Global Health: A Vision for Action

Stephanie L. Ferguson

OVERVIEW

Global health and its challenges remain a top priority for world leaders and health professionals. The Millennium Development Goals (MDGs) developed by the United Nations (UN) showed us that the world can set a vision for global health and action, yielding "unprecedented efforts and profound achievements" (UN, 2015, p.4). Ban Ki-moon, former Secretary General of the United Nations, wrote it best in the Millennium Development Goals Report 2015 when he proclaimed that, "The MDGs helped to lift more than one billion people out of extreme poverty, to make inroads against hunger, to enable more girls to attend school than ever before and to protect our planet. They generated new and innovative partnerships, galvanized public opinion and showed the immense value of setting ambitious goals. By putting people and their immediate needs at the forefront, the MDGs reshaped decision-making in developed and developing countries alike" (UN, 2015, p. 3.). However, despite progress achieved with the MDGs, as an example, the goals of reducing child mortality and improving maternal health were not realized. Today, we anticipate with new hope the global health goals, indicators, strategies, and actions set forth in the vision of the Sustainable Development Goals (SDGs) (UN, 2016).

The effects of globalization have been both positive and negative. From a positive perspective, globalization has increased travel, trade, productivity, and economic growth in many nations. Globalization has allowed populations to rapidly exchange information and share solutions to common problems worldwide. However, the negative effects of globalization have led to an increase in global health security threats such as outbreaks of pandemic influenza, Ebola, Zika, and Middle East Respiratory Syndrome coronavirus (MERS-CoV). Nations have struggled to meet the challenges of these outbreaks due to a lack of public health infrastructure and preparedness capabilities.

The global health challenges faced today are daunting and range from communicable diseases, such as human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), tuberculosis (TB), and malaria, to noncommunicable diseases (NCDs), such as cardiovascular disease (continues)
time to care for the world’s population, the global quest for Health for All, Universal Health Coverage
and Access, and the realization of the SDGs will not be achieved by 2030.

To learn more about global health challenges and issues facing the world, refer to the latest health
topics, data, publications, country statistics, programs, and global governance structures provided by
the World Health Organization. The WHO is the premier United Nations organization responsible for all
policies and governance activities related to public health worldwide. The WHO website (www.who.int)
provides a wealth of information on health. To learn more about the mission and vision of the WHO, visit
their website at www.who.int/about/en/. The United States has been a champion and global leader in
health at the WHO headquarters in Geneva, Switzerland and at all the WHO’s regional offices. To follow
the work of the U.S. in global health, visit the Office of Global Health Affairs (OGA) at the U.S. Department
of Health and Human Services (USDHHS) website (www.hhs.gov/about/agencies/oga/index.html). The
Office of Global Affairs is the diplomatic voice of the USDHHS. OGA fosters critical global relationships,
coordinates international engagement across USDHHS and the U.S. government, and provides
leadership and expertise in global health diplomacy and policy to contribute to a safer, healthier world.

This chapter overview is a snapshot of some of the global health challenges and issues facing the
world today and tomorrow. This chapter is a call to action for all nations to commit to investing in
global health, and for nurses and health professionals to advocate for the investment in global health.
Investing in global health over the next 20 years can save the lives of millions of children and adults,
and result in positive returns on investments for people living and working in lower-middle income
countries (LMICs) (National Academies of Sciences, Engineering, and Medicine [NAS], 2017). The author
of this chapter was selected to participate in the consensus study to determine global health and the
future role of the United States (see the press release: www8.nationalacademies.org/onpinews

To learn more about Global Health and the Future Role of the United States, read the latest report from
the National Academies of Sciences, Engineering, and Medicine (2017).

**OBJECTIVES**

- Define the politics of global health in the context of the latest National Academies of Science’s
- Provide examples of current global health initiatives important for nurses and other health
  professionals.
- Identify roles nurses and other health professionals can play in global health policy and
  advocacy, including ways to get involved and get a seat at the table.

**The Politics of Global Health in the United States of America**

Global health, as a field of study, research, and policy, has grown tremendously over the last
few decades. The United States has achieved a proven track record and legacy of leadership in
providing foreign assistance, excellence in determining global health policies, and funding
global health initiatives to care for populations worldwide. As a nation, the U.S. has been a cham-
pion in the fight against HIV/AIDS, malaria, and TB. For instance, global U.S. investments
include the creation of the President’s Emergency Plan for AIDS Relief (PEPFAR) in 2003 and the President’s Malaria Initiative (PMI) in 2005. The U.S. has also been a key partner in leading and funding the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Global Vaccine Alliance (GAVI).

Likewise, the National Academies of Sciences, Engineering, and Medicine have been front and center studying the United States’s work in global health and, in general, the science in the field of global health, as well as global health risk assessment and security worldwide. The National Academies of Sciences, Engineering, and Medicine, also known as The National Academies (NAS), are the private, nonprofit institutions that provide independent, objective analysis and advice to the U.S. to solve complex problems and inform public policy decisions related to science, technology, and medicine. The Health and Medicine Division of the NAS helps those in government and the private sector make informed health-related decisions by providing reliable and objective evidence. To learn more about the National Academies of Sciences, Engineering, and Medicine, visit their website at www.nationalacademies.org.

