Help Wanted: [Increasing] Racial and Ethnic Minorities in the U.S. Global Health Workforce

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Abstract

The looming crisis of the worldwide health care worker shortage has never seemed more threatening than in recent months, and experts are calling for aggressive actions to attract and retain scarce human resources. The U.S. government is one of a handful of countries playing a significant role in expanding and strengthening the global health workforce through funding and technical training for thousands of doctors, nurses, public health workers, and community health educators around the globe. Ironically, while the U.S. promotes more representative and inclusive programs to address these shortages in other countries, minority Americans are only marginally represented in the ranks of U.S. global health program staff. Investing in and scaling up efforts to include U.S. racial and ethnic minorities who have the requisite technical, cross-cultural and language skills to join the ranks of the global health workforce team should be a priority and serves the long term interests of the nation.

Key words: minorities, Blacks, diversity, global health, global health workforce, HBCUs, health professions, Hispanics,

Help Wanted: Increasing Racial and Ethnic Diversity in the US Global Health Workforce

The recent Ebola health crisis terrorizing a small number of West African nations and threatening the lives of thousands more on the continent (Cooper, 2014; CDC, 2014) is the latest evidence of a global health workforce shortage. Experts in the field have sounded the alarm that the ongoing shortage will continue to negatively impact the health and economic security of many countries, interconnected through a vast global network (DeCock, Simone, Davison, & Slutsker, 2013). Failure to keep pace with the demands for more and better trained health care workers may also threaten worldwide efforts to end preventable diseases, promote healthy lifestyles, create safer environments, increase access to health care coverage and assure equity of health services (Global Health Workforce Alliance, 2013).

The U.S. is one of a handful of countries playing a leading role to address this health worker shortage by giving much needed financial aid and technical training. The U.S. also builds and strengthens the capacity of thousands of doctors, nurses, public health workers, and community health educators around the globe (O’Brian & Gostin, 2011; Schuchat, Tappero & Blandford, 2014). As part of this assistance, the U.S. allocates significant resources to hire Americans to manage these governmental, nongovernmental and contracting agencies in partnership with host countries, other bilateral donors and international organizations.

Ironically, the U.S. also has a critical domestic health workforce shortage and is struggling to keep pace with the growing demands for a more diverse health professions staff (Perlino, 2006). Recruiting and retaining minorities to the domestic health workforce is cited as a difficult but necessary component of national efforts to reduce and eliminate racial disparities in this country (Perlino, 2006). And while these racial and ethnic differences persist in the U S. health professions workforce (McGee & Fraher, 2012; Sullivan, 2004; United States Department of Health and Human Services, 2009), the gap is even greater in the racial composition of Americans working as global health professionals.

The lack of minority representation on the global front is important to examine for the same reasons they are important domestically; namely that the demographics of U.S. population are evolving and the workforce needs to reflect these changes (United States Equal Employment Opportunity Commission, 2009; 2013; Perlino, 2006; National Institutes of Health, 2014). Of even greater symbolic significance are the locations in the world where the U.S. sends its global health workers. These regions have much in common with minority and poor communities in the U.S. Federal officials as well as heads of major U.S. medical and public health organizations are beginning to recognize the importance of recruiting and training a more diverse group of global health professionals (Centers for Disease Control and Prevention, nd; NIH, 2014). But as of yet, minority Americans have been slow to answer the call and are only marginally visible on the world stage.

The purpose of this paper is to describe what is known about racial and ethnic participation as members of the U.S. global health workforce. We briefly examine why this lack of representation is problematic and reversing this trend could have a favorable effect on our overall global health and foreign policy objectives. We suggest factors which may contribute to minority underrepresentation that need further study. Finally, we issue a call for targeted efforts to recruit minorities by increasing opportunities for teaching and training, internships, mentoring, and networking to prepare them to work as competent team members with the rest of the world in confronting the next generation of health challenges.

**Method**

We conducted a systematic review of the literature using relevant and selected search terms. We also performed a content analysis of official reports, documents, and websites of twenty- four (24) U.S. governmental, nonprofit and for profit agencies and organizations with major global health programs. We summarized the literature and completed a meta- analysis using these secondary sources. Our research revealed an extensive literature documenting the underrepresentation of minorities in international programs and study abroad experiences. There are also several studies describing the underrepresentation of minorities in the US domestic health profession fields. However, we found little evidence in the literature of efforts to systematically describe the nature and scope of racial and ethnic composition in the U.S. global health workforce. We consider this analysis to be an important to helping us understand the magnitude of the problem.

