaison; I am in charge of these students’ safety” (Josiah).

Acting as an educator and a caregiver in a foreign context amplified the need for faculty preparation since “the need to be competent is higher because you’re in another context, another environment” (Julie). Because of the elevated and nonstop responsibilities, participants–novice and expert alike–found themselves “totally exhausted” (Hilary) in their roles. After three IEs with students, Tim, a novice, identified, “it’s exhausting. It’s going to be the most exhausting trip of your life; you are there for a month not just 12 hours a day”. Even ten years after her first IEs with students, Melissa also identified the around-the-clock nature of the IE role stating,

> This is a 24/7 practicum. This is not that they go to clinical from 7 till 2. This is full-on from all the pre-departure training to the moment. . . . It is overwhelming in that effect, and you don’t really get days off.

Sharon added that it felt like she was working “even when I was sleeping”. This feeling persisted even after numerous IEs which was different than when teaching in the Canadian setting; she said, “if I’m in Canada, I don't have to worry about all that. They go home. . . . Well, here you don’t get that break!” (Sharon). Teaching in IEs was like being “on a ship . . . encapsulated” (Hilary) with the students. The intensity of responsibilities for IEs was best exemplified by those who “breathed a sigh of relief when it was over” (Sharon).

In summary, Theme Two captured faculty's discovery of the different responsibilities innate to IEs. This realization occurred in their first IEs when participants became aware that the safety and learning needs were different than in the Canadian clinical context. To meet these responsibilities, participants embodied unique educator and caregiver roles that were often blurred. Participants felt constant pressure to enact these roles all day, every day, until the IE was over. With the discovery of these responsibilities–and resultant roles–participants reflected how preparation by learning on-the-job was perhaps insufficient. How participants shifted their approach to preparation is explored in final theme.

Theme Three, Preparing Differently: Learning For-the-Job

The final theme, *Theme Three, Preparing Differently: Learning For-the-Job* indicates how participants adapted their preparation approaches. After they discovered the different responsibilities innate to IEs, participants moved beyond relying on trial-and-error, to more intentional preparation. Intentional preparation allowed participants to better adapt to, and embrace, the unknown because in the high stakes IE, things "change up on a moment's notice" (Sharon). Hilary exemplified this by noting, "you need to be absolutely prepared and make sure that everything that you can possibly have organized is organized, because, once you get there, it doesn't necessarily all play out like that". In this theme, participants also provided recommendations to help others "avoid making the same mistakes over and over that other people have made" (Hilary). Janet affirmed, "I don't want everybody to go back to the trial-and-error model". A key finding of the recommendations was for enhanced *institutional approaches* to support faculty preparation. Participants also highlighted intentional *individual approaches* for faculty preparing themselves. Practical recommendations for *integrated approaches* conclude this theme.

Subtheme One: Institutional Approaches

Many participants identified *institutional approaches* for external support for preparation. This subtheme represents what was considered to be a "missing link . . . because there needs to be that commitment too" (Janet). This included enhanced programmatic, departmental, managerial, and university support outside of the individual participant. A shift to institutional approaches addressed how "sustaining" (Melissa) IEs was otherwise largely dependent on individual faculty and their volunteer efforts. While the institutional approach still required individuals to enact the approaches, the emphasis here was on the responsibility shifting away from the individual alone. Participants recommended how institutions should be investing in the international experience, aligning a curricular commitment and host outcomes, and selecting qualified faculty.

Investing in the international experience. An important institutional approach to preparation was investing in the IE. At a systems level, institutions should demonstrate value by providing resources. Institutional value was recommended from the nursing department, the university, and other funding agencies. Within the department, several participants expressed discouragement that colleagues compared IEs to a vacation "sitting forever on the beach" (Janet). It was difficult for those, like Melissa, to convince her colleagues of the workload. She stated, "I've realized there's a lot that goes into it even prior to us going in; that's a piece that [expels breath] is hard to articulate, especially to faculty . . . they think it is more of a vacation".

Within the university, value was also sought from management. One participant, Susan, emphasized her program was "shut down" because the dean did not value IEs. She added "it's up to the leadership . . . if you don't have that in place, you're not going anywhere!" and suggested the lack of value for IEs was because leadership "had never done it themselves and had no

experience with that. They just wanted it to be treated like any other course that anybody can teach". Melissa shared how it was only after having leadership attend an IE that they "got way more understanding of the nuances of the program". In Melissa's case, management's lived experience of an IE resulted in policy guidance such that "they have both come back, as advocates for the 10-to-1 student-instructor ratio and the need for more pre-departure training" (Melissa). On a macro level, several participants also recommended that importance of research funding agencies. It was thought that if research funding agencies do not value IEs, then there might be little interest for universities program to also value IEs,

> There's no money here! There's no money for study abroad. . . . It's hard for me to get promotion and tenure because I don't have the tri-council grants. Because, I'm not going to get it doing this, and I put my time into this! (Susan)

Susan's perception of research funding was distinct from some other participants who specifically sought out "research grants" (Melissa) for funding, or others who identified that research projects embedded in IEs showed "commitment to the community that you're with" (Janet).

Institutional value was also connected to resources. Lack of resources was demonstrated through lack of appropriate financing, little logistical support through policies, and minimal psychosocial support for faculty. Melissa summarized how she had advocated for resources noting, "my argument is, 'this is a program versus a course'. If you've got a program, there's a lot more that comes with it than just a clinical experience". As was describe in Theme One, participants felt compelled to prioritize preparing their IEs rather than themselves because of overall limited finances.

> You need to have some time to prepare. In our program, it was done off the corner of my desk. . . . If a school of nursing is running a program like this, they really have to set aside hours for that faculty to prepare, because it is a ton of work. (Hilary)

Resources should allow faculty to keep up with the dynamic nature of IEs and give "time to develop that course and remodel it when you come back, because there's always new things that happen" (Hilary). Logistical resources were also important and included having "policies in place" (Janet) for IEs. Melissa celebrated a recent safety policy at her institution where "now, we always have to have two instructors because it's not safe otherwise". Finally, institutional support also meant psychosocial support where faculty would otherwise need to "deal with exhaustion", "missing family", and "emotional and psychological support" (Hilary) on their own.

Aligning curricular commitment and host outcomes. Many participants identified how institutional approaches should be demonstrated through a curricular commitment to student learning outcomes and host outcomes. Participants were otherwise on their own to align outcomes and context. The suggestions for curricular commitment were two-fold. The first was to better integrate IE content in the curriculum such as "weav[ing] global health contexts through the whole program" (Sharon). Hilary suggested, "If you have a global health nursing course, it should be reflected in your curriculum". One participant celebrated a recent shift where global health learning outcomes were integrated into the curriculum:

> Students are not so judgmental as they were in the very early years because they have skills to be able to reflect about why things are the way they are; considering the power, the privilege, the cultural pieces that we weren't really talking about before. (Melissa)

The second suggestion for curricular commitment was in considering the overall purpose of the IE in connection with host outcomes. Josiah expressed concern with the lack of purpose

for his IE program noting, “we’ve just been sending students here for the past 10 years, and we don’t even know what the hell we’re doing!” Participants identified how the institution should have more involvement in aligning student and host outcomes from a “university” (Sharon) perspective to shift the responsibility from individual faculty. Curricular approaches should then consider “reciprocal arrangements” (Sharon) for student learning, the learning context, and host implications. An experienced participant, Janet recommended,

> You need to ask ‘why’? . . . What is it that you are going to get by taking students there as opposed to staying in Canada? . . . What is the nuance, what is the difference? . . .This ‘parachuting’ in a group of people to do something that makes no sense. Where is your commitment? It has to be that longevity. It has to be that long term commitment.

Janet further suggested that parachuting participants into host communities for student learning had potential negative impacts when host communities were left to “disassemble something that somebody else has tried to put together or tried to create”. The IE programs should be “beneficial for both sides” (Hilary) and programs should be cautions to reflect,

> Are we being a burden to this people? Are we actually bringing any benefit at all to this people group? What are the negatives? What are the positives? . . . Are we only going there as colonialists who just go to take the experience? (Hilary)

For both the institution and participants, seeking host input for outcomes required a formal and committed approach such as with a “memorandum of understanding with the ministry of health and the university” (Melissa) or a “memorandum of agreement” (Susan) with the local university. There was also some expressed concern about having the right partnerships with representatives in the host communities. For instance, Hilary expressed concern that her program partnered with “non-governmental organizations” but not “the local people working in

the hospital". Seeking host input also required long term institutional commitment. Melissa shared how over several years there was uncertainty if students needed to be registered to practice in the IE location. It wasn't until years later when "finally, one of our colleagues identified the actual process that we need to be doing . . . and I can't believe we never did that before. How dare we come in and not register our students!" (Melissa). She reflected the importance of institutional commitment,

> You can't just rely on the people; you need to build institutional links . . . because, at the end of the day, people are going to leave and if you haven't considered that, your program is at a huge risk on both ends. . . . All it takes is for somebody to come in and say, "you don't have anything formal, so this program doesn't really exist". . . . Sometimes you don't know what you don't know, or until you have trust. (Melissa)

Patience and humility were also important from a programmatic approach to seeking host input. With her partners, Melissa added how it took "10 years and we're finally there" to see a "high return for both parties". Janet, also an experienced participant, shared how it also took her "10 years" to feel she had appropriately considered the need of the host in her international work, reflecting how before she was doing "totally the wrong project" (Janet). Melissa added a positive recent shift in her IEs where student outcomes were better integrated with host outcomes because student based projects were "based on our partners' asks". She found that "our colleagues are seeing that we're listening to what their needs are" (Melissa) and reflected on arriving at positive reciprocal benefits:

> I've learned to be humble and to really take the lead from our colleagues. . . . They have reminded us that this should be a mutually collaborative partnership and it is challenging to continue to strive for that; it takes a lot of work on both ends. . . . Being with a

> Canadian institution comes with certain expectations, the legal ramifications, all sorts of things that we still need to abide by. It's about negotiating that and providing the best experiences for our Canadian students, but our [host] students as well. (Melissa)

Another institutional approach for preparing faculty to learn for-the-job was through careful faculty selection.

Selecting qualified faculty. Many participants suggested how intentional faculty selection for the teaching position would demonstrate value for the responsibilities of teaching in IEs. Many participants agreed, "faculty selection is really important" (Bonnie) since IEs are not "just like any other course that anybody can teach it" (Susan). Tim added,

> You're selling this global health experience and this incredible opportunity to learn global health. But if your instructor is a super-novice or didn't know global health before this because she just wanted a cool thing to put on her curriculum vitae, I don't think it works well. It's just a slap in the face to the students that pay their money to go on these trips (Tim)

Although there was a wide variation in recommendations for faculty selection, common factors included substantive global health knowledge, prior experience in an international setting, and clinically relevant expertise. Speaking from administrative experience of selecting and mentoring faculty for IEs, Bonnie emphasized a variety of qualifications she would expect for faculty new to the IE teaching position. She selected those with substantive knowledge of global health issues such as "social justice issues", "culture", and "safety" (Bonnie). Experience in the international setting was also desired, with the preference that faculty "have travelled in similar types of countries" (Bonnie). Additionally, Bonnie suggested, "faculty should have clinically relevant skills" including "international development and an interest in culture and cross-cultural

communication" which included being able to work as a guest in the country alongside local staff. Finally, faculty should be able to "pick up when a student is in culture shock, or if they're in it themselves, and make sure that they get the appropriate help" (Bonnie). Other participants aligned strongly with these recommendations.

Academic credentials were also suggested as a faculty qualification; this included recommendations for a minimum graduate level degree for supervising undergraduate students. These credentials suggested faculty would be "a little bit more experienced, in life, and nursing" (Sharon). Bonnie identified, "we mostly sent tenure-track faculty. . . our only exceptions have been PhD students who have got international experience". Even the three participants who began their IEs with undergraduate degrees–Tim, Josiah, and Melissa–agreed that faculty should have graduate level degrees. Tim identified, "I'd like someone that would be an academic-type person. Like, I'm a very clinician-based person; I was chosen on a whim, there was some form of risk involved with me being selected". All three participants went on to pursue a graduate degree shortly after their first IEs with students.

Finally, participants recommended availability as a required qualification. This was important because of the time and energy needed for the IE role.

> The 6-week length is a huge negative drawback, and it's very difficult for them to do that, to commit to it. For others who don't want to be kind of taken away from their life here, and who haven't travelled a lot before, that is a huge piece that they just don't want to take on. And they have heard about the amount of work that goes with it, too. (Melissa)

Several participants emphasized the challenge of staffing IEs because "trying to find instructors for these long term teaching assignments in foreign countries is really difficult" (Josiah). Although availability was an important qualification, participants questioned the tendency for

their institutions to emphasize availability over knowledge, experience, and skills. Melissa shared her program's strategy where "each year, it's kind of decided [sighs] who's available, who wants to go; and that's it. Our pool is small to draw from. It's kind of piecemeal, kind of putting together, like, 'who can go? who has the capacity?" In these circumstances, some programs made exceptions for qualified faculty for the sake of program sustainability. Janet's program directors sometimes "randomly" selected faculty who "needed this in their teaching workload so they had the space and so 'you go' and so it's kind of almost like a punishment! And some people don't like to come". Participants remained concerned with any selection approach that did not consider the need for qualified faculty to meet the responsibilities. While these institutional approaches were seen as a missing link to what otherwise depended on individual faculty, participants also remained committed to necessary individual roles in preparing for IEs.

Subtheme Two: Individual Approaches

The subtheme *individual approaches* identified participants' anticipation that faculty would still have individual responsibilities. Individual approaches were not suggested as being detached from institutional approaches but rather emphasized the personal faculty role. This was especially true because IE settings were different than the Canadian clinical settings where there are often "not others around to support and help" (Julie). Here participants also reflected their emerging clarity on faculty qualities for IEs, including valuing substantive knowledge, learning from experience, clarifying values and attitudes, and engaging relationally.

Valuing substantive knowledge. As participants prepared for their first IEs, several realized they were on their own to fill knowledge gaps about what and how to teach. After implementing their first IEs, participants discovered how important substantive knowledge was for maintaining safety and learning in the dynamic settings. This discovery led to participants

valuing substantive knowledge for future IEs including the importance of knowledge, where to obtain knowledge, and what kind of knowledge was seen as necessary to intentionally learn for-the-job.

Knowledge was important because it helped participants "be able to connect the dots" (Melissa) of elements within the IE. Josiah, a participant who had implemented one IE, identified how limited faculty knowledge had negative implications for student learning because, "if the instructor is struggling to understand, they are not in the position to be able to guide the students as effectively as they would like to, because they, themselves, are still learning". Sharon, a participant with expertise, agreed about the potential negative impact if faculty knowledge was not "authentic" or "up to date" especially since students "watch everything that you do . . . that is part of their learning" (Melissa). Limited knowledge also had potential negative implications for host outcomes because,

> if [faculty] are not prepared, it's serious implications for our partners . . . and there's huge ethical implications if they don't understand the context. If they're not listening to what our colleagues are directing . . . there are lots of dangers there. (Melissa)

Although most participants suggested the institutional responsibility to provide resources for faculty preparation, there was still a strong sense that faculty may still need to seek out knowledge sources independently. Melissa identified how pursuing knowledge helped her feel more prepared than she had felt after her first IEs stating,

> I do feel prepared *now*. What changed was just being forced to dive deeper and being able to explain those concepts; whereas before, I couldn't. I never really named those concepts in my mind until I read all of that literature and prepped for the global health course; and my experience in my master's gave me more foundational pieces. (Melissa)

Other recommendations for obtaining knowledge included seeking "content knowledge not from the Western lens but from the global lens . . . and sometimes you need to find those links in the [host] community" (Janet).

Participants identified various types of substantive knowledge important for preparation. Faculty should have "a depth and breadth of knowledge" (Hilary), including to "know where you're going to; know everything about that country" (Sharon). Tim, a novice, identified, "you have to add so much more to your own knowledge base, you see stuff you wouldn't see in Canada, different diseases or untreated diseases that would be treated here". Janet, an experienced participant, also suggested substantive knowledge such as having "one course in tropical medicine if we are working in these places and I often think that's a deficit in my knowledge". Bonnie informed faculty new to the IE teaching role about the knowledge needed for IEs telling them, "you need to know something about international development; you need to know how to stay healthy; you need to understand some of the things you're going to see commonly that are not common here".

Contextual knowledge related to culture was also seen as important. Some participants recommended "some really good knowledge on cultural competency, that cultural respect, or that cultural competence that allows you to be competent enough to talk about it without criticizing" (Janet). Josiah added how faculty's knowledge of culture contributed to students' learning "because their instructor is not tripping on the cultural customs themselves". Less emphasis, however, was on theoretical knowledge of global health concepts and critical global perspectives such as equity, social justice, and relationships of power. Some participants reported how a lack of knowledge challenged their facilitating difficult conversations with students about health inequities and ethical decisions. An example of this was Josiah's reflections on his first IE:

> Some of the conversations I have with the students can get pretty raw. We're in a foreign environment; we're out of our comfort zones . . . I just want to be better armed to have those global health conversations, those healthcare systems conversations . . . that theoretical knowledge.

Fewer participants identified knowledge of critical global perspectives although some emphasized the need for knowledge of "international development" (Bonnie), "partnership" (Julie), and "equity and social justice" (Melissa). In the interviews, three of the nine participants aligned faculty preparation with the critical global perspectives of equity and social justice. Bonnie recommended, "you have to be comfortable talking about equity, and difference of equity and equality . . . I'm not sure all our faculty have that when they go. . . . You need to have frameworks through which you can talk about poverty". Melissa also emphasized the importance of faculty knowledge about equity stating, "I think everybody needs to have a really solid understanding, especially as an instructor" (Melissa).

At the end of the interview, participants who had not naturally discussed these critical global perspectives were prompted with the question "Global health has equity as one of its core dimensions. How can faculty be prepared to teach this?" Participant responses varied. For instance, Josiah, a novice participant, responded with his perspective on human rights stating,

> We are not here to impose our beliefs, values, opinions on anyone. . . . What we would consider blatant disregard for human rights from our moral superiority of Canadian human rights is such a subjective thing . . . it's something I struggle with, because I'm not an expert on human rights.

Tim, another novice identified how the students had a course for a "global context class" but how he had otherwise learned "firsthand" about equity by being on-site. He added,

> I'm not going to be like, 'Okay, what are the social determinants of healthcare?'. . . I'm not a hundred percent trained. I wouldn't say I was a Global Health expert; I'm a novice still; I'm still learning . . . and that's why I feel like doing my Master's. (Tim)

An experienced participant identified her understanding of equity such that "the world sees equity as the lowest common denominator, and I don't" (Janet). For Janet, when it came to mentoring other faculty regarding equity, she encouraged them to not give money to "begging children" but instead give them water. Another experienced participant, Hilary, stated "I think maybe 'mutuality' might be a better team than 'equity' . . . it's more like sharing knowledge, not just sharing resources . . . it's more 'sameness'".

Although variation existed with participants understanding of critical global perspectives, a common thread was the understanding of the limitations of knowledge in the foreign context. One participant stated, "I'm not the expert about what's going to work" (Bonnie). This was poignant coming from Bonnie after her decades of prior international work experience and doctoral dissertation in international development. She emphasized,

> No matter how long I was there, I was always going to be an outsider. I might be an outsider who had close relationships, close friendships, with people there that I was working with, and I did, but I was never going to truly understand what was going on. (Bonnie)

Despite shifting the expectations of knowledge expertise, knowledge remained on the forefront as a missing piece of participants' first IEs and was therefore a key element in future approaches to preparation. Another individual approach to preparation was learning from experience.

