In This Issue:
25-Year Aftermath of Contamination in Bhopal, India
Pharmaceutical Industry in the European Union
HIV/AIDS and Traditional Belief in Papua New Guinea
And More...
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As the new editors of Stanford Service in Global Health Journal, we are delighted to present this third volume. In the spirit of continuing to bring diverse essays on the subject of international health and volunteerism to the Stanford community, the SSGH staff has compiled a collection of eye-opening articles that will transport readers around the globe, as well as to our backyard here in Palo Alto. From examining the aftermath of the industrial disaster in Bhopal, India, to the Papua New Guinean belief in witchcraft, to the barriers to maternal health care in Oaxaca, Mexico, these articles demonstrate complex interplays between health and society. This issue also includes an interview with Prof. Donald W. Light on the pharmaceutical industry in the European Union, as well as a book review of Jacqueline Novogratz’s *The Blue Sweater*. We hope that these articles, as well as others within these pages, will open and enrich the dialogue in the Stanford community about global health and its connections to development.

This issue, like issues past, attempts to strike a balance between showcasing student perspectives on current global health topics and allowing students to reflect personally and critically on their experiences. Indeed, at its core the SSGH Journal is a conscious attempt to give voice to the individual impacts of students’ experiences in global health and to share some of the observations that are often privately internalized or compartmentalized upon return to the United States. Experiences abroad often become powerful forces that shape students’ lives, but these experiences can be difficult to distill and articulate in everyday conversation, particularly in the hurried Stanford schedule. We hope that the time our writers have taken to tell their stories has been personally meaningful to them, just as we hope that these essays will in some way touch and inspire our readers.

With enormous thanks to our hard-working staff, we proudly present Volume III!
The past two decades have seen a dramatic shift in the attention to global health equity issues as donors and participants have taken on economic and personal responsibility to support global initiatives. Twenty years ago, WHO, UNICEF, UNFPA and bilateral donor nations generated most of the development assistance around health. This millennium has seen the creation of many foundations; most conspicuously the Bill and Melinda Gates Foundation, the US government with PEPFAR, non-governmental organizations (NGO) and, recently, universities take the lead in global health philanthropic and technical assistance overseas, raising the total development assistance for health from $5.6 billion in 1990 to $21.8 billion in 2007.

It is not surprising that students have been responsible for a large push for university global health activities.

It is not surprising that students have been responsible for a large push for university global health activities. A recent survey of 50 U.S. universities revealed that, in only the past 3 years, 302 new global health programs have become active in 92 countries (Consortium of Universities doing Global Health – CUGH survey). Thus, it was no surprise that Stanford responded to student interest by creating a new position which I had the privilege to assume in May: Senior Associate Dean of Global Health. When I arrived, the first interdisciplinary symposium of global health was held with over 150 faculty and student participants offering an overview of the various field research projects at Stanford. This event was spearheaded by Professor Julie Parsonnet who will be organizing a second symposium in the coming year. In July we anchored the new Global Health Corps at Stanford – a NGO headed by Stanford graduates and partnering with various NGOs such as Partners in Health and the Covenant House in New Jersey. From over 1,100 applicants, US fellows were paired with African counterparts to work for a year in carefully chosen service jobs promoting a global health equity agenda. These jobs ranged from teaching health literacy in inner city New Jersey to developing electronic records in rural Rwanda with Paul Farmer’s team, Partners in Health. The Global Health Corps intends to have another competition for graduating university students from the US and Africa this coming year (www.ghcorps.org).

Other exciting initiatives include incorporating my partnered field sites in Uganda, Borneo, Eritrea, Liberia, and South Africa into a Yale/Stanford Global Scholars Program at the medical school (www.info.med.yale.edu/ischolar), and launching a new global health library portal (http://lame.stanford.edu/portals/health.html) and the Stanford Global Gateway (http://global.stanford.edu). The Stanford Global Gateway allows students to identify research and courses by country and find funding to go overseas, and also provides safety guidelines for traveling abroad. Our library portal offers unprecedented access to journals in global health as well as other global health resources.

In addition to these initiatives, I look forward to two upcoming global health conferences sponsored by my new office. “An Africa Bar-Camp,” co-sponsored by the Center of African Studies on March 13, 2010, as well as another conference on February 20, 2010: “After the Shooting Stops: Health After Conflict in the Developing World,” spearheaded by the Stanford Association of International Development (SAID). We also recently inaugurated a Department of Medicine Global Health Grand Rounds series, for which the upcoming speaker will be Sir Richard Feachem. Sir Feachem served from 2002 to 2007 as founding Executive Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria and Under Secretary General of the United Nations, and in January 2010 he will be discussing “Shrinking the Malaria Map - A Guide to Elimination” at Stanford.

In the future, I am hoping that in my new position I will be able to enable bidirectional dialogue and partnerships around global health equity, build upon the strengths of Stanford’s existing global activities, and eventually establish a multidisciplinary Center or Institute of Global Health to enable undergraduate, graduate and professional schools to engage in multidisciplinary initiatives to achieve health equity and universal health access globally – including the somewhat unique concept that “global is local” as applied to our underserved communities in California.

With all of the excitement surrounding global health at Stanford and beyond, I hope you enjoy this compilation of student experiences in research and service abroad.

With Warm Regards,
Michele Barry, MD, FACP
Professor of Medicine
Senior Associate Dean for Global Health
Director of Global Health Initiatives
The Blue Sweater: Bridging the Gap Between Rich and Poor in an Interconnected World

Author: Jacqueline Novogratz

by Ilan Kolkowitz

It is almost impossible to read The Blue Sweater and not be inspired by the experiences that Jacqueline Novogratz describes. What makes the story so stirring is that Novogratz is not a Paul Farmer; she did not start her philanthropic career with one vision and continue upon that same path without straying. Novogratz allowed herself to be shaped by her experiences. Sweater tells Novogratz’ life story, briefly touching on her childhood and subsequent education at University of Virginia, but with the majority of the book focusing upon her time in Africa. Novogratz initially went to Africa to work for a charity focusing on women’s rights, and progressed from there. It is these stories that are the most poignant, and the ones that will hit closest to home for most people who are reading with the intention of pursuing careers in developing countries. The final part of the book details the beginnings Novogratz’ nonprofit organization, the Acumen Fund, and illustrates the foundation’s mission with stories of their first projects.

