Stanford Program On Human Rights
Post-Soviet Medical Treatment in Uzbekistan
LGBT Health and Legislation in Lebanon
Climate Change and Infectious Diseases
SSGH, now in its second year, is still a young and developing publication. With each issue we strive to improve by including a range of new styles, viewpoints and insights on global health issues; it is in this spirit of constant evolution that we hope to propel SSGH into the future. We have stocked these pages with articles that take the reader on journeys both to other countries as well as to the heart of current issues in global health. A quick glimpse inside the journal, for example, takes us to the post-Soviet health care system of Uzbekistan, inside the UN in Geneva, and to the core of connections between global climate change and global health. Each article offers a different perspective, and we are thrilled to share these talented writers' stories with Stanford’s campus. We hope this diversity will contribute to further conversations both within and outside of these walls.

In the past year, as our staff and writers worked on SSGH, two landmark events in global and public health occurred: the passing of the Health Reform Bill here in the US and the earthquake in Haiti. In addition, countless other global health stories have played out at every scale, from the news-worthy to the largely invisible. We want to encourage our readers to seek out global health news frequently; global health is a rapidly evolving field. But even more than the news, we hope our readers will savor the reflections they find on global health topics, both within these pages and beyond. Reflection often gets lost in the Stanford frenzy, yet a deep understanding of the issues of social justice and human rights at the core of global health may only come in this way. May these stories both broaden our perspectives and deepen our convictions that we all have a part to play in the fight for health equity around the world.

Catherine Le
Class of ‘11

Cooper Lloyd
Class of ‘10
In the past decade, new questions have emerged regarding human rights in the international arena. No longer just the province of courts, today’s human rights intersect with many pressing global issues, such as climate change, immigration, cross-border security, and global health. At the same time, a growing range of research disciplines, from economics and medicine to history and cultural studies, have incorporated a human rights perspective. Today, the field of human rights is at once a domain of human knowledge, political practice, and ethical inquiry. A dynamic, innovative, and multidisciplinary approach is more important than ever.

Officially launched in October 2009, the Program on Human Rights was founded to generate multidisciplinary and interdisciplinary human rights research from across Stanford schools and departments, including law, medicine, business, philosophy, political science, sociology, and anthropology. Our research targets academics, practitioners and policy-makers in the international human rights community. The Program on Human Rights is the newest initiative of the Center on Democracy, Development and the Rule of Law (CDDRL) at the Freeman Spogli Institute for International Studies (FSI), an interdisciplinary research laboratory at Stanford.

As part of CDDRL and FSI, the Program on Human Rights has a close connection to policy problems related to global health. On April 26 and 27, CDDRL hosted the Center for Health Policy (CHP-PCOR) at Stanford held a two-day conference on Governance and Health. The conference brought together political scientists, economists, medical doctors, and health policy experts seeking to provide better answers as to how governance may hinder or improve health in developing contexts. The purpose of the conference was to better understand the mechanisms linking governance to health in order to make meaningful policy recommendations to save lives and improve wellbeing.

Future Program on Human Rights initiatives may include, among others, interdisciplinary research on political and legal strategies that would permit health interventions to meet the needs of children in areas of unstable governance. Almost half of all preventable child deaths in the world occur in areas of unstable governance or civil conflict and global efforts to improve child health have largely avoided work in these areas.

Paul Wise, Richard E. Behrman Professor of Child Health and Society and keynote speaker at the Program on Human Rights launch, has already brought attention to the problem at Stanford in his capacity as principal investigator at CHP-PCOR’s Children in Crisis program.

Finally, as the Program on Human Rights Co-ordinator, I regularly guest lecture at undergraduate courses in international human rights and global health and also advise undergraduate students on their global health studies and research projects.

For additional information about the Program on Human Rights and a listing of upcoming events and activities, please visit our website at http://humanrights.stanford.edu.

With Warm Regards,

Helen Stacy

Co-ordinator, Program on Human Rights in the Center on Democracy, Development and the Rule of Law
Senior Fellow, Freeman Spogli Institute for International Studies
Senior Lecturer, Stanford Law School
Faculty Fellow, Clayman Institute for Gender Research
Researcher, Forum on Contemporary Europe

Program on Human Rights

By Helen Stacy

UNAFF (United Nations Association Film Festival) was originally conceived at Stanford University in 1998 to celebrate the fiftieth anniversary of the signing of the Universal Declaration of Human Rights. The festival was started with the help of members of the Stanford Film Society and UNA Midpeninsula Chapter, a grassroots, community-based, nonprofit organization, and has continued to grow ever since. In the past thirteen years, UNAFF has screened more than 500 exceptional documentaries, many of which went on to win prestigious awards, with fourteen films that received Oscar nominations and five that won the Academy Award for Best Documentary.

With its long history, UNAFF has already established a stellar reputation within the documentary film community, both as one of the oldest purely documentary film festivals, and as a high integrity and high quality outlet for the documentary community’s work. Its trademarked branding, which combines the powerful attraction of Stanford University and the United Nations, has produced an uninterrupted growth throughout its existence and a reservoir of respect, expressed most recently by the Nobel Peace Prize recipient Dr. James Orbinsky, who called it “not only the greatest documentary film festival in the U.S., but in all of the Americas.”

UNAFF provides a wonderful opportunity to educate and engage our students, both undergraduate and graduate, and presents them with a wealth of information about the world and arts while broadening their views of cultures that they would not otherwise be exposed to. In the process UNAFF has an impact on nourishing democratic discourse and inspiring their involvement in concrete action, as well as preparing them for the challenges of their future professional careers.

In the spirit of President Hennessy’s international and arts initiatives, UNAFF provides a bridge between Stanford and the wider community locally, nationally and internationally. It has already increased its presence locally in Palo Alto, but also in East Palo Alto, opening new avenues for interaction with a less privileged community and meaningful engagement opportunities for its youth in effecting social change.

Through the UNAFF Traveling Film Festival component (UNAFF-TFF) it promotes the name of Stanford across the country and internationally, including places like Harvard, Yale, etc., where Stanford’s leadership in the area of international human rights documentary film is underlined. Stanford ties with other universities and institutions are formed, and old ties are renewed—an area in which we see an increasing future role for our long-time sponsors the Stanford Bing Overseas Studies and Stanford Alumni Association.

Using films selected and presented at UNAFF, I have been teaching the “Camera as Witness: International Human Rights Documentaries” course through Interdisciplinary Studies in Humanities and International Relations for the last twelve years. The course has become one of the most popular undergraduate classes, offering students a better understanding of international issues and providing them with an opportunity to be involved in discussions in an interdisciplinary environment. Here are some of the students’ comments about the class:

Camera as Witness has gone above and beyond all of my expectations and is undoubtedly the best class I have ever taken at Stanford. From the style of the class to the assignments, and of course, the documentaries themselves—everything about this class has been a dream and I have enjoyed every single minute of it. – K.

The weekly dialogue also taught me to never think of my opinion as the greatest but to listen and respect my fellow classmates’ views. I remember the discourse we had on the issue of race. It was one of the most powerful ones because everyone had a story to contribute based on their experiences. – A.

My awareness of humanitarian crises around the world has sharply increased from watching the documentaries in Camera as Witness. Each documentary exposed a new problem that calls for resolution. This class has inspired me to look at ways to become more socially responsible by becoming an active participant in making life better for others who are less fortunate. – D.

