



# From Global to Local: Bringing International Lessons to U.S. Local Public Health Practice

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**Public Health**  
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# NACCHO

National Association of County & City Health Officials

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**Report Author:** Emily Yox, MPH

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Cover, top graphic from the UK initiative “Health on the High Street.”



## Introduction

Successful health initiatives know no boundaries. Creative and scalable solutions from other countries can provide a wealth of potential for United States local health departments (LHDs) working to address challenges in their own communities. As public health in America strives to address some of its most intractable challenges in community health, looking beyond our country's borders for solutions may provide us with new and effective approaches.

Global health is a bidirectional endeavor. In 2009, Koplan et al. sought to distinguish global health from its historic counterpart, international health. While international health focused mostly on the flow of resources and expertise from the resource-rich countries in the Global North to the resource-poor countries of the Global South, global health sought to encourage a more equal exchange of ideas and expertise. As Koplan and colleagues defined it, global health is "a mutuality of real partnership, a pooling of real experience and knowledge, and a two-way flow between developed and developing countries" (2009). At its core, global health is trying to solve a communication and information-sharing problem and improve the health of all people.



The connection between global health and NACCHO, the National Association of County and City Health Officials, may not be readily apparent to most. What role does global health play in a U.S. national association focused on local cities and counties? NACCHO espouses the belief that all health can be global health, because the health and well-being of all people is intrinsically linked, and local health departments can learn much from successful approaches, models, and solutions that have been developed and successfully executed in other countries.

Therefore, we used our access to the nation's local health departments to assess the following research questions:

1. What challenges are LHDs experiencing that could benefit from global strategies?
2. How open and willing are U.S. LHDs to look at global strategies to address these or any other challenges?

*\* For the purpose of this research, we defined "global strategies" or "approaches" as programs or ideas that originated outside of the United States.*

Our perspective on the needs and barriers of U.S. LHDs gave us a unique advantage to address these questions. LHDs in the U.S. have a challenging communications and information sharing problem; each jurisdiction has had to reinvent the wheel, because they often didn't communicate with each other. NACCHO addresses this by facilitating cross-jurisdictional idea sharing. Now, NACCHO is in a position to extend its communications and idea-sharing network on a global scale by facilitating engagement with the global public health community. This paper is designed to explore LHD interest in NACCHO doing just that.



## Methodology

Data for this paper was collected mainly through the use of focus groups, both in-person at the 2019 NACCHO Annual meeting in Orlando, Florida, and online through the video conferencing program Zoom. All focus groups were recorded and transcribed to provide a full record of what was shared during these sessions. Participation was voluntary and confidential to preserve the anonymity of the focus group members, and all were asked to speak freely and openly, with free reign to disagree with each other or bring up entirely different points.

The focus groups were divided into urban and rural participants, and each had somewhere between three and seven participants. In total, there were 38 participants across all of the focus groups. Of those 38, 25 represented urban health departments, with five of those 25 representing large cities from the Big Cities Health Coalition, a forum for the U.S.' largest metropolitan health departments. There were 13 rural participants. Given that adopting and adapting global solutions to address local challenges could indicate a shift in the way that LHDs look at new program development, we restricted all focus group participants to those who had decision-making power within their organizations. The majority of focus group participants were the directors of their respective health departments.