The book itself is well written and overall an enjoyable read. Novogratz manages to describe her unbelievable experiences and the success she has had with humility. Parts of the book are incredibly powerful, in particular the section describing the role that several of her friends and colleagues played in the Rwandan genocide. Because of all the work that Novogratz did in Rwanda, and the close connection she had with the people involved, her efforts in reconciling their roles is incredibly emotional. Reading this portion of the book the general sense of sadness and moral confusion extend to the reader, and though we lack personal connection, we feel along with her. Novogratz’ writing does at times become heavy-handed with her attempts to illustrate her learning process, and she occasionally seems to be putting too much extra effort into showing her attempted integration into the culture, but overall these small flaws do not detract from the book, and reading depictions of her time in Africa is enlightening and enjoyable. The last portion of the book, in which Novogratz depicts the beginnings of the Acumen Fund, may become less interesting for some readers because it is essentially an advertisement for the fund. However, even this part of the book is highlighted with anecdotes and for those who are interested in microfinance, or in the economic side of effective philanthropy, this portion is at the very least interesting to read.

Jacqueline Novogratz is an extraordinary person in a variety of ways, but what this book illustrates best is her ability to adapt and not remain fixed to her preconceived notions. Her ability to learn and adapt clearly led her to create the Acumen Fund. Her beginnings in banking pushed her toward microfinance, and her experiences with microfinance led her to the Acumen Fund. Throughout the book Novogratz makes the argument that markets define economics, and therefore to improve the economic situation for a group of impoverished people, one has to use market forces. Blind charity will not be, and has not been, the road to improving people’s wellbeing. The Acumen Fund represents Novogratz’ ideal method for helping the largest amount of people in the most effective way.

Acumen’s goal is essentially to provide entrepreneurs with loans (in the same vein as microfinance), but not small ventures—such as one sees on the Kiva website—rather much larger, broader-scale projects. These large projects in turn provide benefits to the impoverished community. Novogratz pitches the idea very strongly toward the end of the book, and does an excellent job of presenting stories of entrepreneurs that have successfully been funded by Acumen. One example that truly hits home is that of a medical group in India known as Aravind. Acumen made the decision to provide the group with a loan to try to improve their telemedicine department, which would make long-distance diagnosis of medical conditions, specifically ocular problems, possible. The loan succeeded and telediagomy became a profitable part of the Aravind business, while also providing inexpensive optical care to thousands of impoverished people in India.

College students find it easy to sit in a dorm room and discuss the world’s problems and propose solutions, and their attempts are certainly admirable. The main message of The Blue Sweater is that trying to change the world is the right thing to do, but a great deal of learning must take place along the way to make this possible. Sweater’s portrayal of this central message is inspiring, particularly to a college student, and the book is well worth a read for anyone interested in developing world philanthropy.
The current state of Bhopal is indicative of an ongoing tragedy. An estimated 120,000 to 150,000 people living in and around the factory site continue to suffer adverse health effects, including respiratory, gastrointestinal, and ophthalmic, musculoskeletal, neurological and psychiatric disorders. Children born to women exposed to MIC gas live with severe and debilitating physical deformities. Research and monitoring of the long-term health effects of exposure to MIC has been abandoned since 1994. No treatment protocols have been established and medical personnel have no choice but to continue to treat case-by-case. From the volunteers’ kitchen on the second floor of the Sambhavna Trust Clinic, I watched women, young and old, carrying water jugs on their heads. They walk to a community well every morning to bring back water contaminated with heavy metals. They have no choice. Immediately following the disaster in 1984, Union Carbide all but abandoned the factory grounds, leaving hundreds of canisters of corrosive chemicals and sacks of poison rotting in crumbling warehouses. These chemicals continue to leach into groundwater, leading to contaminated wells in the surrounding slum communities.

Days are passing, precious days, and the Union Carbide factory has not been cleaned up. How much longer must we wait? How much longer must we draw water from wells contaminated with toxic chemicals? How many more children will be born with terrible deformities? How much longer must we wait for justice? We have given our lives to this cause. Do you know what it feels like to wake up unable to breathe, or to have a miserable pounding headache that won’t go away all day? How much longer must we wait?

These were the voices I heard in Bhopal, India. I traveled to Bhopal in June 2007 with three fellow Stanford undergraduates, planning to volunteer and conduct research at the Sambhavna Trust Clinic, which is located in the heart of the gas-affected region of Bhopal. Twenty-five years ago, on December 3, 1984, Bhopal was the site of the worst industrial disaster the world has ever seen. Union Carbide Corporation had erected a seven-acre pesticide plant in 1970 as part of an initiative intended to fuel India’s Green Revolution. Disaster struck in the early morning hours of December 3, 1984, when a storage tank filled past recommended capacity began to leak lethal methyl isocyanate (MIC) gas. Thousands died in their sleep, while uncontrollable vomiting, esophageal hemorrhaging, and peripheral nerve damage killed thousands more. Union Carbide claimed a death toll of about 1,000 people, while other parties (including Amnesty International) estimated between 3,500 and 8,000 deaths in the immediate aftermath, with the total number of deaths over the next few days as high as 25,000.

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What transforms the Bhopal disaster from a national tragedy into a pressing global health issue is the questions that arise in the 25 years of demonstrations and campaigning that have followed.” – Jack Watson

The enormity of the disaster and the ongoing public health emergency seems to beg further research, yet no large-scale independent investigation has ever been commissioned to catalogue the true extent of the crisis.

Sponsored “Blue Planet Run 2007,” lauded as an “unprecedented 15,600 journey to raise awareness about water as a basic human need,” when at least 15,600 people in one Indian city are forced to drink water laced with heavy metals. Dow Chemical claimed that it did not inherit responsibility for the disaster when it purchased Union Carbide in 2001; nonetheless, a broad coalition of members of Congress recently called on Dow to provide medical care, clean water, and compensation to victims of the disaster. While some argue that the tragedy in Bhopal was an isolated incident of corporate negligence, it is well-documented that developing countries are disproportionately vulnerable to industrial crises due to relative lack of environmental regulations and availability of cheap labor. A 2009 Lancet Student article by Jack Watson noted that “what transforms the Bhopal disaster from a national tragedy into a pressing global health issue is the questions that arise in the [twenty-five] years of demonstrations and campaigning that have followed.” The global coalition of organizations and individuals comprising the International Campaign...
the thousands of people who continue to suffer its effects – can have an immense and far-reaching impact on global health in the twenty-first century.

for Justice in Bhopal (ICJB) have probed the boundaries of social activism in response to an outrageously offensive statement uttered by a Dow Chemical spokesperson in 2002: "$500 [of compensation] is plenty good for an Indian."

