Letter from the Editors
by Joyce Ho and Stacie Nishimoto

The Birth of a New Profession: Transforming Paramedic Education in India
by Ankur Gupta, Aditya Mantha, and Joyce Ho (India)

Wising Up On Children’s Healthcare Policy in the United States: Interview with Dr. Paul Wise
by Shelly Amieva (USA)

The Foul Problem with Global Health
by Jessie Liu (Tanzania)

Breaking the Silence: Femicide in the Congo
by Catherine Le (Democratic Republic of the Congo)

Evaluating the Implementation of a Gender-Based Approach to STI Treatment and HIV Testing in Khayelitsha
by Rebecca A Briggs, Margaret S Chen, William J Hindle-Katel and Travis-Riley K Korenaga (South Africa)

A Visit to Candyland: Reflections on Gawad Kalinga Villages
by Victor Cruz (Philippines)

Global Health Challenges and U.S. Policy
by Gautam Sharma (USA)

Travel Abroad Information

Contents:
LETTER FROM THE EDITORS

We are very excited to present Volume II of Stanford Service in Global Health (SSGH) Journal. In this issue, we’ve diversified and expanded content to include articles by undergraduates who have not necessarily gone on global service trips. In addition to reflection pieces based in India and the Philippines, we are proud to present editorials on current global health issues such as the rape crisis in the Democratic Republic of Congo, an interview addressing US global health policies with Dr. Paul Wise, and a student research project on gender-based approaches to HIV treatment in South Africa. The pieces in Volume II are meant to serve as springboards for further discussion and critical thinking about global health issues, and we hope they will inspire more Stanford students to take up these complex problems.

We both have had an amazing experience bringing the journal from its inception to what it is today, and would like to thank the Program in Human Biology, the Bingham Fund for Student Innovation, and our devoted SSGH staff for making it all possible. With such a strong group of individuals supporting SSGH, we know that the journal will continue to develop in the years ahead under new leadership.

We would also like to thank you, reader, for taking the time to read Volume II. We hope you enjoy reading it as much as we have enjoyed putting it together. Cheers to a new issue, new perspectives, and a summer full of possibility!

Stacie K. Nishimoto
Class of ’09

Joyce Ho
Class of ’09
The Birth of a New Profession:
Transforming Paramedic Education in India

by Ankur Gupta, Aditya Mantha, and Joyce Ho

INTRODUCTION
With 120 empty, puzzled faces looking back at me, I cautiously moved on to the next part of the day's lesson plan. "Alright, class. Now let's discuss your research project. Has anyone completed a research project before?" I asked, expecting to see some positive signs of acknowledgment. But all I received were more confused looks.

There we stood, at the point of a cultural crossing in front of a crowd of eager students whom we had met only a week before. We were a group of nine Stanford undergraduate students stationed at the Emergency Management Research Institute (EMRI) in Hyderabad, India, an institute whose mission was to save one million lives by 2010 through a restructuring of India's emergency medicine system.

The students at EMRI had completed the Indian equivalent of an undergraduate degree and were presently enrolled in a 2-year graduate training program at EMRI to learn the vocational skills necessary to become paramedics. As part of a collaborative initiative, the Stanford School of Medicine, led by Dr. S.V. Mahadevan, had partnered with EMRI to develop its paramedic training curriculum. And now, we had the remarkable opportunity to develop and teach an integral part of it.

PHASE I: HOW CAN WE HELP?
By Ankur Gupta

Our International health project required the collaboration of many individuals during the several distinct phases of its evolution. It began in March of 2007 with three students who had all chanced upon the same press release in the San Jose Mercury News: "Stanford Pumps Life into Effort to Build India's Emergency Medical System." The title not only commanded our attention, but also suggested that paramedics needed help adjusting to the English course format that the Stanford physicians were teaching. They also emphasized the gap in soft-skills training, namely presentation and public speaking skills, which are important for the professional development of EMTs. Bottom line: very few people are comfortable entrusting care to EMTs and the scope of their purely medical training sorely lacked a leadership component, which we bundled with coursework in Medical English and Public Speaking.

Finally, in February 2008, our call to action had a distinct and clear tone in the training of functional EMTs. It was now our challenge to help the Stanford faculty to enable India's future paramedics to become better leaders on their medic teams and in society as champions of the paradigm shift in Indian pre-hospital care.

PHASE II: HOW DO WE DESIGN A LEADERSHIP PROGRAM?
By Aditya Mantha

Physicians from Stanford invited our team of American students to design a two week orientation course that could be integrated into a broader paramedic training program, and we were excited to begin designing the two week orientation curriculum. If the curriculum was designed well, we would be permitted to conduct two pilot programs at EMRI during the Summer 2008.

The central question, however, was why American college students should design and teach a leadership, study skills, and Medical English curriculum for Indian paramedics? The situation was challenging because American college students were teaching advanced topics like leadership to their peers. Though our students are...
capable of discussing academic success and expectations of an American classroom, it was difficult to claim that we have expertise in leadership.

We began by asking Masters’ students from the School of Education to investigate these questions in their curriculum design class. Based on the input from the physicians, we identified four objectives for our curriculum: 1) recognizing, valuing and projecting leadership, 2) practicing effective teamwork and adaptability to changing environments, 3) understanding and applying active learning techniques, and 4) creating communities. Our program did not intend to impart leadership in two weeks, but instead frame the issues that are most relevant when considering the professional practice of pre-hospital care.

Leadership and its professional instruction is inherently risky. An effective program demands trust and promises effectiveness. Our program emphasized activities rather than traditional lectures. The focus of our course would be to introduce and interrogate ideas about leadership while also cultivating certain soft-skills such as public speaking, presentation, team-building.

Stanford students going to India adapted the core curriculum built by the Masters’ students. They included components on medical ethics, study skills, teamwork and presentation skills. The curriculum relied heavily on group activities that explored these issues of teamwork, leadership, and communication skills. Activities were designed from popular leadership books and team-building manuals and included role-playing, orientation activities, and discussions.

The highlights of our program were a speaker series and group presentations. For the special speaker series, EMRI invited community leaders to address the paramedics. Many of these leaders, including ex-President of India Dr. A.P.J. Abdul Kalam, had launched large-scale social and political campaigns. These speakers gave our curriculum an authority. Paramedic trainees also worked in groups to develop a powerpoint presentation on a medical issue relevant to India. Many were excited because this was their first opportunity to present to several hundred people.

Stanford physicians from the Division of Emergency Medicine took time to personally meet and review the curriculum. They even critiqued the lecture materials constructed by students. Our success was measured by student responses on qualitative and quantitative surveys. Students described the value of the curriculum and expressed the need for it several times within the curriculum.

There was a clear sense that we had identified a valuable need and provided a potential solution. With this step in the right direction, we are excited about this year. The ProjectMercury 2009 Field Team will complete the third and final pilot program before passing the curriculum materials on to the Indian trainees permanently.

The development of the curriculum was an incredible learning experience. We had the opportunity to learn from international physicians at Stanford whose wealth of knowledge and experience was invaluable. Under their advice, we were constantly pushed to identify and develop valuable components for a training program that hopefully be sustained by other instructors or better yet, by students at EMRI. As we designed this curriculum, we learned that finding a focused, manageable goal and a direction was necessary for the curriculum its authority. Paramedic trainees were given the benefits of experts and real world experiences.