In 1997, the Institute of Medicine’s (IOM) Board on International Health was commissioned to produce the first report to address the United States’s interest in and commitment to improving human health worldwide. The report, entitled America’s Vital Interest in Global Health: Protecting Our People, Enhancing Our Economy, and Advancing Our International Interests, defined global health issues as “health problems, issues, and concerns that transcend national boundaries, and are best addressed by cooperative actions” (IOM, 1997). Similarly, in 2009, an independent committee was constituted by the IOM Board on Global Health to prepare a report for then-President Barack Obama and his new administration, entitled The U.S. Commitment to Global Health: Recommendations for the New Administration (IOM, 2009). Like the IOM 1997 Global Health report, it was concluded in the 2009 IOM Global Health report that the direct interest of the citizens of the United States are best served when the U.S. acts decisively to promote health around the world. That 2009 report on global health also included a call for better structuring of market incentives to develop medical products.

Much has been achieved since the two IOM reports (1997, 2009). For instance, the U.S. Office of the Assistant Secretary for Preparedness and Response established the Biomedical Advanced Research and Development Authority (BARDA) through the 2006 Pandemic and All-Hazards Act (Public Law. No. 109-417, 42 US 201). Another example is the U.S. Food and Drug Administration (FDA)’s priority review voucher program, established in 2007, which provides our government with the ability to expedite the FDA’s review of new drugs, particularly those needed in an emergency crisis like the 2014 outbreaks of Ebola in parts of West Africa. A great case in point was the expedited review of products to treat Ebola, which became eligible in 2014. Despite these initiatives and achievements, there remains a need for drug and vaccine development worldwide to tackle some of the persistent and emerging infectious disease and other global threats today and tomorrow.

Since the 2009 IOM global health report, much progress has been made in research development in low and middle-income countries (LMICs) through country-led workforce development and the creation of national health plans. In addition, the formation of the Nursing Education Partnership Initiative (NEPI) and the Medical Education Partnership Initiative (MEPI), developed through the President’s Emergency Plan for AIDS Relief (PEPFAR) at the Department of State to address the shortage of health workers in high-burden HIV/AIDS countries. NEPI and MEPI program efforts improved workforce capacity in these LMICs.

The other most notable recommendation that came out of the 2009 IOM Global Health report was the recommendation to create a White House Interagency Committee on Global Health. The proposed new agency would be chaired by a U.S. government senior official designated...
by the U.S. President. The job of the chair of the new global health agency was to lead, plan, prioritize, and coordinate the budget for major U.S. government global health initiatives. President Obama agreed with this IOM 2009 Global Health report recommendation and he created the U.S. Global Health Initiative (GHI).

During this time frame, under the leadership of President Obama and through the GHI, the author of this chapter had the great opportunity to work with the GHI and the State Department, the U.S. Human Resources for Health Administration (HRSA), the National Institute of Nursing Research (NINR) at the National Institutes of Health (NIH), and the Centers for Disease Control and Prevention (CDCC) to provide health diplomacy services to strengthen the research capacity of nurses and other health professionals in countries like Bangladesh.

In addition to the author of this chapter, Dr. Afaf Meleis, former Dean of the University of Pennsylvania, elected member of National Academy of Medicine (NAM, formerly IOM), member of the IOM Global Health Report Committee in 2009; and Dr. Mary Kerr, former Deputy Director of the National Institute of Nursing Research at the National Institutes of Health and Dean of the Frances Payne Bolton School of Nursing at Case Western Reserve, were a part of the delegation that worked to strengthen the nursing capacity in research on behalf of the GHI. Unfortunately, as time moved forward, the GHI was not successful. There was a lack of authority and budget given to the GHI and its leadership; as a result, the only thing left to show progress was an internet presence showing some coordinating priority area of global health programs. Despite the failure of GHI, there was much progress made through PEPFAR, the President’s Malaria Initiative (PMI), and the U.S. Global Health Security Agenda.

With the hope of continued change post-President Obama and “making America Great Again,” global health continued to be in the forefront of the presidential debates of 2016 behind the scenes. Questions were being asked about what the U.S. should do with PEPFAR. Should PEPFAR’s mission and global health mandate remain the same or should it be reformed? Better yet, should the U.S. declare success and move forward with another government global health initiative? Other key stakeholders and citizens questioned what the U.S. should be doing to protect our nation and the world from persistent and/or emerging global epidemics and pandemics, outbreaks, and global health challenges like noncommunicable diseases (NCDs). Moreover, what should the U.S. do to address the unfinished business in the Millennium Development Goals (MDGs) and the new business of the Sustainable Development Goals (SDGs), particularly in the context of women and children? Essentially, citizens, government officials, academics, private and public partners, foundations, businesses, other nations, and global health policy organizations such as the United Nations (UN), the World Bank, the World Health Organization (WHO), the Global Fund, and the Global Vaccine Alliance (GAVI) wanted to know what the next presidential administration and the U.S. government should be investing in related to global health.