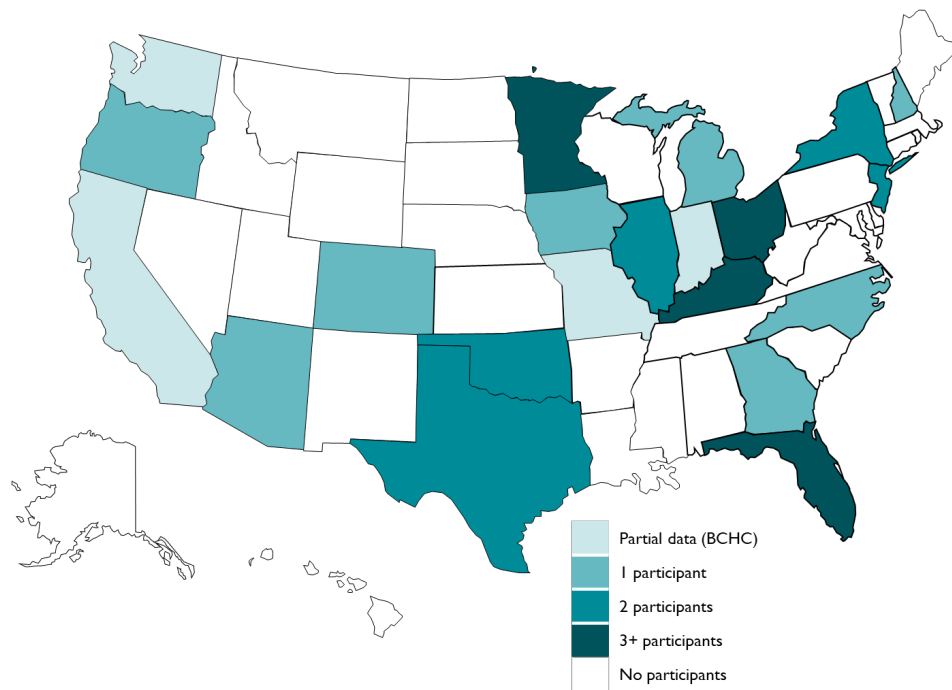


Five focus groups were conducted in-person at 2019 NACCHO Annual. Participants for the in-person focus groups were selected among those registered for NACCHO Annual. All attendees with decision-making power were invited to participate, yet given other priorities that participants had during the conference, turnout was somewhat low. Additionally, given the location of the conference, the geographic representation of the in-person participants was likely skewed toward the American southeast.

Following NACCHO Annual, we conducted four virtual focus groups through the video conferencing program Zoom. To ensure greater geographic representation in the additional focus groups, states that were highly represented in the in-person focus groups (Florida and Kentucky) were removed from the list. Names of decisionmakers were pulled from NACCHO’s member database, NetForum, and a random sample of 75 people was selected from that group. Each person on the list received an email invitation to participate in an online focus group, and those who responded were scheduled to attend. To ensure the most realistic experience to an in-person focus group, all participants were instructed to turn on their cameras, so that everyone would be able to see each other.

Data on the five large cities was gathered through a discussion with the Big Cities Health Coalition. This was not a traditional focus group, but rather a brief period of discussion led by NACCHO during their monthly conference call. Therefore, those five big cities only represent partial data. While there were a number of cities represented in the call, only those who spoke were counted as part of the study population.

All data for this paper was collected between July and September 2019. Below is a map displaying the state representation of the focus group participants.



**Figure 1: Map showing state representation of focus groups**

Focus group questions were designed in collaboration between NACCHO’s Global Health and Research and Evaluation programs. Additional input was provided by NACCHO’s Global Health Expert Advisory Group (GHEAG) to ensure that the questions asked in focus groups were the most appropriate to elicit the information we were looking for. The focus group questions can be found in **Appendix A**.

Each focus group covered four main sections, which included:

1. Participants' experiences and thoughts on global health
2. Areas where LHDs are facing challenging stagnation, where global health initiatives could provide a valued perspective
3. The general value that LHD leaders see in adopting and adapting global approaches
4. The challenges or limitations that LHD leaders have seen or foresee in adopting and adapting global health approaches

These sections will be divided below to provide a comprehensive overview of the qualitative information gathered in this research process. Following this presentation of results, we will provide recommendations based on the research gathered.

“Good ideas are good ideas, no matter where they come from.” — Rural Kentucky

## Results

### Thoughts on Global Health

When invited to a focus group on global health, most participants had thought about how they as U.S. organizations could provide resources and expertise abroad, but most had not thought about the many ways in which looking at other countries could potentially benefit them and their communities. While Koplan and colleagues defined a new era of “global health” a decade ago with its reliance on a “two-way flow” of resources and information, it is still taking time for that idea to permeate through all levels of public health practice. Across all focus groups, the majority had not thought about global health or how it could potentially benefit their work and respective populations. At the start of each focus group discussion, the ways in which participants thought about public health could be grouped into three separate categories:

The **first** was thinking of global health mainly in a global context; thinking about how global challenges like climate change and the spread of infectious disease through travel have an impact on the local level. While this was often stated in the beginning of focus groups, they did not spend much additional time discussing this in significant depth.

“I look at global health as more than just immigrant health; it's also our environmental health, not just in our local area, but around the world. Also, there are emerging diseases that are also part of global health. Obviously, the immigrant health and those populations are the larger piece, but I think that these other parts also play into global health.” — Urban Minnesota

The **second** way in which participants thought about global health was to consider more culturally competent strategies to reach immigrant and migrant populations.