For more details about the 13th UNAFF which has the theme this year POPULATION - MIGRATION - GLOBALIZATION, please visit www.unaff.org.

Best regards,

Jasmina Bojic
Film Critic/Lecturer
Stanford University, International Relations
Founder and Festival Director, UNAFF
www.unaff.org

By Jasmina Bojic
by Shelly Amieva

Worldwide, there are approximately over 41 million refugees and internally displaced people (IDP); meaning that the world’s forcibly displaced population is twice as large as Australia’s entire population. Putting this statistic in terms of Australia’s population helped me comprehend the magnitude of this number since last year I participated in Stanford’s Bing Overseas program in Australia. It just seems incredible that there are enough refugees and IDP in the world to fill-up all of Australia’s cities twice. It was on my first day as an intern at John Snow Research & Training Institute, Inc. (JSI), that I learned this shocking statistic. Perhaps what surprised me even more is that I had never identified reproductive health (RH) care as one of the most essential needs for displaced people because I did not know that the average length of displacement for refugees is 17 years. Ensuring safe access to high quality RH care is difficult in most developing countries, but it is extraordinarily difficult and often neglected in areas affected by armed conflict or crisis. In response to this health care gap for this specific population, the Reproductive Health Response in Crises (RHRC) Consortium was founded to ensure that refugees around the world have constant and safe access to high quality RH care. As one of the consortium’s seven members, JSI administers a 15 year-old project called Astarte. Astarte’s mission is to “enhance access to quality reproductive health services by fostering leaders in communities affected by crisis”; it achieves this by providing small grants and technical assistance to local NGOs. What I found unique and interesting about the Astarte project is that this model is sustainable because it empowers local NGOs. Through the interviews I conducted with the Astarte team and a Stanford student who collaborated with the project, I will be able to provide a panoramic view of this unique project.

Why RH Services are Urgent Even for Refugees:

RH programs focus on women because childbirth can be dangerous and because in some parts of the world, women have less power in choosing and obtaining contraceptives. According to the Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative, lack of access to necessary RH care services in conflict or disaster-affected areas can mean permanent disability or even death for women. As RAISE points out, during a crisis, women and children become more vulnerable to sexual violence and sexual exploitation. Meriwether Beatty commented, “We hear a lot of times that reproductive health is frivolous because in an emergency or crisis this concern is secondary to other priorities. While it is clearly true that people need shelter, food and protection it is also important to remember that RH services, such as emergency obstetric care, are life-saving services.”

Overview of the Astarte Project:

Astarte’s mission and core strategy of working with local NGOs has remained the same for the past 15 years, though many of the activities and avenues for supporting them have evolved. Dr. Molly Fitzgerald explains, “At first it was only the financial support, but then over the years we saw that it would be more beneficial if the organizations had access to other sorts of resources such as reproductive health training as well as providing them with linkages to other information, resources and other people working in other crisis-affected areas and settings. Now we are also focusing on the actual organizational strengthening component to enable the organization to be more successful and more effective.” For Astarte, organizational and capacity development involves assisting local organizations in coordinating an and strengthening communication efforts among themselves. While most international projects and NGOs avoid working in crisis-affected areas or funding programs in unstable countries, Astarte has chosen to work in these neglected areas. How is Astarte able to successfully support local NGOs and their RH programs in such fragile regions? The answer lies in its unique model.

Astarte’s Model and Challenges:

Why is Astarte such a distinct project? Dr. Fitzgerald responded, “Astarte works with the human resources and the leadership that is already on the ground but is often overlooked. Astarte tries to connect those groups with the bigger picture and to provide them with the resources and linkages that they need as opposed to providing a parallel system ….. it’s a much more dignified approach in that way, it’s not to say that international groups don’t also have a role, but it’s just a good approach and very unique, unfortunately.” According to Erika Larson, what sets Astarte apart from other relief or developmental projects is that its “key element (or strategy) is to build the strength of ideas from the bottom up to address dire RH needs. It’s not going into these conflict areas to overlay our own solutions. We

“We hear a lot of times that reproductive health is frivolous because in an emergency or crisis this concern is secondary to other priorities. While it is clearly true that people need shelter, food and protection it is also important to remember that RH services, such as emergency obstetric care, are life-saving services.” - Meriwether Beatty

Astarte Team Interviewees

- Meriwether Beatty, MPH: Director of the Reproductive Health for Refugees Project, including the Astarte Project, for John Snow Research and Training Institute, Inc. (JSI).
- Molly Fitzgerald, Ph.D.: Capacity Building Technical Advisor for the Astarte Project and the division of Reproductive Health for Refugees at JSI, obtained MPH at Johns Hopkins School of Public Health and the DrPH at the London School of Hygiene and Tropical Medicine.
- Erika Larson, B.A.: Program Officer for the Astarte project and division of Reproductive Health for Refugees at JSI, obtained B.A. from Davidson College.

Group work with the 4 Liberian NGOs during a workshop on Adolescent Reproductive Health in Monrovia at the Paracom office.
“Astarte works with the human resources and the leadership that is already on the ground but is often overlooked.”
- Dr. Molly Fitzgerald

Astarte: An Exchange of Knowledge

The local NGOs that receive funding and technical assistance from Astarte benefit greatly, however, those who have worked for Astarte have also gained invaluable knowledge and understanding about humanitarian aid and development, as I learned from interviewing a Stanford undergraduate. Losmeiya Huang, a senior at Stanford majoring in Human Biology, participated in a 6-month-long internship with JSI on Astarte. During her internship, she traveled to Sierra Leone where Astarte had funded local NGOs and was now facilitating a conference on organizational development. Recently, Astarte has been assisting local NGOs in Liberia and Sierra Leone to come together to form strong networks to exchange knowledge and experiences. During this trip, Losmeiya interviewed refugees to learn more about their experiences and what their perceptions of RH were. Additionally, she spoke with the local NGO leaders to learn more about their work, what they had accomplished with the Astarte funds, and what their future goals were. Interestingly, Losmeiya mentioned that it was with this one week trip to Sierra Leone that everything she had been learning about regarding RH and humanitarian aid finally “clicked”: “In meeting them (the leaders of the local NGOs) you realize that they are not that different from you and it changes your entire perception of what it means to be working in the field of development.”

References:
Reflections on Post-Soviet Medical Treatments in Tashkent, Uzbekistan

by Madina Tugizova

As the medication was sprayed into the boy's left nostril, a wail rang through the clinic. I held the suction apparatus firmly in his right nostril as the nurse held his head down on the bed and his mother held onto his feet, which were threatening to kick her as he screamed. Tears ran down his cheeks and into his open mouth. "Just a couple more minutes, sweetie. Don't cry. We're almost done." The voice of the otolaryngologist was soothing. The nurse stroked the child's hair to calm him.

Carefully, the syringe and suction apparatus were removed from his nose and an inhalator was placed over his nose and mouth. "This is the standard procedure for the cold or flu," the otolaryngologist told me. "The inhalator allows the medicine to be directly absorbed by the respiratory tract."

It was August 2009 and I was at Shox Medical Center, a private ambulatory care clinic in Tashkent, the capital of Uzbekistan. I had contacted the clinic earlier in the year and was offered the opportunity to volunteer to broaden my knowledge of medical care outside of the United States. My experience at Shox Medical Center was a journey through seven clinic specialties and an introduction to the history of medicine in Central Asia and the health care system of modern day Uzbekistan.