Now that we were prepared with our materials, the question remained how would it play out. PHASE III: WHAT HAPPENED IN THE FIELD? By Joyce Ho

The first day I walked into the EMRI classroom my heart was pounding heavily as I wondered how I was going to teach and establish rapport with over a hundred students from across the globe. I was no medical student or physician, and I was the same age, if not younger, than most of the paramedic trainees. Over the course of the curriculum, however, I realized that I had knowledge and experiences I could share with them by virtue of my upbringing in an American education system. The students were so excited to interact with individuals from cultures other than their own, and the fact that we were their peers in age made for a very unique opportunity: learning became a flexible, two-way interchange of knowledge that spanned all topics from emergency medicine in the States to the latest dance moves in Bollywood.

From the very beginning of the curriculum, we explained to the students that we, the Stanford instructor figures for this leadership module, were “facilitators.” We are different from teachers in the sense that our goal was to guide physicians to think critically and reach their own conclusions about the topics we introduced to them, rather than simply telling them concepts to memorize. The students themselves were responsible for most of the final lessons they took away from the overall curriculum; in this way, each student personalized the lessons to best serve their individual needs.

Another reason for distinguishing between “facilitators” and “teachers” was to break down the formal barrier usually dividing students and their instructors. We wanted to make sure that the paramedic trainees would feel comfortable asking us questions or even challenging what we were presenting, actions seldom emphasized in Indian education systems due to the intimidating seniority of instructors. After an initial period of getting accustomed to us, the paramedic trainees soon grew to appreciate our role as knowledge facilitators rather than the final authority on the module’s contents.

The theme of encouraging personalized learning also shaped the three main activities that the facilitators performed: lecturing to the large group, moderating small group discussion, and acting as a reference for the paramedic project. My personal favorite was the small group time, which functioned much like section for classes here at Stanford. The small group activities, ranging from ethical debates to role playing, were essential to helping the students step outside of their comfort zones. I will never forget the first time one of my students was able to finish an impromptu speech without freezing up and going back to his seat halfway. The smile spreading across his face as he basked in his classmates’ applause showed me that he was well on his way to conquering his fear of public speaking, something he profusely thanked me for after the curriculum was over.

The smile spreading across his face as he basked in his classmates’ applause showed me that he was well on his way to conquering his fear of public speaking.

One of the most important parts of the curriculum was the Strategic Research Project. The paramedic trainees had never attempted a research project of this magnitude, so learning to do research, working in teams, and designing a research poster and Powerpoint presentations were all new tasks. Delivering the final presentation in front of all their faculty and peers was the ultimate test for the students, and though many were literally shaking with stage fright, all of the students managed to present their parts and field questions about their topics.

The facilitator role was crucial for a number of reasons. First, the facilitators acted as a bridge between the students and the instructors. By virtue of my upbringing in an American education system, it was easier for me to bridge the gap between students and instructors. Second, the facilitators were experts in the assigned topics.

The smile spreading across his face as he basked in his classmates’ applause showed me that he was well on his way to conquering his fear of public speaking.

One of the most important parts of the curriculum was the Strategic Research Project. The paramedic trainees had never attempted a research project of this magnitude, so learning to do research, working in teams, and designing a research poster and Powerpoint presentations were all new tasks. Delivering the final presentation in front of all their faculty and peers was the ultimate test for the students, and though many were literally shaking with stage fright, all of the students managed to present their parts and field questions about their topics. Since only one or two of the facilitators were experts in the assigned topics, the facilitators were crucial for a number of reasons. First, the facilitators acted as a bridge between the students and the instructors. By virtue of my upbringing in an American education system, it was easier for me to bridge the gap between students and instructors. Second, the facilitators were experts in the assigned topics.

The smile spreading across his face as he basked in his classmates’ applause showed me that he was well on his way to conquering his fear of public speaking.

One of the most important parts of the curriculum was the Strategic Research Project. The paramedic trainees had never attempted a research project of this magnitude, so learning to do research, working in teams, and designing a research poster and Powerpoint presentations were all new tasks. Delivering the final presentation in front of all their faculty and peers was the ultimate test for the students, and though many were literally shaking with stage fright, all of the students managed to present their parts and field questions about their topics. Since only one or two of the facilitators were experts in the assigned topics, the facilitators were crucial for a number of reasons. First, the facilitators acted as a bridge between the students and the instructors. By virtue of my upbringing in an American education system, it was easier for me to bridge the gap between students and instructors. Second, the facilitators were experts in the assigned topics.

The smile spreading across his face as he basked in his classmates’ applause showed me that he was well on his way to conquering his fear of public speaking.

One of the most important parts of the curriculum was the Strategic Research Project. The paramedic trainees had never attempted a research project of this magnitude, so learning to do research, working in teams, and designing a research poster and Powerpoint presentations were all new tasks. Delivering the final presentation in front of all their faculty and peers was the ultimate test for the students, and though many were literally shaking with stage fright, all of the students managed to present their parts and field questions about their topics. Since only one or two of the facilitators were experts in the assigned topics, the facilitators were crucial for a number of reasons. First, the facilitators acted as a bridge between the students and the instructors. By virtue of my upbringing in an American education system, it was easier for me to bridge the gap between students and instructors. Second, the facilitators were experts in the assigned topics.

The smile spreading across his face as he basked in his classmates’ applause showed me that he was well on his way to conquering his fear of public speaking.

One of the most important parts of the curriculum was the Strategic Research Project. The paramedic trainees had never attempted a research project of this magnitude, so learning to do research, working in teams, and designing a research poster and Powerpoint presentations were all new tasks. Delivering the final presentation in front of all their faculty and peers was the ultimate test for the students, and though many were literally shaking with stage fright, all of the students managed to present their parts and field questions about their topics. Since only one or two of the facilitators were experts in the assigned topics, the facilitators were crucial for a number of reasons. First, the facilitators acted as a bridge between the students and the instructors. By virtue of my upbringing in an American education system, it was easier for me to bridge the gap between students and instructors. Second, the facilitators were experts in the assigned topics.
panicking and yelling hysterically, and people were pushing and shoving around the patient. The paramedics had to immediately take control of the situation: one managing crowd control and the others setting up the stretcher and transporting the patient onto the ambulance. Watching the paramedics in action, I realized just how important it is for members of this profession to have strong leadership skills and the ability to think on one’s feet, developed from years of experience on the job.

The paramedics also shared some difficulties they encountered on the job. Clearing the streets for an ambulance with the sirens on was not an obvious reflex for society, but with the birth of EMRI and its partnership with the Indian government, the profession is steadily gaining more respect and authority. In addition, the lack of properly trained paramedics puts an extra strain on the workload of the ones that have gone through schooling. After going through our curriculum, the paramedic students will enter the job force having had leadership development, thus sidestepping months of additional training time before feeling confident in their abilities to perform the duties required of the profession.