Learning from experience. The most frequent recommendation for faculty preparation was having experience in the international clinical, and teaching setting. Experience was the

inextricably linked to the *Overarching Theme: Gaining Preparation Expertise Over Time*. Although experience was identified as insufficient on its own, experience gained over time was how most participants learned since, "having experience yourself is critical" (Julie). The "ideal" (Bonnie) experience was "having lived in" (Bonnie) similar international settings. Some participants, however, emphasized that not all overseas experience is beneficial such that "saying 'I went off the resort' . . . isn't the same as 'the government got taken over by a military coup' or doing a needs assessment and working with key stakeholders" (Tim). Julie emphasized challenges associated with not having similar related prior experience because, "well, the power may go out. You need to be prepared for giving your post clinical workshop or discussion without power. . . . until you're in that setting, it's kind of hard to realize" (Julie).

Participants embraced their own prior experience, along with experience gained over time, as having a positive impact on preparation. Experience was connected to "a transformation that occurs within people when they've lived in that environment" (Julie). Another expert participant agreed that "experience is the best teacher . . . it's no longer artificial*"* (Janet). Melissa reflected on how many experiences over time helped her understand global health concepts of equity stating, "I didn't really fully get it until I saw a lot more of those practical experiences firsthand". Bonnie also identified the positive impact of her decades of living and working in similar international contexts sharing, "I knew a lot about international development and colonialism, which not all faculty members do. I've done a lot of cross-cultural work, both in Canada and overseas, so I also knew I could do that". Participants recommended how experience in IEs enhanced understanding of how to fulfil the different responsibilities of IEs.

> Somebody who's never worked in a poor country . . . with different diseases and who doesn't think they need preparation shouldn't be going. Because they need to learn what they're going to have to be concerned about in terms of student safety. (Bonnie)

Several participants reiterated the benefit of prior experience in diverse or "multicultural" (Josiah) settings other than the international setting. This included prior work with "Indigenous populations and refugee and immigrant populations in Canada" (Bonnie). Bonnie suggested that faculty who work in these settings "without any real problems, can also work internationally without any real problems". Melissa shared a success story of working with a novice faculty who did not have prior experience in the international setting noting,

> I would have always said, 'I think [faculty] need to have some global health experiences', but that was proved wrong for me with the instructor who performed so beautifully in the field. What she had was experience in Aboriginal and Indigenous health. . . . Those concepts that she learned working in that field translated really well into the global health realm and concepts around social justice.

Additionally, most participants recommended relevant nursing experience in a related clinical context that supported the faculty's caregiver role in IEs. Tim reflected on the clinical experience he needed for working in an acute pediatric IE placement. He shared, "I asked the clinical instructor beforehand, 'What went wrong? When did it go wrong?' She goes, 'I had no idea what pediatrics was'". Broad clinical expertise was also recommended because of the varied nature of some IE contexts such that "if you've got a good clinical background in not just one place is helpful. . . . Students can be placed anywhere, and you need to have some knowledge or at least know where to get it" (Bonnie).

Prior teaching experience was also considered important. Programs should not send "a fresh new graduate nurse into some foreign environment to teach nursing students . . . unless you're really desperate" (Josiah). Faculty should have clinical teaching experience because "this is a clinical placement, why would you send somebody who just doesn't have clinical teaching experience?" (Bonnie). Although all participants embraced learning from experience, they continued to acknowledge how experience on its own was insufficient for preparing faculty. Other individual preparation included clarifying values and attitudes through self-reflection.

Clarifying values and attitudes. In the first theme, participants identified how interest for meeting perceived student and host needs contributed to being the right fit for the IE role. As participants discovered the responsibilities, they expanded on the values and attitudes needed to enact their roles. Bonnie suggested how values and attitudes contributed to embodying theoretical knowledge adding, "who [faculty] are as a person is probably more important than some of the things they know or don't know" (Bonnie). She explained,

> Having knowledge doesn't mean that you actually have the attitude . . . It's kind of coming from within you, not necessarily knowing about it. It's part of personality. Because you could know all of the stuff about social justice; unless you can actually live it, you're going to have problems. Bonnie

While there was a sense that values and attitudes could develop over time, several participants agreed that when preparing for IEs, "you have to have that attitude and that way of being, to start with" (Sharon). Melissa reflected on her experience of the attitudes of faculty orienting to the IE role:

> The most successful instructor that I've orientated was like me, had never travelled beyond North America. But her attitude was just to listen and learn. And she sought out

> lots of reading, asked lots of great questions, and just took direction. Once we were in the field, she just got it fast; she was just a natural. I don't know what that was? She just engaged a lot more naturally with our partners; they sensed that, they felt comfortable with her. . . . Another instructor did all the same prep, but when we were in the field, she was uncomfortable, she was worried, her ability to cope wasn't innately there.

Key values and attitudes included humility, commitment, adaptability, and self-awareness. Humility was described as having a "non-judgmental attitude" (Janet). This means that faculty should accept they are "not the expert, you are a guest" (Melissa). Julie added, "you've got to be able to accept the way that things work in that society, and not try to change them. You're there for 10 weeks; you're a guest". Bonnie emphasized how humility mitigated harm to the community,

> Somebody who's parachuted in there for 10 weeks and has never been there before, even shorter, really, you can do a lot more harm than good. . . .You don't go in and tell people everything they're doing is wrong. If you do that, you may never get back there. (Bonnie)

Melissa identified how over time, she "learned to be humble and to really take the lead from our colleagues". Janet also shared her growth in accepting host community practices she didn't agree with, such as the practice of infanticide,

> I used to tear up when I would talk with students about 'I know I'll never see that baby again'. Now I don't. Now I realize this is their way, this is there people, and yes, I would love them to change and we have given them opportunities . . . [Pause] nobody has ever done it, the baby still disappears, but it is not our world. . . . I think that's been a change in me in those 5 years.

The opposite of humility was an attitude of “arrogance” (Bonnie) and “overconfidence” (Bonnie). When Bonnie interviewed faculty for the IE position, she identified,

> Anybody who wanted to save the world, we rejected. . . . anybody who felt they could do anything, and thought they didn't need any help, we rejected. . . because those are the people who couldn't cope when they got there and realized the world isn't the way they think it is.

Commitment was also an important value and attribute for participants. Although an earlier subtheme identified institutional commitment as an important approach to faculty preparation, an individual commitment included having “continuity” (Tim) versus “sending a new faculty advisor over every single semester” (Tim) when faculty only wanted to do the IE once. Instead, faculty should “prove as to why they really want to do it” (Susan). Some participants also identified that faculty need commitment to people as situated in authentic nursing practice, “there has to be a genuineness of beliefs about people, no matter who they are or where they are. I’ve done lots of stuff about cross-cultural nursing. Everything that comes out is basically good nursing care for anybody” (Bonnie). Bonnie added how in a “totally different” context it could be harmful to the host community if faculty rely on “professional façade . . . and if in some subtle way if you don’t believe that the people you’re working with are equal” (Bonnie). In addition, Bonnie suggested how commitment was also expressed as an attitude of social justice which she suggested was more important than knowledge of social justice. She stated, “there has to be a social justice orientation. Without that, experience doesn't help . . . having knowledge doesn't mean that you actually have the attitude” (Bonnie).

A third recommendation was adaptability. Although all participants identified “being organized” (Julie) as important, the nature of IEs was not seen as being predictable and therefore

required flexibility to “think on your feet” (Bonnie). Many participants agreed with Bonnies suggestion that “you don’t want somebody with rigid boundaries overseas with a group of students, you’ve got to send somebody who’s flexible” because “you can’t prepare everyone for everything”.

Finally, humility, commitment, and adaptability were best accompanied with clarifying one’s own values and attitudes through “a high level of self-awareness” (Bonnie). This was connected to preparation because “a faculty member that’s prepared is someone that first has a real self-assessment done to know where their strengths and their challenges are” (Bonnie). Sharon identified how self-awareness might illuminate if faculty should accept the IE role:

> If you're a neat freak, don’t come to Africa. Because I go sometimes three days with no running water. It’s not that I want to. I just have no choice. Or, if you're a time freak, don’t work where I work, 'cause people will be 3-hours late!

Josiah, a novice, suggested faculty should reflect on “themselves, their values, their morals, their ethics, their beliefs . . . you really have to know yourself”. For Janet, self-awareness also meant having control over her emotions in challenging situations “until there’s the right moment to debrief” because “you need to have a faculty member who can cope because you may have students who can’t”. Self-awareness could also ensure that faculty seek preparation, because “somebody who doesn't think they need preparation shouldn’t be going” (Bonnie). Finally, self-awareness meant clarifying one’s values about people because “you cannot send a racist, even a hidden racist”. In summary of *clarifying values and attitudes,* participants suggested that individual faculty should embrace humility, commitment, adaptability, and self-awareness. Together, these values and attitudes contributed to participants ability to engage relationally in their IE roles.

Engaging relationally. Individual approaches of valuing substantive knowledge, learning from experience, and clarifying values and attitudes supported faculty to be able to engage relationally with others. In this subtheme, participants recommending essential skills for *engaging relationally* that built on prior themes in which the importance of relationships was emphasized. This included relationships outside, and inside, of the IE team as well as relational skills with students, patients, and host communities.

In general, participants recommended that the same established relationships which supported their first IEs would be considered for future IEs. For instance, Bonnie described a situation where a student became very sick requiring intensive care admission and evacuation out of the country. Bonnie identified "that's the biggest learning thing I had is, you need to have some alliances, so that in an emergency, you actually connect effectively". Relationships within the host community were also reinforced as being important. Melissa, an experienced participant stated, "you need to have people in the field, your partners in the field, who are going to tell you if they think situations are unsafe. Because you actually don't know; you need to trust your partner[s]". Host partners also contributed to student learning because they helped to determine "good clinical placements" (Bonnie) and they helped with "orienting student" (Janet). Hosts also "give us insights and work with us, so that we're doing the right thing at the right time, with the right place and people" (Janet). After their first IEs participants discovered the added emphasis on team relationships. This included relationships with students because participants learned how they needed to "team build" (Sharon) and manage interpersonal challenges. Additionally, participants involved in team teaching emphasized the importance of having "good working relationship with the instructors that are going together" (Melissa).

Relational skills were necessary to establish these important connections. Bonnie identified, “I would be very worried about sending a faculty member who does not have good interpersonal relationships with almost everybody”. She added how faculty should be able to relate with everyone involved in the IE including “people from the village, people at the university, and the students” (Bonnie). Relational skills included “communicating across cultures” (Janet) which was supported by the attitude and value of humility. Relational skills also enhanced commitment because “over time, [the community] began to know us and trust us” (Sharon). Susan expanded on the notion of trust as she identified “you’ve gotta' have people that you trust in another country to build that strong relationship”. Commitment and trust were so important to Melissa that even though she had several years of IEs with students in one location in Africa, she questioned if she could be re-located stating, “Could I go? I guess I could go, but I’m not really the most appropriate fit because I haven't been there in 11 years, and I don’t know any of the partners anymore” (Melissa). Not having relational skills, or established relationships within the community, was seen as a potential for increasing “the burden that may put on our partners” (Melissa). Melissa added,

> It’s really important that you have a good working relationship if you are going to be six weeks in the field in an environment that can be very challenging at times. It’s not just about sending anybody; it’s about sending somebody who’s appropriate (Melissa).

The relational skills of faculty were also discovered to be a means to an end of learning because of the responsibility of being a role model such that, “you’ve got to model egalitarian-type of relationships to the students, there’s a whole modelling of how you relate to people who are different” (Bonnie).

In summary, subtheme two emphasized participants' recommended individual responsibilities for intentional preparation through valuing substantive knowledge, learning from experience, clarifying values and attitudes, and engaging relationally. Unlike their first IEs where preparing was largely, if not entirely, a responsibility of individual faculty, this renewed recommendation for the individual approach was considered in light of enhanced institutional support, which builds to a cumulative integrated approach.

Subtheme Three: Integrated Approaches

The last subtheme, *integrated approaches,* highlights participant recommendations for practical ways the institution and the individual could, together, approach faculty preparation. Julie emphasized this integration noting, "part of the preparation is formal . . . part of it is self-preparation". For participants, these recommendations resulted from what worked well, and what was missing in their initial preparation approaches. With the institution providing resource support, and the individual enacting the preparation, the recommendations for integrated approaches included formal education, on-site orientation, and collaborative teaching.

Formal education. Most faculty recommended having more deliberate, or formalized, "pre-departure or pre deployment training" (Sharon). In this way, formal education was anticipated to set a foundation of knowledge for faculty. Some participants celebrated recent integration of formalized pre-departure training in their programs. For instance, Sharon initiated preparatory training for the whole university after she experienced a safety event in which she evacuated students from the middle of a military coup stating,

> We started to do a pre deployment or a pre-departure thing for faculty. We teach faculty how to do the risk assessment; we help them with the risk assessment; our legal

> department is helping with all the agreements that have to be in there; our study abroad groups are helping us. So, we have a lot of support now for the faculty.

For Sharon, the pre-departure training included "a checklist" and "contact list" and setting up a designated "liaison person they could call 24 hours a day". She also created networking opportunities for faculty to share their challenging experiences and "how they overcame them" (Sharon). Other faculty also recommended "checklists" (Melissa) when training new faculty how to prepare. Julie recalled recent positive changes in her program to formalize pre-departure training for faculty, stating "the last group of students I took there was someone from the health and safety office . . . they came and talked about risks and contacting the embassy and travelling in international settings, from a safety perspective".

At the very least, participants suggested how faculty should have the same training as students. Julie, who had worked in IEs for over 20 years, asserted, "we expect our students to go through a pre-departure preparation; I think that would be ideal if something was organized or available for faculty". For Melissa, her program had recently integrated a mandatory "global health course" and "advanced global health course" for students prior to the IE. To get faculty on the same page, she recommended "all of the faculty that would go should be reviewing the global health course that we're teaching our students; it should be mandatory that they're doing all the readings, basically taking the course" (Melissa). Faculty education was important because,

> The global health practicum itself is how you tease out everything they've learned in the classroom in practice. We all need to be on the same page in knowing what's being taught, because it's our responsibility as the clinical instructors in the field to be pulling all of this out from the students and saying, 'remember, you learned that in global health, now we're seeing it in real life'. (Melissa)

Education to prepare faculty should also include preparation for the conditions of the IE setting.

> Faculty need to have an orientation on how to live in the tropics. . . . Where are you going to live? Where are you going to shop? How are you going to get around? All of that stuff. I had to learn, and it was helpful to know it before I had students going with me. (Bonnie)

Some participants also encouraged formal education outside of the sending institution through other means such as a "global health coalition" (Melissa), other "good courses on global health content" (Julie), or global health "graduate training" (Josiah). This formal education was thought to better prepare faculty for IEs.

On-site orientation. On-site orientation was one of the most idealized recommendations for faculty preparation although very few participants had this luxury due to the extra financial burden. Having an opportunity to experience the host country was ideal because "nothing is going to prepare you until you go yourself" (Susan). Orientation was thought to allow faculty to gain preparation expertise without the potential negative implications of having students there. Tim, a novice, identified how having been to the site prior to taking students was a benefit,

> It would be very difficult if you weren't prepared for what you're going to see, or if you don't know what you're about to walk into. The first time I went [there] was more just a prep to get me involved and to really understand the context.

Sharon connected on-site orientation to her training in the military and said, "we went and did the actual reconnaissance on the ground there". Her site visits were important to "meet all the people . . . build those relationships and find appropriate lodging. . . . I had to make sure I found a place where it was safe for students . . . I had to walk the ground". Melissa echoed the benefit of an on-site orientation for student safety and student learning asserting,

> In advance to bringing students you would have to go and do a visit first to establish some relationships and understand what their context is, 'What is the reality of having students? What would a practicum even look like in their mind? Is it even feasible? Where would they stay?' All of the logistics need to be fleshed out prior to even thinking about bringing students.

She added how an onsite orientation would help faculty to ensure that day-to-day needs could be met–such as sleep, and nutrition–because, "if you go to a site and you don't have that, that will set the students up for failure" (Melissa). On-site orientation was seen as important to mitigate the error of the trial-and-error. Yet for many, the approach was also out of reach because of the extraordinary financial cost. Another beneficial, yet costly preparation approach was collaborative teaching.

Collaborative teaching. The final recommendation for preparing faculty new to IEs was a collaborative teaching approach through mentorship and team teaching. Mentorship was suggested as an ideal for those new to the IE teaching position. Novice and expert participants alike identified the benefits of mentorship because "it's easier for [faculty] to see how it's done, as opposed to telling them how it's done" (Sharon). Tim, a novice, identified how having a mentor helped him because "she is my rock while I am there". Mentorship was also described as "partnering with faculty as they develop their own path in there, they find their own contacts, and they work with their own people" (Janet). Sharon identified how "ideally" a mentor would be "on the ground" with the new faculty to help when "everything changes" because of the innate variability in the IE context. She added,

> If you can, arrange for a new global teacher to go with another one to mentor them. Like, say, 'come with me, and see what I do… come with me so that I can introduce you to the people; you can see how this happens'. (Sharon)

An inherent benefit of mentorship was having a built in co-instructor, and a natural succession plan for the IE program. Melissa noted how, as co-instructors, she and her mentor shared strengths in different areas and "it worked quite well because [she] had the experience and expertise of taking already students abroad. She had been working for 20 years as an instructor; and then, I had more of the kind of experience in the field". Melissa also identified how mentorship contributed to a succession plan because "I was ready to take the lead once she retired. Since then, I have had 30 new instructors that have come through, that I've orientated".

There were, however, financial barriers to a mentorship approach because, "the challenge has always been money in sending two people" (Julie). Despite this, faculty recommended mentorship should be an option for faculty new to IEs because "that's the best way" (Sharon). Janet suggested mentorship should not be a "luxury". Those that recommended mentorship also suggested that finding a mentor might be a challenge because "you gotta work with people that you can work with" (Susan). For the two participants who had mentors, it had happened "informally" (Tim, Melissa) and their mentors were their former nursing professors. Melissa also sought out external mentors from a "global health coalition".

The collaborative teaching approach also included team-teaching. Team teaching was described somewhat differently than mentorship and included logistical and curricular support where there was equal sharing of expertise with more than one instructor on-site. Janet shared how a co-instructor helped with her knowledge gap in one area:

> I am a community nurse, and I've been a nurse administrator, I've run a hospital, I was the vice president of a health region, I've had the experience, but I really don't have the claim to fame at the bedside . . . so, when it's something very clinical often the university will send a different instructor to help.

Team teaching was closely linked with student safety because "having two instructors is really very important; if one person gets sick or one person is just totally exhausted, the other person can step in and just take a bit more of the load" (Hilary). Sharon agreed and suggested a team approach to reduce the burden of the 24/7 responsibility stating, "I was very physically tired all the time. Having a second instructor would have been really nice". Team teaching had similar financial challenges to the mentorship model. Further, Hilary shared how one experience of team teaching did not go so well from a relational perspective and emphasized how the faculty need to "fit" together and be "going in the same direction" (Hilary). Where an on-site team approach was not possible, participants such as Sharon recommended "just having a team of people [in Canada] can help you navigate challenges" (Sharon) .

