

Résumé

La santé mondiale pour la profession infirmière... et la profession infirmière pour la santé mondiale

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Cet article puise dans la documentation pour présenter une conceptualisation de la santé mondiale (SM) qui correspond à la profession infirmière et définit les apports de la pratique infirmière à la SM. Selon l'auteure, la « santé » doit être définie et abordée sous une perspective holistique afin de mettre en évidence le fait que la SM va au-delà de l'éradication de la maladie et que le droit fondamental à la santé, dont tout être humain doit bénéficier, doit être exprimé de façon explicite. Le mot « mondiale » fait référence aux liens supraterritoriaux entre les déterminants sociaux présents partout dans le monde, dans un contexte international. La SM met l'accent sur les déterminants supraterritoriaux et a pour objectif ultime l'équité en matière de santé pour toutes les nations et tous les peuples. Les infirmières peuvent défendre les droits, prodiguer des soins, soulager les souffrances et œuvrer à augmenter la capacité des services infirmiers à l'échelle mondiale. Les priorités en matière de SM ne peuvent être véritablement mises en œuvre qu'en établissant un nouvel ordre mondiale dans le cadre duquel les décisions politiques seront guidées par des principes fondés sur une humanité commune.

Mots clés : santé mondiale (SM), perspective holistique, liens supraterritoriaux, déterminants sociaux, équité en matière de santé

Global Health for Nursing . . . and Nursing for Global Health

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This article draws on the literature to present a conceptualization of global health (GH) that corresponds with the discipline of nursing and defines the contributions of nursing to GH. The author's perspective is that "health" should be defined and considered holistically to reflect the fact that GH involves more than the eradication of disease and that health as a fundamental right of every human being must be made explicit. "Global" refers to the supraterritorial links among the social determinants of health located at points anywhere on earth within a whole-world context. The focus of GH is the supraterritorial determinants and its ultimate objective is health equity for all nations and all people. The contributions of nurses are advocacy, healing and alleviating suffering through caring, and increasing nursing capacity globally. To truly advance the GH agenda, a new world order is needed, one in which political decision-making is guided by our shared humanity.

Keywords: global health, nursing theory, holistic nursing, social determinants of health

Action for social justice and equity worldwide has never been more apparent than it is today. The Occupy Wall Street movement and uprisings across the Middle East are evidence that there is a will to eradicate oppression, poverty, and economic inequality. Simultaneously, environmental degradation, largely due to humans living in excess, and economic policies that value profit over human/environmental health and well-being are warning signs that a shift in values and a change in how we live are necessary for the survival of the human race (Labonte, 2003).

The 1990s ushered in an era of globalization and the world is now more interconnected than ever before. With the international flow of information, goods, services, and people, a new economic, political, and social space has emerged (Kickbusch, 2005). The implications for the health of people worldwide, particularly in low- and middle-income countries (LMICs), are significant. Global health (GH) has also come into existence as an academic field (Brown, Cueto, & Fee, 2006), attracted the attention of governments, non-governmental organizations (NGOs), and private foundations, and led to public-private partnerships in a spirit of hope for global equity. Academics, including nurses, have been writing about this new field: what it is, what it encompasses, who is involved in it, and what it means for education and research.

In this article I present a conceptualization of GH that corresponds with the discipline of nursing. I then explicate how GH is relevant for nursing and its purpose. I next consider, based on the literature, what nursing has to offer GH, including advocacy for global social justice, healing and alleviating of suffering through caring, and increased nursing capacity globally. I conclude by briefly discussing the implications for research and education.

What Is Global Health?

The debate on how best to define GH is of great importance. As pointed out by Koplan, Bond, and Merson (2009), consensus on the meaning of GH is imperative so that there is agreement on what is to be achieved, what skills are required, and in what ways researchers, policy-makers, caregivers, and educators should go about meeting the objective. GH is an interdisciplinary field (Koplan et al., 2009), and nursing, which represents the majority of health-care providers worldwide, is critical to the GH initiative (Dickenson-Hazard, 2004). It therefore seems appropriate that nursing weigh in on the debate.

A number of definitions of GH have been proposed, one of the most commonly cited being that put forth by Koplan et al. (2009): “an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide” (p. 1995). The purpose of GH is health equity *among* nations and for *all* people, rather than *within* a nation (or community), as with public health. It is also more than one nation helping another, as with *international* health. GH is achieved through prevention or treatment and care of individuals and/or populations and through the sharing of knowledge, resources, and experience *across* cultures, societies, and international borders.