In just two short weeks my students transformed from shy individuals reluctant even to ask questions into confident leaders who were able to quickly command the attention of the room. The change was evident in the body language, eye contact, and even tone of the students’ voices. All the trainees told us afterwards that they really enjoyed our leadership module in which they learned skills they had never realized were important to develop before. Most surprising to me was our ability to indirectly affect change in the healthcare setting through education. Though we did not teach intubation or CPR techniques, we developed the students’ confidence, which in many ways is just as important as the technical skills.

Once the leadership module is approved for permanent inclusion into the paramedic trainee curriculum, a new class of paramedics will be created that will be able to revolutionize the emergency medicine system in India. I speak for all of us when I say that I feel honored to have contributed my skills and experiences to such a grand movement.

Ankur Gupta, class of 2008, is a coterm student in the School of Medicine next fall. He spent most of his time in Dr. Michael Longaker’s bone tissue engineering lab and interviewing. Planning a career in medicine, Ankita hopes to contribute to innovations in global health care, particularly in international emergency medicine.

Aditya Mantha is a third year Medical Anthropology student who enjoys dancing, knitting, cooking, and interviewing. Planning a career in medicine, Aditya hopes to contribute to innovations in global health care, particularly in international emergency medicine.

Joyce Ho, a senior majoring in Human Biology, has developed an interest in global health through service experiences in Ghana and India. She is the founder and Co-Editor-in-Chief of Stanford Service in Global Health Journal and is very excited to see the development of the publication in the future. She plans to attend Vanderbilt School of Medicine next fall.

According to “The Status of America’s Children 2008” report issued by the Children’s Defense Fund (CDF), America ranks first in gross domestic product (GDP) as well as first in health expenditures, yet it ranks 22nd in low birthweight rates and 25th in infant mortality rates among the 36 industrialized countries recognized by the United Nations. Why is the world’s richest country delivering such poor child health outcomes? More importantly, is this a reflection of greater and deeper problems within our healthcare system?

Statistics become more dismal when you look at health outcomes in terms of race/ethnicity and socioeconomic status. For instance, the CDF reports that African-American children in the United States are more likely to die from complications of pregnancy or childbirth than women in Uzbekistan. Additionally, one in five Hispanic children, as opposed to one in thirteen White, non-Hispanic children, are uninsured. While Medicaid and the State Children’s Health Insurance Program (SCHIP) are government programs that provide healthcare benefits to the nation’s poorest children, unfortunately, because of limited national government funding and stringent eligibility requirements, about 9 million children in the U.S. are still uninsured.

In 2007, the previous Bush administration posed yet another political hurdle for children’s healthcare when it vetoed a $35 billion extension of SCHIP. Fortunately, the Obama Administration seems to bode well for children’s health issues. On February 4, 2009 President Obama signed the Children’s Health Insurance Program Reauthorization Act (CHIPRA), which is expected to provide health insurance to an additional 4 million children by 2013. What is the overall significance of CHIPRA and how does it fit into the larger picture of the American healthcare revolution? Dr. Paul Wise, a Richard E. Behrman Professor of Child Health and Society at Stanford and a core faculty member at the Center for Health Policy/Center for Primary Care and Outcomes, was interviewed to help put CHIPRA into perspective and to analyze the current situation of children’s healthcare in the U.S. His research covers a broad spectrum of health issues, including children’s health, health-outcomes disparities by race; ethnicity and socioeconomic status; and the interaction of genetics and the environment, as these factors influence child and maternal health.

Question 1
On February 04, 2009 CHIP was renewed with some changes (e.g. “Express Lane”), an initiative to enroll the lowest-income uninsured children; a state option to cover legal immigrant children and pregnant women; a state option to cover pregnant women; and elimination of adult coverage). What do you believe are the most important changes and what are their implications?

Paul: Legal immigrants are definitely a plus, I’m disappointed that non-pregnant women will not be covered. I’ve written about this a lot - if all you are trying to do is to provide services to women once they are pregnant, that’s fine. But you’re not going to prevent a lot of the bad outcomes of pregnancy, which tend to happen very early. And it’s very difficult – it’s impossible – to address women’s needs if all you do is wait until they become pregnant. We’re committed to providing enhanced services to them the moment they conceive and we throw them out of the program the moment they deliver. That’s not a very effective way of delivering services. It’s also completely unjust. I’m not happy that women are still getting terribly fragmented coverage either through SCHIP or something more fundamental.
United States of America

Question 2:
Medicaid covers almost 68 million children, parents, pregnant women, seniors, and people who are already qualified. And there are several “eligibility gaps” for Medicaid, as well as a lack of uniformity in SCHIP. Therefore, should we use Medicaid as the foundation for this healthcare revolution or should a completely new program be created?

Paul:
There are many problems with Medicaid, but starting from scratch scares me because of the extremely pathetic, weak voice child interests have in the political arena. Starting from scratch means basically standing naked in a windstorm of policy deliberations, and that gets me very nervous. I’m happy to scrap Medicaid and start with something new, but I don’t see any political signs that indicate that anything wonderful would be developed. So I’m very conservative when it comes to Medicaid because it is an entitlement program and SCHIP is not. That means that any kid who is eligible for Medicaid gets Medicaid. With SCHIP, any kid who is eligible gets SCHIP until the end of the 6th grade. Those kids get on the waiting list. You can’t be put on a waiting list for Medicaid. That’s crucial, particularly in a time when more and more poor kids are going to need insurance. So that’s something that I want to really protect in children’s health insurance. The likelihood that Congress is going to create a new entitlement program right now is close to zero. By scrapping Medicaid you are basically replacing it with something that will look like SCHIP, and that gets me very nervous. Medicaid is not an entitlement program. Medicaid tends to be very comprehensive, and even though there are differences in eligibility and certainly on benefits, the core benefits are in fact the same in each state. And those core benefits are more comprehensive than many of the SCHIP program’s. So again, Medicaid is more likely to be protective of kid’s health interests than SCHIP would be.

Question 3:
Some say that Medicaid serves as a buffer for parents who are losing insurance for both themselves and their children when they lose their jobs. However, do you believe that the current increase in job losses will strain Medicaid and that we should therefore have an alternative plan?

Paul:
Well, many of them will become eligible for either Medicaid or SCHIP. I am not sure what a new program would look like. The concern is that people don’t know how long they will be out of work. So you can create a transition program for people who have lost their jobs, but at what point do they become permanent, semi-permanent, or long term? They may lose a job for a couple of months and then need a bridge, but who knows? So creating a new structure for this does not make a lot of sense to me. What makes more sense is to create a more much more humane eligibility standard and enrollment capability for Medicaid and SCHIP. The vast majority of kids in this country are either covered or eligible for coverage - it’s less than ten percent who are not. I think we need to be protective of the ninety percent who are covered, deal with the inadequacies of those programs, but also not forget that these programs actually account for a very large portion of the coverage. We should therefore build on those programs rather than create something new, because we are not really sure what the “new” would look like.

Question 4:
With CHIPRA, 83% of the children who were eligible for public insurance were already qualified. For the moment, do you believe that this is enough, or should the requirements for qualification have been expanded further?