Many participants said that these populations are often harder to reach in their communities due to language or cultural barriers, as well as a lack of trust in government institutions. Therefore, many participants saw global health as a way to provide care in a more meaningful way to their immigrant populations. This was a more popular approach in the urban focus groups, likely due to the higher diversity in their populations compared to the rural focus groups.



“We have a lot of immigrants and refugees here from other countries, so their experience with health is important for us to understand in terms of how our system works. We can learn from those approaches, both in delivering services and information to them here, as well as think about how those approaches might work with other populations.” — Urban Minnesota

The **third** way in which participants thought about global health was a recognition of the similarities between their communities and communities in other countries, and the potential wealth of successful interventions that could derive from other countries. This way of thinking was more common in rural populations and often was the conclusion that many participants came to at the end of our discussions; they had not previously thought about global health and its potential in their own communities.



These introductory thoughts set the tone for the conversations that followed. The majority of discussions focused on how adopting and adapting global health programs could improve health outcomes in foreign-borne populations or on how global programs could provide evidence-based successful examples for general use in their communities.

“I’m interested in this topic because I’m interested in how we can learn things from developing countries that we could incorporate into some of our more vulnerable populations. We all talk about addressing social determinants of health and how that impacts health outcomes, but I think even though we’re a developed nation and such a great nation, that maybe there’s an opportunity to learn from others.” — Rural Michigan

## Areas Where Local Health Departments are in Need of Innovation

While LHDs face challenges every day, we were specifically interested in looking at areas where previous practices have started to become less effective and LHDs needed a new perspective. It was important to understand where global health innovations may have the greatest impact and be most beneficial to LHDs. Departments in both urban and rural regions and across all sizes shared some common areas where they are experiencing frustrating stagnation, and subsequently saw the potential benefit of looking at global programs to gain a fresh perspective:

1. Mental health (ex. social isolation, suicide, trauma, Adverse Childhood Experiences (ACEs))
2. Substance use disorder
3. Health access and social determinants of health (including culturally competent care for immigrant populations and health equity)
4. Infant and Maternal Mortality
5. HIV/STI prevention and control

These were specific areas that were cause for frustration for focus group participants, where they saw the potential benefit that a global perspective could bring. Interestingly, many of these align with the top priorities found in NACCHO’s 2019 Member Satisfaction Survey. This survey was released in June 2018 to 2,506 individuals in support of NACCHO’s commitment to continuous quality improvement. The survey achieved a 17% response rate with nearly 450 respondents sharing their perspectives about the ways in which NACCHO can continue working toward our shared vision of optimal health, equity, and security for all people in all communities. The top ten priorities for responding LHDs were:

1. Substance use (opioids, tobacco, alcohol)\*
2. Chronic disease (obesity, diabetes, cancer, CVD)
3. Mental/behavioral health (depression, suicide, bullying)\*
4. SDOH and health equity (housing, poverty, transportation, built environment)\*
5. Environmental health services (lead poisoning, septic/sewage, water quality/supply, climate change, Lyme disease)
6. Communicable/infectious disease (STIs, hep A, hep C, TB, flu)\*
7. Increasing access to care (mental, behavioral, oral)
8. Funding and sustainability
9. Maternal and child health (family planning, teen pregnancy, infant mortality)\*
10. Nutrition and physical activity

This shows that many of the top-of-mind issues and challenges that LHDs are facing could very well benefit from a greater understanding of how other countries manage these problems. While adopting and adapting global health innovations was not a natural connection that most focus group participants made in the beginning of the sessions, many started to converse about how programs in other countries could potentially provide alternative ways of approaching these challenges.

## Value of Global Health

**A**s each focus group progressed in the discussion, we asked participants to consider the value that global health could bring to their processes and programs. Since many had not adopted a global health program, these discussions were more theoretical, but participants did see the potential for significant value in looking outside the U.S. for innovation and inspiration.

**“I don’t have that much experience with this, but I would think some of the value could be that with a global health program, there would be a lot of data, strategies, and interventions that have been tried – some successful, some not. Being able to access that information could help me in planning for my local communities and my county.” — Rural Iowa**

There were three main camps that participants fell into when discussing the value of global health programs. The first was that people see great value in the diversity of solutions and new perspectives that other countries offer. By looking outside of the U.S., challenges are approached through a different lens and perhaps seen in an entirely different light.

