Foreword: Global and Rural Health Disparities

Isabel C. Scarinci, PhD, MPH[1];
Jodie A. Dionne, MD, MSPH[2]

Ethn Dis. 2022;32(4):265-268;
doi:10.18865/ed.32.4.265

Keywords: Global Health; Rural Health

[1] Global and Rural Health, Department of Obstetrics and Gynecology, University of Alabama at Birmingham
[2] Department of Medicine, Division of Infectious Diseases, University of Alabama at Birmingham

Address correspondence to: Isabel C. Scarinci, PhD, MPH; University of Alabama at Birmingham; scarinci@uab.edu

In this issue of *Ethnicity & Disease*, we highlight the importance of bidirectionality in global and rural health. While racial/ethnic, rural/urban and other health disparities have been well-documented within high-income countries (HICs) and between HICs and low- and middle-income countries (LMICs), opportunities persist to better understand these disparities and find solutions based on input from marginalized populations who experience them. Since some factors associated with disparities in LMIC settings are prevalent in low-resource settings in the HICs, shared solutions to improve health can benefit more than one population, allowing bidirectional learning and integration. Although published data are few, our understanding of the intersectionality of global and rural health disparities continues to evolve. The articles included in this themed issue of the journal provide insights on how research conducted in under-resourced US communities can inform global community health efforts and vice versa; some of the research presented within also illustrates how to combat paternalistic patterns of colonialism in global health.

Contributing authors to this special issue call attention to the need for partnerships and other strategies to develop a truly bi-directional approach to addressing global and rural health disparities. A commentary by Adsul and colleagues focuses on advancing the science of implementation for resource-limited settings through bidirectional learning around cervical cancer screening. It has been well-documented that cer-

The articles included in this themed issue of the journal provide insights on how research conducted in under-resourced US communities can inform global community health efforts and vice versa

vical cancer is a disease of poverty as the disproportionate burden of disease occurs in low-resource settings.[1-4] While evidence-based tools (ie, HPV vaccination and HPV testing) have recently become available to eliminate this cancer as a global public health problem, these tools are not reaching all at-risk populations. As shown by Morales-Campos and colleagues, the main factor associated with HPV vaccination in an impoverished region on the US-Mexico border, after controlling for neighborhood-level characteristics, was receipt of vaccines required for school-entry. Their findings suggest that interventions with established providers who administer required vaccines for school-aged children could leverage HPV vaccination uptake and reach underserved populations. Further, Adsul and colleagues offer three foci areas for implementation science research toward the development, implementation, and evaluation of multi-level interventions toward the elimination of cervical cancer as a public health problem: self-sampling for HPV testing among women experiencing intrapersonal and/or structural barriers to accessing clinic-based cervical cancer screening programs; tele-health capacity-building among relevant providers; and a more complete integration of community health workers into cervical cancer prevention and control efforts. In fact, the engagement of community health workers in health care delivery is a major strength in many LMICs where these individuals have long been integrated as a key component of the health care system and a bridge to communities where patients and families reside.[5-7] While a number of studies have successfully used the Community Health Worker model in the United States, most are limited to the research context, and have not yet been incorporated into routine clinical practice nor adopted by health care systems at-large. This is an opportunity for a HIC to learn best-practices from experienced community health workers in an LMIC setting.

The "decolonizing public health" movement provides a unique opportunity for researchers and public health practitioners to truly engage high-income countries and low- to middle-income countries in research and solutions from an equity and participatory perspective where everyone brings skills and knowledge to the table.

Roland and researchers take a broader perspective to address the importance of knowledge-sharing with communities who are at-risk of harmful algal blooms that can cause toxin diseases globally. Their research focuses on how political changes disrupt membership in knowledge-sharing networks, and, consequently, increase public health risk. This framework equally applies to the context of cervical cancer prevention and control discussed above, as well as other health conditions and public health crisis such as maternal morbidity and mortality, addressed by Tipre and colleagues. They demonstrate that after controlling for individual-level factors, residence in disadvantaged neighborhoods makes a unique contribution to maternal morbidity and mortality in a southern US state; their findings have major implications for global health. In both LMICs and HICs, there are sub-populations at higher risk for significant maternal morbidity and mortality. Identification of these deprivation areas can be critical to inform allocation of perpetually limited public health resources.

In addition to shining a light on the global and local health inequalities, the COVID-19 pandemic has highlighted the importance of integration across the research continuum to improve the uptake of effective prevention and treatment tools. For example, behavioral and communication experts must be invited to work side-by-side with clinical and basic science colleagues when novel interventions with safety and efficacy are identified. The work of Khare and colleagues demonstrate

the need to accelerate research on ways to communicate important scientific discoveries and implement them at the population level. Their results, which are consistent with other studies, demonstrate that mistrust of science and concerns about safety hindered COVID-19 vaccination among rural residents in Illinois. The work of Painter and Tabler in this issue also demonstrates the need for researchers to work together across the continuum. In their study among a diverse sample of immigrants to the United States, they confirm the relevance of moving beyond race/ethnicity constructs and examining skin tone and gender in health outcomes. Although their focus was on BMI, their results provide critical insights regarding the heterogeneity of sub-populations that are too often lumped together and labeled as "one" based on arbitrary constructs such as race/ethnicity. Finally, the work of Seiden and colleagues provides preliminary evidence on the importance of starting anticoagulation treatment after atrial fibrillation among symptomatic patients presenting to the Emergency Room in any setting across the world. Their results showed that patients leaving the ER against medical advice, younger age, the ones with CHA^2DS^2-VASc score of 1, and the ones with limited English proficiency were significantly less likely to initiate anticoagulation treatment.