The work of Koplan et al. (2009) is a seminal contribution to the field, as it expands on earlier definitions of GH (Her Majesty’s Government, 2008; Kickbusch, 2006) and has stimulated further discussion. Beaglehole and Bonita (2010), for example, call for a shorter and sharper definition, claiming that the one proposed by Koplan et al. is wordy and uninspiring. Stemming from that definition, Beaglehole and Bonita define GH as “collaborative trans-national research and action for promoting health for all” (p. 5142). Conversely, Fried et al. (2010) argue that GH is global public health and that there should be no distinction between the two fields.

What Definition of Global Health Fits With Nursing?

A thoughtful discussion by Bozorgmehr (2010) is a useful place to begin to answer this question. The author provides an in-depth analysis of how

“global” has been defined, including “transcending national boundaries,” “worldwide,” and “holistic” — the last referring to anything and everything that impacts health — and offers a new approach to defining the term. He also considers how “health” should be defined, a rarity in the debate on how to define GH.

Health. From the viewpoint of Bozorgmehr (2010), health refers to more than just the absence of disease; it includes physical, mental, and social well-being (World Health Organization [WHO], 1947). Bozorgmehr also considers health to be a social, economic, and political issue, as well as a fundamental human right. He claims that this conceptualization sets a foundation for GH on two fronts. First, it implies that GH research, education, and practices go beyond biomedical approaches — thus GH entails more than addressing the eradication of disease. Second, health as a human right puts normative objectives (i.e., equitable access to health) at arm’s length in the debate about GH, not attached directly to its definition. Since there are multiple GH communities, each with its own set of motivations and values, from Bozorgmehr’s perspective GH should be described as what it is rather than what it should be.

For nursing, defining health is key given that good health is the goal of the discipline (Smith, 2008). A definition that goes beyond the absence of disease and that is holistic also aligns with definitions of health within nursing. In fact, a definition with greater emphasis on quality of life and well-being would be more inclusive (e.g., populations living with chronic illness, disability, or mental health issues) and therefore more suited to GH and the goals of nursing (i.e., health promotion and healing). An emphasis on quality of life and well-being is further justified when one considers the limitations of traditional medicine in curing many of the world’s ailments, the growing interest in alternative/complementary therapies, and the existence of and widespread use of non-medical healing approaches all around the world. Also, high-income countries (HICs) might have much to learn from LMICs regarding social well-being.

The World Health Organization (WHO) (1947) considers health a fundamental right of every human being. This view is shared by the International Council of Nurses (ICN) (2011a), which represents more than 130 national nursing bodies. Although *health as a human right* is a shared philosophy across many countries, it often gets diluted in health-care policies. Furthermore, for many nurses a human rights frame of reference does not explicitly guide nursing practice (Easley & Allen, 2007). I believe that, to reinforce a human rights perspective in health and health-care discourse, health as a human right should be made explicit in the definition of health (as in global health). In contrast to Bozorgmehr (2010), however, I would argue that normative objectives should not be separated and that equity (“absence of systematic disparities in health

between groups with different levels of underlying social advantage/disadvantage — that is, wealth, power, or prestige” [Braveman & Gruskin, 2003, p. 254]) should be included in the overall definition of GH.

While political influence is unavoidable in GH, we must not bury social justice objectives within layers of its definition. Even if there is agreement on the detachment of normative objectives, associations with “doing good” will still be made. Furthermore, I would argue that proponents of GH must engage in debate in order to set priorities and must strive to include input across and within countries. A critical or feminist perspective of social justice may be the most appropriate for framing such debate (Pauly, MacKinnon, & Varcoe, 2009). As noted in the literature, justice is not simply a matter of distribution — the focus should be differences that exist along the lines of gender, ethnicity, class, and social positioning and that constrain freedom and impact well-being (Pauly et al., 2009).

Greater transparency and accountability for GH initiatives are imperative if GH is about “doing good.” Nurses and other health-care providers need to advocate for global equity (i.e., health for every human being) as the objective and to not let politics bully the GH agenda. GH also needs an independent governing body, such as the WHO, to ensure that its standards are met. The WHO should not only provide leadership on GH matters but also have financial and legal authority; our shared humanity (via the WHO) should be steering political decision-making rather than the reverse. A similar idea is proposed by Labonte and Spiegel (2003), who advocate for the assessment of world trade agreements with human rights and environmental sustainability goals. This would be congruent with the need and the call for a shift in values and power, as reflected in recent movements, and would ensure that GH missions are not predominately driven by the financial and security interests of the more powerful nations.