The second camp felt that these interventions have already been proven effective, and there is evidence to support them. Many discussed the challenge of shepherding new interventions through their respective approval processes. Having evidence to show success and return on investment was seen as a very significant value.



The third camp considered the potential cost effectiveness of global health programs. Looking at programs particularly from developing countries, participants assumed that these were carried out under sometimes considerable resource constraints. Those who worked in rural health departments found this of particular value, given the budget constraints they so often face.

Crossing all of these camps was also the benefit that programs in other countries often are not as focused on clinical care, but rather preventative and population health. While this is seen as a benefit — because prevention has been shown to be more cost-effective and healthier in the long run — adapting that to the U.S. healthcare system was noted as a potential challenge as well.

**“Our population is consistently changing, so knowing what is familiar to them and what has worked for them really helps build that trust... Having different lenses from all over the world really helps with that fresh perspective. Especially when you may be stumped on an issue or you’ve tried different angles and they haven’t worked.” — Urban New York**

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“Anything that works has value, and we don’t have the resources to waste our time on things that we don’t know if they work. To find research that is evidence-based somewhere else and has practical application has a huge return on investment for us.” —  
Urban Oklahoma

## Challenges to Adopting a Global Intervention

Most participants agreed that adopting global innovations would require some adaptation to be effective in their local communities, and some would be more effective in a U.S. context than others. Many cited the differences between the U.S. health system and other countries’ systems as a substantial barrier to effective implementation of some global health interventions.



While a focus on prevention was seen as a potential benefit to global health solutions, fitting that within the existing U.S. healthcare context was a common challenge. A broader shift to preventive and population-based care is certainly another opportunity for improved health and well-being across American communities, but this consideration is outside the scope of this paper. Overall, participants concluded that certain global health interventions will have to be significantly adapted to fit into the existing U.S. healthcare system framework.

Many also cited the challenge of helping politicians and governing boards understand the value and ROI of programs in general, let alone one from another country. Many noted that while they themselves are very open to global solutions to their challenges, others in their department or along the chain of command may not be as open.

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“I think something that is a challenge is that the way other countries are set up is very different from how our health system is set up... So if you go out and get a screening and they find something, there is a system to take care of you; here, there's not. So getting past the public health space and into the health system space, there's a huge chasm, where in other countries, that chasm doesn't exist. So they can actually focus on the public health prevention strategy.” — Urban local health department

Rural communities in particular said that they would have to be careful in how they presented any global health interventions, and would want to focus on the evidence and ROI, rather than on the origins of the program. Many also mentioned the hesitancy they anticipated in their communities around programs that originated outside U.S. borders. Some even expressed challenges with bringing programs and ideas from neighboring cities, let alone from a different state or even country.



However, many did not think that the challenges posed by adopting and adapting a global health intervention would be impossible to overcome. Messaging and communication of ideas was seen as the crucial element to overcome these challenges. However, these challenges do add another layer of complexity to the broader challenges that LHD leaders face, including limited resources, finding champions in the community, cross-sector collaboration, and staffing capacity. These are challenges experienced by almost every LHD; thus, any innovation must also work into the context of these challenges as well.

“When I want to implement something new, I have to go to my governing board, and I’m from a rural area and we don’t really have a whole lot of diversity on our board. And I think that it would be hard for me to be able to relay to them that it would work in our community. If they can’t relate to it, it’s harder for them to approve it and for a lot of things that I have to implement, I have to get approval from them, so I think that would be a barrier.” — Rural Michigan



## Recommendations

Understanding the openness and willingness of LHDs to look at global strategies to address their challenges was a crucial step in finding ways to improve the health of all communities in our country. However, turning this openness and willingness into actionable change is another process. Many LHD staff had never considered looking at other countries to find replicable examples or provide inspiration for developing programs. Therefore, the first step is to educate LHD staff on the benefits of global health examples as a resource. Second, it became quite clear that LHD staff juggle many competing priorities each day, thus demonstrating the need to fit global examples into their existing research processes when developing new programs.

Many participants researched for new programs in similar ways. In seeking out new ideas from public health organizations, NACCHO, the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) were mentioned frequently. Participants used the available databases and resources provided by these organizations and by attending their conferences.