Thus, because of the upcoming presidential elections in the United States in 2016, the timing was right to ask the National Academies of Sciences, Engineering, and Medicine to conduct a new consensus study on Global Health and the Future Role of the U.S. The 2017 NAS report on global health, the third of its kind (IOM, 1997, 2009; NAM, 2017), was launched in May 2017. The NAS global health consensus report was commissioned to advise the new U.S. president and administration, whether it be Hillary Clinton or Donald Trump.

In August 2016, the author of this chapter was selected and appointed by the National Academies of Sciences, Engineering, and Medicine (NAS) to serve as a member of the Committee on Global Health and the Future of the United States (CGH) (NAS, 2017). This author is an elected member of the National Academy of Medicine (NAM), formerly known as the Institute of Medicine (IOM). The author was fit for purpose because of her expertise, which
ranges from global health security, interprofessional workforce, and leadership development to health systems strengthening, universal health coverage and access implementation and evaluation strategies, HIV/AIDS, and women and children's health. This author has worked in more than 100 nations over 20 years on behalf of the U.S. government, WHO, and the International Council of Nurses.

The National Academies' CGH was charged to conduct a consensus study to identify global health priorities in light of emerging global health threats and challenges and provide recommendations to the U.S. government and other stakeholders for increasing responsiveness, coordination, and efficiency in addressing these threats and challenges by establishing priorities and mobilizing resources. The NAS received financial and expert support from a variety of federal agencies, foundations, and private partners such as the U.S. Agency for International Development (USAID), U.S. Department of Health and Human Services (USDHHS), Centers for Disease Control and Prevention (CDC), U.S. Food and Drug Administration (FDA), National Institutes of Health (NIH), President's Emergency Plan for AIDS Relief (PEPFAR), Rockefeller Foundation, Merck Foundation, Becton, Dickinson, and Company (BD), and Medtronic.

Like domestic U.S. healthcare policy and reform, funding and reforming global health care and initiatives are highly political. In general, “foreign assistance is often considered a type of charity, or support for the less fortunate. Although this can be true for the poorest and most vulnerable populations, most such aid, especially when directed toward health, is an investment in the health of the recipient country, as well as the United States and the world at large” (NAS, 2017, p. S-1, S-2). The CGH agreed that asking the United States for more money alone to invest in global health challenges was not the answer.

Moreover, realizing that there were many global health challenges on which to focus, such as mental health and substance abuse, environmental health (including climate change, food safety, air pollution, and water and sanitation issues), refugee health, and health workforce, to name a few, the CGH focused on priorities with the potential for catastrophic loss of life and impact on society, such as pandemics, persistent communicable diseases (HIV/AIDS, TB, and malaria), and noncommunicable diseases (NCDs), specifically cardiovascular health and select cancers. As well, the CGH focused on areas where significant U.S. funds had been invested and determined what needed to be achieved with the gains and how these investments should be consolidated and sustained in the current presidential administration. The CGH further agreed to focus the report on promoting women and children’s health, building capacity, and global health innovation and implementation.

The Committee identified two overarching themes:

1. Securing against global threats; and,
2. Enhancing productivity and economic growth.

The Committee proposed 14 recommendations in the context of these two themes. As well, four priority areas for action were identified to ensure the greatest positive effect on health. The CGH felt that these two themes with the 14 recommendations and four priority areas set the strategy forward to position and maintain the United States as a global health leader worldwide.

The four priority areas recommended include:

1. **Achieve global health security.**
   - The Committee urged the administration to create a coordinating body within the U.S. government with the authority and budget to develop a proactive, cost-effective, and comprehensive approach to preparedness for and response to international public health emergencies. To learn more about the global health security priority, read Chapter 3 in the NAS Global Health report (2017).
2. Maintain a sustained response to the continuous treats of communicable diseases.

The Committee urged the administration to maintain a sustained focus on HIV/AIDS and malaria, as well as re-evaluate the commitment to fight TB. The progress achieved to combat these communicable diseases needs to be sustained to prevent reversal of the gains achieved in the past decades and avoid the further spread of resistant strains in all three diseases. To learn more about this priority area regarding maintaining and sustaining response to the continuous treats of communicable diseases, see Recommendation 4 (Envision the next generation of the President’s Emergency Plan for AIDS Relief) and read more about this in NAS, 2017, Chapter 4.

3. Save and improve the lives of women and children.

The U.S. commitment to the current survival agenda should be continued but also expanded to incorporate early childhood development as a key component. The Committee noted that adding a multisectoral focus on childhood development to the current survival-focused programs can contribute to resilient societies and growing economies. To learn more about Recommendations 7 and 8, which address the improvement of survival in women and children and ensuring health and productive lives for women and children, you can read more about this priority and these recommendations in NAS, 2017, Chapter 5.


NCDs, cardiovascular diseases (CVD), and cancer are rising in countries around the world. The committee urged improved mobilization and coordination of private partners at the country level and across the U.S. interagency community to implement strategies to ensure that CVD risk factors are targeted for early detection and treatment and particularly as it relates to hypertension, cervical cancer, and immunization against vaccine-preventable cancers. See Recommendation 9 (Promote cardiovascular health and prevent cancer), and read NAS, 2017, Chapters 6 and 8, for more information.