The practice of modern medicine in Central Asia began with Avicenna, the father of medieval medicine. His early education near Bukhara, an ancient city of Uzbekistan. He was the most renowned physician of his time and author of the Canon of Medicine, the standard medical text in Europe and the Islamic world until the 18th century. Russian colonization of Central Asia in the 19th and 20th centuries exposed Uzbekistan to European medical treatments and models of disease since the time of Avicenna. During the Soviet era, medical care in Uzbekistan was centralized: polyclinics served neighborhoods, factories, or professional groups, and hospitals provided specialized care. Physicians were trained in accordance with Russian perspectives on health. Medical care was free and highly accessible, but far behind the West in medical technology.

In the post-Soviet era, Uzbekistan has focused on developing a private health care sector, and today many of Uzbekistan's private health centers utilize Western medical technology and import medications. In a country where 27% of people live below the poverty line, very few have access to the high standards of care provided at private health centers. Nevertheless, free medical care is available to all at state polyclinics and hospitals.

Medical care in modern day Uzbekistan emphasizes prophylactic treatments to prevent and manage disease. In otolaryngology, the study of the ears, nose, and throat, infections are treated at the source before they can spread globally and impact larger organs. At Shox Medical Center, distinct antibiotic “cocktails” are prepared for each individual patient and sprayed directly into the nose or throat. If infections were to spread from these areas to the lungs, the resulting conditions would be more difficult to treat. Likewise, infant massage therapy is commonly used to impede neurological disorders, stimulate normal development, and promote growth. At Shox Medical Center, infants are wrapped in warm paraffin wax, plastic wrap, and towels for 15-20 minutes to moisturize the skin, increase circulation, and relax the muscles. They are then gently rubbed with olive oil before being given a forceful massage. Distinct to Shox Medical Center are infant massages that target acupuncture points to increase infants’ mobility and range of motion.

Homeopathic treatments like massage therapy are as popular among patients at Shox Medical Center as Western allopathic treatments. Herbal therapy and acupuncture are frequently used to treat medical conditions. The most utilized service at Shox Medical Center, however, is live blood analysis, a diagnostic technique that is generally mistrusted in the United States. In live blood analysis, a drop of blood is taken from a patient’s finger and deposited onto a glass slide. The contents of the drop of blood are then magnified two hundred times on a microscope and viewed on a computer screen. This technique is used to determine the state of erythrocytes and their degree of aggregation, the state of the immune system, the presence or absence of parasites in the blood plasma, vitamin deficiencies, the state of the...
Uzbekistan

Demographic Information
Area: 447,400 km²
Population: 28.0 million
Ethnic Groups: 80% Uzbek, 5.5% Russian, 5% Tajik, 3% Kazakh, 2.5% Karakalpak, 1.5% Tatar


<table>
<thead>
<tr>
<th>Cause</th>
<th>Total deaths (%)</th>
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<tbody>
<tr>
<td>1. Ischaemic heart disease</td>
<td>32</td>
</tr>
<tr>
<td>2. Cerebrovascular disease</td>
<td>14</td>
</tr>
<tr>
<td>3. Lower respiratory infections</td>
<td>6</td>
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<tr>
<td>4. Hypertensive heart disease</td>
<td>5</td>
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<tr>
<td>5. Cirrhosis of the liver</td>
<td>4</td>
</tr>
<tr>
<td>6. Perinatal conditions</td>
<td>3</td>
</tr>
<tr>
<td>7. Inflammatory heart disease</td>
<td>3</td>
</tr>
<tr>
<td>8. Tuberculosis</td>
<td>2</td>
</tr>
<tr>
<td>9. Chronic obstructive pulmonary disease</td>
<td>2</td>
</tr>
<tr>
<td>10. Diabetes mellitus</td>
<td>2</td>
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Disease Burden in Uzbekistan (2002)

<table>
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<tr>
<th>Cause</th>
<th>Total deaths (%)</th>
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<tbody>
<tr>
<td>1. Cardiovascular diseases</td>
<td>23</td>
</tr>
<tr>
<td>2. Neuropsychiatric disorders</td>
<td>17</td>
</tr>
<tr>
<td>3. Unintentional injuries</td>
<td>8</td>
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<tr>
<td>4. Infectious and parasitic diseases</td>
<td>6</td>
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<tr>
<td>5. Perinatal conditions</td>
<td>7</td>
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<tr>
<td>6. Digestive diseases</td>
<td>5</td>
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<tr>
<td>7. Respiratory infections</td>
<td>7</td>
</tr>
<tr>
<td>8. Respiratory diseases</td>
<td>4</td>
</tr>
<tr>
<td>9. Cancer (malignant neoplasms)</td>
<td>5</td>
</tr>
<tr>
<td>10. Sensory organ disorders</td>
<td>5</td>
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</table>

Source: Jakubowski and Arnaudova, 2009

Uzbekistan has been enriched by a variety of cultures. Medical care in the region has been influenced by medieval Avicennian learning, European medical treatments, the Soviet healthcare system, and Western technology, creating a plethora of diverse and fascinating treatments and diagnostic techniques. As the young nation continues to discover its identity in the post-Soviet era, only time will tell how healthcare will evolve to meet the needs of a generation that has had more exposure to global culture than ever before.

References:

Ischaemic heart disease has been enriched by a variety of cultures. Medical care in the region has been influenced by medieval Avicennian learning, European medical treatments, the Soviet healthcare system, and Western technology, creating a plethora of diverse and fascinating treatments and diagnostic techniques. As the young nation continues to discover its identity in the post-Soviet era, only time will tell how healthcare will evolve to meet the needs of a generation that has had more exposure to global culture than ever before.

I never thought that I would appear on Rwandan National television singing and waving condoms in the air. But there I was: an American who had never been in Africa before, chanting broken phrases in Kinyarwanda and dancing in a mass of 400 young Rwandans. Nine other Americans stood out in the crowd, my fellow travelers on our winter break journey to Rwanda. As we saw ourselves on Rwandan television later, we couldn’t keep from shouting: “I can’t believe it!” “Cool!” “No one will believe this.” But as we watched, we also realized that our elation stemmed from more than our TV debut. Seeing ourselves was proof that our experience that day had not just been some figment of our imagination after eating one too many plantains for lunch. We had actually been part of a movement that was important enough to attract the National Press. It was a reaffirmation that FACE AIDS, a group that started with a few students with a passion for a cause, had become a viable organization making a real impact on the ground in Rwanda.

The 2009 FACE AIDS Annual Youth Forum brought together 400 young Rwandans from across the country, making a real impact on the ground in Rwanda. As the evening news reported, the 2009 FACE AIDS Annual Youth Forum brought together 400 young Rwandans from across the country to meet one another, learn about HIV/AIDS prevention, and brainstorm strategies to bring lessons back to their own communities. To kick off the conference in the city of Kayonza, all of the students joined the mayor in a community march to promote condom use. How did nine American students find themselves chanting and marching alongside...
their Rwandan peers in a remote city in East Africa during their winter break? We were participating in the first ever FACE AIDS Leadership Trip to Rwanda. Julie Veroff and Romy Saloner, the current executive and managing directors of FACE AIDS, conceptualized the trip as a way to bridge the gap between the Rwandan programs and the US programs, a way to build connections between FACE AIDS members and to understand how the organization can move forward. I was astounded by the work that FACE AIDS does in Rwanda. Even though most of us on the trip had been involved with FACE AIDS at Stanford for years, none of us really understood the depth and breadth of the Rwandan programs.