In summary, Theme Three, *Preparing Differently: Learning For-the-Job,* highlighted an adapted approach to preparation after discovering the different roles and responsibilities for IEs. Participants viewed their discovery as an opportunity to intentionally prepare for their next IE and move beyond a trial-and-error approach. They suggested how intentional learning for-the-job promoted safe and substantial learning experiences. By exhausting what was known about preparation, participants were better supported to adapt to the unknown. This theme also represented participants' recommendations that faculty preparing for IEs would not rely on trial-and-error in the future. *Institutional approaches* were identified as a key missing link to faculty preparation. This, however, did not negate the need for participants to embrace *individual*

approaches. Theme Three concluded with participants' recommendations for practical *integrated approaches*. Preparation did not stop after participants' first discovery of the different needs of IEs, but rather, there was a cycle of preparation that continued after learning for-the-job where participants were consistently preparing, discovering, and preparing differently.

Chapter Summary

The purpose of this study was to explore nursing faculty preparation for accompanying nursing students on IEs. This chapter presented the study's thematic findings by both novice and experienced participants. The key findings were that faculty preparation was seen as an emergent experience. Each new IE contributed learning to how participants could better prepare for the next IE. In this sense, the expectation of preparation was not perfection, but ongoing development and discovery.

Most participants identified feeling unprepared for their first IEs. Instead, faculty learned how to prepare by learning on-the-job. This key finding emphasized how experience was emphasized over formal preparation. The few participants who felt prepared prior to their first IEs attributed this to decades of living and working in similar international settings. Although few felt prepared, most participants pioneered their IE or were otherwise informally selected for the IE position. They drew from serendipitous qualifications such as prior experience, established relationships, and interest in meeting a perceived need. These qualifications helped participants secure the teaching position and also contributed to feeling prepared.

Overall, participants identified a sense that they were on their own because of little financial and resource support received from the institution. Participants directed these limited resources to preparing the logistics and students for the IE. For most participants, preparing was work off the side of the desk that was motivated by their passion for student learning and host

outcomes. Although for some participants preparing the experience enhanced their own sense of preparedness, many facilitated their first IEs without feeling prepared.

The lack of institutional resources, along with the lack of formal training, resulted in participants relying on trial-and-error and learning through experience. Preparation was complicated because most faculty had limited substantive knowledge on what to teach, or how to teach, in IEs. This meant that several participants had to experiment with their learning in the moment and many participants felt uncomfortable admitting they had learned how to prepare through trial-and-error. During their IEs, participants discovered why learning on-the-job was perhaps insufficient to meet the roles and responsibilities required for the unique setting. They reported a heightened around-the-clock responsibility for safety and learning in the foreign environment. Preparation was further complicated by participants being on their own to meet these responsibilities. Several participants felt novice to the complex, and blurred, educator and caregiver roles needed for the IE teaching position.

Participants' discovery of the crucial responsibility for safety and learning motivated them to reflect on how better to prepare for the next experience in a cycle of preparing, discovery, and preparing better. They shifted their approach to preparation from serendipitously learning on-the-job, to intentionally learning for-the-job. While a key approach with intentional preparation was still with the individual participants to seek out resources and training, participants, however, highlighted the missing link of institutional approaches for faculty preparation. Institutional approaches including investing in IEs, aligning IEs curriculum with the nursing program, and selecting qualified faculty. Along with a recommendation that institutions better approach faculty preparation, participants also re-enforced individual approaches to preparation through valuing substantive knowledge, learning from experience, clarifying their

values and attitudes, and have the skills to engage relationally. Institutions and individuals should have intentional integrated approaches to practically prepare faculty such as through formal education, on-site orientation, and collaborative teaching.

In following the emerging experience of preparation, participants acknowledged that preparation requires an intentional approach to ready faculty for safe and robust IEs. Intentional approaches enhanced participant preparation for the reality that there was always more to learn in this dynamic and complex teaching setting. The next chapter will situate the findings of the data into what is known of the literature through a discussion.

Chapter Five: Discussion

Informed by interpretive description methods, Chapter Five moves beyond description by interpreting the findings as they are situated in the little that known about faculty preparation for IEs. This chapter is organized into sections using the findings' main themes of *learning on-the-job, discovering the different responsibilities,* and *learning for-the-job.* The *Overarching Theme: Gaining Preparation Expertise Over Time* is also integrated through sections of this chapter. This organization maintains the narrative of the findings which highlight preparation as an emergent experience. Within this chapter, new interpreted concepts from thematic analysis provide deeper insight into what is really going on for faculty preparation for IEs.

These new interpreted concepts feature a key finding of this study where experience was emphasized over formal preparation and lack of formal preparation negatively impacted faculty knowledge. Perpetuating the lack of knowledge was the overall lack of institutional resources for preparation, which has potentially negative implications for IEs. This discussion considers preparation to be a dynamic and complex endeavor and also further establishes faculty as learners for IEs. Notably, faculty preparation for accompanying students on IEs is not well acknowledged in evidence-based literature as was presented in Chapter Two. For this discussion, however, key findings will be compared with literature from Chapter Two, literature from other disciplines, and other anecdotal and evidence-based literature relevant to this phenomenon.

Learning On-the-Job

In the first theme, *Learning On-the-Job,* participants highlighted how, without formal guidance, they were left on their own to determine what was needed for their preparation. The primary discourse of preparation was centered on learning on-the-job through trial-and-error. In this way, coincidental learning from experience was emphasized over formal preparation. The

emphasis on experience, however, was complicated by the lack of substantive knowledge of global health and critical global perspectives.

Untangling "International Experience Preparation" and "Faculty Preparation"

Data analysis emphasized how IE preparation (students and logistics) was at times conflated as faculty preparation (personal and professional). In general, the emphasis from both Chapter Two and study participants, was the prioritization of experience preparation over faculty preparation. This emphasis suggests an assumption that preparing the IE results in a prepared faculty. Yet, this assumption was challenged by the findings that many participants felt unprepared even though they planned the IE. The assumption was also challenged by participants' wide variation, and sometimes lack, of knowledge. There does not yet exist a standardized framework for creating, or implementing, IE curriculum (Liu, Zhang, Liu & Wang, 2015). This suggests that faculty preparing IEs may need additional support to interpret and apply the wide variation of knowledge related to IEs (C. A. Browne & Fetherston, 2018). An intentional approach to preparation detangles these assumptions while also acknowledging that preparing the IE is part of learning. Learning through experience is further explored in the next section.

Emphasizing Experiential Learning from the Novice to the Expert

The findings' overarching theme reported how participants came to understand how to prepare primarily through experiencing IEs. Some participants also expressed how extensive prior experience in a similar international setting supported them to feel prepared. Most faculty, however, felt unprepared despite prior international activities such as work, volunteer, travel, military, or research. The primary discourse of preparation within these findings was centered on

learning on-the-job through trial-and-error. In this way, experience was emphasized over formal preparation.

Although there is little evidence-based data on faculty preparation for IEs, one doctoral dissertation was discovered to directly support these findings. Burleson's (2015) qualitative description studied nurse educators' experiences of international missions with students. Burleson found that nurse educators discovered how to improve future international missions by learning through experience such that "these experiences were instructive and informed their subsequent international missions course objectives, policies, and student behavioral standards" (Burleson, 2015, p. 101). Experiencing the international mission was celebrated as a significant factor in enhancing nurse educators' knowledge of global health and disparities and strengthening their ability to teach from a "globally diverse perspective" (Burleson, 2015, p. 97).

Faculty reliance for learning on-the-job for IE preparedness was also found in literature from other disciplines. Goode (2008) used mixed methods to study "faculty directors" (p. 149) from a liberal arts university who accompanied students on study abroad experiences. Similar to the participants in my thesis, Goode (2008) found that although faculty directors identified the most helpful learning for future study abroad came from their first time in that role because "there's nothing like being a director to learn about being a director" (p. 159).

Participants' reliance on learning through experience has close links with Kolb's (1984) experiential learning theory and Benner's (1982) novice to expert theory. Kolb's (1984) experiential learning theory is largely recognized as a pedagogical approach in nursing education through situated learning such as clinical practice. Experiential learning is "the process whereby knowledge is created through the transformation of experience, [and] knowledge results from the combination of grasping and transforming experience" (Kolb, 1984, p. 41). The context and

process of learning are considered to be inseparable and learning that occurs through experience is expected. Experiential learning theory has also been connected to how educators learn how to teach. This has relevance to participants new to the educator role on their first IEs. Oleson and Hora (2014) related experiential learning theory to their findings about interdisciplinary faculty gaining teaching expertise such that "one of the most important factors shaping teacher knowledge and growth is on-the-job training . . . and experimenting" (p. 31)

Experiential learning theory is also closely connected with Benner's (1982) novice to expert theory which suggests experience "is the refinement of preconceived notions and theory by encountering many actual practical situations" (p. 407). The novice to expert trajectory highlights how through experience, nurses are better able to adapt to new situations as they become experts who gain "deep understanding of the situation" (Benner 1982, p. 405). This aligns with study participants who reported how experience helped them better prepare for the unknown. The novice to expert theory might also further explain why participants might accept experiential learning in the IE because of its links to professional nursing values. Burleson (2015) also aligned study findings with the novice to expert theory such that participants had to experience the international mission to gain expertise.

In this study, participants being novice or experienced in various domains of the IE role was an important finding because it positioned them in light of their clinical practice, teaching, and international travel experience. Experience in each of these domains was seen as important for enhancing preparation. What seems to be a unique finding of this study was the consideration that prior experience with Indigenous and refugee communities might also be beneficial for the IE teaching role. This is supported by emerging evidence that connects contextual learning in local settings to global health work (Simpson, et al., 2015). In this study, however, it was the

combination of international experience, teaching experience, clinical experience, and substantive knowledge that contributed to faculty who felt prepared for their first IEs. For instance, only two participants identified feeling prepared for their first IEs with students and both of these participants had extensive similar prior international work experience, long term prior teaching experience, relevant related clinical experience, and a strong knowledge of critical global health concepts. All other participants, regardless of prior expertise in any domain, reported a sense of feeling novice for their first IEs with students with an emphasis on their lack of knowledge. A detail that was missing in the findings was participant disclosure of which domain this novice feeling emerged from: clinical, teaching, or international travel. For instance, participants who had little or no prior teaching experience before their first IEs with students and may have felt a double burden of being a beginning teacher and a novice in IEs. This raises a question about the preparation needs for being novice to the IE teaching role specifically and about the ongoing preparation needs for the novice-to-expert continuum.

Regardless of how participants entered their first IEs, the reported sense of feeling *novice* is a significant finding because of how knowledge is transferred from contexts of familiarity to contexts of unfamiliarity. Where this is supported in the literature is the role transition of nursing faculty who move from being a clinical expert to a novice educator (J. K. Anderson, 2009; Schoening, 2013). J. K. Anderson (2009), studied clinical nurses' transition to the nurse educator role and found that clinical expertise did not adequately prepare nurses for teaching. Additional findings included how faculty were required to re-enter the novice to expert cycle when entering a new practice context. It was mainly from learning through experience where new faculty advanced expertise in their new setting, allowing them to eventually adapt to the unknown (J. K. Anderson, 2009). Schoening's (2013) grounded theory study also found that new nurse educators

were challenged with a role transition from expert clinicians to novice educators and relied on learning through experience to re-gain their expert position. The role transition from an expert nurse clinician, to an expert nurse educator, takes years of time and requires numerous supports to be put in place (J. K. Anderson, 2009; Booth, Emerson, Hackney & Souter, 2016). This reinforces how participants in my study gained preparation expertise over time for a new role in a new context. The roles of faculty accompanying students on IEs are discussed later in this chapter.

A focus on the term *expert* was also important as Benner's (1982) theory suggests that the end goal of learning is becoming an expert nurse. This goal of becoming an expert was not substantiated by participants' reports. Instead, some participants acknowledged that in a foreign context, there would always be a chasm of the unknown that no amount of preparation would complete. Preparation instead required an ongoing attitude of learning, and of deference to the host for their expertise. This is further addressed later in the chapter with a discussion on host perspectives and humility. In general, participants embraced experiential learning as an approach to learning how to prepare for the IE teaching role. This is perhaps not surprising because of how experiential learning is an anticipated learning strategy in the nursing profession. A finding that was not found to be substantiated in the literature, however, was several participants' expressed discomfort in relying on learning from experience through trial-and-error. Although the absence of literature related to faculty preparation for IEs does not provide a direct comparison, some understanding may be further gained from Benner's (1982) theory.

Many participants upheld the professional nursing value of adapting to the unknown that is supported by Benner's (1982) novice to expert theory. In their first IEs with students, several participants identified being a novice to this role yet were still faced with the responsibility of

being adaptable within the dynamic setting. In Benner's (1982) theory, novices, however, tend to lack the expertise and knowledge to adapt to the unknown. This perhaps explains why when participants were expected to adapt to the unfamiliar setting, yet did not have the expertise to do so, they felt a sense of discomfort when needing to act without being prepared to do so. In comparison to my thesis findings, Oermann, De Gagne and Phillips (2018) suggested a cautious approach for those new to the nursing faculty role explaining how learning "on-the-job" (p. 1) is unfair to educators, students, and the program. Although there is little denial that learning occurs through experience, learning on-the-job is suggested as being "no longer effective" (Oermann et al., 2018, p. 11) when training nurse educators because of the extensive knowledge, skills, and attitudes needed for this specialized role. Similarly, participants in my study also questioned the sufficiency of learning on-the-job through trial-and-error for this new complex teaching role. This sense of insufficiency is further supported by Benner (1982) who summarizes how "experience, in addition to formal education preparation, is required to develop competency" (p. 406). Participants' identification of the insufficiency of experience was based on lack of substantive focus on knowledge of global health and critical global perspectives.

Attending to the Global Health Knowledge Gap

For several participants, reliance on trial-and-error was perpetuated by a knowledge gap of what to teach and how to teach in the IE. Outside of learning from experience, most participants were on their own to seek resources to fill these knowledge gaps because faculty preparation was not formalized. A lack of knowledge complicated many participants' ability to fulfil their role in accompanying students on IEs. The NLN (2011) encouraged faculty to seek both knowledge and experience such that "a lived experience or immersion in the culture along with book knowledge increases the likelihood of avoiding cultural missteps" (p. 10). Faculty's

theoretical knowledge for IEs has also been encouraged in discussion papers orientated towards critical global perspectives of health (Chavez et al, 2008; Mill, Astle et al., 2005).

Several participants attributed their lack of global health knowledge to a lack of training in their own undergraduate nursing education. This has a strong connection to the history of global health in nursing curricula discussed in Chapter One. Although many schools have integrated international education such as IEs through the past few decades (Ogilvie et al., 2007), only recently have accrediting bodies for nursing programs mandated the integration of these concepts in nursing curriculum. In Canada, the nationally accrediting CASN (2015) recently mandated the integration of "global health issues" (p. 11) in nursing curriculum. Provincial regulatory bodies also have seen recent attention to "global health issues" (British Columbia College of Nursing Professionals [BCCNP], 2013, p. 10) as nursing practice entrance requirement. Following this historical timeline, it is understandable that Canadian nurses graduating before 2015 would likely not have received any formal education related to global health. The historic absence of formal global health knowledge in nursing curriculum might explain why several participants felt that they were learning alongside their students. In Canada, with CASN's (2018a) current 101 accredited nursing programs, representing 50 universities, it is possible that integration of global health knowledge as common nursing knowledge may take some time; the knowledge gap for faculty needs more immediate attention. The need for global health knowledge is also supported through Farber's (2019) recent descriptive study that found faculty were not confident about their transcultural knowledge and "many lacked the cultural diverse experiences or formal training or educational activities that promote cultural competence learning outcomes for students" (p. 82). In this way, it is perhaps not surprising that faculty implementing IEs reported a knowledge gap, unless knowledge was otherwise available to them.

My thesis is not purposed to provide a comprehensive list of the knowledge required for preparing faculty for IEs; however, three elements of knowledge reported by the participants are discussed here. The first knowledge element is related to what Andreotti (2006) might refer to as "critical" global perspectives, which only a few participants reflected as being imperative to faculty preparation. For this study, critical global perspectives are considered through postcolonial approaches to IEs that highlight social justice, relationships of power, and "responsibility towards the other" (Andreotti, 2006, p. 43), while emphasizing the nursing concern of global health equity and global citizenship (Mill, Astle et al., 2005; Mill et al., 2010). Knowledge of this "critical pedagogy" (Caldwell & Purtzer, 2015, p. 578) promotes participant learning and reflection reflect on relationships and actions of power in local, national, and global spheres.

What stood out from the findings was the variation in knowledge of critical global perspectives reported by participants. During the interviews, most participants did not initially report if preparation aligned with critical global perspectives. At the end of the interview, I prompted them with the question of how global health equity relates to faculty preparation. For those who were prompted, there was wide variation of their knowledge of global health equity with several connecting equity to *equality* and *helping people* in the host communities. Few participants related equity to social justice, power, privilege, and unfair advantage, as is understood elsewhere in the nursing profession (CNA, 2009). Participants also reported their most difficult interactions in IEs involved issues of poverty, ethics, human rights, and socioeconomic disparities. A similar finding related to knowledge of critical perspectives was suggested by A. J. Browne et al. (2009) who described lessons learned through exploring clinical nurses' knowledge translation of the concept of "cultural safety" (p. 167). Authors acknowledged

assumptions that nurses have mutual understanding of concepts of cultural safety, equity, and social justice when nursing actions might reflect otherwise (A. J. Browne et al., 2009). This was similar to a finding by Miller-Young et al. (2015) who explored preparation for the concept of "reciprocity" (p. 40) in international service learning by expert nurses and discovered that they perhaps did not have a comprehensive understanding of the concept as it translated to IEs. In a discussion paper, Crabtree (2013) suggested that faculty accompanying students on IEs "may not have deep academic preparation in comparative development theory and ideology, cross-cultural communication and psychology, transformational learning theories, and other relevant fields" (p. 60). Similar to what was found in this study, lack of academic preparation for global health concepts has been suggested to contribute to inconsistent faculty knowledge, which in turn impacts their ability to facilitate IEs (Crabtree, 2013). This literature, along with the variant knowledge expressed by participants, challenges the assumption that those who prepare IEs would consequentially understand concepts related to IEs. This further suggests that more work may need to be done to enhance faculty's global health knowledge.

Besides critical global perspectives, a second emphasized finding of knowledge relevant for IEs is connected to global health competency. Several participants recommended how faculty should be competent to undertake the responsibilities inherent to IEs. Riner (2011) proposed an academic framework for globally engaged nursing education that adopts a shift from cultural competence to global competence. The author suggested that global education should address knowledge, attitudes, and skills about cultural differences in conjunction with "cultural, social, political, and economic systems that shape individuals lives on a global scale, the complex interactions among people, the moral and ethical obligations people have to one another, and who these influence health and health care" (Riner, 2011, p. 312). In the interdisciplinary world

of global health, there has also been a movement towards global health competence by the CUGH that emphasizes "a shared knowledge base" (Jogerst et al., 2015, p. 241) for those working in global health. This includes knowledge in relationship to the eleven domains of global health: (a) global burden of disease, (b) globalization of health and health care, (c) social and environmental determinants of health, (d) capacity strengthening, (e) collaboration, partnering, and communication, (f) ethics, (g) professional practice, (h) health equity and social justice, (i) program management, (j) sociocultural and political awareness, and (k) strategic analysis (CUGH, 2018; Jogerst et al., 2015). A toolkit was also created to help prepare global health educators related to the competencies (CUGH, 2018). In this way, the competencies support global health knowledge for IEs. The development of global health competencies is recent, and the lack of mention of them by the participants points to an opportunity for knowledge mobilization.

