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Lessons from the World: Applying Global Thinking to Local Public Health

By Emily Yox, MPH

Public health professionals around the world face many of the same challenges. While the United States is making advances in some areas of health, public health practitioners beyond our borders – even those with limited resources – have made significant progress in areas where we lag. For example, the **latest reports** by the Centers for Disease Control and Prevention (CDC) show that maternal mortality in the United States is the worst among all high-income countries. Opioids continue to kill hundreds each month. Access to healthcare has become a greater challenge in both urban and rural areas of the country, and many Americans still suffer from poorly managed chronic conditions. As we struggle to make progress on these and other issues, looking beyond America's borders for solutions may provide us with new and effective approaches.

In 2009, the Consortium of Universities of Global Health (CUGH) Executive Board published a manuscript in *The Lancet*, attempting to define global health: *"Global health is 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"* (Koplan et al., 2009).

In grappling with their definition, Koplan and colleagues initially determined what would remain the same and what would be changed from global health's historical counterpart, international health. International health was traditionally seen as countries in the Global North doing health work abroad, focusing on implementing infectious disease, malnutrition, and maternal and child health projects in developing countries in the Global South (2009). Overall, international health emphasized a unidirectional flow of resources and expertise from wealthy countries to poor countries.

Koplan and colleagues made a key distinction in their definition, clarifying that global health should not be a unidirectional endeavor like international health, but rather bidirectional, with *"a mutuality of real partnership, a pooling of real experience and knowledge, and a two-way flow between developed and developing countries"* (2009). While their manuscript defining global

health was written a decade ago, the bidirectionality of global health appears to still be a novel concept to most public health practitioners. However, to find the most effective solutions to complicated health problems, local health departments may gain inspiration by looking outside our borders.

A number of U.S. organizations are dedicated to demonstrating the benefit of a true global health approach, such as GlobaltoLocal, the Icahn School of Medicine Taskforce on Global Advantage, and the Health & Risk Communication Center. These organizations are exploring common global health approaches, looking at which approaches may be exportable to the United States and what would be the most effective ways to do so. The approach of seeking global solutions to local health challenges is referred to as "Global Advantage," "Global/Local," and "Glocal." While this is still a nascent area of practice, research demonstrates the possibilities that this approach can provide for U.S. local health departments.

In their landscape assessment **Bringing Health to Local Communities: Strategies from Global Health**, GlobaltoLocal emphasizes that health system challenges and social determinants of health are two key drivers of poor health. They also noted that the key to successful implementation of global strategies is inclusion of the community from the beginning and securing local buy-in and support. Given this information, they looked at multiple interventions from low- and middle-income countries (LMIC), distilling how these interventions can be implemented to improve health in low-resource areas of the United States. They found that common strategies from LMIC, including community health workers and mobile health solutions, could be highly transferable to the Unites States.

In the **Task Force on Global Advantage Report**, published through the Icahn School of Medicine, the contributors describe Global Advantage as *"The benefit that the United States gains from applying global lessons to improve community health."* They also display the stark inequality in the United States, noting that developing countries have similar or better life expectancies than some U.S. counties. For example, the life expectancies in the bottom three counties in the United States are similar to those found in regions of Kyrgyzstan, India, and South Africa. The report proposed several solutions similar to the landscape assessment from GlobaltoLocal, repeating the potential of community health workers and mobile health, as well as the need to strengthen the

Local health leaders from around the world discuss glocal health.

relationship between primary health and community development, define health packages, and integrate community health goals into national strategies. The report also emphasizes that working locally often allows for experimentation and innovation that may be more challenging at a national or even state level, providing a unique opportunity for local health departments to act creatively.

These two reports show there is ample opportunity for solutions typically implemented in LMIC to be successfully piloted in the United States to address persistent health challenges. However, all countries, regardless of their income status, have bright ideas that could be implemented effectively in the United States. Some U.S. communities have already done so, adapting solutions from LMIC as well as from other developed countries.