Finally, the report followed three cross-cutting areas for action to maximize the returns on U.S. investments to achieve better health outcomes and use funding more effectively. These three cross-cutting areas for action included:

1. Catalyze innovation through both the accelerated development of medical products and development of integrated digital health infrastructure.

2. Employ flexible financing mechanisms to leverage new partners and funders in global health.

3. Maintain U.S. status and influence as a world leader in evidence-based science, economics, measurement, and accountability. To learn more about the cross-cutting themes, review Recommendations 10 through 14 and NAS, 2017, Chapters 7, 8, and 9.

An overview of the Committee’s recommendations is provided in Table 5-1 with actions for nurses and other health professionals to consider they advocate for and participate in the development of global health policies. To read the full text of the NAS 2017 Global Health report recommendations, please see the Recommendations document available at www.nationalacademies.org/hmd/reports/2017/global-health-and-the-future-role-of-the-united-states.aspx. There is also a Blueprint for Action in Table 10-1 of the NAS Global Health report (2017), which outlines the recommendations pertinent to each national entity with actions to achieve global...
### TABLE 5-1 NAS Global Health Report 2017 Recommendations and Actions for Nurses and Other Health Professionals

<table>
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<th>Recommendations</th>
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| Improve international emergency response coordination.| Write letters and meet with your local U.S. Congress members and write letters to the current presidential administration to support the creation of an International Response Framework to guide U.S. response in an international health emergency. In your letter, advocate for three separate funding streams dedicated to investments in preparedness, emergency response, and critical medical product development.  
*Examples of opportunities to serve in international emergencies:*  
- International Federation of the Red Cross: media.ifrc.org/ifrc/what-we-do/volunteers  
- American Red Cross: www.redcross.org/volunteer/volunteer-opportunities/volunteer-internationally  
- Doctors Without Borders: www.doctorswithoutborders.org/  
- Peace Corps: www.peacecorps.gov/resources/media/press/2146/  
*For career opportunities in the agencies above to help fight antimicrobial resistance, check out the official website for jobs in the U.S. government:* www.usajobs.gov/  
*To learn more about antimicrobial resistance, review WHO resources at:* www.who.int/antimicrobial-resistance/en/ |
| Combat antimicrobial resistance.                     | Consider a job in the U.S. Department of Health and Human Services (USDHHS), the U.S. Department of Defense (DoD), the U.S. Department of Agriculture (USDA), and the U.S. Agency for International Development (USAID). These agencies are responsible for investing in national capabilities to accelerate the development of international capabilities to detect, monitor, report, and combat antibiotic resistance.  
*For career opportunities in the agencies above to help fight antimicrobial resistance, check out the official website for jobs in the U.S. government:* www.usajobs.gov/  
*To learn more about antimicrobial resistance, review WHO resources at:* www.who.int/antimicrobial-resistance/en/ |
| Build public health capacity in low and middle-income countries. | Advocate for the CDC, NIH, DoD, and USAID to expand training and information exchange efforts to increase the capacity of low and middle-income countries to respond to both public health emergencies and acute mass casualty disasters.  
*Examples of opportunities to serve are like those mentioned in Recommendation 1.*  
*To learn more about strategies to help build the public health capacity of low and middle-income countries,* see the following WHO consultation paper on health workforce and service for the Global Framework for Public Health:  
*Review the WHO Framework for a Public Health Emergency Operations Centre at:*  
www.who.int/ihr/publications/9789241565134_eng/en/  
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TABLE 5-1  NAS Global Health Report 2017 Recommendations and Actions for Nurses and Other Health Professionals (continued)

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<th>Recommendations</th>
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<td>Envision the next generation of PEPFAR.</td>
<td>Review the next generation of PEPFAR Indicators at: <a href="http://www.nationalacademies.org/hmd/~media/CCCCE5C1068F44A19DFAB5CF2CD914F6.ashx">www.nationalacademies.org/hmd/~media/CCCCE5C1068F44A19DFAB5CF2CD914F6.ashx</a>. What role can you play to advocate for the continued funding of the Global Fund to Fight AIDS, Tuberculosis and Malaria? Check out the Global Fund and notice the job and volunteer opportunities worldwide at: <a href="http://www.theglobalfund.org/en/">www.theglobalfund.org/en/</a></td>
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<td>Confront the threat of tuberculosis.</td>
<td>Consider the recommendations above. In the U.S., we need to advocate for a plan of action to improve the current governance structure and priority activities and investments in new diagnostics, drugs, vaccines, and delivery systems. The CDC, NIH/National Institute for Allergy and Infectious Disease (NIAID), and USAID should conduct a thorough global threat assessment of the rising TB levels and multidrug-resistant TB levels. Learn more about TB from the WHO at: <a href="http://www.who.int/tb/en/">www.who.int/tb/en/</a></td>
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<td>Sustain progress toward malaria elimination.</td>
<td>Consider advocating to keep the funding for the President’s Malaria Initiative (PMI). To learn more about this important effort and how to participate in eliminating malaria, read: <a href="http://www.pmi.gov/">www.pmi.gov/</a></td>
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| Improve survival in women and children. | The U.S. Congress should increase funding for USAID to augment the agency’s investments in ending preventable maternal and child mortality, defined as global maternal mortality rates of fewer than 70 deaths per 100,000 live births by 2020 and fewer children deaths per 1,000 live births by 2030. Encourage your Congress members to invest in the most effective interventions and support monitoring and evaluation in:  
  - Immunizations  
  - Integrated management of child illness  
  - Nutrition (pregnant women, newborns, infants, and children)  
  - Prenatal care and safe deliveries  
  - Access to contraceptives and family planning  
Think about joining and financially supporting Women Deliver at: www.womendeliver.org/. Women Deliver is the lead global organization advocating for the health, rights, and well-being of girls and women. Women Deliver catalyzes action by bringing together diverse voices and interests to drive progress for gender equality, with a focus on maternal, sexual, and reproductive health and rights. |
### Recommendations