What struck me most in the wake of my experience in Bhopal was the fundamental interconnectedness of humanity. As a volunteer at the Sambhavna Trust Clinic, I encountered volunteers and researchers from all over the world, drawn to Sambhavna for a myriad of reasons: to study complementary medicine; to interview female activists like Rashida Bee and Champa Devi Shukla, who shared the prestigious Goldman Environmental Prize in 2004; or to catalogue the true extent of the crisis via photographic or journalistic media. The clinic invariably attracts people who have a deep-seated passion for social justice. As I visited sites of water contamination in adjacent slum communities; gathered data about Union Carbide’s failed chemical waste management system; and assisted with ongoing community health projects at the clinic, I became increasingly hopeful that all of our work combined could provide the momentum needed to bring justice to Bhopal.

On the twenty-fifth anniversary of the Bhopal disaster, we must not forget the implications for the global community. Given that the disaster and its aftermath are uniquely positioned within the rhetoric of global health, it is crucial that we are not complicit in allowing this egregious tragedy to be relegated to the footnotes of history. The lessons we take from Bhopal – as well as the support the international community can provide...

Young children roam throughout the abandoned factory site as though it were a playground, unaware of the dire implications of direct exposure to toxic waste.
It was evident that the locals themselves rarely, if ever, dined in similar fashion. Struggling to fight the marked economic chasm, I attempted to speak to Raul, one of the male leaders of the town. Within minutes, our conversation was interrupted by the scattering of students and locals around the long tables lined with alebrijes.

We sat in front of the locals as they presented the products that, alone, had upheld the existence of their community—the widely known alebrijes. The attempts to integrate ourselves within the community could no longer mask our position as wealthy tourists who could support the community by purchasing their products. Each student was powerfully drawn to the unique personality of at least one of the carved characters. Quickly, the alebrijes became the focus of our attention, and it was then that I had a frightening and disturbing realization: we were connecting more deeply with the carved characters than the people of Arrazola themselves. Amidst the cultural and economical divide, we had allowed the forces of poverty, class, and education to overcome the sacredness of life. To us, the townspeople were no more than talented wood carvers and painters—they were appreciated for their labor, but not as people.

Should indigenous knowledge be commoditized if it is economically profitable for the community? Was our role simply to go for the technical x (buying the alebrije) instead of getting to know them as people? Could we have found a balance between the two? What did they prefer—the meaningful conversations or the technical x (buying the alebrije) instead of getting to know them as people?

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An artisan of Arrazola demonstrates one of the first steps in the multi-week process of creating an alebrije—a colorful wooden animal.

The real-life manifestations of this concept in the clinic were striking and memorable: the obese teenager who was repeatedly told to eat less quesillo and beans despite the fact that eating tacos for lunch was all his family ever knew. The Spanish-speaking doctor who could not understand the distress of his Zapotec patient. The young girl with leukemia who lived in the mountains and locals around the long tables lined with alebrijes.

The babies were fused at the top of the chest down to a stomach that, not fully formed, merged into a mucous-filled membrane sac. One of the babies, though small, was developing normally, but the other was grotesquely malformed; without a well-developed back, it had spindly legs tacked below its shoulders and a darkened, bulbous head. The real-life manifestations of this concept in the clinic were striking and memorable: the obese teenager who was repeatedly told to eat less quesillo and beans despite the fact that eating tacos for lunch was all his family ever knew. The Spanish-speaking doctor who could not understand the distress of his Zapotec patient. The young girl with leukemia who lived in the mountains and locals around the long tables lined with alebrijes.
growth hanging off its side like a rotten water balloon. They were sharing most of their internal organs and quivered together with each collective heartbeat. And then they died, huddled together in eternal embrace, displayed for all under the glare of flashing cameras and thirsty eyes. Born: 9:01 AM. Dead: 9:03 AM. They never even opened their eyes.

We had come to acknowledge the pathologies of power defining the clinical gaze characteristic of western medicine and embraced the notion that physicians are the natural attorneys of the poor.

There were so many questions. Hadn’t they anticipated on the ultrasound that the babies were conjoined? Apparently their young mother – just eighteen years old – had never received any prenatal care. Did she not know she had it? Could she not afford it? Or have no access to it? Couldn’t they have separated the babies and saved at least one? Hospital Civil – the noisy, crowded public hospital with lines that literally wind around the block for service, where the majority of patients are unable to pay for their care – could not have afforded the technology for such a complicated procedure. Could anything have been done to improve the quality of their lives? It is difficult to gauge the extent of any newborn’s consciousness of their being. Did they even know they were alive? What kind of life had they experienced in their two sightless minutes? What kind of life would they have led?

The twins were a wake-up call that shook me out of my reverie: babies born at Oaxaca’s Hospital Civil are not born into some romantic, fresh world perfectly malleable to their ideas and desires. Rather, they are born into a nested world of predetermined constraint shaped by factors beyond our control; there is opportunity, and consequence; the liberty of their birth is curbed by the heavy burdens placed upon them by generations of the border, “but likewise the privileges of those from the other side.” We wished to see in this world. Could anything have been done to improve the quality of their lives? It is difficult to imagine a world that restricts the quality of care that hospitals can provide, that limit the Oaxacan health care system and that affect millions of Oaxacans every day. They didn’t have a chance.

(ANAND HABIB)

Both discomfiting and enlightening, the experiences in Hospital Civil and in Arrazola reinforced our desire to break the cycle between poverty and poor health outcomes. We wanted to be more than “those from the other side of the border;” but likewise to realize the need for cultural competency in any action we took. Capitalizing upon an existing partnership between our seminar instructors and Centro de Esperanza Infantil (CEI), a non-profit providing educational scholarship to disadvantaged youth, we became participant observers. As we assisted with health assessments of the children at CEI, families invited us into their lives, revealing stories of family members who had not been heard from after migrating to America. Through their experiences, we began to understand the cultural beliefs that marked their devotion to the spirit world and that informed their perspectives on Western medicine.