Global. “Globality,” as Bozorghmehr (2010) calls it, in the context of health refers to “supraterritorial links between the social determinants of health located at points anywhere on earth within a whole-world context” (p. 6). “Supraterritorial” refers to a social space that represents the connectedness of the world due to globalization. It is a spatial unit in itself but converges with territorial and transterritorial or interterritorial spaces. In this definition, “global” is more than the sum of its parts and the focus of GH is the supraterritorial determinants that impact people and their health through complex pathways.

In Bozorghmehr’s (2010) definition of “global,” GH is more than public health or international health. It clarifies the object of focus (the supraterritorial determinants) and positions GH squarely in the context of globalization. It avoids the issues inherent in defining “global” as

merely worldwide or holistic, neither of which fully captures the focus or essence of GH. In the supraterritorial conceptualization, populations of interest may include Aboriginal people or migrants or women — groups that are not always thought of in terms of GH — and the level of action may be local or global. For example, maternal mortality in Africa is a concern in GH not because more women die during childbirth in Africa than elsewhere, or because it is a significant issue affecting millions of women, but because the causes of maternal mortality are linked to supraterritorial influences such as the shortage of health workers and the world financial crisis (Bozorgmehr, 2010). Furthermore, humanitarian aid, although necessary in crisis situations (e.g., the Horn of Africa drought or the earthquake in Haiti), would not necessarily be considered GH in this framework. Actions must be sustainable, not short-term fixes, and health promotion and illness prevention must be the primary goal.

Bozorgmehr's (2010) definition also corresponds with the principle of wholeness in nursing science. Leuning (2001) draws on the nursing theories of Leininger, Rizzo Parse, Watson, and Newman to present eight principles, including wholeness, that she believes are required for a global perspective. Wholeness is characterized by the view that the world is unitary and indivisible and that human beings are in rhythmical interchange with their environments. A global perspective requires a focus on patterns of the whole and a recognition that the betterment of humankind is intrinsically linked with the health of persons, the environment, nations, the universe, and the galaxy. Therefore, the complex pathways between the supraterritorial social space and people and their social determinants are patterns that affect the whole. Seeing the patterns occurs through a continual process of zooming in and out from the parts to the whole and through a recognition of uniqueness and diversity, connectedness and meaning. As described by Newman (2002) "the data of pattern are the stories of people and their connectedness with their environment, reflecting the complexity of continuing change" (p. 6). Better understanding of the supraterritorial determinants and their patterns, which are reflected in people's daily lives and in their health, as an object of focus for GH, therefore fits within the nursing paradigm.

In summary, from a nursing perspective any definition of GH should include a sub-definition of health — to make it clear that GH concerns not only the eradication of disease but also quality of life and well-being, and that the means for achieving health are holistic. This sub-definition must also explicitly iterate that health is a fundamental right of every human being. A sub-definition of the global aspect of GH is also necessary. Globality as supraterritorial, as defined by Bozorgmehr (2010), is recommended so as to more clearly delineate the focus of GH (i.e.,

supraterritorial determinants). This description of global also aligns with the principle of wholeness, a core nursing value and a key concept in many nursing theories.

GH is a complex phenomenon that cannot be reduced to a few words. Its intentions and perspectives should not be assumed, but — to ensure clarity for all involved — the objectives of health as a human right and health equity (i.e., the absence of systematic disparities) need to be made explicit. The conferring of greater power to the WHO as a governing body of GH could help to ensure that these principles are upheld in GH initiatives.