**Findings**

**The Slow pace of diversity and inclusion**

The profile of those working in U.S. foreign policy in general (Chicester & Akomolofe, 2003) and U.S. global health programs more specifically, does not reflect the racial, ethnic, and socio-economic diversity of the U.S population (American Foreign Service Association, 2012; 2013; Garzon, 2014). Minority Americans are underrepresented across most of the major government organizations working in global health and their influence has been lacking from problem solving roles in low-income and communities of color in countries to which they may resemble or share characteristics (AFSA, 2012; AFSA, 2013, EEOC, 2009; EEOC, 2013). Although there have been initiatives to promote equal access and opportunity in federal hiring across all agencies (EEOC, 2013), these initiatives suffer from a host of challenges including the fact “equal employment” and accountability are terms which are loosely defined, weak and ineffective links to agency leadership, the overall lack of resources to monitor activities, and the inability to enforce policies (EEOC, 2009; EEOC, 2013). Failure to hire minorities, including Hispanics (Garzon, 2014) and Asians means that they are largely absent from leadership and decision making positions (EEOC, 2009).

Insufficient minority representation is evident not only throughout federal agencies, but other institutions with global health agendas. These include private foundations, national scientific organizations, advocacy organizations, academic and other university affiliated programs, research centers, technical organizations and consulting firms, think tanks and human rights organizations. While statistical data are largely absent, the visuals depicted by their leadership teams and boards on their websites suggest that these organizations are even less inclusive than the federal ones.

There are many reasons to promote and defend the noble concept of diversity in all of its many shapes and forms to build and expand the US global health workforce. First and foremost is the very important work of the federal agencies and its partners around the world to promote democratic representation through diversity and inclusion. Workforce diversity, according to the USAID Global Health Fellows program:

provides concrete benefits vital to success in the global health agenda. It means that workers have opportunities and entrée into the field and global health organizations have the benefits of an influx of fresh ideas, new perspectives and an accurate representation of a broad cross-section of the American people. (United States Agency for International Development, 2014)

Some foreign policy experts suggest that the U.S. policy toward developing countries, especially Africa could have been more coherent had there been more African Americans represented in the upper echelons of any of the federal agencies (Skinner, 2004; Chichester & Akomolofe, 2003) Broadening our team of citizens who understand the unrelenting health crises in developing countries in the form of AIDS, malaria and most recently, the Ebola virus will require us to move beyond our traditional blindspots about who should be at the table or what lessons can be learned and shared. Increasing minority representation means that we deepen our bench of players, drawing from the talents and skills to spark new and innovative ideas about ways to improve health outcomes in other regions and countries (Family Health International, 1994; Hansen, 2012). It also means that we may be able to become more responsive to the needs of resource poor and underserved populations around the world and as a means of promoting greater diversity in our global health presence worldwide.

Of course, one does not need to be Black to effectively participate in discussions about health problems on the African continent or the Eastern Caribbean; but likewise, it is foolish to systemically overlook those Americans for whom the African continent or islands may have some affinity and fail to unleash the potential we have in our own backyard (Chichester & Akomolofe, 2003).

**Missing Persons in the U.S. Global Health Workforce**

Racial and ethnic minorities, described as “missing persons” in Sullivan’s Commission on Minorities in the Health workforce report (Sullivan, 2004), are underrepresented not only in the domestic workforce (Perlino, 2006; McGee & Fraher, 2012; USDHHS, 2009) but also the US global health workforce (AFSA, 2012; AFSA, 2013; CDC, n.d.). Furthermore evidence suggests that they are not embracing these career avenues in medicine or public health in numbers which will statistically change the current trend despite the increasing diversity of the US population.