We had journeyed to Oaxaca to understand the experiences of those who risked everything to reach the fields of California, yet what we found was much more. We discovered an unparalleled richness of culture juxtaposed alongside economic disparity and inequitable hierarchies. We had been compelled to reflect on how the institutions of trade often hide the humanity of the individuals with whom we interact and the injustices present in medical systems – both American and Oaxacan. Yet, through all of it, we had come away with a glimmer of hope. Hope that organizations like CEI can break the cycle of poverty confronting newborns and their families. Hope that we as individuals privy to a plethora of opportunities could stand up for those without a voice and be the change we wished to see in this world.

Pooja Bakhai is a junior majoring in human biology with a focus in global health and infectious disease. She is the President of Global Health Volunteers at Stanford, plays clarinet with the Stanford Philharmonic Orchestra, and is looking forward to researching the viral etiology of Chronic Fatigue Syndrome. As a future doctor, Pooja aims to eliminate health disparities and work with underserved populations in the United States and around the world.

Anand Habib is a junior majoring in biology with additional interests in domestic health policy. At Stanford, he is involved in the Patient Advocacy Program, Project Dosti, and Dance Marathon. After graduation, he hopes to pursue an MD/MPH and to work in a community health clinic in the U.S. while also spending time abroad working with international health organizations.

Michelle Neely is a junior majoring in Human Biology. She is a member of Stanford’s Patient Advocacy Program, a tutor with Habla la Noche, and a research assistant at the Center for Interdisciplinary Brain Sciences Research where she is investigating the neural correlates of humor in children. Michelle has always been fascinated by the myriad external factors influencing internal perception and experience, and hopes to pursue a career in medicine that will enable her to focus on upstream determinants of health.
Far below, past verdant, wet Tanzanian jungle dripping with moss and fern, the Serengeti spreads out toward the horizon. There, lions are the lords, ruling over their grassy domain. Acacia trees, the symbol of the Serengeti, stand sturdy in salute to the mountain that towers above them. The battle surges on in the cradle of life.

At the foot of Mt. Kilimanjaro, a surgeon prepares. Far below the glacier covered summit the Tanzanian operating theater is abuzz with activity. Anesthetists closely eye the patient’s pulse and breathing, monitoring their monitors, scribbling on their charts. Nurses wait patiently and attentively for the next order, arranging gowns and logging vital signs. The scrub nurse, with her eagle eyes and buffalo’s disposition, hands instruments to the surgeons, deftly navigating and defending her sterile table. The assisting surgeon waits nobly next to his

Glaciers above, clouds below, the shale covered slopes of Kilimanjaro stand silent. Mist comes and goes, wrapping the camp in a cold blanket. Loose stones clink together as tourists and locals trek upwards, the sounds halfway between welcome and warning. Africa is laid out before us, below us, as we sit anxiously in the nape of the summit.
guiding the suture along all too familiar trails. Interns and students crane and stretch to see the suture slide through muscle and skin, simultaneously pulling together and students crane and stretch to see the suture slide underneath the boots of the room’s occupants, just asking to be tripped on. The machines themselves are an old mismatched herd, some functional and others long past their prime. The metal instruments have lost their initial shine after a long life surely full of unimaginable experiences. They labor on under the skilled hand of the Kilimanjaro surgeon.

Hush falls at a critical stitching and teaching moment; Dr. Musya instructs verbally and physically, astutely stage – a true theater! Nurses and doctors alike chatter and joke, scalpel and retriever in hand. Despite the heat and serious surgical occasion, these friendly Tanzanians maintain a light ambiance and happy banter. To a mzungu, a foreigner, like myself, this might seem unprofessional at first, but in time you come to see that no inkling of caution or expertise is sacrificed for their conversations and laughter. What a stark difference to the stereotypical austere Western operating room, where the talk and air are more sterile than the instruments! Here, in the land of lions and Masaa, everything, including complex surgery, is hakuna matata – no worries.

But above, in the absolute silence, the altitude is king. Riding the wind a lone African eagle surveys us, the unlikely intruders. Far above the tree line the only signs of life are those that command the wind with their wings or are sustained by the rocks themselves. Red, black, and bright green lichen dots the boulders; the peaks only company.

Except for us. We loud and layered summit seekers and our crew. Seasoned porters and guides laugh and spit and smoke, habituated to this desolate slope after a lifetime of climbs. The remains of past expeditions are abundant and out of place, yet ignored. Scores of humans eager to leave their mark on the highest point in Africa, or just careless in their human needs and perspectives, are now gone. Yet Kilimanjaro remains, unwavering in the silence of the high atmosphere that it calls home.

In much the same way, while visiting doctors bring teachings of new procedures and an array of shiny instruments, maybe they too have much to learn. Despite drastic differences in equipment and facility, much remains the same as any other operating theater around the world. Everyone has their job and carries it out well with earnest and concentration, all in the ultimate goal of healing the sick and injured. They care for their fellow

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Tanzania doctors and nurses smile and converse with the 104-year-old patient during pre-surgery preparations.

Thumbs dirty and mind clear I sit here on the shale-covered slopes of Kilimanjaro, clouds below and glaciers above, thoughts flowing through nerve and muscle and pen onto the page. The pristine silence of the altitude is calming. Dr. cool breeze blows around and past me on its journey to wherever – I can like its invisible route like the smooth incision of a surgical blade: up and over the steep shale precipice, fleeting touches among gravel and balanced cairn stones, a swirling kiss with the shrinking glaciers, then back down the valley, streaking through small arches and between black feathers, and finally through two lichen covered, crumbling boulders, to me.

The mist clears a porthole to the luminous and fluffy tops of the clouds beyond, a landscape I wish I could run on. The sun shines bright, the winds calm, and the peaks are pearly white, each crevasse the highest blue. This is the view that Kilimanjaro has enjoyed since long before my boots disturbed its dust.

My mind mirrors the wind at this point, fluid yet not jumpy, only smoothly winding through peaks and valleys of memories and plans. Cold fingers and toes may ache, and dust may cover my skin, but here with glaciers above and clouds below, thoughts are kindled and words flow like soft glowing flames. To be alone and kept company by a mountain is bliss for the psyche. I recommend you travel, try it, and remember to keep your eyes open for any global gifts of knowledge along the way.