Global Health and Nursing

There is an inherent fit between GH and nursing's theoretical and philosophical foundations. The substantive focus of the discipline of nursing is the person, environment, health, and caring (Smith, 2008). While there is some variation in how health is defined, depending on the particular nursing theory or model, health is viewed from a holistic perspective and involves harmony or balance between body, mind, spirit, and environment (i.e., wholeness). Also, nursing recognizes that each person is unique and that how health is defined by a person, group, or community is subjective. Healing captures the dynamic element of health: The person moves towards balance and wholeness within the self (Burkhardt, 1985). Nursing itself has been described as “the study of human health and healing through caring” (Smith, 2008, p. 3). Caring, or caring consciousness, is a way of being whereby one person is open to connecting with another; it is seeing and knowing a person holistically, which calls for acceptance, non-judgement, appreciation, recognition, sojourning, accompanying, partnering, exploring, dialoguing, and listening (Cowling, Smith, & Watson, 2008). The role of nurses is to enable people to move towards wholeness/health (i.e., healing) through the act of caring. With this frame of reference, nurses are positioned to work with people and communities to promote health, prevent illness, support, and provide care during times of sickness and normal life developments. Advocacy for healthy environments that support wellness/wholeness at macro levels — that is, nationally and globally (worldwide and supraterritorially) — is also within the scope of nursing and is congruent with nursing's unitary and caring conceptualizations.

Activism is deeply embedded in the profession of nursing. Florence Nightingale believed that it was nurses' duty to change conditions (social, political, environmental) for the betterment and health of humankind. Chinn and Kramer (2008) describe a form of knowing in nursing referred to as *emancipatory knowing*, a way of perceiving the world that

grows out of critical analysis of the status quo and a vision of the changes that are needed to achieve equitable and just conditions under which all human beings can reach their full potential. Emancipatory knowing involves reflecting on how social and political forces and power dynamics shape knowledge. Taking action includes advocating for change, changing one's own way of behaving, and conducting research directed at effecting change.

In the spirit of Nightingale, nursing has recently renewed its commitment to this goal and has made GH a priority for the discipline. In 2010, the centennial of Nightingale's death, the International Year of the Nurse (Beck, Dossey, & Rushton, 2010) called on nurses worldwide to become engaged in promoting *health for all*. One of the main drivers of this event was the Nightingale Initiative for Global Health, a grassroots movement of nurses that aims to identify, share, and promote approaches for creating health globally and actively advocates that the United Nations and its member states make health a universal priority. The ICN and many national nursing associations have also explicitly expressed a commitment to GH (Hancock, 2004; Villeneuve, 2008). The ICN has taken action by issuing several position statements related to GH, working with the WHO and other policy-making bodies, and lobbying governments and intergovernmental agencies to implement policies that are environmentally conscious and people-centred. Clearly, GH is within the scope of nursing, and, more than that, nurses are well placed to advocate for and realize the goals of GH.

Nurses Must Reflect and Take Action

The issues that are considered inherently GH concerns are those related to environmental degradation and poverty (Labonte & Spiegel, 2003). They are reflected in the United Nations 2015 Millennium Development Goals (MDGs): eradicate poverty and hunger; achieve universal education; promote gender equality and the empowerment of women; reduce child mortality; improve maternal health; combat HIV/AIDS, malaria, and other diseases; ensure environmental sustainability; and form a global partnership for development (www.un.org/millennium-goals/). Also considered GH concerns are the many non-communicable diseases and conditions such as cancer, cardiovascular disease, diabetes, injuries, and respiratory illness (Magnusson, 2009) that are linked to MDGs via their environmental and lifestyle determinants (diet, tobacco use, work environments, physical activity), the last being related to poverty and the exportation of Western culture. Mental health is also relevant to GH because of the effects of migration, conflict, natural disasters, and global trade policies on well-being (Patel & Prince, 2010). With these issues and the definition of GH in mind, the priority roles of nurses in

GH should be advocacy, healing and alleviating suffering through caring, and increasing nursing capacity globally.

Advocacy. Raising awareness and advocacy together make up the most important role of nursing in GH (Mill, Astle, Ogilvie, & Opare, 2005; Reutter & Kushner, 2010). The ICN has taken a position on many issues related to GH, including international trade agreements, climate change and health, environmental and lifestyle-related health risks, universal access to clean water, the elimination of weapons of war and conflict, child labour, and women's health (ICN, 2002, 2006b, 2007a, 2008a, 2008b, 2010, 2011b). These positions link directly with the supraterritorial determinants of health and speak to all of the MDGs as well as non-communicable diseases and mental health.

Nursing must continue to participate in advocacy, not only at the international level but also nationally and locally, and to echo the statements issued by the ICN. The ICN (2011a) believes that nurses have a responsibility to call attention to human rights violations (including the right to health and health care) and to respect and promote human rights. Nurses work closely with individuals and communities and are therefore well placed to hear and collect stories about the impact of living conditions (and of policies) on people's lives. In Canada, for example, the Canadian Nurses Association (2012) recently opposed government cuts to the health insurance scheme for refugees and asylum-seekers, a federal measure that has resulted in reduced access to care for this population.

