Challenges of Implementing Evidence-Based Practice in the Developing World

Aaron Santmyire, DNP, FNP-BC

ABSTRACT

Nurse practitioners (NPs) are increasingly traveling to the developing world to volunteer and work. Educating and training local practitioners creates opportunities for sustainability, and 1 of these educational and training opportunities is evidence-based practice (EBP). Because NPs have faced challenges and obstacles in implementing EBP in North America, they are uniquely positioned to model EBP for practitioners in developing countries where it is inadequately implemented. By discussing common barriers that NPs face in implementing EBP in the developing world and giving actual examples, this article aims to stimulate thought and discussion.

Keywords: cross-cultural communication, developing world, evidence-based practice, scope of practice

Health care practitioners are increasingly traveling to the developing world to practice with, learn from, train, and educate local practitioners.[1] Educating and training local practitioners creates opportunities for sustainability, and 1 of these educational and training opportunities is evidence-based practice (EBP). EBP is often discussed as a method of sound stewardship of limited resources. In North America, nurses and nurse practitioners (NP) have taken a prominent role in the pursuit and implementation of EBP.[2] NPs continue to face challenges and obstacles in implementing EBP in developed countries. However, these challenges and obstacles have uniquely positioned them to use the knowledge and experience gained to model EBP for practitioners in developing countries where EBP is not currently or is inadequately implemented.

When serving in the developing world and implementing EBP, NPs are often confronted with balancing the standard of care, cost, culture, reliability, and accessibility of treatment. This balancing act can prove to be fatiguing and, at times, discouraging and frustrating. By discussing common barriers in implementing EBP in the developing world and giving real world examples, this article aims to stimulate thought and discussion. Ideally, this article will benefit the NP who plans to work or volunteer, for short- or long-term, in the developing world and assist in modeling EBP.

EXPERIENCE

Since 2004, I have been living and working in the developing world. My first term of service was in Burkina Faso, where my practice focus was caring for women infected with HIV/AIDS and educating communities about the virus and disease. During this time, the prevention of maternal-to-child HIV transmission defined my passion and focus of research. We faced many challenges as we attempted to treat women using the World Health Organization (WHO) guidelines while remaining sensitive to cultural and economic realities.

Most recently, my practice has been in Madagascar, where my focus has been providing dermatology services at a rural hospital and traveling the island to care for individuals with a variety of tropical diseases. Many of the health problems there are common to North America, such as diarrhea, upper respiratory tract infections, acne, and eczema. However, my team and I are also privileged and challenged with caring

for individuals with leprosy, chromoblastomycosis, malaria, and filariasis, all much less common in the developed world.

DEVELOPING TRUST

Although the NP role is beginning to emerge in health care systems outside of North America, the understanding of who we are and the unique set of skills we embody varies significantly worldwide.[3-5] In many sub-Saharan African countries, the shortage of health care workers is a real threat to providing the most basic medical care.[6] Given the lack of physicians in this region, nurses have been called on to provide care that goes beyond their original training and existing scope of practice. However, when education and training are provided, the care they practice proves to be more than adequate.[7] This trend may lead to the situation of the nurse being seen in the community as a "doctor substitute." So when an NP arrives in sub-Saharan Africa, individuals in the community may assume that the NP is a "doctor substitute" because the "real thing" is not available.

Although the misconception is not malicious in nature, the view of NPs as a "doctor substitute" does negatively affect identity, respect, and community influence. Whether in North America or in rural Zimbabwe, the NP knows that he or she is not a substitute for anyone or anything but rather represents a profession that is distinct in its ethos and values.[8] The NP recognizes that she adds value to a health care system in many ways, including modeling and implementing EBP.[9]

Explaining how an NP functions and cares for individuals and families often proves easier to do 1-on-1 than with professional organizations and governments in the developing world. Professional organizations, which may be more concerned with protecting their financial interests than providing