FACE AIDS programs in Rwanda start with the AIDS awareness pins. The organization employs members of AIDS cooperatives, or community groups affected by HIV/AIDS that have come together to organize. FACE AIDS cooperatives, or community groups affected by HIV/AIDS, has been involved with FACE AIDS at Stanford for years. Even though most of us on the trip had been involved with FACE AIDS at Stanford for years, we all gathered for dinner in the home of Marie, one of the members of the Association. Marie’s family and the nine Americans gathered in the flickering light of kerosene lamps and the sound of crickets to feast together on the most delicious home-cooked meal of beans, plantain, rice, goat, and cassava sauce. There is a Rwandan saying that once you have shared a meal you can have no more secrets. Marie’s openness and incredible generosity will certainly stay with me forever.

The Rwandara Association was the pioneering group, and it was amazing to see their success in the aftermath of the pin-making project. But the work of FACE AIDS does not end with these projects. In 2009 FACE AIDS developed a new program, the structured savings and business training program. At the end of the pin-making project, the structured savings and business training program begins. The main difference between our programs and the more common “micro-credit” or similar, small-scale projects is that rather than acting as a lending institution that gives out loans to groups and collects the repayment and interest, we actually supply groups with the tools and skills to become successful lending entities themselves based on the salaries that they initially earn from making pins. So far, FACE AIDS has implemented the structured savings and business training program with three separate groups.

During our trip we met with members of one of the pilot groups, the Girimpuhwe Cooperative. The Girimpuhwe Cooperative is a group composed entirely of AIDS orphans. We gave 30,000 Rwandan Francs per member to each cooperative as the final part of the income they generated from the pin-making project. This money, along with group savings that were collected during pin-making, was used to finance the first loans to the members. At the end of the first loan cycle, the cooperative had a 100% repayment rate. By the end of their first loan cycle, in January 2010, they had already saved an additional $207. Using this profit, Girimpuhwe was able to pay the registration fees to become a fully registered Savings and Credit Cooperative with the Rwandan government while also giving out a second round of loans to its members.

The FACE AIDS programs in Rwanda are having an impact on hundreds of Rwandans and to all of us visiting, the challenge is to figure out how to move forward and how to solidify the connections we made with our Rwandan programs. One of the members of FACE AIDS in Rwanda expressed his thanks and asserted, “FACE AIDS gives us a voice to my objectives!” The gratitude we encountered along our journey was astounding and humbling. I know that I felt proud of the work that FACE AIDS was doing, but at the same time, I felt that the Rwandan students deserved more thanks for their hard work than we did! My hope is that in moving forward we can keep the connection going both ways, so that the programs in United States and Rwanda are not two separate entities but one coherent group working together to fight AIDS, so that our mutual gratitude exists alongside a feeling of togetherness.

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I was excited to recognize their faces from the pin cards that we hand out in the United States! HIV/AIDS that have come together to organize, FACE AIDS trains members to make the beaded pins, supplies members with materials and then pays members of the cooperative to make 100 pins a month for six months. These pins are then shipped back to the United States, where FACE AIDS chapters distribute them at high school and university events.

During our trip we were able to meet and stay the night with members of the first AIDS cooperative that had been involved in the pin-making project, called the Rwandara Association. After hours of bouncing in our van through the Rwandan hillside, we arrived at a small village of red clay huts set between dazzling green fields. The elder members of the village were ready and waiting to greet us with song and dance, and as each member extended their hands to take ours, I was excited to recognize their faces from the pin cards that we hand out in the United States! After introductions, Omar, the leader of the Rwandara Association, led us through their fields of cassava, the entire population of village children following closely behind us. The Rwandara Association was able to buy the cassava fields with the income they generated from the pin-making project.

As the sun descended over the cassava fields, we all gathered for dinner in the home of Marie, one of the members of the Association. Marie’s family and the nine Americans gathered in the flickering light of kerosene lamps and the sound of crickets to feast together on the most delicious home-cooked meal of beans, plantain, rice, goat, and cassava sauce. There is a Rwandan saying that once you have shared a meal you can have no more secrets. Marie’s openness and incredible generosity will certainly stay with me forever.

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The Rwandan students. We saw ourselves shaking hands, passing the ball back and forth on the red dirt turf. For at least two weeks of the US chapters and the Rwandan chapters were finally physically united, speaking face to face in mixtures of English and French; learning and laughing and dancing together to Rwandan and American music. We celebrated our similarities and our differences and made connections that we hope we can keep going. We marched hand in hand under the same banner in the same movement. We remain part of the movement today and in the future, together in solidarity.

Anne Stake is a senior majoring in Human Biology with a concentration in international health. She has been working with FACE AIDS for most of her years at Stanford. She hopes to go back to Rwanda in the near future and pursue a career in global health and development somewhere down the road.

FACE AIDS members from the U.S. and Rwanda team up to play soccer with a guest appearance by founder, Johnny Dorsey.
by Fatima Hassan

Context
Our world is fractured along religious, political, and ethnic lines. Contested ownership of resources fuel extended conflicts and perpetrators of war openly defy international law, as armed factions employ exceptionally brutal tactics against civilians. Dismal security situations paradoxically limit the ability to deliver life-saving assistance to people who acutely require aid. The lethal synergism of poverty and oppression festers as breeding grounds for child soldiers and radical ideologies.

As the 2009-2010 Haas Center and Freeman Spogli Institute’s International Public Service post-graduate fellow, I have supported the United Nation Population Fund (UNFPA) Humanitarian Response Branch on global gender-based violence prevention and response policy. UNFPA is the largest funding source for population and reproductive health, working closely with vulnerable groups like commercial sex workers and youth. Their priority areas include promoting safe motherhood, decreasing sexually transmitted infections and reducing violence against women. UNFPA also co-leads and coordinates inter-agency GBV protection-specific activities like food distribution, water, sanitation, security, shelter and healthcare in emergencies across. Currently, most of my work is heavily research focused and seeks to improve knowledge of GBV prevention strategies employed by protection actors in communities. Understanding local strategies and documenting outcomes will advance the struggle to assure women’s safety, physical and economic security globally.

Recently, I met Adele Kagarabi, provincial commissioner and advisor to the government’s South Kivu, Democratic Republic of the Congo. Her mission to Geneva was to commemorate both International Women’s Day and the 15th anniversary of the adoption of the Beijing Declaration and Platform for Action, but also bring greater awareness to the civilian cost of war.

“I come speaking with the voices of the women who are experiencing violence every day and if I listen now I can hear them scream, I can hear them in Kalemi, in Congolo, in Kabinda”, she said of the rape crisis in her country.

While my fellowship in Geneva initially concentrated on GBV, it has transformed into a tutorial on the legal definitions and international treaties that humanitarian’s have developed to secure the full respect of human rights. Given my exposure to humanitarian policy development, I have chosen to explore the links between violence, health and politics in this article. I will also try to provide insight into some of the humanitarian policy dilemmas befuddling practitioners and academics. Finally, I will argue that while aid groups can deploy quickly to deliver life-saving services, the international political and legal response must move more adroitly in settling conflicts. Otherwise the gains of health interventions an atmosphere of generalized violence can be lost.