Given its position as a resource on best practices in public health, NACCHO is in a unique position to increase the dialog about the global-local public health connection and provide opportunities for the almost 3,000 U.S. LHDs to learn from successful solutions around the world. The following recommendations are provided to add global health to the repertoire of resources that local LHDs consider when they are developing new programs and ensure that NACCHO is meeting the needs of all LHDs, whether they are already looking outside U.S. borders for inspiration, or have never considered doing so before.



## I. Encourage Awareness on the Bidirectionality of Global Health

As mentioned previously, many participants instinctively thought that conversations around global health would be about the migration of ideas and resources from their U.S. communities to communities abroad, not the other way around. Until about a decade ago, the predecessor to global health — International Health — almost exclusively focused on resources and expertise flowing from the Global North to the Global South. With Koplan and colleagues' new definition of Global Health in 2009, the concept of global health's bidirectionality began to take shape.



However, as many who are involved with local government and local health work are aware, change happens slowly, and new ways of thinking can take time to develop. For example, while the current definition of global health has existed for over a decade, this way of approaching global health is still very nascent.

Therefore, it is important for all involved in the global and public health space to embrace this way of thinking about global health and encourage others to do so as well. We need to begin to have these conversations and share the value of a global health approach with our colleagues and those in our community. Changing the ways in which people think is always a challenge, but we must recognize this as an area of significant untapped potential and start to change and amplify the narrative around global health.

Conferences are a commonly used method to share information, so the presentation of global health as a potential resource for LHDs should begin there. Introducing the idea of global health as a resource, sharing success stories of LHDs that have adopted a global health strategy, and sharing ideas on how to adapt global examples will all be effective in sharing the message that global health is not a unidirectional endeavor. As this narrative becomes more common, using ideas and innovations from global health will eventually become commonplace.

## II. Meet LHDs Where They Are

**A**s we thought about where LHDs currently are in their approach of global health solutions, the analogy of a pool came to mind. There are some LHDs who have been involved in the global-to-local space for a while and regularly scan the globe



to address challenges requiring a new approach. We think of those people as swimming laps in the pool; potentially in need of a coach to improve, but overall, happily swimming along. Then there are those who are dipping their toes in, perhaps staying near the shallow end. They may have heard or thought about using global health for inspiration, but need a guide to confidently jump in the water. Finally, there are those who have no idea the pool even exists. These folks haven't considered global health as a resource at all and need help in becoming aware of the possibilities.



Each of these groups have different needs that must be considered if they are going to successfully approach global health. Those who are already in the lap lane will want ways to showcase their work and can serve as a resource to those who are interested in replicating what they have done. As many participants also mentioned, once they surpassed the challenge of securing funding to try a global program, maintaining that funding has also been a challenge. We as a public health community must do more to ensure that these innovative and successful programs are able to be sustainable in their communities. Demonstrating their value and being a champion for these programs is important for their continued success.

Those who haven't yet jumped in the pool will likely need guidance and suggestions for how to adapt global solutions and ideas that have been previously successful. Oftentimes, those who have thought about global solutions experience pushback from their community, their board, or even their own staff. Many mentioned that the communication and messaging around global health solutions would be important to avoid any immediate reluctance to try something considered foreign. Focusing on

the data, cost-effectiveness, and success of previously-implemented global problems are key benefits that should come across in the messaging around these initiatives to decision-makers and other staff. Additionally, knowing that NACCHO is already seen as a potential resource for new program implementation, it is important to work within existing avenues to provide information on global programs alongside existing domestic best practices to interested health departments.

Finally, just by sharing information on the potential connections between global and local public health, we will be able to help guide those who were previously unaware, toward the pool. Through published reports and sharing information at public health conferences, we can start to guide the global health discussion into all health departments. It is important to familiarize public health staff with this idea so that we can fully capture all of the effective, creative, and scalable solutions that are circulating around the globe.

## Conclusion

While the results of this study were enlightening, they were preliminary and do not encompass a broad sample of how all U.S. LHDs feel about global-to-local innovations. Rural and frontier counties were not as highly represented in the research as they likely should have been. Given the differences among urban, rural, and frontier populations and needs, greater representation of these various types of communities in the research. Additionally, more geographic representation is needed to ensure that all states are considered.