A final emphasized finding for knowledge is connected to host input and perspectives. This is relevant for the participants who sought knowledge from the host communities, including seeking input on safety and learning in the IEs. Cherniak et al.'s (2017) landmark study on host perspectives of IEs found that host partners expected visiting trainees to have knowledge and "an understanding of the influence of culture on patients and health care" (p. 365) versus other competencies such as language skills. From hosts in LMIC, 100% of respondents identified that visiting trainees should have "understanding the realities of working and living in a low resource setting" (Cherniak et al., 2017, p. 365). This type of understanding described by Cherniak et al. (2017) was seen in only a few of my participants who identified the need for faculty to have knowledge of working in impoverished areas, and critical perspectives which would emulate

understanding of the influence of culture on health. Overall, the lack of knowledge for participants in their first IEs was concerning when facing the complexities of IEs.

Discovering the Different Responsibilities

After their first IEs with students, participants identified a deeper understanding of their responsibility to safety and learning. They felt challenged to consider how previous approaches to preparation may have been insufficient. The discussion for Theme Two, *Discovering the Different Responsibilities,* interprets how participants' realization of the implications and purpose of IEs informed their future preparation.

Avoiding the "Error" in Trial-and-Error

Participants learned firsthand about the need to avoid unplanned negative outcomes for IEs. This is not to say they reported making mistakes, but rather, they discovered the potential for error that added a substantial weight of responsibility to the teaching role. This was expressed as being a higher level of responsibility than in the Canadian clinical context. Several anecdotal and evidence-based documents emphasize the enhanced responsibility of faculty for safety and learning in IEs (Hegedus et al., 2013; Kohlbry & Daugherty, 2013; Lachat & Zerbe, 1992; Levine & Perpetua, 2006; Mill, Yonge, Cameron,, 2005; NLN, 2011; Sloand et al., 2008; Visovsky et al., 2016; Wittmann-Price et al., 2010). Many authors, similarly, to the participants of my study, have also reported the risk of extreme safety events which, in some cases, were life threatening (Burleson, 2015). Participants in my study also expressed concern for the unplanned negative implications of IEs related to being a burden to the hosts, imposing colonizing behaviors, parachuting into the community, encountering negative legal implications, imposing irrelevant activities, taking learning from the host, or contributing harm to patients if they did (or

did not) intervene as a caregiver. Although participants did not overtly relate these concerns to the term *ethics,* these ideas are sometimes categorized with such terminology.

Regarding ethical concerns, there has been a recent emergence of attention to the potential negative impacts of IEs within nursing and interdisciplinary professions (Brown, 2017; Currier et al., 2009; Hanson et al., 2011; Mill, Yonge & Cameron 2005; Nicholas et al., 2012; NLN, 2011; Palmer et al., 2013; Racine & Perron, 2012; Reimer-Kirkham et al., 2005a; Riner, 2011). In this study, most participants were concerned with the potential negative implications for the host communities along with an expressed a desire to avoid unintentional harm. Similarly, some authors have also emphasized concern for how IEs might perpetuate neo-colonialist activities which enhance, rather than reduce, health disparities; therefore, a critical approach to IEs is recommended to address these ethical concerns (Burgess et al., 2014; Caldwell & Purtzer, 2015; Crabtree, 2013; Harrowing et al., 2012; Racine & Perron, 2012). A hyper-alertness to the possibilities for error, along with a strong desire to implement a positive experience for students could explain why participants were unable to *turn off* during an IE. Rather than providing a comprehensive inventory of the potential negative implications from IEs, this section instead focuses on what the "error" in trial-and-error might mean for faculty preparation. A question that is raised from the previous section's focus on learning from experience is how faculty would be able to anticipate and mitigate the potential negative outcomes, if they are expected to learn by first experiencing them. In this study, when participants experienced the potential for negative implications, they sought further understanding of how to better prepare for the future.

Seeking Input to Know Your Purpose and Your Role

Throughout the findings, participants discussed their role in identifying the purpose of their IE and their responsibility to align this purpose with the learning context. Fulfilling these

responsibilities was challenged by having minimal institutional support. These responsibilities were further complicated by delivering curriculum in the complex foreign setting. An identified purpose of IEs was student learning. Every document in Chapter Two's literature review (n=31) identified student learning as a purpose of IEs. Although numerous anecdotal documents identify positive student outcomes from IEs, "little evidence exists about the design of these educational experiences in relation to what and how students learn" (Riner, 2011, p. 308). Although most literature would attest to the need for student learning in IEs, the myriad of anecdotal, and growing evidence-based, documents suggest faculty implementing IEs may not be straightforward. It is not surprising that responsibilities for student learning, without institutional support, felt overwhelming at times.

In addition to student learning, some participants also identified an objective of the IEs was to meet the perceived needs of the host. This is a similar finding to some literature that has celebrated the intentions of IEs to help host communities (Burleson, 2015, Christofferson, 2008). Although meeting the needs of the host may be part of planning for IEs, Andreotti (2006) might classify any intention to meet host needs, without host input, as being *soft* purposes for IEs that perpetuate positions of privilege and power from the sending institution. Some participants highlighted how it was only after their first IEs when they considered host needs from the host perspective. A consultative approach required time to build trust, to seek knowledge from the community, to enact relational skills, and to demonstrate commitment to partnerships. In their grounded theory study, Leffers and Mitchell's (2011) model included a "process for partnership" (p. 95) with steps of mutual goal building. Their findings also support that the best source of input for mutuality in partnerships is from the hosts themselves. Other authors have found that IEs in nursing education are better positioned to address health equity when they are critically

positioned and when they are grounded in mutually beneficial partnerships that are culturally sensitive (Chavez et al., 2008; Ryan-Krause, 2016).

For student learning and meeting perceived needs of host, both the participants reports, and the literature review agreed that obtaining host input and building mutuality is complex even with the best intentions. In a self-study, Miller-Young et al., (2015) found educators centered an important IE concept of "reciprocity" (p. 40) around the concern of students' learning about reciprocity, and not around actual plans to engage more reciprocally with host partners. Their study exposed faculty's "conceptual and practical struggles with reciprocity" (Miller-Young et al., 2015, p. 40). Recent evidence has also emerged from the host perspective on IEs, which suggests a dissonance between the purpose of IEs as interpreted by the host and as interpreted by the sending institute (Cherniak et al., 2017). A finding from Cherniak et al. (2017) suggested that sending institutions often purpose IEs to fill a health gap, whereas receiving host communities do not share this same expectation because "none of the respondents (n=170) said trainees arrive as independent practitioners to fill health care gaps" (p. 367).

When discussing the challenges of seeking host input, participants also emphasized the need for relational skills. The CUGH (2018) global health competencies highlights skills for global health practitioners that include "collaboration, partnering, and communication" (p. 82). These skills are connected to the relational skills emphasized by participants in my study. This Although the current emphasis of the competencies does not comprehensively emphasize host input, these relational skills suggest congruence with participants' recommendations. Relational skills in the global setting are also well-aligned with nursing's strong professional identity of relational inquiry, which is "a way of relating to people, situations, and knowledge and is guided by the overriding goal of being as responsive, and respons-able *(sic)*, as possible" (Doane &

Varcoe, 2015, p. 6). In this way, relational skills for faculty in IEs are supported both in the global health field and by the nursing profession.

Knowing the purpose and desired outcomes (i.e. student learning and host needs) gave insight into role preparation. The connection between purpose and roles of the nurse educator has been suggested by Pennbrant's (2016) concept determination study. Pennbrant (2016) analyzed the concept of roles for the nurse educator and found that "when nurse educators define their function, a professional role takes form" (p. 431). This suggests that when faculty know their purpose, they are better able to understand their role, and provides insight as to why participants were challenged with identifying their roles for their first IEs. Analysis of the findings raised the question as to whether the role of faculty was that of educator, caregiver, or both.

The educator role for IEs faculty was not contested in the literature reviewed in Chapter Two; this makes sense because IEs are educational experiences. It was suggested in the anecdotal literature reviewed that variations of the educator role that were similar to the participants' reports and included the roles of teacher and facilitator (Kohlbry & Daugherty, 2013; Lachat & Zerbe, 1992; Maginnis & Anderson, 2017; Mill, Yonge & Cameron, 2005; Riner, 2011), collaborator (Kohlbry & Daugherty, 2013; McKinnon & Fealy, 2011), capacity builder (McKinnon & Fealy, 2011), role model (Wittmann-Price et al., 2010), mentor (Lachat & Zerbe, 1992; Mill, Yonge & Cameron, 2005), and planner or implementer of the IEs (Brown 2017; Haloburdo & Thompson, 1998, Hegedus et al., 2013). The NLN (2011) also emphasized numerous other educator roles including preparing the experience, preparing students, facilitating safe travel, debriefing students, and initiating collaborative relationships within the host community.

Although these educator roles are similar to those of a nurse educator in any clinical context (CASN, 2018b; Oermann et al., 2018) participants reported these roles as being more challenging in IE settings than they were in Canadian settings where they had the benefit of familiarity with common health problems, clinical health systems, and policies. Ogilvie et al. (2007) supported that IEs are often more complex than in the local clinical setting. Likewise, Burleson (2015) reported faculty identified that teaching in the foreign context in LIC was challenging particularly when faced with the extreme disparities in wealth and health. Similar to participant findings, an anecdotal discussion paper by Hulstrand (2013) suggested the complexity of IEs are beyond the typical educator role because "being an outstanding academic does not always prepare you to handle all the expectations students, parents, host country contacts, and home campus administrators have of you when teaching abroad" (p. 40).

Besides the role of educator, several participants also emphasized their caregiver role in their IEs. This included emotional and physical care for students as well as nursing and medical care for patients in the host communities. A study from a liberal arts program also found that faculty in IEs needed to provide more care for students in the foreign context, which was different from their familiar setting where campus services cared for students personal, social, and emotional needs (Goode, 2008). Differently, in the IE setting faculty acted as a "travelling university" (Goode, 2008, p. 155) providing care for students independently. In Visovsky's et al.'s (2016) discussion paper, the IE setting was also compared to a "defecto campus" (p. 30). Other anecdotal reports also emphasized faculty caregiver role for students including health care provider (Lachat & Zerbe, 1992; Mill, Yonge & Cameron, 2005; Visovsky et al., 2016), and emotional supporter for culture shock (Maginnis & Anderson, 2017; Mill, Yonge & Cameron, 2005; Nicholas et al., 2012; Wittmann-Price et al., 2010). Being around students 24-hours a day

has also been suggested as the reason why interactions between students and faculty might "evolve into a more personal level" (Memmott et al., 2010, p. 300). A finding that was only found to be corroborated in minimal anecdotal literature was how numerous participants felt they were in a role as a parental figure for the students (Lachat & Zerbe, 1992; Mill, Yonge & Cameron, 2005).

Faculty providing care for students seemed necessary; providing care for patients, however, seemed optional. Some participants highlighted their role as caregiver role, or health practitioner, towards patients. Although few became licensed to practice in the host country, others deliberately avoided patient care because of not being licensed and as such, left clinical oversight to the local nurses. There is little available evidence reporting the role of faculty as a patient caregiver in IEs because much of the literature focuses students' provision of care. Some anecdotal reports identified faculty as advocates for patients in the host communities (Kohlbry & Daugherty, 2013). The responsibility for caring for patients felt by some educators was more comparable to the hands on responsibilities identified of a preceptor, and also the responsibilities of nurse educators working on a clinical teaching unit (Oermann et al., 2018). In many clinical settings in North America, nursing faculty and students are considered guests on the ward, and the faculty are licensed to provide care, but do not assume primary responsibility for the patients (Oermann et al., 2018). The emphasis for the nurse educator in most clinical teaching models is on student learning even though clinical teachers are also responsible to "patients, families, and the nursing profession to identify and exhibit highly effective clinical behaviors" (Oermann et al., 2018, p. 180).

Enacting the role of patient caregiver was complex. In some cases, participants identified that the resource-poor location was justification to provide medical care that they had neither

been trained for in Canada, nor licensed for in the IE location. This finding is seen in the literature where some authors found that working in resource poor settings might cause health practitioners to justify acting beyond one's scope of practice as a sense of duty to provide care (Crump & Sugarman, 2008). The NLN (2011) also suggested that scope of practice for faculty in IEs is closely linked with the purpose of the IE and is also connected to nursing regulations in the host and sending country.

The roles of educator, student caregiver, and patient caregiver seemed convoluted and blurred in IEs. To the best of my knowledge, there has not yet been literature that acknowledges the three roles as being combined in the way this study has found. Separately the roles of the nurse educator, and the patient caregiver are better understood. The nurse educator role is considered by many to be a specialized complex nursing professional role (Oermann et al., 2018). This is supported by accrediting bodies such as CASN (2018b) who identify nurse educator competencies. These nurse educator competencies currently do not include the requirement for global perspectives, although they do require educators to "demonstrate rigorous and reflective teaching related to teaching and learning" (CASN, 2018b, para 2) and also have "expertise in the areas in which they teach" (CASN, 2014, p. 21). For clinically-based courses, nurse educators should have "clinical expertise" (Oermann et al., 2018, p. 12) in the clinical setting. This expertise includes knowledge, clinical judgement, teaching skills, interpersonal skills, personal characteristics, and evaluation skills (Knox & Morgan, 1985).

On the other hand, faculty's patient caregiver roles in IEs are supported with the CUGH (2018) competencies that suggest that those working in the global health setting are considered "global health practitioners" (p. 241). Global health practitioners are those who "spend a moderate amount of time, but not necessarily an entire career, working in the field of global

health" (Jogerst et al., 2015 p. 241). Additionally, global health practitioners are those who practice "discipline specific skills associated with the direct application of clinical and clinically related skills acquired in professional training in one of the traditional health disciplines" (Jogerst et al., 2015, p. 241). By these definitions, participants in this study could be granted this title of *global health practitioner.*

The findings suggest that nurse educators accompanying students on IEs enact a blended role of *nurse educator* and *global health practitioner*. What is less understood is the role of the faculty for caring for students in IEs as there are not specific competencies to address this unique role other than consideration for faculty creating "ethical dimensions of the teacher learner relationship" (CASN, 2018b). When considering these specialized roles, it is understandable why participants emphasized a sense of needing to be more competent in IE settings compared to the Canadian clinical or classroom settings. This interpretation might also support why, even with prior experience in the international setting, several participants felt they were preparing for an unfamiliar clinical teaching role for their first IEs. Participants' discovery of the roles and responsibilities for IEs motivated them to prepare more intentionally.

Learning For-the-Job

The final theme, *Learning For-the-Job,* was a benchmark in preparation. This theme emphasized the missing link of institutional support which previously resulted in participants needing to prepare themselves. To address this missing link, participants recommended intentional approaches from the institutional and the individual, along with their integrated approaches to faculty preparation. This represented a shift to move beyond reliance on learning on-the-job through trial-and-error.

Importance of an Internationalized Curricular Approach

A prominent finding of this study was participants' report of a sense of being on their own when preparing for their first IEs; for some, this continued through all IEs. The lack of support from the institution was considered to be a missing link. Preparing themselves and preparing the IE most frequently relied on the volunteer efforts of individual faculty. Participants recommended shifting responsibility from the individual faculty to the institution, which would result in more support for faculty preparation.

The missing link of external support is highly connected to what is understood as the internationalization of higher education. Internationalization is considered to be a "process of integrating an international, intercultural, and global dimension into the purpose, functions (teaching, research, and service), and delivery of higher education at the institutional and national levels" (Knight, 2004, p. 33). Niehaus and Williams (2016) added to this definition by also considering internationalization of faculty, such that "internationalizing curriculum/a is therefore also an exercise in transforming faculty members' perspectives and increasing their global competence" (p. 60). Oermann et al., (2018) suggested that for nursing education, additional considerations for internationalizing curriculum include integrating global health champions, providing faculty development about global health priorities, and enhancing faculty and student diversity. Ogilvie et al. (2007) presented a survey of internationalization of nursing programs across Canada. This survey was from 1996–1997 and found that "faculties or schools of nursing in universities in Canada were already involved in substantial international endeavors by the end of the 20th century" (Ogilvie et al., 2007, p. 14). For instance, 15 of 27 respondent programs offered IEs although only 0.81% of students participated (Ogilvie et al., 2007). At the institutional level there was international student policy (n=18), general international policies

(n=16), international student centers (n=14), and international linkage offices or centers (n=18) (Ogilvie, et al., 2007). At the faculty and school of nursing level, international policies were reported for only a few respondents (n=4) (Ogilvie, et al., 2007).

Internationalization of nursing curriculum is growing in Canada. In 2007, Hoe Harwood et al. (2009) conducted a survey Canadian nursing programs for their use of innovative clinical placements that included IEs. At this time, they found that 54% of nursing schools offered an IE (Hoe Harwood et al., 2009; Reimer-Kirkham, Harwood, C. H, Terblanche, L., Van Hofwegen, L., & Sawatzky, 2007). This number was representative of 74 nursing programs out of a possible 90 in Canada at the time of the survey (Hoe Harwood et al., 2009; Reimer-Kirkham et al., 2007). Although Hoe Harwood et al. (2009) did not capture the entire spectrum of an internationalization program, the data gives insight into the increasing trends of international endeavors of nursing programs in Canada. The findings from Ogilvie et al. (2007) and Hoe Harwood et al. (2009) are now dated and to the best of my knowledge have not been re-visited. They do, however, provide perspective about how internationalization of nursing curriculum has an emerging alignment what Ogilvie et al. (2007) summarized as a "worldwide movement towards internationalization in higher education" (p. 9). This is perhaps connected to the few participants who identified their institution had a global health committee or global health office. It may also be connected to participants' reports of a recent shift in which institutional offices provided pre-departure training, and also to some participants' report of a recent approach in their nursing programs to better incorporate global health into foundational curriculum.

Although the literature supports some growing momentum in internationalization that was also expressed by participants, it does not explain the dissonance of participants feeling on their own for preparation. Many of the programs represented by participants in this study would

be categorized as internationalized, yet participants from these programs still felt unsupported and alone in their preparation. Most participants needed to work off the side of their desk to plan, implement, and sustain the IEs as these responsibilities fell largely on their shoulders. This finding suggests a disconnect between the translation of institutional internationalization and its implementation of support for faculty preparation. Nursing experts in global health have identified "international work is often not recognized and valued within traditional university evaluation systems of faculty members" (Mill et al., 2010 p. E8). Dewey and Duff (2009) explored a case study of faculty perceptions of internationalized curriculum and study abroad programs finding similar barriers and noting that "passion for internationalization is not enough" (p. 503). They suggested that internationalization should be an institutional priority with provision of resources and support, addressed systemically and systematically, and have mutual understanding of the goals and objective of internationalization (Dewey & Duff, 2009). In their descriptive content analysis of 18 undergraduate nursing programs in Australia, C. A. Browne and Fetherston (2018) summarized the responsibility of institutions to prepare faculty for the complex IE roles.

Participants emphasized how lack of resources was one reason why IE preparation was prioritized over faculty preparation. In the literature, this same explicit connection between the little resource support and prioritization of IEs was not found to be corroborated. There remains, however, significant indications as to how underfunding of IEs is a barrier to preparation (C. A. Brown & Fetherston, 2018; Kulbock et al., 2012; Noone et al., 2019). Participants in this study were motivated by passion for the international work and volunteered time and finances, or creatively found other funding to sustain the program. Similarly to the participants, authors have also described other faculty's creative funding approaches to sustain IE programs such as

volunteering their time (Brown, 2017; Kulbock et al., 2012; Levine & Perpetua, 2006; Mill, Yonge & Cameron, 2005; Palmer et al, 2013; Wittmann-Price et al., 2010), integrating research grants (Bentley & Ellison, 2007; Mason & Anderson, 2007), and incorporating fundraising strategies (Levine & Perpetua, 2006; Mason & Anderson, 2007; Riner, 2011). Oermann et al. (2018) suggested that for nursing programs to integrate an international focus, faculty should be provided released time and workload adjustments to integrate global learning into teaching, practice, research, and leadership initiatives.