Paul:
My view is that it was an opportunity to insure all kids, which means changing eligibility to include kids who are undocumented or kids who are documented but their parents are not, which is a good chunk of them. So yes, I think it should have been a program to cover all kids, and it was a lost opportunity. The reason that it didn’t do that is because this is a very weak political constituency - this is all they could do. They couldn’t even override Bush’s veto for 7 billion dollars. That’s 16 days of the Iraq war - it’s not a lot of money. It just says how pathetically weak this constituency is. So any political equation you create in thinking about these programs needs to respect the fact that the ability to get things done, in the interest of children, is actually fairly weak in this country right now.

Question 5:
CHIPRA provides funding from April 1, 2009 to the end of fiscal year 2013, but it is financed mainly by a nearly $0.62 increase in the tax on cigarettes. Do you believe that this tax is an appropriate source of funding for this new law?

Paul:
Well, it’s totally perverse, nobody is going to argue with that. But whether it was appropriate or not is a political consideration and not an economic one because it was politically unfeasible to raise income tax or to raise anything other than tax for CHIPRA. That’s because this is a very weak political constituency. It’s easier to tax smokers, but of course it’s perverse because you are taxing something you want to disappear. So clearly it’s a stop-gap, though hopefully it’s a stop-gap kind of funding mechanism. But it’s basically because of the political weakness. Could you see them increasing the military budget by going after the tobacco tax? No, because it comes out of real taxes and because there is a strong political constituency for it. So this is another sign of the political weakness. Is it appropriate? Sure, because it was the only way it was going to get done. Is it perverse? Sure.

Question 6:
What accounts for the relatively high mortality and low birthweight rates of children in the U.S. If there were to be a ranking of countries as to where we would come out? We would rank about 23rd. And we focus on babies because they are babies, but in fact, our record of performance for women who are in the reproductive age range is terrible, and my view is that this is directly expressed through infant mortality. So when we talk about universal insurance for women, regardless of pregnancy status, then I think that in time is because the majority of our infant deaths are occurring to extremely premature babies. So 60% are occurring to babies born less than 26 weeks gestation. Normal birth is 40 weeks gestation, and when you get down to being that premature and that small, that’s precisely when the definitions begin to vary a lot. So it’s definitely true that the definitions are affecting our standing internationally. However, it doesn’t affect it so much that we are out of the doghouse. In other words, instead of being 23rd in the world we’re 19th. Big deal. I do not believe that providing greater insurance for women to get prenatal care is going to have a dramatic impact on our infant mortality rate, and that is because the bulk of our infant mortality problem - certainly why it’s so much worse than every place else - is simply why we have big racial disparities - is because of extreme premature. And if all you’re doing is attempting to enhance care once a woman knows she is pregnant, that does not provide you a big window of opportunity to prevent anything. The other way to think about it is that the vast majority of our infant deaths and the vast majority of the disparities in infant deaths in the United States are occurring to women who get some prenatal care, and in fact, who are getting adequate prenatal care by standards that most people would consider adequate. And if I am in favor of prenatal care? Absolutely. Am I in favor of insurance to cover prenatal care? Absolutely. But that alone is not likely to address our infant mortality problem. More important is the fact that we have infant mortality problems and our poor international standing as a legacy of the poor general health of women. It’s women health prior to pregnancy that is not good. And if you ranked women’s mortality for women between the ages of 18-44, do you know what rank we would come out? We would rank about 23rd. And we focus on babies because they are babies, but in fact, our record of performance for women who are in the reproductive age range is terrible, and my view is that this is directly expressed through infant mortality. So when we talk about universal insurance for women, regardless of pregnancy status, then I think that in time

- Dr. Paul Wise

“A more important is the fact that I see our infant mortality problems and our poor international standing as a legacy of the poor general health of women.”

- Dr. Paul Wise

United States of America

Credit: https://www.sxc.hu/photo/676878

A cigarette tax will largely fund SCHIP

Ultrasound being performed on a pregnant woman.

Stanford Service in Global Health Journal

layout design: Ronny Hamed
that could make a real difference in our low birthweight and infant mortality rates.

Question 7:
According to the CDF, “Among two-year-olds, 1 in 3 is not fully immunized (1...). On two of the recommended vaccines for one-year-old children, the U.S. ranks near the bottom of industrialized countries.” What might account for this?

Paul: It’s a direct reflection of the quality of pediatric care. So the immunization record is crummy because the care is crummy. It’s not because once kids get into school because there are state laws that say you must have your immunizations in order to get into school, generally do get them, and the first day of school, every clinic in the area is jam packed with parents who need shots for their kids. But for the little kids there’s no requirement, and then it’s just the adequacy of care and that’s where we’re pretty bad.

Question 8:
If you had five minutes with President Obama, what would you tell him or ask him?

Paul: Besides “good job,” “good luck,” “make sure you keep the lines of communication open,” and “don’t lose sight of the importance of children,” I would start consulting now, but pick topics and constituencies of interest that are going to be catalysts for the current healthcare revolution.

Question 9:
What can undergraduate students do right now to serve as catalysts for the current healthcare revolution?

Paul: That’s a broad question because there is a need for political organization, there’s a need for programmatic support, and there’s a need for developing skills that will help in the future. So students should mobilize political support for children’s interests, which of course are young women whose parents are poor and whose needs are often not met, because that in the push for health reform, kids will be forgotten. That health reform can set back kids’ health more than the status quo.

I would tell him [President Obama] that the thing I worry about most is that in the push for health reform, kids will be forgotten. That health reform can set back kids’ health more than the status quo. Dr. Paul Wise

You have earned to be at a place like Stanford because there is a role for that as well. And then the last thing is be a good student. I get very unhappy when students come to me and trash their courses, when they really want to do is to something in the community or in politics but are failing all their courses. First of all, I’m not happy when they fail their courses, but the point is you’re here to gain skills that are going to serve the needs of people later on. We have a lot of people who never went to college. What we need are people who are going to use very selective skill sets even if they don’t go on to professional school. But a lot of people are going to go on to be doctors or nurses or public health analysts. To be a good student, get the most out of your classes so that you’re going to be genius Ph.D.s or you’re going to be genius doctors who really know what it is like to be growing up in Africa, to really understand what “cross-cultural” means. Get the most out of your classes.

So while I am very supportive of extracurricular work, first be a good student and get the most out of your classes because I don’t want dumb doctors; I don’t want dumb nurses; I don’t want dumb public health analysts. To be a good student, get the most out of your classes, because those are the people I want taking care of the people I care about. And that means you have got to study. I know that I sound like your parents, but I’ve seen this too often, where young people or students get caught up in the alternative to classes. And that’s okay because it’s important, but it’s not ok to devalue the utility of the classes because that does nobody a service. It implies that the people we care about most, who are basically underserved communities, don’t deserve people who have really gotten the most out of their undergraduate education, who really got the most out of medical school or public health school, and I don’t buy that. I think these people deserve the best. Which means that you better be darn good in your classroom work. I don’t care what you do after that, but get the most out of these teachers and what your colleagues and classmates can provide. Get into the library, go out into the community, and do your projects, don’t just be a part of the community. I think this is something students also need to hear.

Medicaid & CHIP

What is Medicaid?