Clayton Crawford is a junior majoring in Human Biology with an Area of Concentration in International Health. Both his international familiarity and third-culture-kid upbringing have contributed to his love for travel, extraordinary experiences, and worldwide human diversity. Clayton plans to attend medical school after graduating and hopes to practice medicine globally in the future.
Camp Kwizera is inspired by the Kinyarwandan word for “hope” and represents the FACE AIDS view of the next generation as the hope of the future.

When I was in middle school, being active in service meant volunteering at your local food bank or picking up trash at the neighborhood park. While these are undoubtedly meaningful activities, the type of service activities that were available to me were extremely limited in their reach. Service meant making a difference in your local community, but beyond local issues, little was taught and few service opportunities were available. Global issues like extreme poverty and AIDS in Africa were rarely spoken about with middle school students.

Today, only a decade later, the world in which middle school children are growing up is completely different. With easy access to the internet and celebrity endorsements of every issue imaginable, children are aware of global issues and looking for ways to be involved in the global fight for social justice. After a conversation with an enthusiastic twelve-year-old volunteer, FACE AIDS embarked on a journey to bring the message of social change to middle school students in the Bay Area.

FACE AIDS is a Palo Alto- and Rwanda-based nonprofit dedicated to mobilizing and inspiring youth to fight AIDS in Africa. It began as an organization that provided structure and resources to college chapters who were devoted to hands-on service activities in the local community. Students were given cameras to document their journey into service. At the end of the camp, the photos were displayed for their parents to see. Using media as a way to engage and spotlight service action was a unique initiative inspired by one of the Camp Kwizera counselors. Media is not only used to document one's actions but also to document injustices, as the students learned through a documentary on political justice and a visit to the MLK Papers Project.

Throughout the program, students were given cameras to document their journey into service. At the end of the program, the photos were displayed for their parents to see. Using media as a way to engage and spotlight service action was a unique initiative inspired by one of the Camp Kwizera counselors. Media is not only used to document service but also to document injustices, as the students learned through a documentary on political justice and a visit to the MLK Papers Project.

Each day, the students led discussions and debates over issues ranging from why education was so important to issues of stigma and prejudice in the health care system. Learning to lead in service is a particularly valuable skill that FACE AIDS hoped to emphasize to the middle school students. At the end of camp, one of the campers commented, “I came out of camp feeling much more confident! It felt so great to help people. That is just a gift in itself. Two leadership skills I developed were communication, which I learned through having discussions at camp, and taking charge, which I exercised when we put on a skit on the last day. I also felt more confident because I have truly learned how to make a difference, and not many camps do what we did at Camp Kwizera.”

I also felt more confident because I have truly learned how to make a difference, and not many camps do what we did at Camp Kwizera.
Media is not only used to document service but also to document injustices, as the students learned through a documentary on political justice and a visit to the MLK Papers Project.

By integrating hands-on activities, such as decorating picture frames for sick children at the Ronald McDonald House, gardening in an organic farm at Hidden Villa, and working in a soup kitchen at Sacred Heart Community House, gardening in an organic farm at Hidden Villa, and picture frames for sick children at the Ronald McDonald

The United States

Credit: Saloner & Shriram

Credit: http://courier-journal.com/blogs/greenblog1/blog.html

The campers learned about Martin Luther King Jr. at the MLK Paper Project at Stanford University. This is a camper presenting a letter that he wrote to a local politician.

By integrating hands-on activities, such as decorating picture frames for sick children at the Ronald McDonald House, gardening in an organic farm at Hidden Villa, and working in a soup kitchen at Sacred Heart Community Center, Camp Kwizera challenged students to gain a different perspective on the issues of social justice. Starting to become actors in the field of social justice and learning about ways in which local service relates to global challenges are the first step that these students will take on their journey into the world of service. Bringing the students into their first public service activities, FACE AIDS hopes to foster a sense of leadership and service at a young age.

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The United States of America

The purpose of the camp was to promote leadership and awareness of social action. FACE AIDS held two one-week sessions during the summer, each hosting twenty children between the ages of 10 and 14. Each day was devoted to one theme: Poverty, Health, Environment, Political Justice, and Action.

Mozambique

A Tale of Two Wells

WATER AND MANAGEMENT IN MOZAMBIQUE

by Lauren Platt

“Why, with this wonderful pump sitting right here in the middle of the village, were they still walking for hours daily to fetch water?”

“Six months,” responded the group of villagers from Manhica with whom I was talking.

I stood there, shocked, just staring at the pump that had written on it, “Pela Cruz Vermelha de Mozambique” or “By the Red Cross of Mozambique,” and tried to comprehend the implications of what I had just heard.

“We have been getting all of our water from the river,” responded a villager, who added that the nearest river was over 5 kilometers away. How could they have been living without water for so long?

Why, with this wonderful pump sitting right here in the middle of the village, were they still walking for hours daily to fetch water?

This last question stayed with me as I struggled to make logical sense out of this problem. I sat down with the village water representatives and asked them specifically why the pump had not been fixed. They explained: “Six months ago, the pump broke. We have no way to fix it because our water fund is not enough. Our people, especially the women, are suffering. It takes hours every day for them to walk to the river and bring back just a single tank of water. The river is dangerous—there are crocodiles and the water is dirty. We are glad you are here. Will you please fix it for us?”

Initially, I was taken aback—wondering why they were asking me, a young college student, without power or money, to fix their water pump for them. At this point, I had only been in Mozambique for six weeks volunteering for a non governmental organization (NGO) that worked in health, water, and agriculture. But then I had a critical realization that the villagers were asking me to fix their pump as a result of two observations: One, I was a foreigner; two, I was white.

The village of Mucatine is 5 kilometers south of Manhica and also has the problem of water scarcity. Also like Manhica, a few years ago an NGO came to Mucatine and offered to help install a water pump that would allow the village to get clean water straight to their village—so they wouldn't have to travel hours daily for contaminated water.

A villager I interviewed commented that, “Having this water pump has changed our lives. Now we no longer have to go down to the river and get dirty water. We have less disease and the women no longer have pain from carrying the water.”