**Ensure healthy and productive lives for women and children.**

USAID, PEPFAR and their implementing partners, and other funders should support the integration of principles of country ownership, domestic financing, and community engagement to:

- Provide adequate nutrition for optimal infant and child cognitive development.
- Reduce childhood exposure to domestic and other violence.
- Detect and manage postpartum depression and other maternal mental health issues.
- Support and promote early education and cognitive stimulation in young children.

To learn more about these recommendations read the *Lancet* Series on Maternal and Child Health:


Also, check out the *Every Women Every Child* Strategy (2015) at: globalstrategy.everywomaneverychild.org/.

### Actions

**Promote cardiovascular health and prevent cancer.**

To learn more about these recommendations read the *Lancet* Series on Maternal and Child Health:


Advocate for USAID, the State Department, and CDC to provide seed funding through their country offices to mobilize and involve the private sector in addressing cardiovascular disease and cancer at the country level. Strategies should include:

- Target and manage risk factors (e.g., smoking, alcohol use, and obesity) for major NCDs and adopt fiscal policies to regulate tobacco control and healthy diets.
- Detect and treat hypertension early.
- Detect and treat early cervical cancer.
- Immunize for vaccine-preventable cancers (e.g., human papilloma virus [HPV] and hepatitis B vaccines).

To learn more about how to advocate and fund NCD prevention strategies, join the NCD Alliance: www.ncdalliance.org/

**Accelerate the development of medical products.**

Advocate for U.S. government agencies to invest in reducing the costs and risks of developing, licensing, and introducing vaccines, therapeutics, diagnostics, and devices needed to address global health priorities. The approaches need to enable innovations in trial design, streamline regulations, ensure production capacity, create market incentives, and build the capacity for international capacity for research and development. The CDC, NIH, and DoD should increase the number of people and institutions in partner countries capable of conducting clinical trials for global health priorities and build the skills of principal investigators.

To learn more about the development of medical products, read: www.ncbi.nlm.nih.gov/books/NBK234438/

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### TABLE 5-1 NAS Global Health Report 2017 Recommendations and Actions for Nurses and Other Health Professionals (continued)

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<td>Transition investments toward global public goods.</td>
<td>USAID, the State Department, and USDHHS should, together, systematically assess their approach to global health funding to ensure long-term investments in high-impact, country level programs. As advocates, keep your eye on what the U.S. is investing in globally and why and what is the impact of the goods provided for the global public?</td>
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<td>Optimize resources through smart financing.</td>
<td>USAID and PEPFAR should structure their financing to promote greater country ownership and domestic financing. Ministries in countries should be engaged to design and finance the plan, model refinement, and expansion of the return on investment analysis for financial execution. Simply put, USAID and the State Department should motivate the World Bank, GAVI, the International Monetary Fund, and the Global Fund to Fight AIDS, Tuberculosis and Malaria to promote transitioning to domestic financing, assist countries in creating fiscal space for health, leverage fiscal policies to improve health, and attract alternative financing sources. <strong>Actions to take:</strong> When writing your advocacy letters, never forget to discuss your arguments in a policy framework to include cost, access, and quality. As global health threats, challenges, and issues continue, money will matter and how nations, including the U.S., pay for the money matters. No national government will be able to pay for this alone. Private and public partnerships will need to be forged and new financing mechanisms that are smart will need to be created.</td>
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<td>Commit to continued global health leadership.</td>
<td>The United States should commit to maintaining its leadership in global health and actively participate in global health governance, coordination, and collaboration. The U.S. needs to be at the table to influence and improve the performance of key United Nations agencies such as the World Health Organization (WHO). WHO needs greater resources to address the health challenges of the 21st century, and many of its priorities align with those of the U.S. government. However, U.S. government financial contributions to WHO should come with a requirement that the organization adopt and implement the much-needed management and operational reforms. The U.S. also needs to remain partners in financing GAVI, the Vaccine Alliance, and the Global Fund to Fight AIDS, Tuberculosis and Malaria, as well as new entities such as the Global Health Security Agenda and the Global Financing Facility. The U.S. needs a more strategic approach implemented to achieve global health goals. The State Department should create a global health career track and seek congressional action to enable the establishment of a cadre of global health experts within the U.S. Department of Health and Human Services through an amendment of the Foreign Service Act. This would create the environment necessary to expand the health attaché program, particularly in lower and middle-income countries (LMICs). As nurses and health professionals, you should advocate for nurses and health workers to be at the tables in all WHO and other UN agency global health policy and evaluation works. By 2030, the health workforce shortages will be enormous and there will not be enough health workforce to meet the global health needs of the world’s population. Without adequate health workers, there will be no progress achieving global health outcomes. Know what is happening in your nation and at the WHO from a health workforce perspective.</td>
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**Keep up with the latest global policy strategies and initiatives on human resources for health at:**

