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REVIEW

Global/Local: What Does It Mean for Global Health Educators and How Do We Do It?

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Abstract

BACKGROUND There has been dramatic growth in the number of innovative university programs that focus on social justice and teach community-based strategies that are applicable both domestically in North America and internationally. These programs often are referred to as *global/local* and reflect an effort to link global health and campus community engagement efforts to acknowledge that a common set of transferable skills can be adapted to work with vulnerable populations wherever they may be. However, the concepts underlying global/local education are undertheorized and universities struggle to make the global/local link without a conceptual framework to guide them in this pursuit.

OBJECTIVES This study reports on the outcomes of a 2015 national meeting of 120 global health educators convened to discuss the concepts underlying global/local education, to share models of global/local programs, and to draft a preliminary list of critical elements of a meaningful and didactically sound global/local educational program.

METHODS A qualitative analysis was conducted of the discussions that took place at the national meeting. The analysis was supported by videorecordings made of full-group discussions. Results were categorized into a preliminary list of global/local program elements. Additionally, a synthesis was developed of critical issues raised at the meeting that warrant future discussion and study.

FINDINGS A preliminary list was developed of 7 program components that global health educators consider essential to categorize a program as global/local and to ensure that such a program includes specific critical elements.

CONCLUSIONS Interest is great among global health educators to understand and teach the conceptual link between learning on both the global and community levels. Emphasis on this link has high potential to unite the siloed fields of global health and domestic community public health and the institutions, funding options, and career pathways that flow from them. Future research should focus on implementation of global/local programming and evaluation of student learning and community health outcomes related to such programs.

KEY WORDS community engagement, global health, global health education, interprofessional education

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INTRODUCTION

This article reports on a working meeting that took place in conjunction with the 2015 Consortium of Universities for Global Health (CUGH) conference in Boston.* The meeting, **"Global/Local: What Does It Mean for Global Health Educators and How Do We Do It?"** was the first meeting of global health faculty and administrators to tackle the explicit theme of global/local education and practice.

The number and scope of global health programs is growing rapidly in universities across the United States.[1] At the same time, most universities are restating and enhancing their commitment to active community engagement, often in the form of efforts to affect the social determinants of health in the community and include participation of community partners in the educational process.[2] Increasingly, universities are trying to find ways to link their global health and community engagement initiatives. The terms *global/local* or *glocal* are frequently used to describe these efforts and to express an important but poorly articulated understanding that global health's traditional international focus must be linked—conceptually and in practice—with the needs in our own domestic communities. However, little work has been done to define the underlying concepts and goals of global/local programming and many universities struggle to make the global/local link in the absence of a conceptual framework or models to guide them in this pursuit.

Global health has always focused on the health of communities, but almost exclusively on communities outside the global north and outside the home communities of global health faculty and students.[3] This is consistent with historical forces that encouraged the transfer of skills and services from countries with more resources to countries with fewer resources.[3] However, in recent years, global health educators have recognized that virtually all of the skills that characterize good practice in an international low-resourced setting are appropriate when working with vulnerable populations domestically and vice versa. In other words, the idea that one set of skills is needed for international global health work and another for community health (ie, domestic) work is mostly inaccurate and squanders opportunities for shared research and solutions. Furthermore, this gap has led to a number of downstream consequences, including siloed global health and community public health educational programming; an absence of educational models that successfully link global and local health; limited pathways for sharing lessons and innovations from the local level to the global level and vice versa; and rigid career paths that limit movement between both fields.

It is hard to pinpoint the emergence of the global/local movement in North America, but it is a recent phenomenon—very few programs used the term *global/local* 10 years ago. The movement is likely the unintended but happy result of 2 recent developments in education—the rapid growth of global health as a field of study and a national movement to renew the civic mission of US colleges and universities. Over the past decade, interest in global health among undergraduate and graduate students has reached unprecedented levels.[1] This growth reflects multiple trends including greater student awareness and interest in global issues and a demand for educational opportunities to meet this interest; heightened public awareness of the global health agenda primarily because of HIV/AIDS and influenza outbreaks; and expansion of public and private funding in global health that creates research funding for faculty and career paths for students.[1] Additionally, a strong push by US colleges to increase their study-abroad participation rates is generating interest in the field of global health and the opportunities it offers for international educational experiences and later, careers.[4-6]