“The Medicaid Program provides medical benefits to groups of low-income people, some who may have no medical insurance or inadequate medical insurance. Although the Federal government establishes general guidelines for the program, the Medicaid program requirements are actually established by each State. Whether or not a person is eligible for Medicaid will depend on the State where he or she lives. A person’s status in one State may or may not be the same in another State. Many states have their eligibility requirements outside of the Medicaid program, in some states it is separate, and in some states it is a combination of both types of programs. These programs are for children whose parents have too much money to be eligible for Medicaid, but not enough to buy private insurance. Most states offer this insurance coverage to children in families whose income is at or below 200% of the Federal poverty level.”


What is CHIP?

“The Children’s Health Insurance Program is jointly financed by the Federal and State governments and is administered by the States. Within broad Federal guidelines, each State determines the design of its program, eligibility groups, benefit packages, payment levels for coverage, and administrative and operating procedures. CHIP provides a capped amount of funds to States on a matching basis. Federal payments under title XXI to States are based on State expenditures under approved plans effective on or after October 1, 1997.”

Source: http://www.cms.hhs.gov/NationalCHIPPolicy/

Shelly Amieva is a junior majoring in Human Biology with an area of concentration in Global Health, and an area of concentration in Global Health, and Human Rights.” She plans in pursuing an MPH and Ph.D. in Global Health. Her favorite hobbies include reading, SCUBA Diving, and playing beach volleyball.
The foul thing about diarrhea is that there is no simple solution, and weak links exist everywhere. If a sewage system is faulty, then the water cycle becomes the dirty water cycle. Hazardous human waste gets used and reused, and, in the case of cholera or other gastrointestinal diseases, even multiplies. If the water stays clean but the tap is far away, getting enough water for hygiene, drinking, cleaning, and cooking is a challenge. Given the choice of handwashing versus thirst, which would win out? Mothers think there is nothing they can do to prevent their children from getting sick, and that it is normal for young children to die of “natural” causes. These perceptions of self-efficacy play a crucial role in the continued cycle of health hazards resulting from diarrhea.

Oral rehydration salts have played a huge hand in decreasing the number of deaths due to dehydration, but morbidity tolls have risen. While children are not dying, they experience stunted growth and slowed mental development due to lack of critical nutrients.

Given the way medical innovation only goes as deep as the pockets of funders, medical technology has become adept at saving the lives of people who can pay. Money opens the gateways for accessing medical interventions. Like we have learned in all our health policy classes, those interventions help only a few, while the masses who don’t have the means to buy their voice in the supply-demand market are left to stave off afflictions that just a little extra ingenuity could help mitigate. But while Western innovations have developed environmental-friendly pyrethroid insecticide sprays to prevent malaria and mechanisms to solar-disinfect water for drinking, what responsibilities do Western nations have to ameliorate the health problems of the developing world? I do not believe we can morally stand aside while billions die of preventable deaths, but we must find ways to empower individuals to act as leaders within their own countries, whether that be at a nation-wide policy level, or through community health worker programs with peers educating peers.

I do not believe we can morally stand aside while billions die of preventable deaths, but we must find ways to empower individuals to act as leaders within their own countries, whether that be at a nation-wide policy level, or through community health worker programs with peers educating peers.

While I applaud the $50 billion dollars PEPFAR has pledged to addressing HIV/AIDS, tuberculosis, and malaria, we should demand investment in people as well as technology to ensure that all people have adequate sanitation systems, clean water, and healthcare. Solving the diarrhea problem is not rocket science, but it is going to take creative solutions, much like the ones we have implemented regarding The Big Three. We have ignored the stench of neglected diseases such as diarrhea for long enough, and it is high time we follow our noses to approach this next major challenge in global health.
Civil war in Congo is spurred by economic reasons, and rape is a simple and cheap tool of war.

With a portable camera in hand and a translator by her side, she asked the soldiers what the world wanted to ask. The answers, stripped of lies, left their lips without hesitation and were all the more terrifying for the honesty behind each word. Did they feel guilt? No. Why did they do it? We are suffering and are not above using force to satisfy our needs. How many did they rape? Three to eight.

The documentary is appropriately titled. The Congolese women, like most rape victims have suffered silently for the past two decades, stigmatized, shamed, and crushed under a culture of silence. In a country with a limping judicial system ruled by men with guns, women find no peace and no justice against perpetrators. In efforts to break this silence, organizations and campaigns have begun to sprout worldwide.

The Muslim Student Awareness Network (MSAN) aired “The Greatest Silence” on April 21, 2009, at Stanford University, as a part of the student organization’s campaign on the state of refugees. “I hope that seeing the movie will turn some gears in the minds of Stanford students,” said Alena Syed, Political Director of MSAN. Featuring the documentary will be part of their year-long campaign to bring attention to the plight of refugees and displaced persons worldwide. MSAN has also released an educational flyer, which was also sponsored by the Stanford Students Taking Action Now: Darfur (STAND).

Back in February 2009, STAND also worked with the Women’s Community Center to bring Eve Ensler and Dr. Mukwege, who were at the time on the “Turning Pain To Power Tour,” a world-wide tour to raise awareness about the violence against women in the DRC, to Stanford. Eve Ensler is best known for writing The Vagina Monologues and founding the V-Day movement to end violence against women. Dr. Mukwege, an honored humanitarian, dedicates his life to giving counseling, treatment, and life-saving surgeries to Congolese rape victims at Panzi Hospital in Bukavu of eastern Congo. Ensler and the V-Day movement have become deeply invested in the difficulties facing the Congolese women.

“I have traveled extensively since my first of three trips to the Congo and everywhere I go people are incredibly moved,” comments Ensler, “You cannot deny evil when you see its results, and the Congo stares you right in the face.”

In truth, the occurrence of mass rape during times of conflict is not historically unique. During World War II, Japan took approximately 100,000 women hostage and forced them into sexual slavery. The Bosnian genocide, ethnic cleansing, and mass rape are also unsettling events of recent history. What is unique to the conflict found in Congo, however, is the animalistic brutality and extreme viciousness of the rape attacks.

Unfortunately, there is plenty of blame to go around. Soldiers from all sides of the civil war are suspected of having guilty hands. Even UN peacekeepers of the United Nations Mission in DRC have been incriminated in partaking. The atmosphere in the country is further complicated by the presence of the multitude of armed groups in the area. The FDLR is only one of the major
Democratic Republic of the Congo

“Children drumming in UNICEF’s North Kivu, DRC camp.”

Democratic Republic of the Congo

5.4 million people have died since the conflict began in DRC 1998.
49% of children account for the deaths.
Approximately 1.5 million internally displaced or refugees have resulted

Sources:

Democratic Republic of the Congo

5.4 million people have died since the conflict began in DRC 1998.
49% of children account for the deaths.
Approximately 1.5 million internally displaced or refugees have resulted

Evidenced by a series of articles in The New York Times, CNN, The Times of London, to name a few,” says Ensler, “This is in direct correlation to the increased activity and the public demand by women on the ground to bring justice to perpetrators.”