This study's findings and the literature also suggest a curricular commitment to IEs. Many participants were on their own to determine what to teach and how to teach in IEs. They identified needing to adapt the objectives of their program's nursing curriculum into the objectives for the IE. This approach to IE curriculum is reaffirmed strongly in literature from Chapter Two in which many authors report adapting the IE to the curricular needs and philosophy of the program (Lachat & Zerbe, 1992; Mason & Anderson, 2007; Memmott et al., 2010; Nicholas et al., 2012; Noone et al., 2019; Reimer-Kirkham et al., 2005a). What some participants questioned was if the unique outcomes of IEs were also then reciprocally integrated back into the program's curriculum versus being a stand-alone course. Other authors have also identified concern for how the lack of integration of the unique learning from the IE back to the program's nursing curriculum may negatively impact students' ability to translate learning back to the local setting (Reimer-Kirkham, Van Hofwegen, & Pankratz, 2009). For participants, this lack of IE outcome integration back into the curriculum made preparation more challenging. Some authors have identified attempts at better internationalizing their nursing curriculum. In a recent discussion paper, Dawson, Gakumo, Phillips and Wilson (2016) described the process for mapping global health competencies in nursing curriculum. The project was supported by their

university's goals and the program's strategic plan. A key to their process was "obtaining buy-in from administrators and faculty" (Dawson et al., 2016, p. 38). This is similar to a case study provided by Niehaus and Williams (2016) about strategies to internationalize curriculum at a large public university. Data were gathered from observation, interviews, and document analysis from 15 interprofessional faculty. Their findings included that "curriculum transformation can clearly not be successful in a vacuum; rather it should be part of a broader internationalization strategy" (Dawson et al., 2016, p. 73). Dawson's et al. (2016) findings are relevant to my study because some participants found themselves working on their own to obtain buy-in for their IE. For instance, in one case, a participant reported working against program goals as evidenced by her program being shut down because her manager did not believe in the program.

Along with finding ways to support faculty and to integrate programs into a nursing students' overall learning, the final discussion point about an internationalized approach is the responsible hiring practices for the IE role. This was different than how most participants were selected for the teaching role more serendipitously. To the best of my knowledge, there is no evidence-based literature around the hiring practices of nursing programs for faculty for IEs with students. It would be generally understood that nursing programs hire for the educator role with an expectation of subject matter expertise (Oermann et al., 2018). In the anecdotal literature, some authors identified an office that selected qualified faculty; others identified faculty self-selected for the teaching position based on interest (Bosworth et al., 2006; Hegedus et al., 2013; Memmott et al., 2010; Sloand et al., 2008). This is similar to the findings in which one participant applied to a global health committee, whereas others self-selected for the teaching role or were informally selected. In a commentary paper, Hulstrand (2013) suggested most institutions in higher education do not recruit for IEs but instead find someone internal who

might be a fit and, in some cases, “faculty initiate programs inspired by their own travels” (p. 41). To contend with this arbitrary method, participants suggested faculty qualifications should include considerations for experience, knowledge, skills, and attitudes for the IE role. Similarly, C. A. Browne and Fetherston (2018) noted that first time facilitators reported apprehension for their role in the IE based on a lack of experience, knowledge, and skill. The focus of this section, however, will be on the qualification of prior experience as a continuation of the discussion of learning from experience. Global health knowledge and relational skills were discussed earlier, and reflexive attitudes will be discussed later.

Previous experience in international settings was identified in the literature as the most commonly listed qualification (Brown, 2017; Christoffersen, 2008; Hegedus et al., 2013; Mason & Anderson, 2007; Memmott et al., 2010; Noone et al., 2019; Palmer et al., 2013). Notably, some authors have also suggested that prior related international experience is not essential for the IE teaching role (NLN 2011). In this study, participants suggested that local experiences in Indigenous or refugee communities may be a substitute for international experience, however, participants were concerned some programs select those without relevant related experience, without teaching experience, or without clinical experience. Some other anecdotal literature also reflects hiring practices that did not consider prior experience as a requirement. In some cases, interest was a substitute for experience (Hegedus et al., 2013; Mason & Anderson, 2007; Memmott et al., 2010; Palmer et al., 2013). Other substitutes for experience included cultural skills (Palmer et al., 2013), access to professional contacts (Memmott et al., 2010), and language skills (Memmott et al., 2010; Noone et al., 2019; Palmer et al., 2013). In one case, an author worried her lack of experience and clinical expertise would disqualify her from facilitating IEs, and she was surprised to be recruited for the position (Christoffersen, 2008). In my study, some

participants reported how their programs selected faculty for IEs even when the faculty were not interested. In general, this approach was seen as inadequate for the foreign setting.

The exceptions to prior related experience that have been identified in participant reports, and in anecdotal literature, are particularly notable for my study because of how learning how to prepare was primarily linked to learning from experience, yet often not accompanied with theoretical knowledge. If experience is overlooked, and knowledge is also overlooked, then this combination may be a challenge when mitigating the potential for negative implications of the IE. Instead participants have recommended that faculty qualifications could include experience, knowledge, skills, and attitudes. This approach to hiring practices suggests that faculty should also reflect on their own strengths and limitations.

Importance of Critical Reflexivity

Another key finding for the participants in this study was the process of self-discovery whereby participants realized a dissonance between their initial preparation actions and what was actually needed. Self-discovery also supported participants in clarifying values and attitudes for the IE teaching position. Reflection is also a key part of experiential learning theory because reflecting on concrete experiences is the foundation for which new action is formed (Kolb, Boyatzis & Mainemelis, 2001). When individuals reflect on and challenge ideologies and presuppositions, along with "self-conscious criticism" (Kincheloe, et al., 2017, p. 243), they enact critical reflexivity. Although participants did not use the term *critical reflexivity*, their language of *learning, discovery, epiphany*, *awareness*, or *realization* supports this interpretation. For instance, many participants reflected on concerns they might burden the host participants, they challenged "parachuting in" and taking the learning, they made adjustments in their attitude towards the host participants to be less judgmental, they reflected on their own humility and the

humility of others, they celebrated their growth with understanding situational ethics, and they challenged their positions of power and privilege.

In general, critical reflexivity is not prominent in the literature pertaining to faculty in IEs. The limited documentation that exists about faculty reflection and discovery for IEs are twofold. The first evidence about reflection and discovery are about the IE program itself. Many of the anecdotal discussion papers of individual or teams of faculty who implemented IEs may be considered a form of reflection (or evaluation) as several documents are reports of lessons learned. An example of the many program reflections that exist are Kostovich and Bermele's (2011) "The Top Ten List: Lessons Learned from Teaching a Study Abroad Course". Although notably, these program reflections (evaluations) mostly relate to how to better plan IEs and not how to better prepare faculty for IEs.

In an even smaller pool of literature is encouragement for faculty self-reflection as it relates to IEs such as awareness of interests, comfort needs, and physical abilities (Christoffersen, 2008; Lange & Ailinger, 2001; Memmott et al., 2010; Palmer et al., 2013). In Palmer et al.'s (2013) discussion paper, the authors reported concern that one of the faculty was not "mature enough to handle the responsibility" (p. 201) and did not have "personal awareness" (p. 200) of their limitations. The CUGH (2018) competencies also promotes self-reflection for those engaging in global health experiences through "acknowledging one's limitations in skills, knowledge, and abilities" (p. 87). For instance, if practitioners engage in global health activities in which they might have limitations, it is seen as an unethical practice (CUGH, 2018).

Although little documentation exists about faculty's self-reflection for IEs, some authors have also emphasized the importance of faculty's critical reflexivity of health beliefs and personal biases when teaching global health courses. Crabtree (2013) suggests that faculty can

mitigate the potentially colonizing attributes of IEs through "ongoing critical reflection about their teaching and research related to international service learning" (p. 58). Critical reflexivity aligns well with Andreotti's (2006) "critical" global framework which supports self-reflection of "epistemological and ontological assumptions" (p. 43). In a discussion paper reporting their IE program implementation, Chavez et al. (2010) embedded critical reflexivity in the course design noting that, "faculty must be reflexive evaluators of global health courses that have far reaching implications for global citizenship health care" (p. 19). Similarly, Miller-Young et al. (2015) highlighted a collaborative and self-study approach to critical reflexivity in nurses varied understanding of "reciprocity" (p. 32) in service learning including IEs. Key findings included the importance of critical reflection through collaborative self-study that "generate the necessary critical reflection [and] make space for the required discourse which in turn increases understanding and generate learning (p. 34). Miller-Young et al.'s (2015) research reflects how participants in the findings of my study also had varied understanding of the global health concepts for IEs. A collaborative process for reflection, as indicated by Miller-Young et al. (2015) is different from this study's participant reports of reflection and discovery being an individual process.

Finally, critical reflection is connected to how participants clarified values and attitudes of humility, commitment, and adaptability for the teaching role. These values and attitudes correlate with what was found in the literature review of Chapter Two although some variances warrant further discussion. The first being the assumption that faculty values and attitudes contribute to positive outcomes for IEs. To the best of my understanding, only one document has reported a direct correlation between faculty's values and attitudes and student outcomes in IEs. In their qualitative study, Reimer-Kirkham et al. (2005a) found that faculty's "passion for social

justice" (p. 269) was key to student learning, and its absence contributed to a less positive experience. Another variation of values and attitudes comparatively to the literature is the focus on humility. For several participants, humility was the most important value and attitude necessary to meet the roles and responsibilities for IEs. In the literature, however, humility is not strongly represented from the perspective of faculty preparation. The NLN (2011) does encourage the importance of faculty "being a student before being a teacher" (p. 11) suggesting this approach will "make Western educators and scholars more effective and acceptable because of the attitude and humility such an approach embodies" (p. 11). Although notably, there is limited direction for how humility would be enacted.

A significant finding related to humility in IEs was Cherniak et al.'s (2017) qualitative study. As one of the few of its kind, this study investigated host perspectives on competencies for visitors in IE roles. Authors found a dissonance between what sending partners might identify as important competencies, versus what the host might expect and desire. One of these areas of disconnect was host identification that "the ability to demonstrate humility as being more important than confidence" (p. 362). The critical approach of humility supports how some participants reported needing host input. Humility is also connected to participants' reports that preparation was dynamic and complex, occurring before, during, and after the IE. The goal of preparation was not to become an expert but rather to gain expertise.

Importance of a Practical Approach

In closing this section, participants identified intentional approaches for moving beyond trial-and-error. Many of these were practical approaches supported at both an institutional level for funding and providing the approach, and an individual level for enacting the approach. These practical recommendations were thought to address knowledge gaps, enhance experiential

learning, mitigate potential negative implications, encourage collaborative input, clarify the educator role and purpose, and enrichen critical reflection. In this way, faculty preparation should be intentional and concrete. Mill et al. (2010) also endorsed practical approaches for faculty preparation related to global health education. They noted "faculty require professional development opportunities to ensure that they have the necessary knowledge and comfort to teach global citizenship; and global citizenship must be endorsed by leadership at both the faculty level and the university level" (Mill et al., 2010, p. E9).

Although there is a growing body of anecdotal and evidence-based knowledge about various aspects of IEs, such as preparing students, preparing logistics, or preparing partnerships, in comparison there is little evidence about activities for nursing faculty preparation for IEs. This gap perhaps explains why participants sought other external sources–such as attending conferences, consulting with the host community, networking with global health coalitions, and pursuing graduate level training–to learn. What participants found was that they needed support in translating knowledge to practice. Recent seminal work has been undertaken to approach faculty preparation for IEs from an interdisciplinary perspective that addresses knowledge translation. In Costa Rica, Evert et al. (2019) hosted a *Faculty Development for Global Placements* interdisciplinary workshop for faculty to provide practical, experiential, and collaborative guidance on implementing the CUGH (2018) global health competencies in international settings. This workshop used presenters' expertise in global health and IEs to prepare nursing and non-nursing participants for global experiences in and outside the classroom. Participants of the workshop were oriented to the definition of global health, global citizenship, the global burden of disease, and the global health competencies. This workshop also promoted critical reflexivity when engaging with host communities. No formal outcomes assessment has

been made available yet and the cost of tuition and travel may be a barrier for those seeking this resource.

Another recommendation by participants was providing faculty with formal education and on-site orientation. Some forms of pre-departure training for faculty have also been reported in some anecdotal reports such as those by Brown (2017) and Hegedus et al. (2013). Overall, however, little detail about orientation content was provided. Orientation has been reported to include policies and procedures (Brown, 2017; Doyle, 2004); health, safety, and liability (Bentley & Ellison, 2007, Doyle, 2004); handling student emergencies (Lachat & Zerbe, 1992); the health care system of the host country (Delpech, 2013); and language and cultural learning (Riner, 2011). There is also little understood about the mode of delivery for faculty education and orientation. In a discussion paper, Palmer et al. (2013) noted how emails, phone calls, and optional preparatory classes may have been an insufficient approach to preparing faculty. Similar to participant recommendations of the ideal for on-site orientation, some anecdotal documents also recommended multi-day pre-course orientation in the destination country, specifically when establishing a new site (Hegedus et al., 2013; Memmott et al., 2010; Wright, 2010). Lack of finances, however, were also considered a barrier similar to how participants identified the added cost was a challenge. This form of orientation, however, was a key recommendation as it allowed participants to learn from experience while also mitigating the risks of error in the trial-and-error approach.

Finally, a recommendation was made for collaborative teaching approaches through mentorship and co-teaching for IEs. This team approach was necessary to address participants' sense of being alone. Mentorship is a term that has wide variation in understanding and needs more investigation; however, this was the term that many participants used. In their anecdotal

descriptions, some authors also report preparing faculty for IEs through mentorship (Brown, 2017; Hegedus et al., 2013; Kostovich & Bermele, 2011; Palmer et al., 2013). In a literature review of expert to novice nursing faculty, Grassley and Lambe (2015) also endorsed mentorship but found a consistent lack of access to adequate mentorship and formal orientation in the academic setting. Common barriers to mentorship included limited institutional commitment for the time and training needed (Grassley and Lambe, 2015). Researchers at the Johns Hopkins Center for Global Health also recently conducted a qualitative retrospective study for their field placement program for global health education. They identified a mentorship relationship in global health training as either a "catalyst or a hindrance" (Charron et al., 2019, p. 1). Barriers to mentorship included a lack of institutional resource and training support for mentors and some students were left still feeling alone (Charron et al, 2019). The results of Charron et al.'s (2019) study echo what participants in my study reported as they had praised the involvement of their mentors, yet also identified financial barriers to a mentorship model. Participants who had mentors similarly identified feeling on their own; however, this was not attributed to a poor mentorship relationship.

Participants also suggested collaborative teaching as another meaningful, albeit costly, approach to faculty preparation because it enhanced both safety and learning in preparation. Brown (2017) identified a model of co-instructorship where experienced faculty mentored novice faculty during an IE. Hegedus et al. (2013) also described a programmatic team based approach to an IE that also included hosts as an important part of the teaching team. Collaborative teaching approaches in IEs would also support collaborative critical reflexivity, which was a suggestion from Miller-Young et al. (2015). For the participants, and supported by the literature, a practical approach to preparation was. considered an important consideration for

faculty preparation. Together, internationalized curricular considerations, individual critical reflexivity, and integrated practical approaches to faculty preparation support moving beyond the insufficiency of a reliance learning on-the-job through trial-and-error.

Chapter Summary

This discussion provided an interpretation of the study findings as they relate to faculty preparation for accompanying students on IEs. With a careful stitching together of empirical and anecdotal literature, many of the findings of this study aligned with the little that is reported in the literature. For example, the emphasis of preparing the experience over preparing for the experience is common both in the literature (as reported in Chapter Two) and in the participants' perspectives. This entanglement suggests an assumption about what can be learned from experience. Furthermore, this emphasis on experience can be understood as resulting from the lack of formal preparation available for faculty. This study begins to provide direction for the type of formal preparation that would be helpful (discussed in more detail in Chapter 6).

The strong reliance on experiential learning, along with a concurrent lack of reference to the substantive knowledge (i.e. about global health and equity) that one would expect to underpin these types of IEs, suggested that a more intentional approach to faculty preparation is needed. This is concerning considering faculty's responsibility for safety and learning while also mitigating the potential for unplanned negative outcomes. Both study findings and the literature suggest that seeking clarity on their purpose and role for an IE also promotes better preparation. This includes consideration of the student learning needs and of the hosts' perspective. Approaching the IE teaching role through the perspective of competency language for experience, knowledge, skills, and attitudes supported further understanding of *who* the nurse educator is in IEs.

In both the literature and the participant experience, there was a strong sense that a lack of institutional support negatively impacted faculty preparation. This did not reflect the serious nature of the teaching role and context of the IE. Without the resources, finances, and training from the institute, participants were on their own in preparation. Participant recommendations, supported by the literature, were for a wider internationalized integration of curricular components into the IE program. Institutional approaches did not, however, negate the need for faculty to continue to critically reflect on their own experience, knowledge, skills, and attitudes for IEs. This was especially important when considering how faculty would facilitate an IE that aligns with critical global perspectives, which was otherwise missing from several faculty's preparation.

Finally, this discussion provided beginning direction on formal preparation for faculty included an integrated approach from the institution and the faculty to consider intentional activities such as education, on-site orientation, and collaborative teaching. These approaches incorporated the emphasis on learning through experience, while addressing knowledge gaps for safer learning than from trial-and-error alone. This discussion supported that although there is always more to learn about preparing for IEs, intentional approaches contribute to more robust preparation.

Chapter Six: Summary and Recommendations

The purpose of this study was to explore faculty preparation for accompanying nursing students on IEs. Chapter Six presents a summary of the study, discusses the importance of faculty preparation, and outline conclusions drawn from the findings. To end this chapter and conclude the study, I offer recommendations for faculty preparation in nursing domains of education, research, leadership, and clinical practice.

Summary of the Study

Nine faculty from nursing programs across Canada were interviewed about preparation for accompanying students on IEs. These participants represented a range of expertise within nursing practice, nursing education, and travel experience. In primary interviews and follow up interviews, participants shared their experience, expertise, and perspectives. Qualitative ID methods, informed by critical inquiry, supported thematic analysis of the findings that resulted in an *Overarching Theme of Gaining Preparation Expertise Over Time.* This theme captured a key finding of preparation being an emerging experience and was woven through three main themes of *How I First Prepared: Learning On-the-Job; Why I Prepare: Discovering the Difference;* and, *Preparing Differently: Learning For-the-Job.*

Informed by the trajectory of gained expertise over time, the findings revealed how experience was emphasized over formal preparation. A lack of substantive focus on global health knowledge and critical global perspectives complicated preparation for IEs. Preparation was further impeded by a lack of institutional support by way of finances, resources, and formal training. Challenges with the dependence on learning on-the-job was identified when participants discovered the increased responsibilities and risks inherent with the IE context. Participants sought to intentionally prepare by increasing their competence through embracing experience,

seeking knowledge, engaging relationally, and reflecting on values and attitudes. These intentional approaches were also seen through the collaboration of institutions and individuals for practical approaches to preparation that included formal education, on-site orientation, and collaborative teaching. In these approaches, participants moved away from the insufficiency of reliance on learning on-the-job through trial-and-error and moved towards more comprehensive and intentional preparation.