At the same time, major professional organizations, including the National Association of State Universities and Land-Grant Colleges, the American Association of State Colleges and Universities, and the American Association of Community Colleges have developed significant initiatives to promote a civic-oriented agenda among campus presidents, faculty, staff, and students with community stakeholders and partners.[2] The community engagement movement of the past decade is framed as a step away from the 1-way approach to delivering knowledge and service to the community in favor of "engagement" or a 2-way approach to interacting with community partners to address societal needs.[2]

*The pre-CUGH meeting was organized and sponsored by the Virginia Rowthorn, JD, and Dr. Jody Olsen of the University of Maryland Baltimore Center for Global Education Initiatives; Dr. Jane Lipscomb and Dr. Lori Edwards of the University of Maryland Baltimore Center for Community Engagement and Learning; and the USAID Global Health Fellows Program II (Dr. Sharon Rudy, director). Materials from the meeting can be found at http://www.umaryland.edu/global/globallocal-initiative/cugh/.

This collaborative model, whereby community partners play a significant role in creating and sharing knowledge to the mutual benefit of institutions and society, mirrors a similar effort by global health educators to increase bi-directional sharing of successful interventions across communities, including from the Global South to the Global North. Finally, many participants at the meeting noted that pandemic infectious diseases outbreaks, most notably the West African Ebola crisis, have made it clear that our current paradigm for health education is gravely lacking in its ability to foster understanding, empathy, and bi-directional collaboration between health care professionals, patients, and communities across the globe.[7]

In the past 10 years, there has been a concerted effort on the part of some global health educators to explicitly acknowledge the relevance and value to global health of working with vulnerable populations in the United States. There has been growth in the number of innovative courses, experiential learning programs, and clinical opportunities at the undergraduate and graduate levels that focus on social justice and teach culturally appropriate community-based strategies that are applicable in settings both domestic and international. Only some of these programs use the terms *global/local* or *glocal*, but all are framed as a way to link global and local learning.

METHODS

Faculty members from the University of Maryland Baltimore held a working meeting in conjunction with the annual CUGH conference on March 16, 2015. The meeting was advertised as a preconference session with the title, "**Global/Local: What Does It Mean for Global Health Educators and How Do We Do It?**" to which any CUGH conference registrant was invited to attend; 120 people attended the meeting primarily from North American institutions. The meeting consisted of plenary lectures, lightening presentations, and structured small-group discussions. Video recordings were made of full-group discussion. Participants were given specific topics to discuss during small-group discussions that were facilitated by the organizers. Two note takers recorded discussion in each of the 10 small groups. A qualitative analysis was conducted of the small-group discussion and the results were categorized into a preliminary list of global/local program elements. Additionally, the author synthesized discussion of other critical issues in global/local education that warrant future discussion and study.

RESULTS

> Global/local (glocal), as applied to health and health care, means having a global perspective or understanding of transnational health issues, determinants, and solutions, and applying that perspective to address health care problems at the local level. It means learning from others and adapting lessons learned in other contexts to local contexts. It goes beyond national political borders and means that we are all citizens of a global planet. It means thinking globally and acting locally AND globally!
>
> —*meeting participant Dr. Lynda Law Wilson, professor and deputy director, PAHO/WHO Collaborating Center on International Nursing (retired), School of Nursing, University of Alabama at Birmingham*

At the meeting, participants agreed that there is no clear definition of what constitutes a global/local or glocal program in the context of health, nor even a common understanding, and many expressed a sense of frustration regarding the lack of a guiding set of goals or principles to direct their work in this area. To assist universities and faculty members in creating global/local programs, meeting organizers asked participants to identify the critical elements of global/local programs during small-group discussion. Based on a qualitative analysis of the small-group discussions, the author was able to establish a preliminary list of 7 program components that global health educators consider essential to both categorize a program as global/local and to ensure that such a program includes specific critical elements. Participants agreed that it may be impossible to include all these elements in a single course or program but this aspirational list can serve as a useful guide.

Community Engagement. Global/local programs should be more than a teaching tool, but rather they should meet a need in the community. Identifying community needs requires engaging the local community in the process, a central tenet of community engagement and global health. This will ensure that new initiatives have value for both communities and students.