- **World Health Organization Strategy on Human Resources for Health:**
  - [www.who.int/hrh/resources/globstrathrh-2030/en/](http://www.who.int/hrh/resources/globstrathrh-2030/en/)
- **World Health Organization Strategic Direction for Nursing and Midwifery 2016–2020:**
- **Join the Global Health Workforce Alliance:**
  - [www.who.int/hrh/network/en/](http://www.who.int/hrh/network/en/)
health security and enhance productivity and economic growth worldwide.

Conclusions

Global health, its challenges and threats remain a top priority for world leaders and health professionals. This chapter, titled “Global Health: A Vision for Action,” focuses on the politics, policies, and the advocacy strategies that nurses and health professionals need to engage in to improve health services and ensure positive health outcomes for our world’s populations. It is a call to action for the United States and other nations to commit to investing in global health, and for nurses and health professionals to advocate for investment in global health. To learn more about Global Health and the Future Role of the United States, read the latest report from the National Academies of Sciences, Engineering, and Medicine (NAS, 2017). (http://nationalacademies.org/hmd/reports/2017/global-health-and-the-future-role-of-the-united-states.aspx)

Discussion Questions

1. What are politics of global health in the context of the latest National Academies of Science’s report, Global Health and the Future Role of the United States (NAS, 2017)?
2. Identify global health initiatives important for nurses and other health professionals.
3. Describe specific actions nurses and other health professionals can take to become advocates for global health policy and advocacy.

References


Restoring Humanity in a War Zone: One Nurse’s Experience

Mosul Case Study

Valerie Gruhn

Background

Overnight, the people of northwestern Iraq were suddenly stripped of all forms of human rights. In October 2016, Iraqi military forces, along with an international coalition, launched an operation to defeat the Islamic State in the governorate of Nineveh. International humanitarian groups boosted all efforts to install trauma stabilization posts, as well as field hospitals in and around Mosul, to provide lifesaving care.

In March 2017, I had been deployed to West Mosul by the humanitarian organization Médecins Sans Frontières (MSF), also known as Doctors Without Borders (Doctors Without Borders, n.d.), to open a hospital and assist with the escalating humanitarian crisis. At that time, 400,000 civilians were still trapped in the Old City alone (United Nations, 2017). In their attempts to escape, civilians were often targeted by snipers or used as human shields. Women and children were exploited and turned into sex slaves. Civilian men, if captured, were tortured and/or executed.

The battle for Mosul became a complicated urban war that created immense suffering and countless casualties. The use of massive firepower and aggressive military tactics by the Iraqi Forces, the International Coalition Forces, as well as the Islamic State were responsible for the innumerable loss of life that occurred since the beginning of the battle. The BBC stated, “The mission is now regarded as the single largest urban battle since World War II (Rodgers, Stylianou & Dunford, 2017).”

It Is Personal

I was no longer a third party. For years, I had watched sensational 3-second videos of parents carrying bodies of their children dangling in their arms as they ran through the streets of some unknown war torn city. Then, on my first day, I saw a father holding his lifeless boy with a despairing look on his face just like I had seen countless times on media channels. Only this time, he was running towards me.

On my first day working in the field hospital, I bore witness to the horrors I had seen on their faces and to the true meaning of inhumanity. Ambulances packed with dismembered people came crashing in waves. Once the ambulance doors opened, with every person I triaged, I was struck by the absurdity of the words I was dictating: “toddler with a mortar injury,” “man with a left leg amputation,” “woman with an abdominal wound from a sniper attack,” “child with a blast injury from a landmine.” I ran back to a small area within the emergency room designated for stabilizing the most critical patients, the red zone, to direct the local nurses towards different tasks. I then proceeded to finding the woman who’s disembodied leg I had picked up along the way.

Reflecting back upon this, I realize that in the midst of all the chaos of stabilizing patients, I did not notice how unhinged some of the things we did and witnessed were at the time they happened.

Not far off, loud explosions followed by black smoke and white mushroom clouds painted the sky. I could hear the sound of whistling bullets flying overhead, and just down the street from the field hospital, a military point shelling into the old city. I could hear the sound of whistling bullets flying overhead, and just down the street from the field hospital, a military point shelling into the old city. The conditions were horrendous and at times I found myself questioning my presence there.

MSF local staff had been living under the Islamic State of Iraq and the Levant (ISIS), and were victims of war themselves. They chose to take the risk to work with us, and were motivated to help these victims within their own community. Most of the staff worked and slept at the hospital, a military point shelling into the old city. The conditions were horrendous and at times I found myself questioning my presence there.