So why the disconnect? Two villages with the identical problem of a water crisis where both are recipients of water pumps put in by outside organizations. Yet now, a few years later, one village still has a well-running pump, while the other village has been, in their own words, “suffering” for more than six months.

Why, with this wonderful pump sitting right here in the middle of the village, were they still walking for hours daily to fetch water?
I sat down with several members of the water association of Mucatine. “How does the water association work in this village?”

“Well, whenever a person gets a container of water they pay 1 meticais (three US cents). Lupe, who is our pump employee, collects the money and monitors the pump every day. Every week we make sure that the money is being collected and is enough to pay for the pump. The money is used to buy parts and the diesel fuel.”

I casually said to him, “I’m confused. The water association said they had a system for collecting money so that when the pump breaks they would have money to fix it. The only way to get money out of this fund is for the money to go into a bank account that was started by the association. This fund is for the future—if the pump breaks. The only way to get money out of this fund is for three members of the water association to all sign a check.”

He paused to point out to us a single, dying papaya tree amongst the brown landscape. He then continued, “Also, there was just one man who would come around to collect the money, and we don’t know, but people think he probably took some of it for himself because when the pump broke, he told us he didn’t have enough and so we all had to pay him more. So, for the last few months, people keep saying we need to collect money again, but people who had been paying all along refuse to contribute more, and the others also won’t pay.”

We had reached the shallow beach where women from the village come daily to gather 45 pounds of water to carry, on their head, back to their home, which is over three miles away.

After my meeting with the water association of Manhica, the village with the broken pump, I asked if they would take me down to see where they get their water. One middle-aged man said he wouldn’t mind taking me, and so we started our hour-long walk towards the river.

As we walked past the brown fields that characterized the plains of Mozambique during the dry month of August, I began talking to him about life in his village—what kinds of things do people do during the day, how many families lived there, and so on. After talking for a while, I casually said to him, “I’m confused. The water association said they had a system for collecting money so that when the pump broke they would be able to fix it. So, why hasn’t it been fixed?”

His simple response: “Yes, our village did have three members of the water association to all sign a check approving the withdrawal. We are also already talking with the government about other things our village can have in the future, like electricity.”

The need for clean water around the world is unambiguous. Nearly 80% of illnesses in developing countries are linked to poor water and sanitation conditions. Mozambique is no exception, as only 42% of the population has access to an improved water source. Health and clean water are inseparable, but the intricacies of development are complex and not simply solved by material solutions. The key difference that I saw between the projects in Mucatine and Manhica was the way that the project in Mucatine was dedicated to building up the human capacity and skills of the villagers, from the bottom up. Though the project in Mucatine addressed the tangible need of the villagers for fresh and close water, it also focused heavily on building the skills of the people in the village for the future. Villagers learned key management skills—calculating the revenue, cost, and profit, paying the salary of an employee, cooperating in an association, and more.

This project also circumvents the lack of financial transparency that is often experienced in villages. For example, in Manhica, many villagers told me that they were suspicious that the man collecting the money for water was just taking the money for himself. However, they had no way to prove their suspicions and no mechanism for accountability. Mucatine solved this problem by creating a bank account that required permission from three or more people, building in financial accountability to ensure that no person was stealing from the village and to guarantee that when the pump breaks down, there will be money to fix it.

I will never again look at an advertisement: “Give clean water. Sponsor a well!” without first thinking of Manhica and wondering how that well is going to be solved by material solutions. The key difference that I saw between the projects in Mucatine and Manhica was the way that the project in Mucatine was dedicated to building up the human capacity and skills of the villagers, from the bottom up. Though the project in Mucatine addressed the tangible need of the villagers for fresh and close water, it also focused heavily on building the skills of the people in the village for the future. Villagers learned key management skills—calculating the revenue, cost, and profit, paying the salary of an employee, cooperating in an association, and more.

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Nearly 80% of illnesses in developing countries are linked to poor water and sanitation conditions.
On three small vessels with American flags waving strong and high in the air, polemic filmmaker Michael Moore and several ill Americans navigate from Miami to Guantanamo Bay seeking the free medical care that Guantánamo detainees receive at this prison. Among this group of Americans are three 9/11 rescue workers who are now suffering from medical conditions from exposure to harmful pollutants and toxins while working at ground zero. Logically these heroes cannot afford to pay for the medical services they desperately need and deserve. Upon arriving at Guantánamo Bay (American hell), Michael Moore and the group of sick Americans are essentially ignored by the American authorities. Since Cuba offers free universal health care, Michael Moore decides to take these Americans in search of Cuban doctors and pharmacies with the hope of helping them receive inexpensive medical care. Upon arriving at a pharmacy, one of the 9/11 rescue workers learns that the inhaler and medicine that she pays $125 for in the U.S. costs only 5 cents in Cuba. She begins to cry and, in reference to the absurd price differences, says, “It’s just the biggest insult. It doesn’t make any sense.”

The scene described above is taken from Michael Moore’s film Sicko, a documentary that in an entertaining and dramatic fashion shows the different health care systems that exist in the U.S., England, France, Canada, and Cuba. The film aims to demonstrate how successful medicine can be, except for the U.S., have been at providing high quality universal health care to all their citizens; however, it also briefly but importantly touches on the issue of the U.S. pharmaceutical industry selling what many deem to be significantly overpriced drugs. By now, the U.S. pharmaceutical company is stereotyped as one of the most lucrative, deceitful and unscrupulous industries in the U.S. But how do European pharmaceutical companies compare to those in the U.S?