The federal government has contributed more than $50 billion dollars to support global health programs from FY 2009 to FY 2014 through the Department of State (Office of the Global AIDS Coordinator and Department of Health and Human Services), the U.S. Agency for International Development, the National Institutes of Health, the Centers for Disease Control and Prevention, the Food and Drug Administration, the Peace Corps and the Millennium Challenge Corporation. The Department of Defense has also been an important participant in promoting and support US global health goals and objectives. The size and scope of each agency differs, however the prevailing trend is the relatively small and disproportionately low number of American racial and ethnic minorities working as part of these global health teams (United States Global Health Programs, 2014). Several examples from this group serve to illustrate the point:

The U.S. government’s global health assistance program has evolved over the years (US Government Global Health Initiative, n.d.; O’Brien & Gostin, 2011; US Department of State, Office of Global Health Diplomacy, 2014), and relies on several agencies. The relatively new Office of Global Health Diplomacy in the Department of State uses the “strength and voice of diplomacy to improve and save lives through global health efforts and foreign assistance investments” (Department of State, n.d.). The DOS works with other USG agencies on the President’s Emergency Program for AIDS Relief (PEPFAR), the President’s Malaria Initiative, Feed the Future, and other global health programs.

Almost entirely white at one point in the 60s and 70s (Postwar Foreign Policy, n.d.), the Department of State, has slowly brought more diversity into its numbers (especially in the lower ranks) and made efforts to improve racial, gender and sexual minorities in its senior ranks of Foreign Service Officers (FSOs) who serve in overseas posts. According to agency reports, in 1985, African Americans comprised 5.4% of the Foreign Service professional staff. In 2005, that percentage had increased to 6.5%, reflecting a net change of 1.5 percentage points in a period of 20 years. The percentage change for Hispanics, Asian and Native Americans was even worse. There reflects room for considerable growth in recruiting and retaining minorities as part of the DOS team, and by extension, its global health programs. (Office of Personnel Management, 2011, 2012).

The United States Agency for International Development (USAID) is “the government’s main agency responsible for implementing health programs in developing countries” (USAID, 2014) USAID’s mission statement includes “ending extreme poverty and promoting the development of resilient, democratic societies that are able to realize their potential.” Their website also describes an “approach to address hunger and food insecurity, illiteracy and innumeracy, ill-health, dis-empowerment, marginalization and vulnerability” (USAID, 2014).

These issues are important to highlight because they are similar in nature with the plight of many minority Americans, and those from poor and rural communities throughout the United States (O’Brien & Gostin, 2011). It is surprising, therefore, to note their relative lack of participation in addressing these issues on a global scale. For example, in 2011 and 2012 surveys of USAID agency employees indicated that approximately 83% are White and there remains significant under-representation of Blacks (8%) and Hispanics (5%) and other minorities in the foreign service component of the agency although they represent 33 % of the civil service. This suggests that although Blacks and Hispanics are USAID employees, they are most likely sitting in Washington versus field positions which tend to lead to greater career ascension within the agency. According to analysis from these surveys, barriers continue to pose challenges for entry into these positions. They also point to the need to model values of inclusion and full representative participation of all citizens in this country which are the ideals that USAID promotes throughout the world (Garzon, 2014; AFSA, 2012, AFSA, 2013).

The U.S. Peace Corps describes itself as the “preeminent international service organization of the United States” (Peace Corps, 2014). During its 53 years of sending more than 215,000 Americans overseas to work in developing countries in partnership with host countries to address the “most pressing needs of people around the world.” The organization also helps Americans become global citizens and encourages them to bring back home to share all that they have learned and experienced with others in the United States to promote peace and understanding (Peace Corps, 2014).

Despite its many benefits and widespread appeal to young white Americans, Peace Corps has struggled over the years to recruit and maintain the participation of minority Americans through various strategies to address these barriers (Amin, 1990). As of November 2013, Peace Corps reported that 24% of current volunteers are minorities (compared to 36.3% of the overall U.S. population). According to the Peace Corps website, this group includes American Indians or Alaska Natives, Asian Americans, Black or African Americans, Hispanic or Latino, and Native Hawaiian or Other Pacific Islander. While this represents a significant increase from earlier years, the numbers fall far short when compared with overall US demographics. Fortunately, the trend is moving in a positive direction. However, for some groups, especially African Americans, the numbers who have served as Peace Corps volunteers are estimated to be between 3% (6,300) to 5% (10,500), well below the 2012 US Census data of 14.2% of the total US population, however more studies are needed on the overall experiences of African Americans and other minorities who have served in the Peace Corps.