Yet the greatest change will come not from the outside world but from within the country, where rape is not a mere story but an everyday reality. The tide of the women, who have endured but survived, has begun to rise. These women band together, tell their stories to each other and to the world, and are pushing for a change. These are the women having the courage to divulge their stories. These are the rape victims turned volunteers and activists.

They can be seen in “The Greatest Silence” flashing on the screen. They can be heard through the newspaper clips in The New York Times. They can be heard over the radio through recordings and interviews. They can be felt on television and in black and white photographs plastering the Internet.

On the Doctors Without Borders webpage (http://www.condition-critical.org/), a video shows clips in April 16, 2009. It is a recording of a volunteer singing the theme song for a group of volunteers in Drouma, DRC. These volunteers help women who have survived rape and captivity.

“The woman is capable. La femme est capable de tout et de tout.” sings Charlotte Pasapas, a volunteer.

The song, an anthem for the women and volunteers, reminds us of a simple message. The woman is capable.

Catherine Le is a sophomore at Stanford University a bit confused about majors and life, vacillating between English and Biology. She enjoys volunteer work and writing and hopes to one day travel to India and Thailand to work. After graduating, she hopes to pursue a career researching in international health research.

layout design: Katrina Hui
By Rebecca A Briggs, Margaret S Chen, William J Hindle-Katel and Travis-Riley K Korenaga

BACKGROUND AND INTRODUCTION

It is no understatement to say that South Africa lies at the heart of the HIV epidemic. Since the first case of HIV reported in South Africa in 1982, the number has increased exponentially; South Africa now houses the highest number of infected individuals in the world. It was estimated that in 2007, one in five South Africans was infected with HIV. In particular, it has been noted that Khayelitsha, a black township in the Western Cape, exceeds this national average, with one in every three Khayelitsha community members infected with the virus.

HIV’s long incubation period contributes heavily to the epidemic because the virus can reside in one’s body without causing symptomatic illness for up to ten years. Thus, the most immediate action that should be taken to slow the HIV/AIDS epidemic is to increase individuals’ awareness of their status through a simple blood test.

First initiated in South Africa in 1998, the practice of voluntary counseling and testing (VCT) has served as the cornerstone of HIV awareness, prevention, and treatment by providing individuals with extensive information about HIV and a blood test, as well as a supportive network and tools for dealing and coping with the result. As of November 2006, 4,172 VCT sites are currently operating within South Africa.

While VCT plays a crucial role in curbing the HIV/AIDS epidemic in South Africa, a recent study shows that only one in five South Africans has been tested for HIV, and of those that have been tested, only one in five are men. While social stigma, cultural constructs of masculinity, and men’s poor healthcare-seeking habits stigmatization attached to the virus

HIV is widely viewed as a death sentence and many would rather live in ignorance of their status than with the viral load.

In general, may be to blame for the study’s missing men, males must be reached in order to control the epidemic. Thus, gendered healthcare has recently been incorporated into the South African AIDS prevention paradigm. Hope Worldwide South Africa (HWSA), a non-governmental organization funded primarily by USAID and PEPFAR, has begun to address the current need for gendered healthcare by establishing a male clinic in Khayelitsha. This clinic, currently staffed by one male nurse and three male counselors, provides a specific set of services primarily to men, including sexually transmitted infection (STI) screening, STI treatment, and HIV VCT. The clinic exclusively caters its services to men in hopes that the all-male environment will also encourage men to more comfortably test and know their status, effectively serving as a first port of entry for men into the healthcare system.

Our research team has been working with HWSA in Khayelitsha in a collective effort to improve the efficiency and efficacy of the male clinic. Our research was guided by four main questions:

1. How successful and/or necessary is gendered care?
2. What is preventing males from testing for HIV?
3. How does Xhosa culture influence high-risk sexual behavior, HIV stigma, STI treatment and HIV testing?
4. Why are fewer older males attending the clinic and what changes can be made to attract them?

RESULTS

In-clinic surveys

A total of 50 in-clinic surveys were completed. 30 surveys were done in Xhosa and 20 in English. The results of the surveys are separated into demographics, clinic utilization, sexual behaviors, comfort, and improvements (see Table 1).

The average age of the patients was 25.8 years and the median was 23.5 years. 11.1% of respondents were married, and 40.9% had children.

Of the patients surveyed, the average number of clinic visits was 1.38, including their current visit. 62.2% of respondents had an HIV test done before, and 52.2% had their last HIV test done at the male clinic. 42.8% of respondents had an STI treated before.

The average self-reported comfort level of the patients was 9.3 out of 101. When asked what was the most important factor to their comfort, 48.7% chose having

MATERIALS AND METHODS

Data collection was performed using three methods: in-clinic surveys for patients in the waiting room) out-of-clinic surveys (or community members in the area surrounding the clinic, and HWSA staff interviews. Anonymous surveys were chosen as a primary data collection method because they could be completed in a short amount of time and encouraged participants to accurately provide private information. Interviews were selected as the data collection method with HWSA staff members in order to create a dialogue around human resources and marketing concerns. Key informant interviews were conducted with four clinic staff members and four employees at the HWSA Khayelitsha office.

Finally, the research team held a presentation and a final discussion about the male clinic to offer the results of the study and to start creating solutions around the areas of improvement. Approximately thirty people attended, including HWSA staff members, counselors from the clinic, and community members.

TO STI TREATMENT
AND HIV TESTING IN
KHAYELITSHA
A CASE STUDY

By Rebecca A Briggs, Margaret S Chen, William J Hindle-Katel and Travis-Riley K Korenaga
TABLE 1

<table>
<thead>
<tr>
<th>Sample Size (n=)</th>
<th>Xhosa</th>
<th>English</th>
<th>Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>30</td>
<td>20</td>
<td>50</td>
</tr>
<tr>
<td>Mean Age (years)</td>
<td>27.1</td>
<td>23.8</td>
<td>25.8</td>
</tr>
<tr>
<td>Median Age (years)</td>
<td>24</td>
<td>23.5</td>
<td>23.5</td>
</tr>
<tr>
<td>Married (%)</td>
<td>13.8%</td>
<td>5.9%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Have Children (%)</td>
<td>46.67%</td>
<td>26.67%</td>
<td>40.9%</td>
</tr>
<tr>
<td>Average clinic visits (including today)</td>
<td>1.5</td>
<td>1.24</td>
<td>1.38</td>
</tr>
<tr>
<td>HIV test done before</td>
<td>48%</td>
<td>80%</td>
<td>62.2%</td>
</tr>
<tr>
<td>Last HIV test at male clinic</td>
<td>75%</td>
<td>40%</td>
<td>52.2%</td>
</tr>
<tr>
<td>STI treated before</td>
<td>30.4%</td>
<td>57.9%</td>
<td>42.8%</td>
</tr>
<tr>
<td>Average number of partners in the last month</td>
<td>2.14</td>
<td>2.1</td>
<td>2.1</td>
</tr>
<tr>
<td>Average condom use (out of 10)</td>
<td>8.27</td>
<td>6.88</td>
<td>7.53</td>
</tr>
<tr>
<td>Median condom use (out of 10)</td>
<td>10</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Average comfort level (out of 10)</td>
<td>9.11</td>
<td>9.21</td>
<td>9.3</td>
</tr>
<tr>
<td>Male nurse most important for comfort</td>
<td>60%</td>
<td>41%</td>
<td>48.7%</td>
</tr>
<tr>
<td>Male counselor most important for comfort</td>
<td>27%</td>
<td>36%</td>
<td>32.4%</td>
</tr>
<tr>
<td>Male waiting room most important for comfort</td>
<td>6.7%</td>
<td>23%</td>
<td>16.2%</td>
</tr>
<tr>
<td>Other factor most important for comfort</td>
<td>6.7%</td>
<td>0%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Not return if had female nurse (%)</td>
<td>52.2%</td>
<td>40%</td>
<td>46.5%</td>
</tr>
<tr>
<td>Think more people will come if more services provided</td>
<td>85%</td>
<td>88%</td>
<td>86.4%</td>
</tr>
</tbody>
</table>