The Organisation for Economic Co-Operation and Development (OECD) reports that in 2003 the U.S. was and continues to be the country with the highest total drug expenditure per capita (over U.S.$700 per person), but European countries do not lag too far behind. In terms of total drug expenditures, France ranks second (over U.S.$600 per capita) and Italy (along with Canada) ranks third (approximately U.S.$500 per capita). According to the European Union’s (EU) official portal site, Europeans spend €214 billion per year on pharmaceuticals, which is equivalent to 2% of Europe’s GDP. Moore’s film led many to ask why pharmaceutical prices were so high in the U.S. but it failed to touch on the issue of pharmaceutical prices in Europe. Why are Europeans spending so much on medical drugs? On July 8, 2009 the European Commission released a report claiming that, “Market entry of generic drugs is delayed and there is a decline in the number of novel medicines reaching the market ... the sector inquiry suggests that company practices are among the causes, but does not exclude other factors such as shortcomings in the regulatory framework.” This then also raises the following question: Are regulatory bodies such as the EU’s European Medicines Agency (EMEA) contributing to the problem of pharmaceutical price inflation? The creation of the EMEA in 1995 was a step in the direction of a single European pharmaceutical market. The EMEA is a decentralized body of the European Union and provides “independent, science-based recommendations on the quality, safety and efficacy of medicines, and on more general issues relevant to public...health that involve medicines.” However, several serious concerns have been raised about its transparency, financial dependency on the pharmaceutical industry, and methods of drug assessment. For instance, when a new drug is being evaluated for approval, it is not compared to other similar drugs for quality or efficacy.

Clearly, member states of the EU face a difficult balancing act between ensuring the public’s safety and not stifling the pharmaceutical industry’s innovation. Professor Donald W. Light, who is a Lorry I. Lokey Visiting Professor in Human Biology and conducts research in comparative health care systems and policy, answered several questions regarding the future of a single European pharmaceutical market and the role of the EMEA.

Question 1: About 70% of the EMEA’s budget comes from the fees charged to pharmaceutical companies that are seeking approval through the EMEA. The U.S.’s approach concerning drug regulation has always been more centralized and slightly less dependent on pharmaceutical companies as compared to other European countries. Will the EMEA’s economic dependency on the pharmaceutical industry likely be a continuing trend?

Don: The EMEA, which is the European FDA, depends almost entirely on fees paid by companies for reviewing the drugs they submit. In both cases this is a violation of the intent of setting up these regulators because they were established when drug disasters occurred and hundreds or thousands of people became seriously ill or died. So, it is unfortunate but it does seem to be a clear trend.

Question 2: Considering the different health care systems of European countries and the different levels of government regulation of the pharmaceutical industry, is it likely that there will be a harmonious single drug market? If so what are the main risks and benefits?

Don: There is a great and sustained effort by the industry to create a single European pharmaceutical market and there is a series of meetings around harmonization. The independent reports that have been done of those meetings indicate that the harmonization is finding the lowest common denominator rather than the highest standard for things like monitoring and safety.

What is the European Union’s approach to drug regulation and the pharmaceutical industry?

The European Union’s approach to drug regulation and the pharmaceutical industry.

Don: The EMEA which is the European FDA depends almost entirely on fees paid by companies for reviewing the drugs they submit and there is no evidence of that changing. “There is a great and sustained effort by the industry to create a single European pharmaceutical market and there is a series of meetings around harmonization. The independent reports that have been done of those meetings indicate that the harmonization is finding the lowest common denominator rather than the highest standard for things like monitoring and safety.” - Professor Don Light.
In the degree in which they are promoting and rewarding the prescribing of generic drugs and a number of doctors resist that. These doctors are subject to billions of dollars of persuasion and pressures and marketing from the pharmaceutical companies to continue to prescribe the patented drugs.

The European Commission on Competition has recently issued a very strong report against the anti-competitive behaviors of pharmaceutical companies using various kinds of legal maneuvers and other tactics to delay generics getting on the market and paying generic manufacturers to keep their drugs off the market; essentially paying them a bribe to not put their generic drugs on the market. That is the larger European picture. States vary on how strongly their incentives are for producing generics and whole national price competition that you would see on cell phones and computers and other kinds of products are weaker in European generics than in the U.S. So generic prices tend to be higher in Europe than in the U.S. because they have more constraints on generics competition.

"Independent reviewers comment that "free-market" prices of patented drugs in the U.S. are monopoly prices set by the companies so the companies are controlling prices here and they also point out that there’s evidence that European prices fully recover research and development costs so that robust research and development is possible with European prices."

- Professor Don Light

meetings indicate that the harmonization is finding the lowest common denominator rather than the highest standard for things like monitoring and safety. But aside from those efforts every country is really interested in keeping national control of how they negotiate prices. So I think the main decisions regarding marketing, buying, and using of drugs will stay national for a while.

Question 3:
If only a centralized pathway for drug approval (through the EMEA) existed, would this affect the availability of generic drugs to members of the EU, considering that some member states create incentives for the use of generic drugs?

Don: Generic drugs are bio-equivalent, exactly the same product as a patented drug, and they are supposed to come on the market 20 years after the original molecule or active ingredient was discovered. Countries are varied in terms of health care systems, Europe is like a fluid mosaic with each country providing universal health care services through varying means that depend on varying degrees of price regulation as a means of cost containment. Additionally, regulations and rules for approval of new medical drugs vary from member state to member state. Therefore, a single European pharmaceutical market could create serious tensions between national and supranational priorities among member states. Another major problem is that currently the pharmaceutical regulatory bodies, FDA and the EMEA, are both plagued with European approaches concerning cost containment of pharmaceuticals could bring invaluable lessons for the U.S. given that it is the country that spends the most per capita on pharmaceuticals and its health care system is undergoing revolutionary changes.

References:

Shelly Amieva is a senior majoring in Human Biology with an area of concentration in “Global Inequalities, Global Health, and Human Rights.” She plans on pursuing an MPH and Ph.D. in Global Health. Her favorite hobbies include reading, SCUBA Diving, and playing beach volleyball.
I would go on to hear much more about sorcery when I moved to the island of Karkar, where the sorcerers often come to drink. I had heard that the bird cawing faintly in the trees signaled the sorcerer’s arrival, and that if I were to be seen, I would get my heart ripped out and eaten (a practice known as “sanguma”).

I had decided to sneak out to sit on the beach, listen to the waves, and watch the stars. It wasn’t too long before I was greeted by a group of village boys, urging me to return home. When I asked why, I was told that I was sitting where the sorcerers often come to drink. I had heard that some people believed in sorcery on the island, but I had no idea that I would encounter it first-hand. But here they were, a group of my soon-to-be students, warning me that the bird cawing faintly in the trees signaled the sorcerer’s imminent arrival, and that if I were to be seen, I would get my heart ripped out and eaten (a practice known as “sanguma”).