Brutal Impact on Health
The impact of conflict on health status varies with the length and background of the conflict, the military technology employed and the prior health status of the population. Generally in settings with weak public sector services (i.e. health, legal, police) there can be severe consequences on the mental and physical health of the over-all community. These ramifications are particularly heightened for elderly, disabled and other traditionally marginalized groups like women and children.

During conflict public health implications are grave and over-whelming. Overt violence - such as sexually based crimes, gruesome murders and torture - can overshadow less sensational implications. Preventative medicine, such as immunization, antenatal care, or prescription drugs, becomes difficult to access in insecure situations. Infant mortality often rises in association with reduced access to health services and impairments of the water and sanitation infrastructures.

PRE-EXISTING HEALTH CONDITIONS MIGHT BE DRAMATICALLY EXACERBATED BY FOOD INSECURITY AND MALNUTRITION COUPLED WITH INFECTIOUS DISEASE. DESTRUCTION OF HEALTH CENTERS LEAVES COMMUNITIES WITH LITTLE OR NO ACCESS TO CARE; REmAINING HEALTH WORKERS MAY HAVE LIMITED TRAINING, REFERRAL AND SUPPLY SYSTEMS ARE DISRUPTED, AND TRANSPORTATION ROUTES ARE DESTROYED. THESE “INVISIBLE CASUALTIES OF WAR” CAN PERPETUATE OVER MANY YEARS AND DEEPEN STRUCTURAL INEQUALITIES.

Conflict, natural disasters and forced displacement dramatically expose women and girls to new vulnerabilities. Women’s bodies transform into battlegrounds as sexual violence is used as a tactic of war to humiliate, control and disrupt social ties. The resulting breakdown of social networks and formal institutions reduce important protection mechanisms for women and girls. The devastating impact of GBV includes painful physical and psychological repercussions including STIs, unwanted pregnancies, obstetric and traumatic fistula, social stigma and death. Widespread sexual violence is also endemic in many post-conflict situations, perpetuating a cycle of anxiety and fear that impedes transition into recovery.

The Challenges of Effective Humanitarianism
As the delivery of humanitarian aid in complex emergencies provides a growing number of challenges, one questions the future of current assistance paradigms. Positioning human rights in intrinsically vicious situations may seem ludicrous, especially in contexts controlled by unethical leaders. Insecurity limits operations in difficult environments like Somalia or Afghanistan where aid workers are routinely kidnapped or killed. As the humanitarian space to work becomes narrow, staff is can be reduced to collecting data on human rights abuses and choreographing the release of reports that denounce the alleged perpetrators.

Humanitarian aid is inadequately substituting for the gap of serious political mediation. The international system is increasingly (and uncomfortably) conscious of “subsidizing humanitarian operations as a way of filling the political and moral void”. In order for technical and durable solutions to work, we need peace. Material and medical assistance is limited in confronting the root sources of conflict. While such services are extremely necessary, they are constrained in preventing abuses and confronting immunities. Therefore the role of relief community risks being diminished to documenting the “well-fed dead” and “well-fed raped”.

VIOLENCE, HEALTH, AND POLITICS
The Challenges of Effective Humanitarianism

Humanitarian aid can never fill the gap of serious political mediation.
There cannot be a shift from relief to development without political peace and security.

"Medicine is a social science, and politics is nothing else but medicine on a large scale. Medicine, as a social science, as the science of human beings, has the obligation to point out problems and to attempt their theoretical solution: the politician, the practical anthropologist, must find the means for their actual solution." - Rudolf Virchow

Many humanitarian organizations aim to separate relief and politics. Perhaps the complex realities of prolonged conflict today necessitate dual humanitarian and political operations. In these complex emergencies, there cannot be a shift from relief to development without political peace and security. Humanitarian response is typically viewed as a compassionate reaction to need in need. Many relief agencies are founded on human empathy. However, avoiding the social and economic root causes of conflicts hinders the chance to develop strategies that can produce sustainable peace.

Moving forward

As members of a community who seek to heal we have an obligation to advocate for solutions that address the factors of increased suffering. Given how often human rights violations result in humanitarian situations that determine health we must support conflict-resolution. We must support ethical political leadership to build even strong institutions to establish or improve public sector programs.

The nebulosity but often invoked 'international community' will not catalyze the fundamental change needed. In order to achieve long-term human security, we must urge individual states and communities to engage in robust political interventions and peace-building. We need to demand more of our governments' international aid efforts by insisting they not only budget money for assistance and military deployments, but better utilize skilled political efforts to build consensus and compromise.

Even amidst the indignities of war crimes, societies reconstruct and strive to build an environment conducive to respect for humanity. Community involvement, however complicated with regards to ingrained gender norms, possess powerful potential in ending GBV. The humanitarian community is critical in restoring protective environments and health care. Even so culturally and politically astute mechanisms must be engaged in order to truly prevent horrors from being unleashed.

Fatima Hassan graduated in 2009 with degrees in Human Biology and African Studies. She was the 2008 recipient of the Americans for UNFPA's Student Award for the Health and Dignity of Women and traveled to Uganda and Rwanda, blogging about her trip on mariedaire.com. Even before that trip, Fatima served as research assistant with the Stanford University Eritrea Maternal Health Project and contributed to the group's fistula repair/prevention initiative in collaboration with the Eritrean Ministry of Health and the UNFPA; worked as the Sexual Assault Prevention Program Coordinator for the Stanford Women's Community Center; and served as the president of the Muslim Student Awareness Network. Currently based in Geneva, she hopes to pursue graduate studies linking health and human rights to better advocate for social justice and peace.

The interview felt like a prolonged battle; we had to defend our every assertion, from projected costs to transportation plans to our ability to find and work with a translator.
We believe that researchers, whether they are students or professionals, have an obligation to the communities with which they work to finish their research and give back in some way.

But then sometimes low expectations are a good thing, as finding out that UAR and the Beagle had decided to jointly fund us was undoubtedly the highlight of our junior years. From there, everything else related to the project felt like it would fall into place. We had already submitted an application for federal funding to work with human subjects through Stanford and knew how to do the same in Zambia.

Before we arrived, we found someone to translate our research questions into Tonga - the language spoken in Zambia. Although we had not found a translator while in Stanford, we believed we could use our own paper work until we could make up the difference, and do all of this gladly, as an expression of our deep gratitude and commitment. At the very least, reaching a community's level of understanding is vital to making an impact on their health, particularly when it comes to global health work.

Victoria Falls, the world-renowned waterfall and primary tourist attraction in Livingstone, Zambia.

W hat begins as an inspiring dream can fall by the wayside or crumble to dust when researchers arrive at their destination, even if they were sure that the project was feasible and worthwhile, and most students believe was feasible and worthwhile, and most students never fund a project that the professors or staff did not complete. These latter cases are tragic. Stanford does not have any options for graduating seniors however, does present an entirely new challenge. Finding funding to return to a project after graduating, however, does present an entirely new challenge. Stanford does not have any options for graduating seniors but others fall by the wayside or are started but never completed. These latter cases are tragic. Stanford would never fund a project that the professors or staff did not believe was feasible and worthwhile, and most students continue to care about their projects just as much if not more than when they began. Even more importantly, we believe that researchers, whether they are students or professionals, have an obligation to the communities with which they work to finish their research and give back in some way. Too many researchers enter a community, collect their data, and then publish a paper for the benefit of their own career without contemplating the vital role of the local community's permission and cooperation.