Both the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) support US government global health goals by providing health professionals with public health, social sciences, behavioral, biomedicine and clinical expertise. Many of the 27 Institutes and Centers of the NIH are engaged in global health research, training or support cross-cutting global health programs (NIH, 2014). CDC supports more than 300 employees in 55 countries (CDC Global Health Strategy, 2012-2015). Both agencies have produced less than optimal results for its pace of inclusion of more racial and ethnic minorities in global health activities through its various selection processes for candidates for prestigious awards, grants, and fellowships and both agencies have recognized the need to promote more diversity in its ranks (CDC, n.d.; Nakamura & Rocky, 2014).

Another large and influential group, not recognized as US government employees,yet they are key actors funded by the US government and responsible for the implementation of the federal government global health agendas. These include US international contracting organizations and non for profits agencies.As an illustration of their importance**,** USAID’s obligated funding for its top 20 contract awardees in fiscal 2012 accounted for nearly three-quarters of its contract spending that year (Piccio, 2013). Despite budget pressures in Washington, contract spending witnessed an increased and USAID awarded more than $4.9 billion in contracts, with the bulk of it going to for-profit groups and nongovernmental organizations (Piccio, 2013). Among the top 20 firms, 55% have major health project portfolios, channeled through multiyear umbrella agreements. Most striking is the complete absence of Black representation on leadership and executive teams in most of these US based organizations. Several of these firms had little to any racial or ethnic diversity on their executive and leadership teams, based on their public face, their websites. Whether the lack of photos is oversight or not, it signifies that Blacks and other US minority groups have little to no representation on this large government health contracts and therefore we question whether American minority groups have an equitable voice in the governance and managements of these organizations.

**Factors Contributing to Underrepresentation**

This brief overview describes the nature and scope of the minority presence in US government agencies and programs and reveals that the number of minority Americans participating in these programs is not proportional to their presence in the overall U.S. labor force – a fact that no one really disputes. But to what can we really attribute this overall lack of representation? We choose to consider this question from the perspective of the college student, since this is often where they are initially introduced and exposed to global career options, experiment through internships, fellowships and participation in globalization and study abroad activities.

Aside from a few studies from the late 1990s following the cross-cultural adaptations of medical and nursing students, we could find little research which addressed the lack of minority participation in global public health specifically. However, there is a tremendous body of work by scholars seeking to describe and explain reasons for the low rates of minority student participation in overall globalization activities on college campuses (Davis, G., n.d., Salisbury, 2011). **Individual** *or personal factors*include a general apathy due to a lack of awareness and understanding about global issues. Washington (1998) found the “awareness factor to be a significant contributor to the participation of African American students in study abroad and their understanding of how this specific knowledge and skills set would be relevant post graduation.” Other factors at this level include economic constraints and the cost of travel abroad, the fear of discrimination abroad (Sanders, 2000), anxieties about language difficulties (Russ & Hembroff, 1993); distance from family and friends, the opinions of significant others, especially immediate family members and the intention (or not) to work globally as a critical motivating factor (Salisbury, 2011). Health disparities in the U.S. may also play a role in keeping minorities focused on the myriad of problems at home (Perlino, 2006). Scholars point to the fact that some minority students feel that they are already bicultural and Hispanic students most notably, who are already bilingual, lack sufficient motivation to explore other cultures (Millington, 2002).

*Community* factors influence the level of engagement of civic and religious support, and the role of leaders who are actively promoting community service and service learning activities, in settings outside of the U.S. Religious organization groups, for example, can have large health projects and may send thousands of missionaries overseas every year to serve in their foreign missions. However, it has been noted that the underrepresentation of minorities can be seen in the number of Blacks who do not go serve as part of foreign missions. The number of black churches in the Southern Baptist Convention (SBC) has increased dramatically with approximately 3,400 congregations in the United States, however “only 27 of the SBC's 4,900 international missionaries are black. That's about half a percent in a missions-minded denomination where 6.25 percent of churches are African American (totaling about 1 million members)” (Zylstra, 2013). There are certainly other groups who send black missionaries - the Lott Carey Foreign Mission Convention, COMINAD, and the Reconciliation Ministries Network have deployed more than 100 missionaries over the past few years on short term missions. However, the number of blacks and black congregations who support foreign missions is woefully small compared to their white religious counterparts which may in turn affect support in the community.