The eighth MDG, a global partnership for development, requires particular attention from advocates for GH, as it may be the most important goal. Sub-goals of this MDG include developing a trading and financial system that is open, rule-based, predictable, and non-discriminatory and addressing the debt problems of LMICs. Falk-Rafael (2006) speaks to this matter by detailing the harrowing effects of globalization on human health and urges nurses to advocate for a change in the global order. This includes advocating for debt cancellation (which the ICN has already done (Anderson, 2005), more democratic governance and application of global rules, and global policies that favour LMICs but are non-protectionist of HIC. Falk-Rafael takes it a step further and suggests that environmental protection and people need to be at the centre of all trade agreements and domestic practices. Profit can no longer be the driving force; a new world order is urgently needed.

Healing and alleviating suffering through caring. Primary health care has been deemed the key strategy for GH and for achieving *health for all* (WHO, 1978). It has also been said that many of the world's ailments could be addressed through nursing care (Villeneuve, 2008). Indeed, poor maternal health, child mortality, and HIV/AIDS, malaria, and other dis-

eases, as well as mental disorders and non-communicable diseases, are all addressable by primary health care delivered by nurses. Primary health care focuses on health promotion (enabling people to improve their health) and illness prevention, mostly by tending to the social determinants of health (social, economic, and environmental factors that affect health). As frontline caregivers, nurses counsel individuals, families, and communities on health promoting behaviours (e.g., healthy eating, basic hygiene); support development over the lifespan (e.g., parenting, death and dying); and encourage illness-prevention activities (e.g., vaccination, general health screening). Primary health care may be provided by nurses in the community or in the context of primary care (e.g., chronic illness management, prenatal care). While advocacy is the approach for ultimately changing policies and social structures that underpin health inequities, in their work nurses maintain a stance of caring consciousness, view people and communities holistically, and tend to address social determinants with the resources at hand. More importantly, nurses accompany, sojourn, partner with, explore, converse with, and listen to individuals and families to make them more resilient to the ecological and social factors that affect their health. It is because of such compassionate care for humanity that people may begin to heal and suffering may be alleviated.

Increasing nursing capacity globally. The ICN (2007b) position statement on nurse retention and migration stipulates that quality health care depends on an adequate supply of qualified, committed nursing personnel. Certainly, the provision of nursing care requires basic resources, infrastructure, and nurses. For this reason, investing in primary health care and increasing nursing capacity globally must be a GH priority for nursing.

While the nursing shortage is a global problem, its effects are most severe in Africa and Asia. The ICN believes that nurses have the right to migrate as a function of choice but also that the international migration of nurses can negatively impact health-care systems by siphoning nursing personnel from the regions most in need. Additional concerns, in LMICs and HICs, are the poor treatment and working conditions of (migrant) nurses and the relaxing of training standards in order to fill nursing positions or to minimize health-care costs.

The nursing shortage requires socially responsible solutions (Tyer-Viola et al., 2009). A number of strategies have been proposed (Dickenson-Hazard, 2004; ICN, 2006a, 2007b; International Organization for Migration [IOM], 2006). These include investing in health-worker education, enhancing the image of the nursing profession, reducing barriers to education for vulnerable groups, ensuring proper regulation of nurses, improving working conditions, developing models

for management, retention and resource allocation, and “brain circulation” — whereby nurses from LMICs migrate to HICs and then return home. Ethical recruitment and protection of migrants’ rights are also essential (Dickenson-Hazard, 2004; ICN, 2007b; Tyer-Viola et al., 2009).

Mechanisms to improve the availability of human and material resources need to be identified (Dickenson-Hazard, 2004). Strategies for financing health-care systems in LMICs might be provisions in trade agreements — that is, conditions requiring countries to invest in health care (Labonte, 2003), recruitment/migration policies that offer financial incentives to health/education institutions in migration source countries, and cost-sharing mechanisms across borders.

Finally, qualifications and skill requirements must be improved across nations (IOM, 2006). This will not only serve to improve quality of care, but also help to retain nurses in LMICs and raise the status of women (Sullivan, 2000), which addresses the third MDG. Distance-learning initiatives (within LMICs or between HICs and LMICs) and knowledge and skill transfer via migrants returning to their home countries (Tyer-Viola et al., 2009) are examples of strategies that could be used to increase and improve nursing education in LMICs.