Global Frameworks/Local Solutions and Transferable Skills. Students should be taught universally recognized health frameworks such as the social determinants of health, international human rights law, ethics (clinical, research, professional), cultural competence, program development, and program evaluation with a practical focus on how to adapt these frameworks to the needs of a particular community. These skills should be taught along with (or as part

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of) professional skills to form a set of transferable skills that can be adapted to vulnerable populations wherever they exist.

Focus on Social Justice and Health Care Disparities. Given that the availability of adequate health care is almost always affected by socioeconomic factors, global/local programs must maintain a focus on health disparities and social justice.

Bi-directional Learning. Understanding health and health care in context is the door to reciprocal sharing of successful local strategies in a way that has not occurred historically and thus global/local programs should teach students the value of bidirectional learning and how to adapt tested strategies to meet local needs.

Experiential/Clinical Learning. Global/local programs should offer students the opportunity to step out of the classroom and develop their ability to work with individuals, groups, and organizations that are new to them. A global/local program can provide this opportunity locally, internationally or, ideally, in both settings. For graduate students, this can take the form of clinical work in which students practice their professional skills under appropriate supervision. In other cases, experiential learning can expose students to community engagement through structured observation, interaction, and service.

Interprofessional Approach. Improving health requires a broad array of multidisciplinary and multifaceted methods. Global/local programs should teach the students the value of an interprofessional approach at the curricular level by incorporating faculty and students from different schools in a single program.

Reflective Component. Participants noted that the value of structured reflective opportunities for students taking part in immersion experiences. Reflection is critical to guide the learning process and facilitate personal growth.

DISCUSSION

In addition to discussing the important elements of sound global/local programming (noted in the Results section), the meeting organizers posed additional questions to participants during small-group discussion. The important and repeating points raised in response to these questions are set forth here. This section is divided into the same questions the meeting organizers posed to participants. Each section also includes background information relating to the particular topic.

What Do Global Health Educators Mean by *Global/Local* and *Glocal*? Meeting participants agreed that a significant obstacle to discussing global/local education and practice is the inadequate language educators have to describe what they mean. "Global" can refer to communities both near and far, just as the word "local" can. They also agreed that the difficulty they experience discussing and framing global/local is not a superficial problem of language, but a reflection of deeply rooted conceptions of international relations and foreign aid. Complicating matters is a lack of clarity as to whether global/local is a noun (a type of program) or a verb (a thing we do) and whether it refers to education or practice or both and at which level—undergraduate or graduate or both? It is critically important to work through these language obstacles to bring needed rigor to the global/local discussion.

Little scholarly work has been done to define or flesh out global/local or glocal concepts. Many of the themes that are discussed in this article already exist in global health and community public health scholarship, whereas others are drawn from the fields of global citizenship; service and experiential learning; study abroad; program design and evaluation; and cultural competence among others.

No explicit definitions of global/local or glocal are described in the health sciences or public health literature but some prominent global health leaders have used the term *glocal* to describe the interaction between the local and the global. In 1999, Dr. Ilona Kickbusch in her editorial, "Global + Local = Glocal Public Health," noted that the term *glocal* should be used to refer to global initiatives ("visions") such as the World Health Organization's Healthy Cities program that "become real at the local level and can in turn be significantly strengthened because of this local base."[8] She noted the intense interaction between the global and local and argued that Healthy Cities, which was designed to promote local public health, has become vital enough to serve as a "forceful constituency of interest for global health."[8] Her underlying theme, that global ideas can be adapted to local use and, when successful at the local level, create a global movement was echoed in a 2007 article by Evelyne de Leeuw, Kwok Cho Tang, and Robert Beaglehole, "Ottawa to Bangkok—Health Promotion's Journey From Principles to 'Glocal' Implementation."[9] In this journal introduction, the authors asserted that the Internet and growing awareness of poverty, debt, and health issues that transcend national borders now require "connecting global phenomena with everyday

life."[9] They argued that a "glocal" approach to health promotion is necessary to ensure "sustainable, resilient and persistent action at all levels—local, regional, national and international" and that using a glocal approach is both "feasible and necessary."[9]

Using this approach, global/local programs can be seen as a method of training students how to adapt global solutions to local problems and share solutions across global communities. With vulnerable communities in our own backyard and the responsibility of universities to engage with neighboring communities, meeting participants noted that it seems artificial and shortsighted to insist that such learning can only take place abroad. Of course, as Paul Farmer noted correctly in *Reimagining Global Health*, "many of our students want to follow the economic gradient down to some of the poorest and most disrupted places on the face of the earth. They want to learn how to work in the places that are in greatest need of modern medicine and public health."[10] This commitment on the part of global health students and practitioners to take on the struggle for equity in the places of greatest need is something meeting participants agreed is critical to foster. However, they also agreed that a robust global health program should offer students the opportunity to study and work in a variety of community settings from less needy to more needy and, importantly, that working with vulnerable communities in the United States may be particularly useful in developing a deep sense of commitment to the needs of others, many of whom are neighbors.