Conclusions of the Study

The following conclusions were interpreted from this study's findings and discussion.

1. Faculty situated themselves as learners in IEs. Each experience taught them something new about how to better implement the next IEs. For instance, after their first IEs with students, participants identified a deeper understanding of their responsibility to safety and learning. The emphasis of preparation was learning through experience, more so than learning from formal approaches. Faculty also tended to conflate IE preparation with faculty preparation. Although it is undeniable that learning occurs through experience, experience, on its own, was insufficient to fulfil the responsibilities for safety and learning in the foreign learning environment. Faculty recommended how learning from experience might be approached safely through onsite orientation, mentorship, or team teaching.

2. The emphasis on experience over formal preparation was perpetuated by a lack of institutional support for IEs. The minimal financial and resource support for faculty preparation contributed to a sense of being "on my own" and working off the side of the desk to determine what to teach and how to teach in IEs. This meant prioritizing preparing IEs over preparing themselves. Enhanced institutional investment in the IEs including curricular integration, hiring practices, and funding strategies, were thought to be a benefit to preparation.

3. The lack of formal preparation was further complicated by an overall lack of substantive focus on knowledge related to global health concepts. With a review of the historical context for global health nursing in Canada, it is expected that faculty might have a gap in knowledge related to these concepts. Although some faculty sought external education outside of the nursing discipline, others had no formal training prior to their first IEs. Participants identified the challenges of having a lack of knowledge and for most participants, critical global perspectives were not a reported consideration for preparation. There was also a wide variation in the understanding of global concepts (i.e., equity) as they relate to teaching in IEs; participants reported the most challenging learning to facilitate was related to health disparities, human rights, and socioeconomic status. This suggested that preparing the experience and learning from experience did not always consequentially result in faculty's understanding of these concepts.

4. Although some faculty were initially selected for the role serendipitously, there was a sense that not any generalist clinical nurse or educator would qualify for the teaching role. The IE teaching position required a blended role of educator, caregiver for students, and caregiver for patients. These blended roles were thought to be unique and necessary to meet the responsibilities for safety and learning in IEs. The roles were different than in the Canadian clinical setting and they were felt to be persistent through every moment of the IEs. Furthermore, the roles were informed by the purpose of the IE, which, for some, included host input. To meet these roles, faculty identified needing to be more competent in the areas of experience, knowledge, skills, and attitudes. Competence was supported by professional nursing values, the nurse educator role, and global health practitioner roles. The complexity of the IE teaching role contributed to unfamiliarity with the role even if faculty had prior experience in international work, teaching, or clinical practice.

5. With each new experience, participants discovered the potential of unplanned negative outcomes in IEs. Faculty preparation was identified as important to support safety, learning, and host outcomes, while mitigating the potential for harm. Despite this line of reasoning, most faculty felt unprepared for their first IEs teaching position but still accepted, or pioneered, the teaching role.

6. Over the decades of IEs in nursing programs in Canada, there has not been significant change with how IEs are approached in terms of preparing faculty, yet our knowledge and understanding of the risks has emerged. Those who are responsible for preparing IEs also need preparation themselves.

7. The end goal of preparation was not perfection. Faculty embraced the unknown, but they also identified the importance of being prepared for the unknown. This was a shift from the nursing professional value in which the end goal is to be an expert. The goal, therefore, of preparation was an emerging, ongoing, forward trajectory of gaining expertise through experience, knowledge, skills, and attitudes. This goal required a value and attitude of humility, commitment, and adaptability.

Recommendations

The following recommendations focus on the most relevant areas of the study as they relate to the nursing domains of education, research, leadership, and clinical practice. The recommendations are reflective of the study's findings and are also grounded in prior research as they are informed by the discussion of the study.

Nursing Education

Within the historical context of global health education in Canada, it is considered that faculty currently teaching in IEs may not have substantive global health knowledge from their

undergraduate nursing programs. The recommendations for education are multifold. One is a program wide affirmation of CASN's (2015) requirements for integration of global health concepts in nursing curriculum. The dynamic nature of global health would also suggest that approaches to global health education are also rigorous and ongoing. Nursing education should seek to keep up with the momentum of global health.

Programs may consider upscaling nursing faculty's knowledge in global health concepts and critical global perspectives to address the gap of knowledge. This could include educational and developmental opportunities. This study found that the theoretical understanding of critical global perspectives varied as did the translation of knowledge to practice. Knowledge translation of critical concepts has been found to be challenging in the nursing profession and may continue to require more attention in nursing education (Browne et al. 2009). A goal would be to normalize these concepts. True to nursing education, whatever might be expected of students, faculty should have mastered. Perhaps McKinnon and Fealy (2011) put it best stating, "all participants in global service-learning programs are, in actuality, students" (p. 97).

Critical reflexivity and self-awareness are also important as faculty should carefully consider if they are the right fit for the IE teaching position. Faculty should reflect on their prior experience, substantive knowledge, relational skills, values, and attitudes as it relates to the responsibilities and roles required for the unique setting. Critical reflexivity also creates space for faculty to consider how the action of preparing and doing an IE might not equate to doing global health unless otherwise supported by global health knowledge, critical global perspectives, and host collaboration.

With the emphasis on learning from experience, pedagogical approaches to global health education for faculty might consider experiential learning in ways that mitigate risk for harm,

and that include mentorship, on-site orientation, and collaborative teaching approaches. This might also include seeking work experience in settings with structurally vulnerable populations such as with Indigenous communities or refugees. Pedagogical approaches could also assist faculty in translating knowledge to practice such as was seen with the CUGH (2018) competency toolkit and subsequent workshop.

Furthermore, with the emphasis on the importance of relationships and relational skills and collaborative teaching, collaborative approaches to upscaling faculty knowledge may also be considered. Collaborative approaches to preparation could include participating in communities of practice for faculty to learn from one another and might address the sense of feeling alone. Communities of practice and external mentorship networks could also have a positive impact on supporting institutions and leaders who are also new to global health.

Nursing Research

There is overall limited empirical evidence related to faculty preparation for accompanying students on IEs. More understanding is needed regarding this phenomenon. Additionally, because this study is one of the first of its kind, there are multiple paths one could take in the future for research. A first recommendation is related to the research design. Although ID was an appropriate approach for the little that is known about faculty preparation, other methodologies might have explored other areas of faculty preparation. For instance, with the importance of the historical and current context of Canadian nursing education, it may be beneficial to survey the available preparation for faculty offered in each program that integrates IE education. Furthermore, because of the emphasis on learning from experience, a study design that integrates focus groups of experienced faculty might garner collective information related to

this complex phenomenon. Additional research designs could consider a larger, more stratified sample to further enhance the applicability of study findings to other contexts.

Other areas for future research are related to the phenomenon of preparation in general such as how preparation is measured, who defines preparation, and what outcomes are linked with preparation. With the nature of IEs being in a foreign environment, further research should also consider the host perspective. In addition, research could be conducted to contextualize the needs of preparation such as teasing out preparation for those who are newer to teaching, newer to the global setting, or newer to the clinical practice site. In contrast, more research is needed to further assess the comparative needs of preparation from first IEs to ongoing development. Further research may also expand understanding on what preparation needs are connected to IE settings being local, international, high income, or low income. Additional exploration of faculty roles and responsibilities in IEs would also be beneficial. From a systems level, research funding agencies could prioritize and invest in research related to IEs as a signal to higher educational institutions that this is valuable knowledge.

Nursing Leadership

For leaders in nursing education such as administers, deans, and other managerial roles, the recommendations are to provide more support and additional resources to those who embark on IEs with students. For IEs sustainability, strong support at the institutional level is recommended. Managers can advocate for budgetary decisions, champion policies, and provide a systems level approach to IEs. With this important role of the institution in supporting faculty preparation, institutional leads would benefit from being supported in clarifying, and expanding, their own experience, knowledge, skills, and attitudes for IEs.

Nursing leaders could be supported in their roles of human resourcing and hiring to

ensure they understand the implications of sending faculty on IEs who might not be qualified or prepared. They might consider integrating job descriptions and qualifications for the teaching role related to teaching competencies, global health competencies, and critical global perspectives. Leaders could also be encouraged to resist the tendency to fill a vacancy and send anyone who is available. Even though nurses and nursing faculty are well-positioned for the role, teaching assignments may better be informed by a competency approach to qualifications in seeking out subject matter experts for the global health setting. Reframing IEs as *global health experiences* and participants as *global health practitioners* may better orient faculty to the purpose of IEs. Regardless of their title, faculty should be considered a variable in the success and challenges of the programs. Leaders could interpret faculty qualification and preparation as a chance to mitigate the potential negative outcomes. For instance, the goal for global health practitioners to accompany students on IEs is much like the goal of having other content matter experts teaching in their related practice area. With all that we are coming to know of IEs, and of their potential for harm to students and host communities, leaders in the sending institution may benefit from preventing unnecessary distress by sending unqualified, and unprepared faculty.

Leaders can also advocate for, and develop policies for, IE education, such as safety policies to send more than one faculty and policies for faculty preparation. With nurse managers often responsible for budgets, consideration for faculty workload concerns and additional professional development for the unique environment for IEs might warrant a renewed approach for the unique teaching assignment. To mitigate costs, leaders may collaborate with faculty to find creative ways to bring funding to the IE program.

Recommendations are also considered for curricular leads. As these leaders are often entrenched in the requirements for entry to practice competencies for nurses, curricular leads can

be champions for integrating IE concepts into the curriculum and vice versa. For enhanced faculty preparation support, IEs might work best if they are not a stand-alone course.

Nursing Clinical Practice

IEs are a clinical practice area. In this study, many participants identified a sense that their IE teaching role also included a caregiver role for patients in the host community. Like any clinical practice setting used in higher education, the IE clinical setting also has a strong emphasis on establishing and maintaining partnerships, clarifying roles and purpose, and fulfilling responsibilities. Depending on the clinical model used in the practice setting, faculty may also seek licensure to practice in the host location. Finally, other models of clinical facilitation might be considered.

What was highlighted in this study is that the professional nursing values of learning through experience, adapting, and problem solving were important for faculty in IEs. Faculty may also benefit from support for enacting their professional nursing values in IEs. Although professional values are supported in the Canadian clinical setting through policies and access to resources, in foreign IE settings these professional values may not have the same innate support.

Chapter Summary

Chapter Six provided a summary of this study, including the conclusions interpreted from the findings and discussion. Several recommendations were suggested for domains of nursing in education, research, leadership, and clinical practice. With the little that is understood about faculty preparation for IEs, recommendations were suggested with humility that the findings are not interpreted as absolutes (Thorne, 2016). Application of these findings would best be considered with the study as a whole, including its limitations. This study confirms there is much more to be explored and understood about the faculty preparation for IEs. In doing so, this study

has put a spotlight on faculty as a variable in IEs by considering that those who are responsible for preparing the IE may themselves also need preparation. In essence, faculty should first be considered learners in IEs before engaging as teachers in IEs. As such, more needs to be done to prepare faculty for IEs.

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Appendix A: Table of Nursing's Approach to Culture

Cultural Essentialism	Dichotomy of nursing's conceptualization of culture	Critical Perspectives of Culture	Critical Perspectives of Global Health
Transcultural Nursing *(Leininger, 1995)*		Critical critique of multiculturalism *(Culley, 2006)*	Global Consciousness (*Thorne, 1997; Giddings, 2005)*
*Cultural competency *(Purnell, 2002; Campinha-Bacote, 2002)*		Cultural safety in nursing *(Ramsden, 2002; Anderson et al., 2003)*	Critical global citizenship *(Andreotti, 2006)*
Soft Global Citizenship *(Andreotti, 2006)*		Critical cultural approach *(Culley, 2006)*	**Global citizenship in nursing *(Chavez et al, 2008; Mill et al., 2010; Simpson et al., 2015)*
			**Global health competency in nursing *(Currier et al., 2009; Cherniak et al., 2017; Jogerst et al., 2015; Wilson et al., 2012)*

Note *This term has occasionally been used as a buzzword when authors articulate that issues of social justice and equity have been addressed. **At times these terms have still been used to describe more narrow perspectives culture (Andreotti, 2006).

Appendix B: Figure of Literature Review Concepts

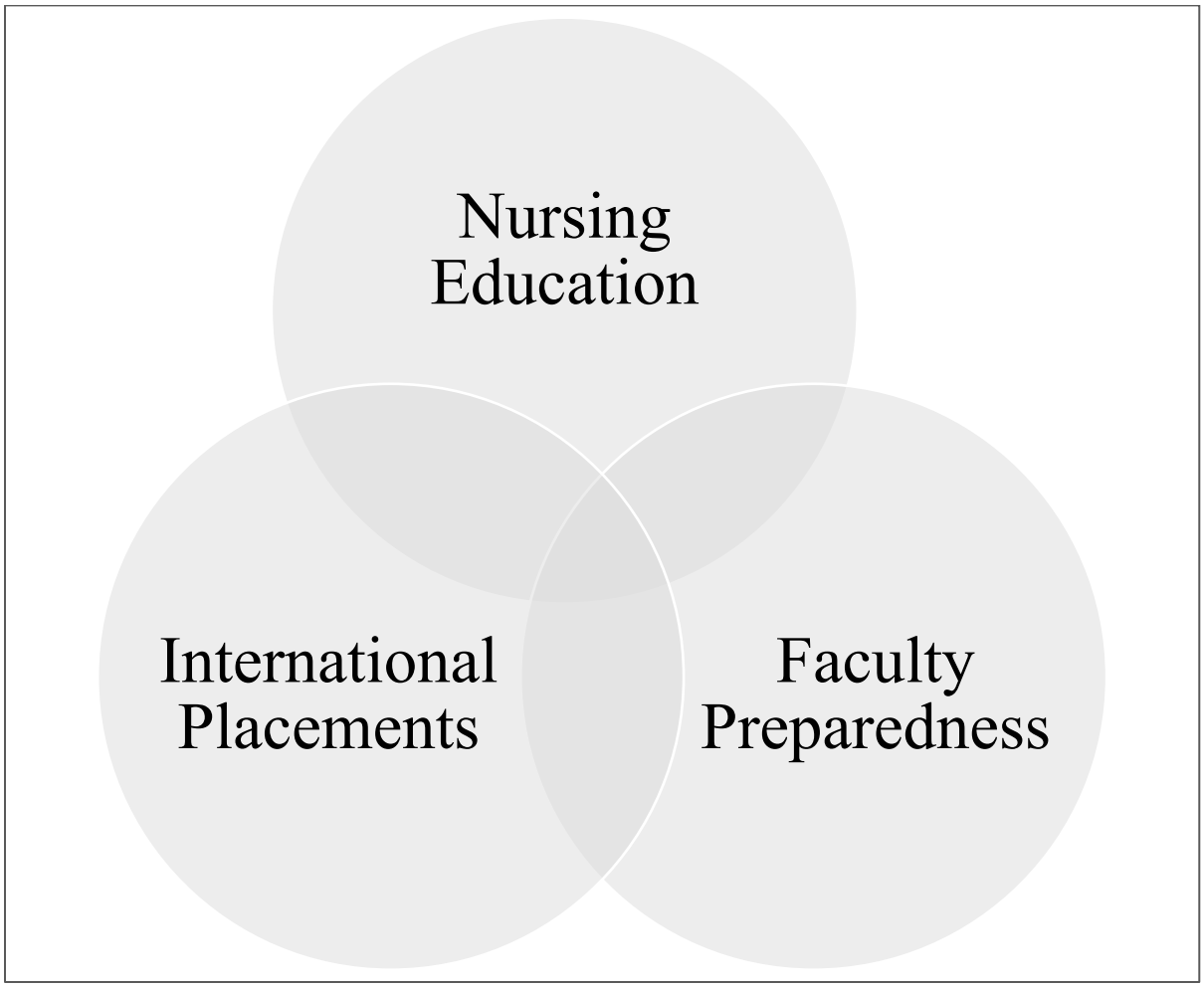

Figure 1: *Concepts informing the literature review*

Appendix C: Figure of PRISMA for Literature Review

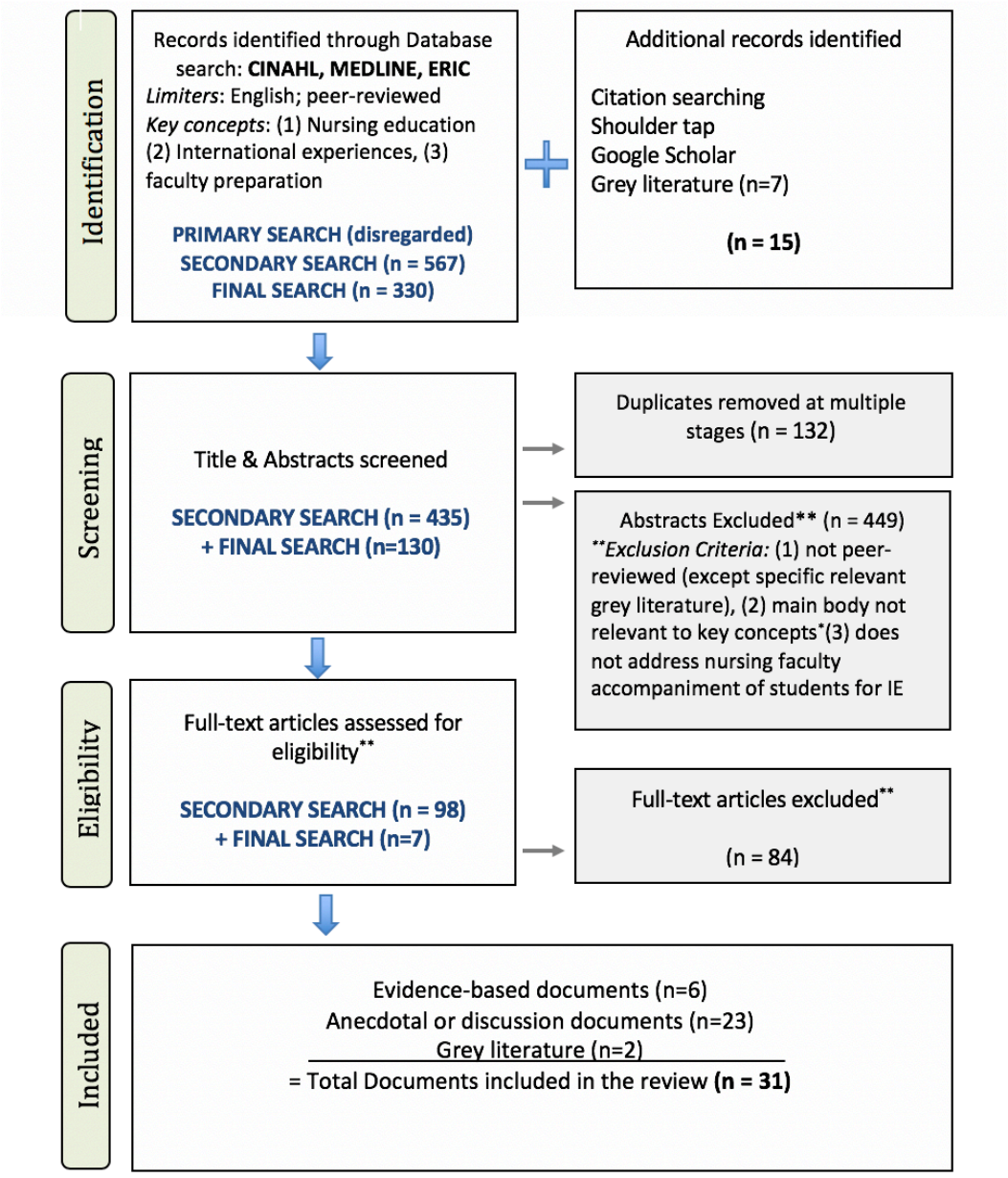

Figure 1. PRISMA chart. Adapted from D. Moher, A. Liberati, J. Tetzlaff, D. G. Altman, the PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *PLoS Med* 6(7): e1000097. doi:1131371/journal.pmed1000097. Copyright: © 2009 Moher et al.