Published research can raise awareness of the people who were studied and the issues they face, while unfinished projects keep the researchers from engaging in this kind of reciprocal action.

In our case, we believe that we owe it to the communities with which we worked to finish our project, both as a means of giving thanks for their generosity and, we hope, of shedding light on areas in which HIV counseling may be improved in these communities.

Finding funding to return to a project after graduating,
by Ronny Hamed

... whereas on the other hand the law didn’t define a specific concept of nature or a standard to measure how the act is in conformity with or against nature or its laws; whereas if it were up to the Judge’s decision, we believe that man has not been able to understand all the aspects of the laws of nature and is still trying to explore nature and his own even; whereas based on the aforementioned, the concept of the ‘unnatural’ is related to society’s mindset, customs and its acceptability of new natural patterns which he’s not familiar with or that are not acceptable yet; whereas man is part of nature and one of its elements, and a cell within a cell in it, it cannot be said that any practice of his or any behavior of his is against nature even if it is a criminal act because it is the laws of nature. If it rained in summer, if a heat wave struck in winter, or if a tree bore fruit after its usual time, it is all in accordance with the system and laws of nature for it is nature itself...

LGBT Health in Lebanon:
The Pivotal Role of a Queer Rights NGO in Eliminating Discrimination in Courts and Clinics

On December 2nd, 2009, a municipal judge ruled against the use of Article 534 of the Lebanese Penal Code, which has historically criminalized lesbian, gay, bisexual, and transgender (LGBT) individuals. The clause, dating back to 1943, stipulates, “punishment of all sexual relations that are unnatural with imprisonment from one month to one year, and a fine ranging between LBP 200,000 and one million Lebanese pounds” (S134-S667). The landmark verdict, although not yet resulting in equal rights for LGBT individuals in Lebanon, may raise pressure on the Lebanese Government to repeal the Article from the judicial books. This move would ultimately pave the way for legal and social recognition of LGBT members, improving their daily life conditions including access to better healthcare.

Having grown up as a gay person in the Arab Israeli sector of Israel, a family of mixed American and Palestinian heritage, I have familiarity with Middle Eastern attitudes toward LGBT issues ranging from progressive to traditional along the ideological spectrum within both Arab and Jewish communities.

My interest in LGBT health in the Middle East had resurfaced when I volunteered in the West Bank, Palestine, for a United States-based international medical NGO known as Physicians for Peace. As a student, I was assigned to document surgical and neurological case studies and to interpret in Hebrew and Arabic for international healthcare volunteers. After completing medical training, and the more likely they will be to treat a queer patient.

I became especially intrigued by the health conditions associated with the Lebanese queer population when I learned about the US$ 534 ruling and of working with such a Lebanese NGO to develop need-based interventions such as HIV prevention campaigns, to improve community health, and to dispel stigma and discrimination against the LGBT population.13 Rabbi Mahery, the health project coordinator of Helem, explained that Helem’s services in legal support and psychosocial counseling, both group and individual-based, have given the organization more credibility in the eyes of the Lebanese society and the concerned ministries.

With greater demand for healthcare services, Helem developed programs in Volunteer Counseling and Testing (VCT) and outreach projects in collaboration with the National AIDS Program (NAP) and other governmental agencies. Helem was later able to provide VCT to the queer community as well as the rest of the population properly and anonymously with the support of the Ministry of Health and the NAP. According to Mahery, this program was made feasible through the help of a group of NGOs that had reached out to the queer community, mapped the region, and developed a structured referral system covering all the Lebanese territories.

In addition to this implemented model, other projects have sprung out of Helem’s grassroots work such as Think Positively programmes, the Sermon Muslim, and “activists from Helem who wanted an organization to focus on HIV+ gay/bisexual men/women, which would attract people who would feel comfortable as HIV+ in a homophobic mixed environment,” Kassab explains. Recently, Helem gained the support of Medico International and the WHO, launching a clinic that merges various healthcare services provided by part-time physicians and psychologists. Mahery emphasizes Helem’s attempt to overcome the social phobia within the community by collaborating with official partners and by opening up the clinic to the general population rather than having it labeled as the LGBT clinic.

In December 2009, Helem published a groundbreaking report called “Homosexual Relations on Penal Codes: General Study on Laws in Arab Countries with Reports in Lebanon and Tunisia.” The report addressed the legal, economic, cultural, and medical conditions the queer community faces as a marginalized group in Arab countries. Helem also released a publication titled “Only 534” to analyze Article 534 more thoroughly, drawing...

On the other hand, the Lebanese Ministry of Public Health has in fact shown interest in Helem, acknowledging that the NGO to develop need-based interventions such as HIV prevention campaigns, to improve community health, and to dispel stigma and discrimination against the LGBT population. Helem’s services in legal support and psychosocial counseling, both group and individual-based, have given the organization more credibility in the eyes of the Lebanese society and the concerned ministries.

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attention to its violation of several United Nations and international conventions.

In the same month, the historic judicial ruling against the clause was announced. While the ruling does not automatically overturn Article 534, Makarem believes that the verdict “gives us an example to use with other judges and lawyers,” possibly leading to its amendment or turning it into an artifact or “defining” it as not to include consensual homosexuality. At a 2009 discussion organized by Helem, Nizar Saghieh, one of the chief human rights attorneys condemning the clause, explained that in practice the clause is rarely applied, but its legal ramifications should be heeded nevertheless as it still poses an obstacle for the pursuit of queer rights in Lebanon. Any initiative, such as a legal publication or a medical conference, is therefore worthwhile in order to be used during a court case against the clause.46

With the gradual rise of this civil rights momentum, Helem released an additional report covering two studies: “In Rights of Gays and Lesbians to Universities” and “Homophobia in Clinical Services in Lebanon: A Physician Survey”.47 The latter study sought to assess attitudes of healthcare providers regarding patients of different sexual orientations. Helem concluded that 60% of surveyed physicians view homosexuality as a disease that requires medical assistance (despite its removal from the Diagnostic and Statistical Manual (DSM) of Mental Disorders in 1973). 50% of physicians would not attend to homosexuals.

However, physicians who are aware of a queer relative or friend (only 29%), most of whom are urban, are more likely to perceive homosexuality as an acceptable behavior or natural orientation and are more willing to provide medical care to LGBT patients.

Alarmingly, approximately 93% of physicians have not received training concerning the queer community (64% are willing to obtain it). According to Makarem, Helem is attempting to address this training gap by working directly with public health and medical departments in universities, starting with the American University of Beirut, and by providing educational materials for students in health-related professions.

It is likely that the more personally familiar medical providers are with the queer community, the more tolerant they will be of obtaining LGBT medical training, and the more likely they will be to treat a queer patient. Once the legality of homosexuality is resolved in Lebanon, other issues can then be carefully addressed such as medical care, transgender-specific stigma within and outside the queer community, and anti-discrimination laws in employment and education. And while adoption by same-sex couples is not within the scope of discussion in the current climate given society’s expectations of the image of a family unit in the Arab World, perhaps someday domestic partnership or civil marriage could be discussed as a reality (probably not until the distant future).