TABLE 2

<table>
<thead>
<tr>
<th>Sample Size (n=)</th>
<th>Xhosa</th>
<th>English</th>
<th>Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>10</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>Mean Age (years)</td>
<td>30.3</td>
<td>31.3</td>
<td>30.7</td>
</tr>
<tr>
<td>Median Age (years)</td>
<td>27</td>
<td>30</td>
<td>28</td>
</tr>
<tr>
<td>Married (%)</td>
<td>22.2%</td>
<td>40%</td>
<td>31.6%</td>
</tr>
<tr>
<td>Have Children (%)</td>
<td>60%</td>
<td>70%</td>
<td>65%</td>
</tr>
<tr>
<td>Employed</td>
<td>44.4%</td>
<td>75%</td>
<td>58.8%</td>
</tr>
<tr>
<td>Median (out of 10)</td>
<td>9.5</td>
<td>9.5</td>
<td>9.5</td>
</tr>
<tr>
<td>Be to Male Clinic</td>
<td>44.4%</td>
<td>33.3%</td>
<td>38.9%</td>
</tr>
<tr>
<td>Sexual Partners in last month</td>
<td>9.5</td>
<td>9.5</td>
<td>9.5</td>
</tr>
<tr>
<td>Condom use out of 10</td>
<td>5.8</td>
<td>9.5</td>
<td>7.8</td>
</tr>
</tbody>
</table>

DISCUSSION

GENDERED CARE

At the initial outset of this research project, it was decided that the necessity and success of the gendered care aspect of the male clinic would be evaluated. Through various key informant interviews, we learned that the clinic staff held a positive outlook with respect to the male clinic’s gendered care approach to testing for HIV. Members of the clinic staff felt that the all-male aspect of the clinic, including an all-male waiting room, an all-male counseling staff, as well as a male nurse,
created a comfortable environment for male clientele to undergo a process as uncomfortable as HIV testing. Several members of the clinic staff commented on having an all-male clinic facility with camaraderie between men, ultimately leaving the male clientele feeling increasingly free to discuss their cares and concerns with respect to HIV. Essentially, it was communicated through these interviews with the clinic staff that Xhosa men feel most understood by other Xhosa men, and thus only feel comfortable disclosing personal information about their sexual behaviors to Xhosa men.

Such impressions were confirmed through the results of our survey. Overall, patients reported very high comfort at the clinic. A large proportion of respondents indicated that the male nurse was the main contributor to their comfort with the clinic. Conversely, when asked if they would return to the clinic if a female nurse were employed instead of a male nurse, 46.5% of respondents indicated that they would not return. This indeed confirms the notion that the male nurse is a critical component of the gendered care approach of the male clinic. **Barriers to Care**

Though the clinic provides a uniquely all-male environment, there are other barriers besides gender that prevent men from utilizing the services of the male clinic. In exploring the many different factors, issues of stigma, anonymity, and age surfaced throughout.

The most prominent barrier was the social fear and stigma of HIV and AIDS. When asked to speculate on reasons for people not testing, 19 of 32 respondents (59.4%) attributed it to fear of knowing one’s positive status. HIV is widely viewed as a death sentence and many would rather live in ignorance of their status than with the stigmatization attached to the virus. As a result, people avoid testing for HIV. Stigma and fear create a multitude of problems, the most notable being the unknown transmission of HIV and the delay or absence of HIV treatment. For those who do choose to test regularly, social stigma proves to be problematic. Oftentimes those who test for HIV are assumed to be positive and are subject to the same social stigma that they are trying to avoid. Not surprisingly, maintaining anonymity is important in HIV testing. There is little the male clinic can do to address the social stigma and fear around HIV, other than to sustain a comfortable environment and provide maximum confidentiality.

The issue of age and respect surfaced as a barrier to HIV testing. Manhood in Xhosa culture is highly constructed and not very flexible. One is considered a true man once he has “been to the bush” to be circumcised and learned what it means to be a man. When one returns from the bush, one is accorded certain respect and privileges. It is no surprise that private issues like sexual behavior may only be talked about with other men, not boys or women. Thus, the age of the counselors and nurses is as equally important as their sex. Even between two men, the age dynamic is important. Though a younger man may still be a man by traditional Xhosa standards, older men may find it difficult to discuss such private concerns as HIV with a young man. Thus, it is important to have a staff with a wide range of ages to ensure that they can relate to an equally wide range of patients.

**Having an all-male environment facilitates camaraderie between men, ultimately leaving the male clientele feeling increasingly free to discuss their cares and concerns with respect to HIV.**

employ a male nurse at the clinic to maintain the all-male atmosphere that is critical to the comfort of its clientele. Finally, HWASA should increase its advertisement and publicity efforts through utilizing multiple forms of media, including flyers, signage, radio, newspapers, taxis, and even men’s social structures.

Despite these suggested improvements, HWASA’s all-male clinic in Khayelitsha is a valuable resource for men in the community. By appealing to high-risk populations and providing comfortable testing conditions, the male clinic is doing its part to battle the HIV epidemic in South Africa.

**CONCLUSION**

After careful evaluation, we conclude that the gender-based approach to STI treatment and HIV testing utilized by the Khayelitsha male clinic is indeed effective in encouraging more men to test. However, HWASA’s Khayelitsha office can implement certain changes in order to improve or maintain the efficiency and efficacy of the clinic. Firstly, HWASA should maintain a counseling team of a wide age range to properly cater to men of all ages. Secondly, it is critical that HWASA continues to

**HHaving an all-male environment facilitates camaraderie between men, ultimately leaving the male clientele feeling increasingly free to discuss their cares and concerns with respect to HIV.**

employ a male nurse at the clinic to maintain the all-male atmosphere that is critical to the comfort of its clientele. Finally, HWASA should increase its advertisement and publicity efforts through utilizing multiple forms of media, including flyers, signage, radio, newspapers, taxis, and even men’s social structures.

Despite these suggested improvements, HWASA’s all-male clinic in Khayelitsha is a valuable resource for men in the community. By appealing to high-risk populations and providing comfortable testing conditions, the male clinic is doing its part to battle the HIV epidemic in South Africa.