Appendix D: Table of Literature Documents

Reference	Year	Purpose/Findings of the Study	Preparation of Faculty	Critical Perspectives
Evidence-Based Sources (RNAO Level IV)				
1. Browne, C. A., & Fetherston, C. M. How do we facilitate international clinical placements for nursing students: A cross-sectional exploration of the structure, aims and objectives of placements. *Nurse Education Today*, *66*, 1-7.	2018	Descriptive content analysis methods of undergraduate nursing programs to outline "the structure, aims and learning outcomes associated with international clinical placement opportunities".	Findings related to importance of preceptorship and facilitation in IEs to enhance student learning outcomes. Educator attributes included: adapting to culture, language skills, and comfort with the living condition.	
2. Haloburdo, E. P., & Thompson, M. A. A comparison of international learning experiences for baccalaureate nursing students: Developed and developing countries. *Journal of Nursing Education*, *37*(1), 13–21.	1998	Grounded theory study exploring factors for IE curriculum and comparing outcomes between 'developed' and 'developing countries; to explore benefits and barriers to effectiveness of IEs. Created a "Model for International nursing education".	Conceptual model includes the role of the faculty in preparing the IE and debriefing students. All faculty had previous experience in the IE destination country.	
3. Leffers, J., & Mitchell, E. Conceptual model for partnership and sustainability in global health. Public Health Nursing, *28*(1), 91-102.	2011	Grounded theory study to investigate partnership and sustainability for global health.	Conceptual model for partnership and sustainability in global health. Process for partnership included nurse partners such as educators. Encouraged self-assessment of personal biases, power, privilege, and ethnocentric values.	✓
4. Miller-Young, J., Dean, Y., Rathburn, M., Pettit, J., Underwood, M., Gleeson, J., . . . &	2015	Qualitative methods of Decoding the Disciplines self-study to determine how faculty learn about	Participants identified there was more to learn about reciprocity than they had learned through experience alone.	✓

Clayton, P. Decoding ourselves: An inquiry into faculty learning about reciprocity in service-learning. *Michigan Journal of Community Service Learning*, 32-47.		reciprocity in service learning. Findings highlighted Mezirow's (2010, as cited in Miller-Young et al., 2015). transformative learning as foundational to faculty learning reciprocity in service learning including: • the decoding research process, • multidisciplinary self-study, • external interviewers • critical friends, • facing embedded norms		
5. Reimer-Kirkham, S., Harwood, C. H., & Van Hofwegen, L. Capturing a vision for nursing: Undergraduate nursing students in alternative clinical settings. *Nurse Educator*, *30*(6), 263-270.	2005	Interpretive description methods to explore alternative clinical placements, such as international health settings, as a student learning opportunity.	Findings identified faculty attributes of a "vision for excellence in community nursing and social justice" (p. 268) supported student learning.	✓
6. Riner, M. E. Globally engaged nursing education: An academic program framework. *Nursing Outlook*, *59*(6), 308–317.	2011	Combined literature review methods with author expertise to develop a "Framework for Globally Engaged Nursing Education".	A framework component called "program characteristics" (p. 313) included "securing qualified faculty" (p. 313), and the "role of faculty in facilitating the onsite experience" (p. 313) although instruction for preparation for these roles was not included.	✓
Anecdotal & Discussion Documents (RNAO Level V)				
7. Bentley, R., & Ellison, K. J. Increasing cultural competence in nursing through international service-learning experiences. *Nurse Educator*, *32*(5), 207–	2007	Describes a nursing program experience with the development and implementation of an international placement. Provides a list of recommendations.	Identified faculty attending orientation sessions alongside students. Orientation from partnering NGO.	

211.				
8. Bosworth, T. L., Haloburdo, E. P. , Hetrick, C., Patchett, K., Thompson, M. A., & Welch, M. International partnerships to promote quality care: Faculty groundwork, student projects, and outcomes. *The Journal of Continuing Education in Nursing*, *37*(1), 32–38.	2006	Describes faculty and student experiences and projects resulting from a partnership with a nursing program in Guyana and to report the outcomes of an IE. Provides a list of recommendations based on lessons learned.	Faculty initiated the program after connecting with future partners during a conference.	
9. Brown, C. L. Linking public health nursing competencies and service-learning in a global setting. *Public Health Nursing*, *34*(5), 485–492.	2017	Describes a course that uses global placements to develop PHN competencies, improve health and well-being of global communities through intra-professional collaboration, and service-learning principles.	Faculty mentorship & co-instructor model with experienced and inexperienced faculty. Faculty attributes of flexibility and adaptability Faculty roles other than planning the IE include collaborating, and mentoring.	✓
10. Christoffersen, J. E. Leading a study-abroad group of nursing students in Nicaragua: A first-timer's account. *Nursing Forum, 43*(4), 298–246.	2008	Firsthand account of the author intended to encourage others to do the same.	Personal reflection on her abilities. Felt uncertain if she was qualified. Previous experience leading cyclists in the Nicaragua. Reflection on the process of committing to the time and finances.	
11. Delpech, P. A. Developing a short-term international study-abroad program: From beginning to end. *A Journal of Regional Engagement, 2*(2), 156-173.	2013	To describe a faculty led short-term study abroad for BSN students. Concluded with a list of 'lessons learned'.	Faculty participated with students in a classroom orientation about the health care system of Guyana.	
12. Doyle, R. M. Applying new science leadership theory in planning an international nursing student practice experience in Nepal. *Journal of Nursing*	2004	To describe new science leadership and relate it to the planning for international placement in Nepal and for nursing education.	Along with students, faculty examined their leadership styles, the potential impact on career and family life.	

Education, *43*(9), 426–429.			Faculty self-oriented to institutional legalities, safety and security. Most faculty had international experience and it was faculty and student motivation that inspired the IE.	
13. Hegedus, K. S., McNulty, J., Griffiths, L. M., Engler, A., Cabrera, L., & Rose, V. Developing and sustaining a study abroad program as viewed through a caring lens. *International Journal for Human Caring*, *17*(1), 24–32.	2013	Describes a unique program that allows nursing students and faculty to participate in a study abroad experience.	Faculty received 1-week on site orientation in Puerto Rico with preparatory sessions held prior to departure. New faculty are mentored by the internship coordinator, the resident assistant and nursing study abroad committee. Orientation from international coordinator, internship coordinator, resident assistant. Section on various roles and job descriptions of each person involved in the implementation of the IE which includes their criteria for selection (previous experience and interest), responsibilities (one woman quite after not being able to work with resources), and time commitment (need faculty who value international education and participation in international service activities (p. 31). Other attitudes included: courage, grace, caring and persistence.	✓
14. Kohlbry, P., & Daugherty, J. Nursing faculty roles in international service–learning projects. *Journal of Professional Nursing*, *29*(3), 163–167.	2013	Describes faculty roles related to the design and implementation of an international nursing service–learning project.	Identifies support services available for IE. In a section called “summary of faculty roles and responsibilities” describes roles of initiator, collaborator, facilitator, and advocate" with	

			corresponding steps of each role (Step 1, Step 2, Step 3). Other described qualifications include: 'unbridled enthusiasm' (p. 166), interest and past experience in IEs.	
15. Lachat, M. F., & Zerbe, M. B. Planning a baccalaureate clinical practicum abroad. *International Nursing Review, 39*(2), 53-55.	1992	Describes some "pointers" (p. 53) on how to plan a study abroad programme based on the successful experience of. The School of Nursing at Georgetown University.	Includes a section on "Faculty Selection" (p. 54) including adjusting family and teaching schedule, being prepared for emergencies, representing the school. Includes a section on "The Role of Faculty"(p. 55) which include educator, mentor, advisors. Balancing student interaction with teaching. Balancing privacy from students.	
16. Levine, M. A., & Perpetua, E. M. International immersion programs in baccalaureate nursing education: Professor and student perspectives. *Journal of Cultural Diversity, 13*(1), 20.	2006	To describe the unique perspective of one specific professor and a student in immersion programs.	Faculty had significant prior international experience before starting IEs with students. Faculty volunteered their time to help offset cost of tuition for students.	
17. Maginnis, C., & Anderson, J. A discussion of nursing students' experiences of culture shock during an international clinical placement and the clinical facilitators' role. *Contemporary Nurse, 53*(3), 348-354.	2017	Describes anecdotal discussions with students about their experiences on an IE and compares them to the Oberg's (1960) four stages of adapting to culture shock.	Faculty role in reducing students' culture shock has suggested correlation with ability to debrief students, provide a supportive framework, and facilitate the link between theory and clinical.	
18. Mason, C. H., & Anderson, M. C. Developing an international learning experience in the Gambia, West Africa: The rewards and	2007	To discuss the ongoing process, rewards, challenges, lessons learned and recommendations for other nursing programs	Faculty with prior experience and interested made an exploratory trip. Attitudes included willingness to try something new and be flexible.	✓

challenges of a complex partnership. *Journal of Cultural Diversity*, *14*(1), 35-42.		interested in developing a successful partnership.	Program initiated by a political science faculty member who saw a health need in a country and shared with the nursing department.	
19. McKinnon, T. H., & Fealy, G. Core principles for developing global service-learning programs in nursing. *Nursing Education Perspectives (National League for Nursing)*, *32*(2), 95–100.	2011	Discusses key principles for global service learning that have been "shown to foster ethical and compassionate learning experiences, local or global, and are key to the successful development of effective and sustainable service-learning programs" (p. 95). Developed a guideline of "Seven Cs of Global Service Learning".	Seven Cs of best practice are interchangeable with faculty attitudes of compassion, curiosity, courage, collaboration, creativity, capacity building, competence.	
20. Memmott, R. J., Coverston, C. R., Heise, B. A., Williams, M., Maughan, E. D., Kohl, J., & Palmer, S. Practical considerations in establishing sustainable international nursing experiences. *Nursing Education Perspectives*, *31*(5), 298–302.	2010	Discusses "essential factors in establishing sustainable IEs as an integral part of the curriculum" (p. 299).	Section titled "Selecting and Developing Faculty". Faculty should visit host site prior to course. Faculty self-assessment. Anticipating effect on personal life (suggested questions). Self-assessment on if able to tolerate prolonged student interaction. Suggests the importance of institutional support for finances for the IE. Suggests faculty selection is based on previous experience, interest in country, language expertise, and/or professional contacts.	
21. Mill, J. E., Yonge, O. J., & Cameron, B. L. Challenges and opportunities of international clinical	2005	Reviews the history and development international practica for nursing students and the research that has been carried out	Recommends faculty self-reflection of their health beliefs and practices.	✓

practica. *International Journal of Nursing Education Scholarship*, *2*(1), 1-11.		to evaluate the effectiveness and impact of international practica.	Identifies faculty role as teacher, tour guide, nurse, and even parent.	
22. Nicholas, P. K., Corless, I. B., Fulmer, H., & Meedzan, N. Preparing nursing students for education in the global village. *The American Journal of Maternal/Child Nursing*, *37*(6), 367–372.	2012	Describes a specific framework and opportunities for nursing students in caring for the underserved in our global village. Includes discussion of the Fulbright Student Exchange Program, awards, and partnerships.	Suggests use of NLN (2011) toolkit.	✓
23. Noone, J., Kohan, T., Hernandez, M. T., Tibbetts, D., & Richmond, R. Fostering global health practice: An undergraduate nursing student exchange and international service-learning program. *Journal of Nursing Education, 5*8(4), 235-239.	2019	Describes how processes and structures were established for an international undergraduate nursing student exchange and service-learning experience between two schools of nursing.	Described faculty qualifications including interest and experience in global health; fluency in language. Recommended for faculty to visit the site prior to the experience with students.	✓
24. Palmer, S., Wing, D., Miles, L., Heaston, S., & de la Cruz, K. Study abroad programs: Using alumni and graduate students as affiliate faculty. *Nurse Educator*, *38*(5), 198–201.	2013	Describes the use of alumni and graduate students as affiliate faculty in the study abroad nursing setting.	Volunteer affiliate faculty oriented by site directors through phone and email. Oriented to roles and expectations, course outcomes, syllabus, university mission, college mission and vision mission. Recommendation for future affiliate staff to attend the same preparatory class as students did. Qualifications included prior experience or contacts in the IEs location, cultural skills, clinical expertise, interest, language ability.	

			Needed to be willing to pay their own way, use their own vacation time.	
25. Sloand, E., Bower, K., & Groves, S. Challenges and benefits of international clinical placements in public health nursing. *Nurse Educator*, *33*(1), 35–38.	2008	Describes the development of international clinical sites.	Faculty role for the increased responsibility in IEs.	
26. Visovsky, C., McGhee, S., Jordan, E., Dominic, S., & Morrison-Beedy, D. Planning and executing a global health experience for undergraduate nursing students: A comprehensive guide to creating global citizens. *Nurse Education Today*, *40*, 29–32.	2016	Describes a guide for faculty in the planning, infrastructure needs, and implementation of a global clinical experience for undergraduate nursing students.	Recommends faculty orientation to student safety, logistics, discipline issues, policies and procedures, social behaviors of the country, etc. Recommendation for faculty attributes of flexibility, adaptability, willing to learn, and act as ambassadors for future cohorts (p. 31).	
27. Wittmann-Price, R., Anselmi, K. K., & Espinal, F. Creating opportunities for successful international student service-learning experiences. *Holistic Nursing Practice*, *24*(2), 89–98.	2010	Describes safe implementation related to the converging systems of student experience, service learning, educational and institutional responsibility, and international holistic healthcare.	Encourages faculty self-reflection on personal healthcare, money management, food and drink, and appropriate clothing. Suggests a preliminary visit by faculty (p. 91). Qualification include language skills. Description of time and financial cost to faculty.	
28. Wright, D. J. Planning a study abroad clinical experience. *The Journal of Nursing Education*, *49*(5), 280–286.	2010	Describes a study abroad learning experience for senior nursing students and discusses the issues that need to be considered before undertaking such an endeavor.	Recommendation if faculty have current IEs then pre site visit is optional. If no international experience then it is necessary.	
Grey Literature (RNAO Level V)				

29. Chavez, F.S., Petter, E., & Gastaldo, D. Nurses as global citizens: A global health curriculum at the University of Toronto, Canada. In V. Tschudin & A. J. Davis (Eds.). *The Globalization of Nursing* (p. 175-186). Oxon, UK: Radcliffe.	2008	Describes the possibilities and challenges of undertaking curricular change to integrate global health at the baccalaureate program in the Lawrence S. Bloomberg Faculty of Nursing, University of Toronto, Canada.	"Those teaching global health" have to articulate principles coherently" (p. 184). Faculty should also have a commitment and knowledge of critical global health principles to facilitate students critical understanding of the intersections between health and power, race/ethnicity, gender, social class, and nationality.	✓
30. Evert, J., Waggett, C., Faerron Guzman, C., Astle, B., Seymour, B., & Whitehead, D. Faculty Development Workshop: Integrating experiential learning into undergraduate global and public health programs & courses. Brunca, Costa Rica.	2019	A resource guide collated in a workshop which was multi-disciplinary and included a nursing focus. The workshop used presenters' expertise, in global health and IEs, to orient global health educators for global health experiences in and outside the classroom.	Participants were oriented to the definition of global health, the global burden of disease, and the CUGH global health competencies (Jogerst et al., 2015). The workshop also provided a networking opportunity for nursing faculty with other disciplines involved in IEs.	✓
31. National League for Nursing (NLN). *Faculty preparation for global experiences toolkit*.	2011	This toolkit is an initiative of the International Nursing Education, Services, and Accreditation (INESA) joint taskforce of the National League for Nursing (NLN) and the National League for Nursing Accrediting Commission. Information included in this toolkit is intended to aid those in nursing education in the US who are considering international involvement (p. 5).	Divided into sections to guide the preparation of faculty for IEs: Section one: details the various roles faculty may assume in a host country, such as educator, researcher, or consultant. Practical considerations to help faculty prepare for international travel and general guidelines for faculty/student exchanges and collaboration are provided. Section two: issues and perspectives faculty should consider prior to traveling abroad, including how to select a host country. Considerations for determining what is needed prior to departure are included.	✓

			Section three: practical recommendations for the physical preparation of traveling long distance to international countries. This section also provides some preparation for embracing or adjusting to unfamiliar customs. Section four: The role of faculty in a host country and emphasizes the role of visiting faculty as "guests". Section five: Debriefing tips upon returning to the US The tips include evaluating the experience, writing about lessons learned, and designing next steps. Bibliography: Reference and resources to guide faculty.	

Appendix E: Table of Countries Represented in Literature Review

Sending Country	Host country			
USA *: 21 Canada *: 3 Australia *: 1 Not Stated: 5	North America Mexico: 2+ Caribbean Grenada + Dominican Republic: 2 + Jamaica + St. Vincent Grenadines + US Virgin Islands * Haiti ° Middle East Jordan ±	Central America Belize + Nicaragua: 2 ± Guatemala: 5 ± Panama + Europe Belgium * Netherlands * Denmark * Russia + Croatia * Finland * United Kingdom: 2 * *Not stated: 5*	South America Ecuador: 3 + Guyana: 2 + Argentina * Puerto Rico * Brazil * Africa South Africa: 2 + The Gambia ° Ghana: 2 ± Botswana +	South Pacific Australia * Tonga + Asia Nepal ° Taiwan * India: 2 ± Bangladesh ± Hong Kong *

Note: Table of sending and receiving countries represented in the literature review. A number associated with the listed country indicates how many times this country was represented as an IE destination. No associated number indicates the country was represented once.
* High income economies: $12,236 OR MORE
+ Upper middle-income economies: $3,956 TO $12,235
± Lower middle-income economies: $1,006 TO $3,955
° Lower income economies: $1,005 OR LESS
Retrieved from The World Bank (2018)

Appendix F: Rapid Critical Appraisal Tool

Print & Use to Rapidly Critically Appraise Qualitative Evidence

1) Are the results of the study valid (i.e., trustworthy and credible)?

a) How were study participants chosen? _____

b) How were accuracy and completeness of data assured? _____

c) How plausible/believable are the results?

i) Are implications of the research stated? Yes No Unknown

(1) May new insights increase sensitivity to others' needs? Yes No Unknown

(2) May understandings enhance situational competence? Yes No Unknown

d) What is the effect on the reader?