This pattern will become substantially more feasible once cultural norms and political conditions allow LGBT members to gain formal recognition and live openly and safely as equal citizens within Lebanese society. ■

References:


Ronny Hamed is a senior majoring in Biology and minoring in Anthropological Sciences. His professional interests include international human rights law, health policy, and LGBT advocacy. Ronny has participated in international service and academic programs with hospitals in the West Bank, Palestine, a clinic in San Pedro Sula, Honduras, and an indigenous community in Western Australia. He is also involved in the United Nations Association Film Festival. Ronny enjoys learning American Sign Language, cooking at his co-op, and hiking in different ecosystems, preferably temperate rainforests.
Reducing malaria is one step forward in the larger picture of ending Africa’s devastating state of poverty.

In September 2009, I won the “World Briefing: Telling the Malaria Story” national essay contest hosted by the NGO Malaria No More (MNM) and the company Novartis Pharmaceuticals. On November 1st, I arrived at the humid Nairobi airport in Kenya to claim my prize: attending the 2009 Multilateral Initiative Against Malaria Pan-African Conference (MIM), the largest international conference to convene global players in the effort to eradicate malaria. MIM showcases the latest advancements in malaria treatment and prevention, providing an international forum for experts from all fields to collaborate. Not only were prestigious scientists and politicians of MNM’s Policy Center who has helped craft U.S. policies surrounding foreign aid in women’s rights, AIDS, tuberculosis, and malaria. Ambassador Green highlighted the fact that while malaria is highly treatable and preventable, we still lack the political will to finish the job. Applying our tools to reduce malaria requires extended attention from the public and policymakers. According to Ambassador Green, many people would conclude from Zambia’s 1% malaria rate that malaria is not a problem anymore. But when this attitude emerges, malaria comes roaring back. As Mr. Green put it, “mosquitoes don’t respect national borders.” Malaria eradication is an all-or-nothing battle requiring sustainable commitment, and this presents a definite challenge to an apathetic public constantly bombarded by pleas to support new causes. One way to maintain this dedication is by demonstrating that problems like malaria are not isolated but rather are linked to many other global issues.

No Disease is an Island: AIDS/HIV and Malaria
Dr. Nathan Muleure, head of Novartis’s African Operations, divulged advocacy strategies addressing the sustainability issue during his interview. When Dr. Muleure was in medical school in Nairobi, he was taught that malaria could not be eradicated. Dr. Muleure has helped shift this fatalistic attitude by leading continent-wide meetings with African healthcare workers and leaders to share better techniques for expanding anti-malarial access in their respective communities. Dr. Muleure has wedded his interests in medicine and policy to develop a holistic approach to malaria that combines medicine with sociology and economics.

I came to Nairobi aware that prioritizing funding and attention in global health initiatives is extremely challenging. When I asked Dr. Muleure how he would present malaria to college audiences to communicate its urgency without detracting from other causes, he demonstrated that these different illnesses and poverty are interconnected. Dr. Muleure previously worked on HIV/AIDS. He noted that malaria is a major killer of African AIDS patients. Additionally, malaria is a leading cause of African poverty, costing Sub-Saharan African $12 billion a year from malaria prevention, treatment, and economic losses. Abating malaria would not only eliminate a major threat to AIDS patients, but it would also free up an annual $12 billion to devote to other epidemics. Reducing malaria is one step forward in the larger picture of ending Africa’s devastating state of poverty.

Creating Community Through Self-Sufficiency
At Mwea Mission Hospital, a health center north of Nairobi, I learned for the first time about the role of African communities in halting malaria. We traveled past rice paddies and dilapidated buildings to meet Dr. John, director of the Vector Control Center at Mwea. Dr. John told us they had reduced malaria occurrences to almost 0% in the surrounding area through a combination of prevention and treatment measures. They led campaigns with popular community figures to encourage families to sleep under pesticide-treated beds and ensured that powerful antimalarial treatments were readily available. Mwea successfully encouraged compliance in culturally sensitive, sustainable ways that actively involved community members. Mwea’s slogan: “mosquito out, we are under the net together.”

Credit: Jessica Uno

By Jessica Uno

Mosquito Out, We Are Under the Net Together
integrating approaches to eradicate malaria in sub-saharan africa

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Credit: Jessica Uno

By Jessica Uno
Novartis does more than distribute ACTs; they are highly active in malaria prevention and promoting responsible business practices that give back to the global community.

Mr. Gabriel applies his views of corporate-social responsibility to malaria initiatives. According to Mr. Gabriel, anyone can give money to the malaria cause, but pharmaceutical companies like Novartis must provide the expertise and education to give healthcare access to the impoverished patients who need it most. It is the job of these companies to ensure that we are using funds as efficiently as possible to affect the most change. Mr. Gabriel pointed out that companies can maintain a sustainable impact by raising awareness about their efforts among other companies and setting an example. Novartis aims to make nonprofit, community-focused work a routine part of corporate activities.

Promoting integrative work paves the way for powerful partnerships, such as that between Novartis and Malaria No More.

When asked about what motivated him to push forward when the odds seemed against him and the thousands of Africans affected by malaria, Mr. Gabriel offered encouraging advice about being realistic yet optimistic. First, we must think of the patients and their needs, focusing on the solution rather than the problem. Mr. Gabriel refuses to become overly discouraged, instead devoting his energy to increasing access to antimalarial treatments and prevention strategies. “Think how many lives we can save, not how many people are dying,” concluded Mr. Gabriel.

... communities use malaria to create opportunities for growth, unity, and action independent of foreign aid.

Corporate-Social Responsibility: The Novartis Case

Executive Vice President of Novartis Malaria Initiatives, Silvio Gabriel, has been instrumental in Novartis’s role in fighting malaria and sustaining far-reaching nonprofit efforts from a for-profit company. Since 2001, Novartis has delivered over 300 million treatments of highly effective artemisinin-based combination therapy (ACT) without profit to malaria endemic countries. However, healthcare access. By empowering the community, promoting corporate-social responsibility, demanding public accountability, and demonstrating that a victory for one cause is a victory for all, the conference has shown me the limitless possibilities not only for eradicating malaria, but for striking at the roots of poverty itself.

Stanford students are constantly planning to make the world a better place. I now believe that those ambitions won’t fade in the working world. I met scientists, healthcare professionals, entrepreneurs, policy makers, journalists, and others who have built impressive careers dedicated to ending malaria. Improving the world is not an elusive ideal, but a thriving operation that calls for people from all walks of life. The requirement is determination.

This article is dedicated to Roanak Desai, a student in the Stanford Graduate School of Business who passed away on April 3rd, 2010, from complications due to malaria. He reminds us that malaria can affect everyone. Look out for the upcoming World Cup in South Africa where soccer players and their fans rally around the malaria cause. 

Jessica "Juno" Uno hails from the San Francisco Bay Area and is a junior majoring in Human Biology with a concentration in Global and Community Health. She is especially interested in neglected infectious diseases and has researched tropical parasites such as malaria for the past four years at UC San Francisco. She loves Spanish, Latin American studies, Taiko drumming, Chinese martial arts, salsa dancing, and getting boba with her sorority sisters. She is currently studying abroad in Madrid, Spain.
CLIMATE CHANGE AND GLOBAL HEALTH

by Gautam Sharma

While we may still debate about climate change and its connection to activities driven by man, much less debatable is the connection between climate change and the future risk to global health. Climate change is happening and it has already introduced a host of emerging infectious diseases into previously unaffected territories. Most scientists agree that there is an identifiable upward trend in global temperature in the last fifty years, a trend that has most likely been a result of human activities,1 (Fig 1.2) This trend causes disruptions in the hydrologic cycle resulting in different weather patterns in different geographic ranges. In the future, along with these environmental changes, demographic factors specific to each region will also play a role in undermining health infrastructures, resulting in death and disease, and susceptibility to infections will be enhanced by malnutrition, stress, and ultra-violet radiation. Climate change-induced human health risks are important to consider when discussing global health and call for well-coordinated and effective responses.