Definition of Global Health: Is It Broad Enough?

Meeting participants were asked to consider whether and how the idea of global/local and glocal fit within the existing global health education paradigm. Some noted that current definitions of global health fully incorporate the type of local community engagement envisioned by global/local programs. The most commonly cited definition of global health—that of Koplan et al.—describes 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"[11] (italics added). A review of the 5 most commonly used definitions of global health conducted by Campbell et al. in 2012 (which included the Koplan definition) distilled the common elements of each definition into 5 primary characteristics: equity, global conceptualization, understanding causes of health issues, means (focus on interventions as well as research), and solutions.[12] These primary definitional elements of global health seem not only broad enough to encompass global/local education, but to encourage it. In the "global conceptualization" bucket, Campbell et al. found that the 5 definitions they considered all defined "global" as

> ignoring borders altogether and bridging gaps between need and care wherever they may exist. This is not to say that borders are porous or nations unimportant. National governments continue to provide the bulk of funding for development assistance in health, although the channels through which they are funneled are increasingly becoming global actors…What is truly "global" is the conceptualization of health itself, represented by the goal of health for all people, irrespective of location or nationality. Not surprisingly, all five of the definitions considered by the expert panel embrace a global conceptualization and refer to the goal of "health of all people or health for people worldwide."[12]

It is clear that the field of global health, as articulated by scholars supports global/local programming. But if this is true, why are there so few global/local programs and why are many global health educators clamoring for more direction in this area? One problem appears to be that—for historic and sociological reasons that are beyond the scope of this article—faculty and students in the global north have trouble seeing vulnerable communities in their backyard in the same way they see vulnerable communities overseas and understanding that the same community-based approaches we use domestically can be appropriate internationally and vice versa. Working group participants noted that this inability to see health disparities in our own communities is outdated and will be harder to sustain as the ethnic and cultural diversity of the United States grows, but it is one of the critical gaps in learning that educators need to address with global/local programs.

One of the few scholarly works to explicitly define the link between global and local health is the book *Developing Global Health Programming*.[13] The authors argues that the fields of global health, public health, and international health share important themes and that "local health and global health practitioners are one and the same."[13] The book further emphasizes the importance of teaching global health students that "they must recognize the two-way transfer of knowledge and skills between communities near and far, and apply a keen focus on the members of society carrying the greatest burden of disease."[13] This conception of global health comports with what many see as the goal of global/local education. The authors list 7 themes connecting global and local health:

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1. Health care disparities among populations in local communities and international settings.
2. The importance of public health principles to effect large-scale change in both local communities and abroad.
3. The importance of understanding health care access issues in order to advocate for resources.
4. The importance of cost-effective, evidence-based care for sustainable global and local health initiatives that improve access, affordability, and effectiveness of care.
5. The importance of cultural competency in any setting given the movement of people around the globe and increasing diversity of patient populations.
6. The value of working in multidisciplinary teams, highly with community health workers who are particularly effective in reaching patients with limited access to health care.
7. The importance of working with local agencies and community partners.[13]

Many participants at the meeting noted that these principles flesh out the definition of global health in a useful way and are a good starting point to help frame global/local education and inform global/local program development. In other words, reframing global health or expanding existing definitions is not necessary, rather global health educators need to find ways to actualize the stated goals of global health as Evert et al. suggest in their book.