In summary, several articles in this special issue of *Ethnicity & Disease* provide a snapshot of how global and rural health are intertwined and the importance of "decolonizing public health."[8] While global health has been conceptualized as focusing on health issues across the globe, over time, many global health researchers and funders also adopted a colonial or paternalistic approach to transfer resources and expertise from HICs to LMICs. Likewise, researchers in HIC academic centers tend to work in under-resourced areas with good intentions but from a deficit perspective rather than an asset perspective. This perpetuates what Paulo Freire refers to as the "oppressor-oppressed" relationship.[9] The "decolonizing public health" movement provides a unique opportunity for researchers and public health practitioners to truly engage HICs and LMICs in research and solutions from an equity and participatory perspective where everyone brings skills and knowledge to the table. This enables global health and rural health researchers to move beyond a service or a "helper" mentality that is unidirectional. As researchers and public health practitioners, we carry the responsibility of assuring that our partners have a seat at the table. As a result, efforts will be community-driven and sustainable and work within our own institutions and funding agencies to guarantee true partnerships beyond "contracts" and "subcontracts" where the academic centers lead the efforts perpetuating the "oppressor-oppressed" relationships.

We would like to thank both the contributing authors for articulating the relevance of the bidirectional approach in global and rural health and this journal for providing the opportunity for us to reflect on how we can move forward toward the true meaning of global health.

Peer Reviewers

Many thanks to the reviewers who diligently worked with authors and editors to ensure scientific rigor of the articles in this themed issue on Global and Rural Health Disparities:

Andrea Boan, PhD
Medical University of South Carolina

Teresa Boitano, MD
University of Alabama

Vence Bonham, Jr, JD
National Human Genome Research Institute, NIH

Henna Budhwani, PhD, MPH
Florida State University

Jodie Dionne, MD, MSPH
University of Alabama at Birmingham

Stella Harden, PhD-C
Simon Fraser University

Kearston Ingraham, MPH
Duke Cancer Institute

Angela Malek, PhD
Medical University of South Carolina

Nicole Phillips, PhD; MS
UNT Health Science Center

Mindy Richlen, PhD
Woods Hole Oceanographic Institution

Isabel Scarinci, PhD, MPH
University of Alabama at Birmingham

Danting Yang, MPH
University of Florida

References

1. Scarinci IC, Garcia FA, Kobetz E, et al. Cervical cancer prevention: new tools and old barriers. *Cancer.* 2010;116(11):2531-42. https://doi.org/10.1002/cncr.25065.
2. Falk D, Cubbin C, Jones B. County-level poverty and barriers to breast and cervical cancer screening in a health education and patient navigation program for rural and border Texas residents. *J Cancer Educ.* 2022;37(2):421-429. https://doi.org/10.1007/s13187-020-01832-z.
3. Kuroki LM, Massad LS, Woolfolk C,

Thompson T, McQueen A, Kreuter MW. Cervical cancer risk and screening among women seeking assistance with basic needs. *Am J Obstet Gynecol.* 2021;224(4):368.e1-368.e8. https://doi.org/10.1016/j.ajog.2020.12.018.
4. Keetile M, Ndlovu K, Letamo G, Disang M, Yaya S, Navaneetham K. Factors associated with and socioeconomic inequalities in breast and cervical cancer screening among women aged 15-64 years in Botswana. *PLoS One.* 2021;16(8):e0255581. https://doi.org/10.1371/journal.pone.0255581.
5. Castle PE, Silva VRS, Consolaro MEL, et al. Participation in cervical screening by self-collection, Pap, or a choice of either in Brazil. *Cancer Prev Res.* 2019; 12(3):159-170. https://doi.org/10.1158/1940-6207.CAPR-18-0419
6. Scarinci IC, Kienen N, Wiltenburg TD, Bittencourt L, Person SD. Efficacy of a gender-relevant smoking cessation intervention among women in Brazil: findings from a group randomized controlled trial. *J Womens Health.* 2022; Published online, 17 May 2022: https://doi.org/10.1089/jwh.2021.0443.
7. Finkelstein EA, Krishnan A, Naheed A, et al. Budget impact and cost-effectiveness analyses of the COBRA-BPS multicomponent hypertension management programme in rural communities in Bangladesh, Pakistan, and Sri Lanka. *Lancet Glob Health.* 2021;9(5):e660-e667. https://doi.org/10.1016/S2214-109X(21)00033-4
8. Kwete X, Tang K, Chen L, et al. Decolonizing global health: what should be the target of this movement and where does it lead us? *Glob Health Res Policy.* 2022;7:3. https://doi.org/10.1186/s41256-022-00237-3.
9. Freire P. *Pedagogy of the Oppressed*. New York: Continuum; 2005.