Through the Health & Risk Communication Center, Dearing et. al studied diffusion of a variety of global health solutions through the lens of five interventions that migrated to the United States:

1. **AgeWell Global**: Originating in South Africa and with pilot implementations in Cleveland, OH; Fort Lauderdale, FL; and New York City, NY; AgeWell Global is a model of elder care coordination combining peer-based social engagement and mobile technology to improve health outcomes and drive down medical costs.
2. **Cardiff Violence Prevention Model**: Originating in the United Kingdom and with implementations in Atlanta, GA; Decatur, GA; and Milwaukee, WI; the Cardiff Violence Prevention Model provides a way for communities to gain more information about where violence occurs and how to prevent it by forming partnerships among hospitals, law enforcement, and community members interested in violence prevention.
3. **Ciclovía:** Originating in Colombia and adopted in many communities including Los Angeles, CA; New Brunswick, NJ; Wayne County, MI; and Portland, OR; Ciclovía is a free community-based recreational program in which certain streets are temporarily closed to automobiles for the exclusive use of cyclists, runners, and pedestrians.
4. **ConsejoSano**: Originating in Mexico and scaled up in parts of California, Texas, Illinois, and New York, ConsejoSano is a private company that contracts with U.S. health insurers and community clinics to help clinics better communicate with their lower-income, non-native English-speaking community members to seek health services.
5. **Swedish Rheumatology Quality Registry**: Originating in Sweden and in the United States – having been reinvested as the Swedish Quality Registry at Dartmouth College – this innovation enables both patients and healthcare providers to input information about a patient's progress in care. Through partnerships with disease-specific national foundations, the Quality Registry serves patients with cystic fibrosis, inflammatory bowel disease, and other chronic conditions.

It is important to note that these ideas come from both resource-rich and resource-poor countries, and they represent a diversity of health challenges, from increasing physical activity and managing chronic illnesses, to ensuring that the disenfranchised have access to quality care. Good ideas have no borders and global solutions provide ample opportunities for innovation.

Given the differences between the communities where these strategies were developed and where they were implemented, diffusion tactics are needed to adapt these solutions to fit local contexts. In their analysis **A Model for Introducing Global Ideas to the U.S.**, Dearing et al., also considers the process of Designing for Diffusion, which is "*the taking of strategic steps early in the process of creating and refining an innovation, such as an evidence-based health intervention, to increase its chances of being noticed, positively perceived, accessed and tried, and then adopted, implemented, and sustained in particular practice settings*." The main idea behind designing for diffusion is that it iterative in its intent, rather than descriptive; it can be flexibly used to apply evidence to understand the impact of global health solutions in different contexts.

There are eight elements of this model that were considered to determine their potential impact on the diffusion of global health strategies in the United States: (1) costs and benefit (monetary and non-monetary), (2) effectiveness, (3) external validity, (4) compatibility, (5) simplicity, (6) trialability, (7) observability, and (8) stigma. The researchers determined that when diffusing global health solutions in the Unites States, there was a consistent appreciation for the importance of a positive cost-benefit analysis and compatibility. Also deemed important were trialability, simplicity, and observability. External validity and stigma were rarely raised in the researchers' interviews and were deemed tertiary to the other elements.

Under the Design for Diffusion model, NACCHO would be considered a Linking Agent, which is an "*individual or organization that functions to tie together information about an innovation with actors who can help to broaden its availability*." In moving toward embracing more global health solutions, NACCHO is looking to identify links between local health departments and global solutions that have made strides in areas of mutual interest. The organization is in a unique position to form relationships and share resources that can benefit local health departments, global health organizations, and communities around the world.

Many global programs might not be feasible for large-scale adoption, but success begets growth. The flexibility that local implementation provides is a key factor in understanding how these programs could work in a domestic setting, and their ultimate success will help to advance efforts towards ensuring that best practices from around the world can be tested in the United States to reach the most vulnerable at home. NACCHO believes that collaboration and a mutual understanding of the value of new ideas is crucial to ensure the health and well-being of all Americans. The goals of NACCHO's work in this space will be 1) to establish a culture of openness among local health departments that sees the value and adaptability of global health solutions, and 2) to provide opportunities for these solutions to be effectively shared with and adopted by local health departments.

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About NACCHO

The National Association of County and City Health Officials is the voice of more than 3,000 local health departments across the country. These city, county, metropolitan, district, and tribal departments work every day to ensure the safety of the water we drink, the food we eat, and the air we breathe.

For more information, please contact:

Emily Yox
Program Analyst, Global Health
202.888.0228
eyox@naccho.org

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The mission of the National Association of County and City Health Officials (NACCHO) is to improve the health of communities by strengthening and advocating for local health departments.

1201 Eye Street, NW 4th Floor Washington, DC 20005

P 202.783.5550 F 202.783.1583