Climate change-induced human health risks are important to consider when discussing global health and call for well-coordinated and effective responses.

A controversial but, scientifically sound report presented in 2007 by the IPCC (International Panel on Climate Change) supports the fact that the activities of mankind are affecting the global climate. There has been an increase in the surface temperature of about 0.6 degree Celsius since the Industrial Revolution and most of this increase has been in the last fifty years. It is anticipated that the global temperature will increase by 2 degrees Celsius by the year 2100. Interestingly, this increase in Earth’s atmospheric temperature is paralleled by the increase in greenhouse gases which in turn has resulted from burning fossil fuels, deforestation, irrigated agriculture and oil extraction. By the most conservative estimates, if we take the 2 degree raise in temperature as a consensus number, there is the potential for a 10% increased risk of waterborne diseases and 3-5% increased risk for malaria on a global level.

The majority of the infections fall into two categories, vector borne and water borne, which are both affected by global warming. Malaria, one of the most deadly vector borne diseases, is also highly sensitive to climate change. There has been an increase in the malarial incidence rate as a result of warming trends because high temperatures speed up the maturation process in the mosquito. At 16 degrees Celsius, development of malarial larvae may take 45 days, while at 30 degrees Celsius this development may take only 10 days. In addition, at higher temperatures, the Extrinsic Incubation period, defined as the time between entrance of an organism into the vector/host and the time when that host can transmit the disease, shortens and the mosquito begins infecting sooner.2 (Fig. 2) Malaria has already entered the highland regions of East Africa because of the now warmer temperatures in this previously colder area.

In addition, population migration, deforestation, and floods caused by excessive rain also compound the epidemic of malaria. As has been well-studied on the South Asian continent, the stagnant water caused by floods and monsoons becomes an ideal breeding ground for malaria’s mosquito vectors.

Dengue is another emerging vector-borne disease caused by climate change in tropical and sub-tropical regions. Dengue is prevalent in urban settings and is transmitted by Aedes Aegypti, the day-biting mosquito strain that transmits the virus. There is a strong connection between rainfall and increased transmission of dengue fever, especially during floods caused by El Niño. El Niño is a pacific weather phenomenon that consists of periods of strong and warm water currents followed by air pressure in the east and the west pacific regions called southern oscillations. These currents bring heavy rains and droughts. Dengue thrives shortly after these rains in warmer and wetter regions of the world. Plastic containers, used tires, cans and flower pots can become active breeding sites for the mosquitoes.

Heavy rainfall, storms and flooding all lead to contaminated water supplies that can also result in outbreaks of water-borne diseases like cholera, Hepatitis A, E. coli, Giardia, and the Shigella infection. Human exposure to these infections occurs by contact with dirty drinking water, recreational water, or food that is contaminated; unpredictable weather often results in the improper disposal of human excreta.3 (Table 6.1)

Population displacement further increases the risk of communicable diseases. Extreme weather such as drought, floods, and storms force local populations to migrate, further interrupting the local supply chains and straining medical resources. These weather patterns affect mostly the poorest of the poor in developing countries. Those who can migrate to urban areas form their own shantytowns or slums, and these living conditions often become breeding grounds for these communicable diseases. Many of these urban cities are also on coastal areas and thus susceptible to damage from the rising sea level as well as inundation of salt water. Changes caused by population displacement may further damage an already fragile health infrastructure.

Malnutrition is yet another burden of climate change. Most victims of climate change are already poor, hungry, and live on very limited resources. Although climate change may

Raising awareness of global warming, starting from our homes and communities, can help mitigate the effect of climate change. Simply being poor is the single greatest source of vulnerability to climate change and the poorest members of our global society will bear the brunt.
Gautam Sharma is a sophomore who is majoring in Psychology. He plans to attend medical school in the future and finds global health to be one of his passions. On the side, he enjoys filmmaking, music production and sports.

increase productivity in some temperate climates, the warming of even one degree in other regions – most of them already impoverished - may reduce the yield of grain crops. Further, the grains that are produced in these crops are often of poor quality and nutrition. This change puts migrant populations in particular at high risk for infections because their immune systems become compromised. In this sense, climate change has the potential to exacerbate global health concerns related to the malnutrition that seen in many countries.

Interestingly, all these events tend to act synergistically and reinforce each other. Climate change leads to displacement and migration of populations, along with compromised hygiene and nutrition, and these patterns ultimately make populations more vulnerable to outbreaks of infectious diseases. Despite the seemingly overwhelming challenge that climate change presents, many of the worst-case projections may be preventable.

References:

i. WHO IPCC WGII Chapter 8: Climate and Human Health Impacts (2007).


v. Shuman, Emily, NEJM, Global Climate Change and Infectious Diseases, March 25th, 2010.

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Travel Abroad Information

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<tr>
<th>Student</th>
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<tr>
<td>Alex Greer and Cooper Lloyd</td>
<td>Zambia</td>
<td>Independent Research Study</td>
<td>Department of Anthropology, Stanford University</td>
<td>UAR Major Grant and Beagle II Award</td>
<td>Beagle II Awards support voyages of scientific discovery, modeled after Darwin’s Voyage of the Beagle. Major grants are awarded through the Office of Undergraduate Academic Life. A return trip to Zambia in 2010 will be funded by a local Zambian NGO.</td>
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<tr>
<td>Fatima Hassan</td>
<td>Geneva, Switzerland (United Nations)</td>
<td>International Public Service Post-Graduate Fellowship</td>
<td>Jon McConnell, Haas Center, Stanford University</td>
<td>Fully funded post-graduate fellowship</td>
<td>Special assistant with the UN protection cluster and GBV AoR.</td>
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<tr>
<td>Anne Stake</td>
<td>Rwanda</td>
<td>FACE AIDS Leadership Program</td>
<td><a href="mailto:Romy@faceaids.org">Romy@faceaids.org</a> (Managing Director)</td>
<td>Self-funding</td>
<td>FACE AIDS is always looking for students who are passionate about HIV/AIDS, global health equity or social justice. Applications to join the Director Corps Teams and opportunities to get involved with the Stanford FACE AIDS Chapter will be available in the fall.</td>
</tr>
<tr>
<td>Jessica Uno</td>
<td>Kenya</td>
<td>Contest organized to promote awareness of the malaria cause through electronic and social media and reach out to younger college-age audiences</td>
<td>Malarianomore.org</td>
<td>All expenses were paid for by Malaria No More and Novartis Pharmaceuticals</td>
<td>Entered a 500-word essay about why malaria matters to the rest of the world to Malaria No More’s and Novartis Pharmaceutical’s “World Briefing: Telling the Malaria Story” national collegiate essay contest. Won the contest and earned a free 3-day trip to Nairobi, Kenya to attend and report on the 2009 MIM Pan-African Malaria Conference.</td>
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