*Lastly, institutional factors* suggest that the extent to which these activities are promoted at the university can be important considerations affecting minority participation during their college years and the opportunities they pursue after graduation. But participation of black and other minority students remains consistently low (Andriano, 2012; Nahel, 2012) However, during 2009-2010, only 4.7 percent of about 270,000 U.S. students who studied abroad were African American as compared to Caucasian (78.7 percent), Hispanic (6.4 percent), and Asian (7.9 percent) students (Institute of International Education, 2010; Salisbury, 2012). This is indeed unfortunate since these types of experiences lend themselves to exposure to professionals and an introduction to trajectories which can spark enthusiasm and lead to global health opportunities.

**Organizational factors** including the role of the federal governments and non-for-profits. There is a need for networking, fellowships, internships and mentoring opportunities for recent college graduates or those with significant interests in working in this area, but difficulties remain in gaining access to those entry level positions which introduce students to the possibilities of a global health career (Education of Health Professionals, 2010).

**Discussion**

**Revamp and Innovate Recruitment and Outreach Strategies**

The need for heightened attention to the global health care worker shortage was pronounced during the Third Global forum on Human Resources in Health held in Brazil (Global Health Alliance, 2013). The US continues to have a major stake in helping to address this crisis but a paradigm shift needs to occur. Investing in and scaling up efforts to diversify and leverage the human resources currently available is necessary but daunting given historical trends. Racial and ethnic minorities who have the requisite technical, cross-cultural and language skills to contribute to the ranks of the global health workforce will only be able to do so if they have exposure to the idea and opportunities to develop and hone their interests and skills through educational and apprentice-like settings.

Many institutions and organizations have already recognized the need to augment their efforts to match the changing demographics of the US population and have begun a renewed push to promote globalization minority students (Peace Corps, 2014). U.S. global health leaders should match their awareness of the challenges through more aggressive targeted recruitment of minority students. These include:

* Introducing students to opportunities for cross-cultural experiences early in their college career through international education and study abroad which will increase their knowledge and expose them to the global health career options;
* Establishing fellowships and partnerships with universities and institutions;
* Increasing, expanding and strengthening global health curricula throughout campuses
* Linking Minority Serving Institutions with PWIs with strong global health programs
* Establishing student chapters of global health organizations like GlobeMed and Nourish International with heavy minority recruitment drives
* Promoting global health service to minority fraternities, sororities, religious and civic organizations
* Recruiting minority veterans ( who are overrepresented in the medical and health military ranks) and who may already have the travel, language and cross-cultural training skills (Segal, 2007)
* Promoting greater outreach by organizations such as the Global Workforce Alliance to include HBCUs and organizations serving minority students
* Requiring contracting organizations follow US government equal employment regulations and guidelines through its inclusion and diversity initiative as a condition for funding
* Marketing to religious and church groups to build norms and support for global service learning

While the US global health operations has relied almost exclusively on a cadre of employees from White and middle class backgrounds whose educational, study abroad, overseas internships, and volunteer activities have privileged their access to the next level of professionalism in this arena, the demographics of the country are changing and our strategies for inclusion need to keep pace. The major concern presented in this paper is not that there are too many white Americans engaged in the global health workforce movement, but rather that there is a woefully insufficient number of U.S. minorities who are currently prepared and ready to meet the challenges of this global health worker shortage.

Urgent action and innovative approaches are now needed to counter the current shortage of health workers (Global Health Workforce Alliance, 2013). We need a broad coalition of health workers - doctors, nurses, public health education specialists (Education of Health Professionals, 2010; Geiger et.al. 2011). Our focus then should be on increasing the ability of minority students who have these skills through a targeted proactive, rigorous and inclusive process, encouraging the participation of those who are similar, in many ways, to the communities that we are trying to help in our global health programs. Our failure to successfully identify and recruit a broader coalition of Americans to the task reflects a missed opportunity to bring more people onto a team whose talents are so needed in this “all hands on deck” stage of our global health care worker shortage crisis.

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