How Does the Irresistible Lure of Studying and Working Abroad Affect the Global/Local Discussion? A persistent theme at the meeting was the value accorded to international study and work over local community engagement and the effect of this phenomenon on education. The preference for international engagement likely starts at the undergraduate level, if not earlier. Undergraduate education has been highly influenced by studies that show the value of "global learning," and US colleges have used this as a mandate to increase participation in international study abroad. As noted earlier, many universities are actively promoting study abroad with 150 colleges recently agreeing to work together to double the number of US college students that study abroad by 2020.[14] This effort, known as the Generation Study Abroad Initiative, cites a number of prominent national studies that support the value of a global perspective for personal growth, increased cultural competency, and development of cutting-edge technical skills that many employers now seek in a global market.[14] As laudable as this effort is, there is an important discussion taking place in the undergraduate study-abroad community that is highly relevant to the global/local discussion. Among faculty and administrators who work in the study-abroad field, a number are embracing the concept of "study away."[15,16] The rationale behind the study-away movement is that many of the transformational learning experiences that students obtain abroad can be achieved through programs that take place domestically through community engagement experiences. One such scholar, Kenneth Koth, succinctly summed up the argument for making *both* domestic and international community engagement programs available to students:

> Any short list of skills for success in the twenty-first century should include the ability to understand, engage, and lead across cultures. Indeed the continuing demographic shifts in the Unites States as well as the incredibly globalized nature of the workplace make these skills essential. College and universities frequently see study abroad as a central strategy for helping students develop these skills. Yet, while significant, international study does not have to be the only strategy. Local engagement…can provide opportunities for intercultural learning.[17]

Participants at the meeting noted that the value of study abroad is its offer of disruptive immersion experiences that train students to manage complicated logistical issues, handle the complexity of unfamiliar situations with unfamiliar people, and work outside their comfort zone toward defined learning objectives. A recently published book, *Putting the Local in Global Education*, argues that these goals can be achieved in local settings.[18] The contributing authors describe innovative examples of programs that take place in the United States to demonstrate that a well-designed immersion program that provides students with the structured opportunity to step off the campus, interact with communities they may not be familiar with, and reflect on the experience can meet the goals of study abroad and foster global citizenship in students. Furthermore, these domestic experiences may be more accessible to students with fewer resources and older students with family obligations. The editor of the book, Neal Sobania (who participated in the working meeting), argued in the introduction that if undergraduates are trained as "global learners" the distinction between global and local—a false dichotomy—will fade.[19]

Meeting participants found the study-away discussion very useful for a number of reasons. First, the push for increased study abroad at the undergraduate level may explain the preference for international opportunities at the graduate level

and even explain the allure of global health over community public health. The study-away conversation—although focused on undergraduates and developing global learners—provides insight into how graduate global health education can justify and create well-designed opportunities for students to learn in the local community.

What Are the Challenges to Working in the Community? As counterintuitive as it may seem, many meeting participants noted that there are real and perceived barriers that making teaching and working at the local (domestic) level seem more challenging than teaching and working internationally. Participants enumerated process-related issues that may seem overwhelming at the community level (eg, the need for permits, approvals, fear of infringing on other faculty already working in the community, and not wanting to conflict with bigger university-level community goals). Although there are innumerable process-related challenges in global work, many agreed that encountering such challenges in their own backyard may be particularly frustrating because they have to traverse the same bureaucracies in their daily lives outside their university work. Participants also noted funding and career barriers to community engagement, including less funding for community-level activities, less career return on investment for community activities than for global activities, and research saturation at the local level. Furthermore, some noted that working abroad offers faculty protected time for engagement and research that is not possible when working in their home communities.

More difficult to describe and worthy of additional research are barriers relating to the perception of poverty in our own communities. Some meeting participants noted that there may be more judgment of local poverty and this can dampen enthusiasm for community engagement, as can unfavorable feelings toward local politicians and governments and paralyzing despair with intransigent local problems. There may exist skepticism on the part of local partners who have either not benefited from neighboring universities in the past or have been the subject of numerous assessments or projects that have not led to ongoing collaboration.

Finally, some participants noted that global work might be perceived by some as "easier" because short-term projects create the illusion that progress can be made quickly with a lasting result. This situation can arise when language barriers, unfamiliarity, and deference to outsiders masks the complexity of local needs. Some interventions that may be useful in low-resourced settings, such as hand washing and oral care, seem easier to advance than more complicated health system interventions that require long-term dedicated collaboration with local partners, something harder to observe and understand during a short-term project. Participants strongly agreed that this perception among some students is a reflection of inadequate teaching, improper understanding of the root causes of health disparities, and superficial attitudes toward solving them.