It was all very surreal. The war that was at first happening to strangers in a distant country in the Middle East was now happening to people I called my friends and my family. Working in global health
makes every crisis, every war, every bit of injustice, bigotry, or inequality, personal. What many often fail to understand is how fragile basic human rights are and how easily they can be taken away. Ultimately, the one and only factor that makes us different from any of these victims or stories is simply the luck of where and when we were born.

**Restoring Dignity**

Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world, Whereas disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind ... (United Nations, 2015, p. 10)

One month after my arrival, I was asked to open a hospital in West Mosul close to the frontline. The road towards West Mosul reflects the skeletons of what once used to be a bustling city. Empty streets, abandoned homes, collapsed buildings, and old car bombs are overturned on the roads. Additionally, truckloads of people who fled months prior were forced to come back and reinstall themselves to the rubble that once was their home, in order to make room for newly liberated people in the camps.  

By the beginning of August, more than 800,000 were still regarded as displaced by the International Organization for Migration (IOM), more than half of those housed in camps or emergency sites,” only to face conditions in the camps that are an amalgam for the spread of infectious diseases (Rodgers, Stylianou & Dunford, 2017).

When opening a project, you have the chance to watch it evolve and bring in ideas and protocols that will immediately affect your patient population. However, it does not come without frustration, especially in such a complex context. Finding a stable structure to open an emergency project so close to the frontline, without putting everyone at risk is near impossible. Yet, we were able to find one of the last standing buildings to provide emergency lifesaving care with surgical capacity near the frontline. We hired newly liberated staff and provided them with opportunities they did not have in years. I remember a conversation I had with a local staff doctor who told me how he managed to flee: “My wife and I, we ran from building to building and hid with my son. We took a boat to get to the other side of the Tigris River. It only took thirteen minutes, but it felt like days. I thought we were going to die! When I heard about an organization that was helping my people, I immediately applied to work for MSF. We were afraid that you would think that we were all ISIS, but you didn’t. You gave us work, you gave us life, and you made us human again.”

Towards the final phases of the battle, when the city of Zanjili was liberated, in an effort to escape, many people had been wounded. The exodus meant that hospitals were activating their mass casualty plan, and were planning to receive an influx of wounded patients within the hour. Among them was a 4-year-old girl, with an open head injury, who arrived to our hospital separated from her family while escaping. I was hopeful that they had been brought to other facilities, yet the alternative had not bypassed my thoughts. When she woke up, she cried for her mother until I took her in my arms in order to comfort her, and slept by her side to keep a much-needed close eye on her. The local nurses circulated her picture on Facebook, which would get shared by others. Many families were reunited in this manner, including our little fighter. Within 2 days, the mother appeared with her two siblings, injured, but relieved that her baby was still alive. Their father had been killed in their attempt to escape. I take comfort in these abstruse survival stories.

**The Politics of Caring**

These are the stories of the people of Mosul. Those who survived now have an uncertain future; limbless and malnourished, people are starting over by finding the remains of their families to give them a decent burial. The children only know the sounds of war, and many are orphans who suffer from posttraumatic stress disorder.

The general infrastructure of Mosul is crippled; homes, health facilities, and schools are in ruins, and there is no electricity or access to clean water or food. It will take years to rebuild and cost millions of dollars the country does not have. Moreover, vaccination schedules were interrupted, and noncommunicable diseases were neglected, which is sure to cause meaningless disease and suffering for years to come.
No matter how much I feared the rockets and airstrikes, I was driven by the resilience of the survivors and the local nurses, who revealed to me what my obligation as a nurse truly is. By simply stepping out of my living room, I was no longer a passive bystander. Once you become the person a pleading father runs towards to hand his wounded child to, you are never the same again.

Iraq will continue to bleed for many years to come. The truth is the politics of caring on a global scale is difficult, yet it has the power to restore humanity. In the words of Martin Luther King Jr. “Our lives begin to end the day we become silent about things that matter.” Nursing gives us the ability to go beyond our own borders and use our voice to speak out about what we witness. “The choice of where or how we care is ours (Personal Communication, Donna Nickitas, 2017)*

Case Study Questions

1. What do you think motivated the author to help this particular patient population? What motivated the local nurses?

2. Do you think the benefits of working in such a context outweigh the risks? Could she have been more effective helping a local population at home?

3. What were the most significant challenges you think the author faced in her initial days?

4. Using the American Nurses’ Association Code of Ethics as a guide, describe what you see as the most significant challenges you might face in respecting the professional boundaries of nursing vs. caring on a more emotional level? Does this change with a pediatric patient population?

5. Do you think the exposure to a life-threatening environment affected the author’s ability to perform her duties?

6. Referencing Maslow’s Hierarchy of Needs, describe how the author fulfilled each tier for her patients. What about for herself? How do you think your experience would differ, if at all?

References


when over 4 years she visited 50 countries and was able to see health care in action, and meet nurses and health ministers.