Implications

Education

GH programs have become commonplace, particularly in North America (Macfarlane, Jacobs, & Kaaya, 2008). Their emergence partly reflects the shift from international health to GH by the WHO as well as a growing demand by health professionals and students for education in GH. Numerous articles have been published on the topic of GH education, including several in nursing (Hodson-Carlton, Ryan, Ali, & Kelsey, 2007; Leuning, 2001; Mill & Astle, 2011; Mill, Astle, Ogilvie, & Gastaldo, 2010). Generally, there is agreement that GH education should include learning about interconnectedness and wholeness; justice, human rights, and social responsibility; social determinants and disparities; environmental issues; economics, demographics, and politics; respect and tolerance for difference and openness to learning from others; GH concerns (e.g., MDGs); and burden of disease. Current thinking, however, is that the core curriculum for all health professionals should educate them to be globally conscious and prepared to “participate in patient and population-centred health systems as members of locally responsive and globally connected teams” (Frenk et al., 2010, p. 1924).

GH training often includes clinical (and research) placements, mostly in international settings in LMICs. These may put an undue burden on

already taxed health and education systems in host countries (Crump & Sugarman, 2010). Developing partnerships and identifying benefits for host institutions must be part of placement planning (Hickey, Gagnon, & Merry, 2010). Local GH placements (migrant or Aboriginal populations) may offer alternative training opportunities. Increased funding to develop GH programs is also needed (Kishore et al., 2011), as stronger, sustained programs may help to address these issues (i.e., long-term partnerships and money to develop innovative ways to accrue benefits to host institutions).

Research

Global health research (GHR) is essential for guiding health-care providers and other stakeholders in developing policies and appropriate interventions. GHR objectives must be oriented towards locating the upstream drivers (supraterritorial determinants) — political, social, cultural, economic, and environmental — of health and/or developing approaches that increase resiliency with regard to these factors (Stephen & Daibes, 2010). Interdisciplinary teams, including partnerships of decision-makers, care providers, and communities affected by the policies/interventions, are necessary to ensure that the knowledge developed is relevant and can be implemented. A long-term vision, adequate time, and funding are also essential, to ensure that partnerships and knowledge translation/transfer will be achieved and to account for unforeseen disruptions or a change of course in research (due to input from partners or newly identified needs). Funding may be a particular challenge, as nursing research is not recognized in GHR (Jairath, 2007); this not only limits access to funds but also diminishes the role of nursing in GH.

Other points of consideration for GHR include methods and ethics. To more comprehensively answer GHR questions, a variety of methods and approaches are needed (Stephen & Daibes, 2010). Since the use of diverse methods is a strength of nursing, the discipline has much to contribute to GHR. Empirical methods as well as other modes of inquiry, such as phenomenology, ethnography, and even aesthetic forms (hermeneutics), that might more effectively communicate experiences, feelings, and struggles are part of the research tradition in nursing. Regarding ethics, GHR is itself a budding field of research (Stephen & Daibes, 2010). The ethical issues are numerous — for example, the potential for exploitation, unequal power between HIC and LMIC partnerships, and the application of Western bioethics (Crigger, 2008; Harrowing, Mill, Spiers, Kulig, & Kipp, 2010; Ijsselmuiden, Kass, Sewankambo, & Lavery, 2010; Powell, Gilliss, Hewitt, & Flint, 2010; Stephen & Daibes, 2010) — and are beyond the scope of this article.

Conclusion

The body of literature on GH and nursing is expanding rapidly. Nursing has a fundamental role to play in GH and the perspective and unique contributions that nurses make to the field need more visibility within and outside of the discipline. This article has addressed conceptual issues in GH as they relate to nursing, with the objective of advancing nursing-specific knowledge in this area. Nurses engaged in research, education, or GH work must continue to write about and conceptually describe GH in order to further define the field and its relevancy to nursing. This could serve to maintain clarity on what constitutes GH and whether we are achieving our objectives as we move forward and the global perspective becomes more integrated into everyday nursing practice. Most importantly, it will provide a foundation for improving the education of nurses so that they will be better prepared to participate in patient- and population-centred health-care systems as members of locally responsive and globally connected teams.

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