Some participants noted that community engagement in the students' backyard is sometimes perceived as less important, less glamorous, less meaningful, and less valuable from a career perspective. Discussants agreed that global education and practice has come to mean something exotic and different, whereas working in the community is often integrated into our daily lives and therefore does not satisfy the urge many students and faculty feel to experience new places and people.

The existence of real and perceived barriers to working in our own communities raises many difficult and sensitive questions that need to be addressed to reframe and encourage community engagement. Participants noted that these barriers are very costly to community engagement efforts and strip local communities of vast student energy and resources. These barriers must be addressed head on by universities, community engagement faculty, and global health faculty. Linking global and local education can be both a start to these conversations and an end result.

What Is the Effect of the Global/Local Divide on Employment? As part of the meeting, Sharon Rudy, director of the USAID Global Health Fellows Program II discussed informal research her program conducted to study the hiring practices and biases of global health employers.[20] She surveyed 49 experienced global health program directors in 2015. The survey respondents affirmed that they would "tend not to hire those with only local or domestic experience unless they needed a specific skill set." The survey revealed that global employers who hire individuals to develop, implement, and evaluate international programs *believe* that applicants with only local (non-global) experience lack the following traits:

1. Understanding the context and realities of global health;
2. Flexibility;
3. Adaptability;
4. Creativity;

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5. Cultural sensitivity and cross-cultural communication; and
6. Knowledge of key players, systems, and processes.

These results indicate that, although academia may be coming around to understanding that global and local health work requires the same set of skills, employers are not there yet. As a result, the siloing that has occurred in academia is played out in the employment world, which may not be ready for students trained outside of established academic paths. Participants agreed that part of the global/local movement must be geared toward education of global health employers regarding the relevant knowledge, skills, and attitudes that can be gained from community-based work.

What Are Examples of Successful Global/Local Teaching Tools? If, as many participants agreed, global health and community engagement are 2 sides of the same coin, does it make sense to teach students the same didactic material in 2 separate curricular paths? The obvious consensus was "no" but no clear path emerged regarding how to break down existing educational silos. Shared curriculum currently takes place in some public health programs that require students to take the same core requirements in addition to courses in their global health or community health concentrations. However, outside of the public health context, shared curriculum across global health and community health programs is less common. Shared curriculum is the holy grail of global/local proponents and many agreed that faculty and universities have a responsibility to be disruptive in this area. Nonetheless, participants agreed that there are numerous initiatives that can be developed without achieving a grand structural overhaul.

At the meeting, participants were asked to share global/local teaching strategies that they have employed. The following are some useful strategies raised at the meeting:

1. In a public health school, one faculty member created a global health survey course that involves looking at global topics (eg, gender violence, hunger, access to clean water) and studying how that issue affects a population in the United States and a population overseas. A different topic is tackled each week with separate modules that focus on the issue from a local and international perspective.
2. Several faculty members discussed their experiential or clinical courses that allow students to practice their skills both locally and internationally with opportunities for reflection on the experiences in both situations. These experiences are typically structured so that students gain experience in a local setting, such as a homeless shelter or community clinic, before an overseas learning experience.
3. A further teaching tool discussed at the meeting was mapping a particular community's needs in the United States and a community's needs overseas to uncover common points and variances. This type of "community mapping" exercise, often used by Peace Corps volunteers as they enter a community, has been used by this social work faculty member to show the common bonds—and critical differences—among populations.

The appropriate use of technology was discussed as the greatest friend to bidirectional learning. Interested faculty members can work with local and global partners and be creative in thinking about how to link learners in different settings. One frequently discussed idea was using Skype or similar technology to bring students in different settings together to discuss a case study or conduct a simulation. Time differences present a problem in this area, but creative scheduling can address this concern.

CONCLUSION

Although the overwhelming tenor of the workshop was positive, some participants noted that the path ahead is not easy. University-level barriers include administration and faculty resistance to a new conception of global health, rigid silos that make innovation difficult, and limited funding for cross-disciplinary initiatives. Also, although participants believe that global/local is the right thing to do for our students, for global health, and ultimately for the health of the world's populations, there is no evidence that a global/local approach improves student outcomes or health outcomes and therefore, more research is in order. Sharing of curriculum and successful models will aid the creation of new programs. As with any educational innovation, change is driven by students who are increasingly diverse and globally focused. It is our responsibility to teach students the universality of need and the importance of contextually appropriate solutions wherever they are needed.

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