In 2020, this research will continue through NACCHO's Forces of Change study, which will be sent to a representative sample of LHDs to continue to gather information on global health. This research will seek to gather a better understanding of where LHDs are when it comes to global health; how many are swimming laps, who's in the pool, and who is still struggling to find it. This will be a key piece in reaching LHDs where they are and providing resources tailored to their specific needs. We will also use this as an opportunity to build a cohort of LHDs who are already implementing global health programs and share their success more broadly through NACCHO avenues and other opportunities.

Broadly speaking, the global-local connection for U.S. LHDs hasn't been made yet for a lot of people. This is a huge opportunity to bring a fresh perspective to vexing challenges, and creativity to programs. Most LHDs are open and willing to adopt and adapt global health programs. Many see benefits like the availability of data, cost-effectiveness, and demonstration of success when looking outside U.S. borders for new programs and policies. However, funding and getting buy-in from necessary stakeholders are seen as the biggest potential challenges to implementation, particularly in groups that are resistant to change or take a heavily localized approach.

## Appendix A: Focus Group Questions

### Introductions

Let's start with introductions. Tell us your name, the local health department you are representing, and what you think of when you hear the phrase "global health."

1. What is your personal and professional background as it relates to global health?
  - a. Have you traveled extensively?
  - b. Have you worked globally?
  - c. Have you hosted interns/fellows/etc. from other nations?

### Openness

2. Describe your process for developing new programs.
  - a. Where do you get ideas for new programs/solutions?
    - i. For example: CDC, WHO, etc.
  - b. What strategies and resources have helped you develop new programs?
  - c. Have you ever considered looking at global programs for solutions to local public health concerns?
    - i. What sources provide information on global health solutions? Where can local health officials go to learn more about global programs?
  - d. Have you ever researched programs in other countries as possible programs to implement in your health department?

**[If yes & have used a global strategy]** Can you tell us more about the international origins of the program? How did it move to the U.S.? Were there some stops and starts along the way? Has this strategy been combined with other strategies?

**[If yes & have not used or no]** Can you tell us more about your perception of global health programs?
3. Do you think other countries have good ideas that could be implemented in your local counties?
  - a. Has the idea of adopting and adapting global innovations ever crossed your mind?
  - b. What is your current understanding about any global health practices related to public health concerns that show up in your jurisdictions?
  - c. Which countries would you look to for global health innovations? What makes you interested in looking to those countries?
    - i. Probe: high income countries vs low/middle income countries

## Willingness

4. I want to gauge the group's reaction to the idea that programs or solutions in other countries could be successfully implemented here. Would you be willing to look to global health programs for potential solutions to the problems in your jurisdictions?
  - a. What do you consider the value, if any, of adapting global approaches to your local public health concerns?
  - b. What do you consider the facilitators to implementing global approaches?
    - i. For example: simplicity, trialability, availability of funding, compatibility, external validity
  - c. What do you consider the limitations? What are the challenges that your health department has encountered when trying to understand and implement global approaches?
    - ii. For example: differences in populations, culture, values, health systems, social contexts, political contexts, etc.; lack of funding for implementing or sustaining; stigma
  - d. How could limitations be addressed?
  - e. What kind of a collaboration/partnerships does it takes to bring global approaches to a new country to benefit a new population?
5. What resources do you wish you had to learn more about successful global health programs?

## Areas of Focus

6. In which areas do you feel like your LHD is stalling or needs innovation? Are there health outcomes in your community that have remained stagnant?
  - a. Where have you sought inspiration to try and address these issues?
  - b. Do you think other countries might have effective programs for addressing these problems?
  - c. How would you go about searching for successful public health programs implemented by other countries? What resources come to mind?
  - d. What would be an ideal resource to help facilitate this search for best practices?
7. What would a successful implementation of those strategies look like in your jurisdiction?
  - a. What would be your next steps?
  - b. What resources do you need to implement? Are you confident in your ability to acquire those resources?
  - c. What local, state, national, and global partners should be involved for this work to be effective?

## Closing

8. Would you be interested in joining an advisory group or community of practice on global health?

Thank you for your participation in this focus group! Is there anything else you think we should know about your experience with global health solutions?

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*The National Connection for Local Public Health*

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**Public Health**  
Prevent. Promote. Protect.

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 I Street, NW, Fourth Floor • Washington, DC 20005

Phone: 202.783.5550 • Fax: 202.783.1583

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