Towards the end of that time, she learned of the growing epidemic of NCDs not, as once thought, diseases that only affected rich, elderly, fat Americans closely followed by the British, and she learned two startling facts: First that this epidemic was disproportionately affecting low and middle-income countries (LMICs), and second, it was happening at an earlier age than in western countries.

There are 40 million deaths from NCDs occurring each year: 70% of the total. Most of these are caused by four diseases: cardiovascular disease (CVD), cancer, chronic obstructive pulmonary disorder (COPD), and diabetes. Eighty percent of these preventable deaths occur in LMICs and 48% NCD deaths in LMICs occur in people under 70 years old.

The World Health Organization (WHO) estimates that 80% of heart disease, type 2 diabetes, and stroke, and 35% of cancers are preventable by focusing on just four risk factors: smoking tobacco, increasing physical activity, reducing harmful alcohol use, and eating a healthy diet with less salt, sugar, and fats and more fruit, vegetables, whole grains, and nuts.

There has been increasing global recognition that prevention and the risk factors of NCDs are critical issues. However, our work has become more urgent as the NCD epidemic escalates and health systems buckle under enormous financial demands.

Using their extensive connections to bring together organizations, C3 Collaborating for Health began to imagine a world where there are no premature or preventable deaths from NCDs, by working towards a world where:

- It is easier to live healthy lives.
- Fewer fathers and mothers, brothers and sisters, and daughters and sons are dying at young ages from largely preventable diseases.
- Prevention, health, and well-being are core to proper health care.
- The focus is on not just on individual behavior change, but also on changing our environment.

C3 is unusual as it is global (not national or local), it is not disease focused like most charities, and it uses multisector collaboration to focus on the unhealthy behaviors that lead to NCDs: tobacco use, unhealthy eating and drinking, and physical inactivity. While C3 does not work with the tobacco industry, a fundamental principle is to engage the business world, and that includes the food industry; many of these companies have played a part in our unhealthy lives, and C3 believes they need to be part of the solution.

Although NCD prevention frequently focuses on individual behavior change, C3 knows that the environment in which we all live very much dictates our behavior. It can be difficult, if not near impossible, to adopt healthy behavior if your surroundings make being unhealthy the cheaper, easier option. That is why C3 uses a partnership approach to bring together different groups—individuals, communities, organizations, businesses, and policymakers—to collaborate on societal solutions that make it easier for people to live healthy lives.

C3’s main work areas include businesses, including the workplace, professionals who can influence others, and local communities.

Why would businesses care about NCDs? It is estimated that NCDs will cost the world’s economy about £30trillion over the next 20 years. The World Economic Forum has stressed that the NCD epidemic is one of the most important global risks in terms both of likelihood and severity.

Health starts where you live, learn, work, and play, says Sir Michael Marmot, President of the World Medical Association. The place where you are born, grow up, and live is critical to your health throughout your life. Too often, governments and well-meaning people focus on convincing (they often say “educating”) individuals to change their unhealthy lifestyle, but fail to recognize the importance the environment has on our ability to choose healthy options: fresh or fast food? Green space or concrete? Walking and cycling or driving? Social networks or isolation? All of these can influence the risks to our health. This is particularly true for disadvantaged communities, where healthy food options and opportunities for physical activity can be nonexistent, expensive, and/or unrealistic.

The best way to break down the barriers to living a healthy life and creating sustainable change is to work with community members who are the experts in their environment and their

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health; the empowerment of people is essential to address the NCD epidemic.

Health professionals are among those best placed to give the trusted, accurate advice needed to prevent and treat NCDs. C3 wants to stimulate a global movement to raise awareness, motivate, stimulate, educate, and support the global health workforce in promoting healthy behavior to combat the NCD epidemic. C3’s Healthy Nursing Collaborative is a network of nurses, nursing organizations, and other stakeholders, which aims to encourage sharing of evidence, resources, materials, and experiences to support nurses in leading healthier lives so they can better lead and help their colleagues, family, friends, and communities to live more healthily. C3 is interested in sharing evidence and good practice from around the world.

**Conclusion**

There are more than 20 million nurses across the world; in some parts of the world they are the only health professionals people meet. Imagine the progress that could be made if all those nurses were supported with the knowledge, skills, and opportunities to promote healthy lifestyles and prevent NCDs.

C3’s NCD nursing model does just that:

- Help and support nurses to understand and improve their health.
- Educate and promote health among their patients, families, and communities.
- Disseminate knowledge and promote skills development with their colleagues.
- Advocate for NCD prevention locally, nationally, and internationally.

Are you interested in making it easier for people to be more active, eat and drink better, and stop smoking tobacco?

**Case Study Questions**

1. To what extent do health professionals have a responsibility to role model healthy behaviors?
2. What changes are needed in the work environment to ensure that health professionals are enabled to lead healthy lives at work?
3. How can initiatives such as C3’s Healthy Nursing Collaborative and ANA’s Healthy Nurse: Healthy Nation help build a culture of health in nursing?
4. What changes are needed to ensure that healthcare professionals receive appropriate education input and appreciation of public health issues to ensure a skilled workforce knowledgeable in preventive health care, well-being, and public health?

**References**