(1) Are results plausible and believable? Yes No Unknown

(2) Is the reader imaginatively drawn into the experience? Yes No Unknown

2) What were the results?

a) Does the research approach fit the purpose of the study? Yes No Unknown

i) How does the researcher identify the study approach? Yes No Unknown

(1) Are language and concepts consistent with the approach? Yes No Unknown

(2) Are data collection and analysis techniques appropriate? Yes No Unknown

ii) Is the significance/importance of the study explicit? Yes No Unknown

(1) Does review of the literature support a need for the study? Yes No Unknown

(2) What is the study's potential contribution? _____

iii) Is the sampling strategy clear and guided by study needs? Yes No Unknown

(1) Does the researcher control selection of the sample? Yes No Unknown

(2) Do sample composition and size reflect study needs? Yes No Unknown

b) Is the phenomenon (human experience) clearly identified?

i) Are data collection procedures clear? Yes No Unknown

(1) Are sources and means of verifying data explicit? Yes No Unknown

(2) Are researcher roles and activities explained? Yes No Unknown

ii) Are data analysis procedures described? Yes No Unknown

(1) Does analysis guide direction of sampling and when it ends? Yes No Unknown

(2) Are data management processes described? Yes No Unknown

c) What are the reported results (description or interpretation)?

i) How are specific findings presented? _____

Appendix G: Human Research Ethics Board Approvals

TRINITY WESTERN UNIVERSITY

Human Research Ethics Board - Trinity Western University

Certificate of Approval

Principal Investigator: Amanda Egert

Department: Nursing

Supervisor (if student research): Barb Astle

Co-Investigators:

Title: Perspectives on nursing faculty preparation for accompanying students on international experiences

HREB File No.: 18G09

Approval Date: June 22, 2018

Certificate Expiry Date: June 21, 2019

Certification

This is to certify that Trinity Western University Human Research Ethics Board (HREB) has examined the research proposal and concludes that, in all respects, the proposed research meets appropriate standards of ethics as outlined by the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans.

Elizabeth Kreiter for Bill Badke

Elizabeth Kreiter, M.L.I.S., HREB Coordinator

Bill Badke, M.Th., M.L.S., HREB Chair

This Certificate of Approval is valid for one year and may be renewed.

The HREB must be notified of *all* changes in protocol, procedures, or consent forms.

A final project form must be submitted upon completion.

The required forms for the above are at:

https://www.twu.ca/research/research-services/research-ethics/approval-forms

7600 Glover Rd., Langley, BC, Canada, V2Y 1Y1 T: (604) 888-7511, F: (604) 513-2047

Dear Amanda

The Human Research Ethics Board of Trinity Western University has accepted your request for continuing approval of your study, and you may proceed.

Date of approval: May 30, 2019

WILLIAM BADKE, HREB co-chair
Associate Librarian, Trinity Western University, for
Associated Canadian Theological Schools and Information Literacy
ACTS Seminaries | Trinity Western University
7600 Glover Rd. Langley, BC, Canada V2Y 1Y1
t: 604.888.7511 ext. 3906 | f: 604.513.2063

William Badke, Research Strategies:Finding your Way through the Information Fog, 6th ed. Bloomington, IN: iUniverse.com, 2017.

http://williambadke.com/textbook.htm

Appendix H: Letter of Information

INSPIRING HEARTS & MINDS

TRINITY WESTERN UNIVERSITY | SCHOOL OF NURSING

Letter of Information

July 16, 2018

Hello,

My name is *Amanda Egert,* and I am a Masters of Science in Nursing graduate student working under the supervision of *Dr. Barb Astle* ***and*** *Dr. Sheryl Reimer Kirkham* in the School of Nursing at Trinity Western University in Langley, British Columbia, Canada.

I am conducting a qualitative study to explore: **Perspectives on nursing faculty preparation for accompanying students on international experiences.**

Your name has been brought to my attention as a person with expertise in global health nursing education, and I am therefore inviting you to participate in this study.

The Human Research Ethics Board at Trinity Western University has approved my study.

If you volunteer for this study, you will be asked to share your experience in a one-to-one interview with the Principal Investigator. Interviews will be 30-60 minutes and audio recorded with some written field notes. There may be an additional 15-30 minute interview to clarify or extend findings. All information collected is confidential and each person's identity will be kept anonymous. For these interviews, I am able to either travel to your location, or meet virtually.

My own personal and professional experiences inspired my interest in this topic. I also have experience in international humanitarian work; however, I have not accompanied nursing students on international experiences. If the opportunity arose, I would respond, "Yes! But how"? This sparked my curiosity on faculty preparation for accompanying students on international experiences.

If you are unable to participate, I thank you for your time in considering my request and would be grateful if you could pass my project along to a colleague with expertise in accompanying nursing students for international experiences.

If you are interested in participating, you can contact me by email ***amanda.egert@mytwu.ca*** to discuss next steps.

Thank you.
Sincerely,

Amanda Egert, RN, BSN
MSN Student, Trinity Western University

Appendix I: Demographics Tables

Pseudonym	Years as a Practicing RN	Years as a Nurse Educator	Number of IEs with students	Location of IEs with students	Current Status	Highest education
Janet	29	24	>20	LMIC	Professor	PhD & Post Doc
Susan	47	25	4	LMIC; HIC	Associate Professor	PhD
Josiah	5	3	1	HIC	Faculty Advisor/ Instructor	BSN
Melissa	11	9	9	LMIC	Adjunct Professor	MPH
Sharon	18	9	9	LMIC; UMIC	Professor	PhD
Bonnie	47	40	3	LMIC; UMIC	Semi-Retired	PhD
Hilary	47	18	6	LMIC; UMIC	Retired	MSN
Julie	48	18	5	LMIC	Retired	PhD
Tim	5	2	2	LIC	Clinical Instructor	BSN
Note: Pseudonyms and prior experience of participants.						

Province	Age	Gender	Self-identified ethnic heritage
BC = 3 AB = 3 SK = 2 ON = 1	<20 = 0 21-30 = 1 31-40 = 2 51-60 = 2 61-70 = 4 >70 = 0	F = 7 M = 2	European* = 8 Did not answer = 1
Note: *Participants self-selected heritage as European, Scottish, German, English, Irish, Polish, and Canadian			

Appendix J: Interview Guide

Topic: *Previous International Experiences*

1. Tell me about your previous international experiences? [in general]

    a. Prompt: where have you travelled in the past? Outside of Canada? What was the purpose of your international trips?

    b. Prompt: what is your experience taking students on an international experience

        i. Where did you go? What was the location like? How long? How many students were with you? When was your first experience? When was your last experience? What were your specific responsibilities while you were on the international trip with the students? [For example, "Did you supervise clinical"? or "Were the students with a preceptor?"] Tell me more about specifically your role and responsibilities while you were on the international experience.

        ii. What preparation did you, as the Nurse Educator have prior to going on these international trips with students?

        iii. Did you feel prepared? What was it that contributed to feeling prepared/unprepared?

        iv. [Listen if they felt unprepared at first yet felt more prepared overtime]. What is it that contributed to the transition of feeling 'unprepared' into feeling 'prepared'?

        v. What is your background in global health, beside your experiences have you had any training in international/global health?

Topic: *Nurse Educators "Lessons Learned or what I learned during these trips"*

2. Now that you have taken students on an international experience once [or how many times they have], what have you learned from it?
    a. What worked well? Why do you think that worked well?

    b. What do you wish you knew before you went? Why would you do you wish you knew that?

        i. What have you learned about any mistakes that you've made?

        ii. What would you do differently?

iii. [For those who have had multiple trips with students]. If your next international experience was in a "new" location what knowledge and skills from your previous experiences would you bring with you to prepare for this new location?

Topic: *Preparation for Nurse Educators based on "own" experience*

3. Looking back at your initial experiences and reflecting on where you are at now – What would you tell other Nurse Educators who might be in a similar situation, as you, with taking students for an international experience?

    a. Prompt: how best to prepare before going?

    b. [For those with multiple experiences]. How does preparation vary across different experiences?

Topic: *Requirements for Nurse Educators taking students on International Experiences*

4. What specific elements are necessary for "faculty preparation" for these types of international experiences with students?

    a. What specific knowledge and skills does a nurse educator, like yourself, need to have to be prepared to take students on an international experience? Prompts: Specific Topics of study? Background? Qualifications? Qualities?

    b. What are your thoughts on if a nurse educator who accompanies students internationally has a bachelors, masters, or PhD?

    c. How do you handle when your students have experienced difficult situations in the global context for example "poverty"? Did you feel comfortable (prepared for) when you were in that situation?

        i. What kind of knowledge (skills, attributes) is needed for faculty to provide a response to these difficult conversations? How did you prepare?

    d. [Listen for social justice/equity themes. If they do not name them explicitly, ask]: Global health has equity as one of its core dimensions. How can faculty be prepared to teach this?

        ~~i.~~ How can faculty prepare to teach important concepts of global health during international experiences?

Topic: *Selection of Nursing Educators for International Experiences*

5. Tell me - how were you selected to take nursing students on an international experience?

a. Prompt: For example, how were you chosen as the Nurse Educator to take students on an international experience?

b. [For those with multiple experiences]: If you were in a position to select faculty - What would you look for in faculty who are selected for these experiences? What would you see as important to prepare them? How would you help them prepare?

Topic: *Implications of Faculty Preparation*

6. What do you think the implications of faculty preparation are?
    a. Prompt: What are some potential outcomes if faculty are not prepared? What are some potential outcomes are prepared?

Topic: *Conclusion*

7. We have completed the questions I planned on asking you - Is there anything else you would like to add, or a topic I might have missed?

That concludes our interview; Thank you for sharing your time and your perspective with me today, your contribution to this area of research is valued.

I will be contacting you sometime within the next month regarding a secondary interview of about 15-30 minutes as per the consent form.

----------(End recording)----------

Appendix K: Informed Consent

TRINITY WESTERN UNIVERSITY | SCHOOL OF NURSING

Informed Consent

Perspectives on Nursing Faculty Preparation for Accompanying Students on International Experiences

Principal Investigator: Amanda Egert, RN, BSN, Graduate Student, Masters of Science in Nursing, Trinity Western University, Langley, BC.
Phone: 604-365-2575; Email: Amanda.Egert@mytwu.ca

Supervisor: Barb Astle, PhD, RN. Associate Professor, Trinity Western School of Nursing, Langley, BC. Phone: 604-513-2121 ext. 3260; Email: Barbara.astle@twu.ca

This research is part of a Capstone Project submitted in partial fulfilment of the requirements for the degree of Masters of Science in Nursing at Trinity Western University.

Purpose: The purpose of this project is to explore nursing faculty preparation for accompanying nursing students on international experiences. You are being asked to participate because of your expertise as a nurse educator and your experience with international experiences.

Procedures: If you agree to participate, you will be interviewed for 30 – 60 minutes by the Principal Investigator at a mutually agreed upon time and location. If needed, there may be one follow up interview of 15-30 minutes to clarify or extend data obtained from the research. The interviews will be audio-recorded. After the interview there will be a short debriefing session. You will receive a copy of the consent form to take home. A summary of the research findings will be made available to the participants by contacting the Principal Investigator.

Potential Risks: No potential risks or discomforts are anticipated. If you feel at any point you need to withdraw from the study, please know you can do so with no negative consequences.

Potential Benefits to Participants and/or to Society: Nurses often benefit from the reflexive activity of talking with other nurses about their professional practice. Your expertise may contribute to furthering the understanding of preparation required by faculty who take nursing students on international experiences. This information may then be used to prepare future nursing faculty who are interested in taking students internationally.

Confidentiality: Any information that is obtained in connection with this study and that can be identified with you will remain anonymous and will be disclosed only with your permission or as required by law. Research materials will be identified by a participant numbers and kept in a secure digital file stored on a password-protected computer. A key code number (linking

Appendix L: Demographic Information Form

DEMOGRAPHIC INFORMATION

Name: _____ Code: _____

Interview date: _____ Time: _____

Interview location: _____

Age range: 21-30 years ☐ 31-40 years ☐ 41-50 years ☐

51-60 years ☐ 61-70 years ☐ 70+ ☐

Gender: _____

Self-identified orientation to culture:

Country of birth: _____

Languages spoken fluently: _____

Languages spoken conversationally: _____

Ethnic heritage: _____

Years of experience as a professional nurse: _____

Years of experience as a nurse educator: _____

Number of trips accompanying nursing students: _____

Locations of international experiences: _____

_____

Number of times assisting with faculty development for another nurse educator: _____

Current position or role: _____

Highest level of education: Masters: _____ Doctoral: _____ Other: _____

Email address: _____

Phone: _____

Mailing Address: (if interested in receiving an executive summary)

_____

_____

Appendix M: Follow Up Questions

In the last interview we talked about nursing faculty preparation for accompanying nursing students on international experiences. At that time, I mentioned that I might ask you for a follow-up interview of 15 – 20 minutes to clarify or extend the data obtained from the research. I have a couple more questions that I would like to ask you.

1. Describe other elements that you think would be unique or different in preparing Nursing Faculty to take students on a Global Health placement?
    a. For example, in comparison to teaching another nursing course but in Canada (i.e. Clinical in the hospital/community).
    b. For example, in comparison to other disciplines such as Engineering, Education, for example?

2. Describe how would you define "faculty preparation" (for accompanying students on IEs)?
    a. Describe how would you describe a faculty who is prepared?
    b. Describe how would you describe a faculty who is unprepared?

3. Is there anything else you would like to add?
4. Do you have any other questions for me?

Appendix N: Code Book

1. Past Faculty Global Experience(s)
    a. Research
    b. Travel
    c. Volunteer (missions vs. humanitarian aid vs. work)
    d. Work Related
    e. Serendipitous
    f. University (School)

2. Perceptions of Preparation "for" the students (by faculty)
    a. Responsibilities for safety (emotional & physical; responsible *to* student/parent/institute)
    b. Responsibilities for pre-departure logistics (immunizations, passports, travel, finances)
    c. Responsibilities for "what is being taught" [pre-trip (training), during-trip (schedule/experience), post-trip (debriefing)]
    d. Responsible for translating learning to another context (local to global connection)
    e. Responsibilities for student selection
    f. Responsibility for "team dynamics"/"facilitating interpersonal relationships"
    g. 24/7 responsibility
    h. Responsibility for "sustaining the program"

3. Perceptions of Faculty Preparation
    a. Unprepared (and "what it felt like"; Memo: the consequence is 3j, 7c)
    b. Changed over time (preparation changes over time; preparation as context dependent)
    c. Knowing "why you're going" (having purpose including Attitudes)
    d. Knowing "what one can or cannot do" (competencies - [Skills])
    e. Knowledge of global health (**critical perspective** - e.g. equity, away from "western" thinking, critical perspective – global relations of power/ social relations of power –)
    f. Knowledge of global health (**non-critical perspective** - e.g. cultural competency, cultural knowledge)
    g. Mentored for the role (formal/informal)
    h. Lack of formal training (i.e. no information on how to supervise students in global settings)
    i. Working with "like-minded" persons (colleagues and hosts; networking)
    j. "On my own"
    k. "Trial-and-error" (learning on-the-job) (code with 3a, 7c)
    l. "You can't be prepared for everything"
    m. Personal commitment/sacrifice ("off the side of my desk", time, finances, "a lot of work", and commitment over time - sustainability)
    n. "I felt prepared"
    o. Connecting research and professional practice with IE

4. Faculty Perceptions of Hosts
    a. Formal & informal partnerships (how to partner; who to partner with; maintaining local-global connection)

b. Formalizing partnerships (i.e. MOU)
c. Building sustainable informal and formal partnerships (How to?)
d. Challenges of informal and formal partnerships

5. Who should/is going?
a. Innate qualities (e.g. passion, "want to go", adaptability, commitment, OK with discomfort, interpersonal SKILLS)
b. Experience over time (experiential, content, teaching; global health/bedside/clinical teaching, language)
c. Credentials (BSN, MSN, PhD, retired)
d. Mentored ('should be' mentored). CONSIDER: Two faculty at once (different than just mentorship) – P6, P2?
e. Orientated (i.e. site-visit, instructor guide)
f. Role models (for the profession of nursing)
g. Managing multiple roles (managing groups/course/experience/relationships etc.)
h. Successful faculty selection process (i.e. interview, self-selection)
i. Those with previous established relationships in host country (add – and elsewhere – like P6 ally doctor who saved the student)
j. Prepared for 'anything and everything'

6. Reflections Post Experience
a. Insights about best practices (i.e. optimal student profile; #of weeks; student: faculty ratio)
b. Need stronger **Knowledge, Skills, Attitudes,** (global health/critical perspectives etc.)
c. Self-reflection/personal epiphany/aha moment
d. 'Buy in' from stakeholders in the sending institute ("not a vacation", value curriculum)
e. "there's just something different about IEs"

7. Consequences of Unprepared Faculty
a. Relying on trial-and-error (3a, 3j)
b. Negative impacts for students
c. Negative impacts for hosts
d. Negative impacts for faculty (i.e. I feel like an imposter)

8. Context (i.e. This is what we did, how many students were there, where we went?)
a. Context of the I.E
b. Context of the Faculty (pioneer of the program)

9. Emotions

Appendix O: Enhancing Study Credibility

Strategy	Description	Implementation for this Study
Epistemological Integrity	Defensible line of reasoning from the assumptions made about the nature of knowledge through to the methodological rules by which decisions about the research process are explained.	Research questions have been grounded in the philosophical underpinnings of knowledge being constructed truths situated in the subjective naturalist human experience.
Disciplinary Relevance	The relationship between research and the disciplinary knowledge that is sought to be advanced.	The background and current literature of faculty preparation for IEs supports the relationship, and importance, to the nursing discipline.
Moral Defensibility	Convincing claims about why the knowledge extracted from people is necessary and the purpose of the knowledge once it is obtained.	The background and current literature of faculty preparation for IEs provided reasoning for the conception of the study and relevance to nursing education.
Contextual Awareness	Researcher acknowledgement that the epistemological claims within which qualitative research methods are grounded solidly locate the new knowledge within the society that constructs it.	The contextual positioning of the researcher and research questions through exploration of the historical background of IEs, a reflexive journal, and an audit trail.
Analytic Logic	Explicit reasoning of the researcher from the fore-structure to interpretations and knowledge claims.	Decisions from the inception of the research design how interpretations and knowledge claims were made were tracked through an audit trail and supported by a reflexive journal.
Interpretive Authority	Assurance of the trustworthiness of the researchers' interpretations.	Member-checking through secondary interviews to extend initial interpretations and conceptualizations.
Representative Credibility	Theoretical claims are consistent with the manner in which the phenomenon under study was sampled.	Triangulation between interviews, literature review, and research committee.

Pragmatic Obligation	Researchers are obliged to consider their findings "as if" they might indeed be applied in practice.	Findings will be presented with the intention that they could be applied to practice, but the caution that sweeping generalization may result in inappropriate application to practice.
Probable Truth	A reverence for the ambiguous zone of validity and shared reality.	Findings will be presented with caution to sweeping generalizations and instead adhere to the understanding that findings from a carefully constructed study can prove to be untrue in future and differing contexts.

Note: This chart is adapted from the chapter "Enhancing Credibility" in Thorne, S. (2016). *Interpretive description: Qualitative research for applied practice* (Second edition). New York, NY: Routledge. *permission for adaptation has not been received.

Appendix P: Transcriptionist Confidentiality Form

INSPIRING HEARTS & MINDS

TRINITY WESTERN UNIVERSITY | SCHOOL OF NURSING

Appendix S

Transcriptionist Confidentiality Form

June 11, 2018

I agree to participate in the research project: ***"Perspectives on Nursing faculty preparation for accompanying students on international experiences"***.

I will protect CONFIDENTIALITY in this study by translating any names of persons or institutions I encounter during transcription into pseudonyms. As well, I will not disclose any information from the research materials to any persons or agencies.

I will not email transcripts or research materials, but rather upload them to Owncloud. All research materials will be kept secure on a password protected, encrypted computer while in my possession. Once I have completed each transcription, I will also erase all transcription materials from the hard drive of the computer I am using.

I have discussed these requirements with the research team and have received a copy of this consent form.

_____ Printed Name of Transcriptionist

_____ Signature of Transcriptionist

_____ Date