I would go on to hear much more about sorcery than I had anticipated during my time in PNG. What was more disturbing to me, however, was not what it was rumored these sorcerers were “capable of,” but the brutality that results from such beliefs. For instance, one of the headmasters on Karkar Island told us the story of how his best friend was almost beaten to death over sorcery allegations. When I asked my host mom about this, she went on to tell me of a killing in Goroka, a city in the Highlands of Papua New Guinea. When a man in a Gorokan family died, the family blamed a couple believed to be possessed by evil spirits, and two of his nephews chopped off the heads of this couple with a machete, burying the bodies just outside the village.

These sorts of stories demonstrated to me the unswerving conviction that may be found in ingrained traditional ideologies, and the harm it is capable of producing. It would seem to me that in the process of development, it is imperative to understand the impact that traditional beliefs may have. During my time in Papua New Guinea, I distinctly noticed the intersection of this sort of cultural belief and the efforts that have been made to improve healthcare and scientific understanding.

The relatively recent rise of HIV/AIDS provides an interesting case study for what can happen when old beliefs meet new world. The presence of the disease in traditional communities has resurrected beliefs in sorcery. Generally, within traditional Papua New Guinean culture, there is a tendency to seek out alternative reasons to explain sicknesses. It becomes fairly easy to point fingers at personal or public enemies, especially when common knowledge fails to provide an adequate explanation. HIV/AIDS has made Papua New Guinean communities particularly susceptible to this. The increase of AIDS deaths is not blamed on promiscuity or lack of condoms, but on evil spirits. In general, the deaths of individuals between 16 and 35 are often attributed to spiritual causes, as opposed to natural ones, as it is difficult to believe that someone young and in good health could suddenly fall sick and die. The problem is compounded when people feel strongly that sorcerers, possessed by these evil spirits, exist within their communities; they feel the need to kill the perpetrators of black magic, before everyone falls victim to misfortune. Consequently, as the HIV/AIDS rate rises, so does the rate of sorcery killings.

Of course, the story of AIDS and sorcery, though prominent, is merely one example. But I did notice several other instances how the traditional lifestyle in general seemed to be a hindrance to healthy behavior in today’s medical context. Throughout the country today, people hold misconceptions about public health, simply because they haven’t been taught anything other than what their communities have believed in for ages. For instance, when a fellow Stanford student on my trip developed a serious eye infection, many of the locals argued that it was because she had gone hunting for wild pigs with me and a group of men. Women don’t go hunting—it’s just not a part of the culture—and naturally her violation of custom precipitated her malady.

Yet what I found most useful was the insight I gleaned regarding the world around me: I learned to expect the unexpected.

What I had experienced in PNG demonstrated to me ways in which traditional belief systems sometimes may prove to be stumbling blocks to any nation seeking a comfortable transition into the developed world, particularly with regards to medicine and healthcare. But this is not due to the absence of modern medicine in the country. There is a functional healthcare system in place, at least from what I have experienced. Many people from the island make the short trip to the mainland for doctor’s visits, and malaria treatment and other useful antibiotics are readily available as well. However, most doctors are Australian or European ex-patriots, and many Papua New Guinean children have tinea versicolor, an alteration in skin pigmentation that is caused by harmless yeast on the skin. While a solution of selenium sulfide is prescribed in most Western countries, in PNG, the treatment is to burn the affected skin. Furthermore, the locals hate windy days, as they think that the strong gusts bring the kus, or the cold. And when someone gets malaria, the advised treatment for the terrible fevers is to bundle up as much as possible and lie in the sweltering sun. It seemed that people treated themselves for illnesses in certain ways simply because their community had been doing it like that for ages. While this may not necessarily be a terribly bad thing, it prohibits modern medical practices from truly reaching traditional communities.

Sing-sings are still a strong part of Papua New Guinean culture, demonstrating the societal presence of tradition and custom. Above are my students and my host mom with me after a sing-sing.

Sing-sings are still a strong part of Papua New Guinean culture, demonstrating the societal presence of tradition and custom. Above are my students and my host mom with me after a sing-sing.
New Guineans heading into the medical field aim only as far as nursing school, instead of pursuing careers as physicians.

It would seem to me that the optimal way of addressing the presence of persisting medical misinformation is, fittingly, to take on an educational approach. I myself have seen the success that results from such an approach. In the past few years, the national government has mobilized a nationwide HIV/AIDS program. As part of the awareness campaign, billboards have been put up near major roadways in many village and city centers, and I have seen educational pamphlets that have made it all the way to Karkar. Many schools on the island have “AIDS Educators,” primary school teachers who have undergone the appropriate training to teach an HIV/AIDS curriculum to students on a yearly basis. Furthermore, a national HIV/AIDS week was incorporated into the curriculum during the term I was teaching. I found it wonderfully effective to hold question and answer sessions for the students, simply to dispel all the misconceptions many of the students held about the disease. The older students also had the opportunity to put on skits, acting out scenarios to show their peers how to handle disease. The older students also had the opportunity to have an opportunity to infuse practical, real-life teaching. I found it wonderfully effective to hold question and answer sessions for the students, simply to dispel all the misconceptions many of the students held about the disease. The older students also had the opportunity to put on skits, acting out scenarios to show their peers how to handle disease. The older students also had the opportunity to have an opportunity to infuse practical, real-life teaching. I found it wonderfully effective to hold question and answer sessions for the students, simply to dispel all the misconceptions many of the students held about the disease. The older students also had the opportunity to put on skits, acting out scenarios to show their peers how to handle disease.

Papua New Guinea

1) There are over 850 indigenous languages in Papua New Guinea.
2) 18% of the population resides in urban centers; the majority of people practice subsistence agriculture.
3) Over 200,000 undiscovered species were identified in the kilometer-deep crater of Mount Bosavi, one of several untouched jungle habitats in Papua New Guinea.

Source: CIA World Factbook

Teaching was one of the most rewarding experiences I have had, and I am happy to have had an impact on the lives of this community; above is the thank you gift that they gave me. I have seen the strength of character in the Papua New Guinean people, and I see a bright future ahead.

Stephen Miranda is a sophomore undergraduate at Stanford University, from Long Island, NY. He is majoring in Classics and plans on attending medical school after Stanford. Stephen loves traveling, is an avid soccer fan, and enjoys playing piano.

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Papua New Guinea

Education is empowerment in PNG, and may prove to be the future for these children.

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