**REFERENCES**


Siegfried http://www.avert.org/aidsouthafrica.htm

The English survey had 4 options for comfort which we coded 1-4 and the Xhosa survey had 3 codes for comfort which we coded 1-3. In order to correct for this, we divided the average English responses by four and divided the Xhosa responses by 3. Then we took the average of the two numbers and multiplied it by 100 to place it on a scale of 0-10.

* The only “other” response was “short wait times”

Rebecca Briggs is a senior majoring in Human Biology. While one of her major research interests has been studying molecular characteristics of HIV, she has greatly enjoyed this hands-on experience of working with the male clinic. Rebecca plans to work more in issues of infectious disease before attending medical school.

Maggie Chen is a senior majoring in Comparative Studies in Race and Ethnicity and Human Biology. As a health educator in women’s clinics, she greatly appreciates the chance to explore the dynamics of men’s health through this project. Maggie plans to work in reproductive health policy before attending medical and public health school.

Will Hindle-Katel is a senior majoring in Human Biology and minoring in Physics. On campus he can be found at the pool for water polo practice, working in an Alzheimer’s lab, and rooting for his lapless Clippers.

He was incredibly thankful for the opportunity to work closely with community members in this project.

Travis Korenaga is a senior majoring in Human Biology. Continuing his interest in understanding social disparities, Travis will return to Hawaii as part of Teach for America next year, then pursue medical school.
A Visit to Candyland: Reflections on Gawad Kalinga Villages

by Victor Cruz

This article chronicles two medical volunteer trips I went on in the Philippines. In the first trip, I learned from a physician about the difficulties of practicing medicine in a developing country and received some unexpected advice. On the second trip, I volunteered with an NGO called Gawad Kalinga that builds houses, schools, and health clinics to combat poverty. I observed a model of international development that renewed my interest in international health by showing me the impact that development work can have on people’s lives around the world.

When we went to a non-GK home just a couple blocks away, I saw a stark contrast: There was no running water, and we left tracks in the mud floor.

Summer 2006

At the Aman Rodriguez Hospital in the Philippines, I still a scalpel along an elderly man’s swollen purple foot. He had diabetes and it was starting to rot. Underneath his foot, flies buzzed at the thin pan that caught the rancid brown water. The smell would stick in my nose and under my fingernails for four days. I prodded the metal slab with his skin, but he said he couldn’t feel a thing. With that, I handed the scalpel to the medical resident, and the young man fell into his skin, but he said he couldn’t feel a thing. With that, I handed the scalpel to the medical resident, and the young man fell into a convulsing baby girl whose small brown body was barely twitching, I watched the chest of another baby boy beside her to make sure his chest was still moving with air. Dr. Tsai again unloaded some anguish, told me the hospital needed money for medications, diagnostics, and machines, and then re-emphasized that I should be a nurse.

My time at the public hospital provided a sobering perspective of international public health, including the frustrations that a doctor can have, especially in an overcrowded public hospital.

As I explained to Dr. Tsai, I would be leaving her hospital after a week to volunteer for the NGO Gawad Kalinga (GK) Development Foundation, Inc, an organization dedicated to solving the problem of poverty in the Philippines through efforts and action projects. I thanked her upon my departure, but I left the public hospital feeling a little shaken. If my summer trip had ended there, I would have left the Philippines with Dr. Tsai’s discouraging rhetoric on international health’s formidable obstacles, and I may have given up on the field right there. However, that next week, my volunteer work with GK brightened my view on international health.

On this first volunteering trip with GK, I went on a medical mission doing patient intake. Dr. Christian Gomez, a large, fair-skinned Filipino man who was dripping with sweat from the humidity, brought me along to one of the housing projects that GK built for the poor. I had never been to a GK site before and was struck by the brightly colored homes. There were probably thirty homes, bungalows, straw-covered, red, baby-blue, and others, facing each other with concrete cobblestone pathways in between.

“All the houses are painted like that,” he said. “Tony Meloto, the founder of GK, says that poverty is a psychological problem, not just an economic one. The houses are bright to create a good mood.”

I nodded my head, not realizing that by all the houses, he meant every one of many issues in international development, and how individuals can try to mitigate it.

My first GK trip showed me that poverty is the root cause of many issues in international development, and how individuals can try to mitigate it. My first time with GK eventually inspired me to continue with medical education and another GK trip. Even though Dr. Tsai’s comments were negative, they provided an opportunity for me to re-affirm, through my GK trip, my ambition to become a doctor for the right reasons and with a more realistic view.

Summer 2007

Although my first trip had come to an end, I was impressed by the organization’s integrity and decided to team up with another Stanford student and lead a trip back the subsequent summer. After a year of recruitment and planning, we had four Stanford students, a student from the University of Chicago, and a high school student on the team.

When we returned to the Philippines in the summer of 2007, I met Dr. Tsai again unloaded some anguish, told me the hospital needed money for medications, diagnostics, and machines, and then re-emphasized that I should be a nurse.

My time at the public hospital provided a sobering perspective of international public health, including the frustrations that a doctor can have, especially in an overcrowded public hospital.

As I explained to Dr. Tsai, I would be leaving her hospital after a week to volunteer for the NGO Gawad Kalinga (GK) Development Foundation, Inc, an organization dedicated to solving the problem of poverty in the Philippines through efforts and action projects. I thanked her upon my departure, but I left the public hospital feeling a little shaken. If my summer trip had ended there, I would have left the Philippines with Dr. Tsai’s discouraging rhetoric on international health’s formidable obstacles, and I may have given up on the field right there. However, that next week, my volunteer work with GK brightened my view on international health.

On this first volunteering trip with GK, I went on a medical mission doing patient intake. Dr. Christian Gomez, a large, fair-skinned Filipino man who was dripping with sweat from the humidity, brought me along to one of the housing projects that GK built for the poor. I had never been to a GK site before and was struck by the brightly colored homes. There were probably thirty homes, bungalows, straw-covered, red, baby-blue, and others, facing each other with concrete cobblestone pathways in between.

“All the houses are painted like that,” he said. “Tony Meloto, the founder of GK, says that poverty is a psychological problem, not just an economic one. The houses are bright to create a good mood.”

I nodded my head, not realizing that by all the houses, he meant every one of many issues in international development, and how individuals can try to mitigate it.

My first GK trip showed me that poverty is the root cause of many issues in international development, and how individuals can try to mitigate it. My first time with GK eventually inspired me to continue with medical education and another GK trip. Even though Dr. Tsai’s comments were negative, they provided an opportunity for me to re-affirm, through my GK trip, my ambition to become a doctor for the right reasons and with a more realistic view.
2007 for my second trip with GK, we discovered GK's development model that was changing the face of the Philippines. It consisted of seven integrated programs designed to attack the underpinnings of poverty. When we got there, GK was promoting their projects at a rally with over 10,000 people. It was the GK 1 Million Heroes rally, where GK proposed the goal of getting one million volunteers for GK worldwide. The rally was held at an enormous stadium, the Araneta Coliseum, and a French dance troupe performed as we entered the hip-hop championship, the Philippine All-Stars, performed. At the rally, we met a few senators, mayors, beneficiaries, and CEO's of various companies who were otherwise lost in the crowd. At the rally, we met Dylan Wilkes, an English under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billionaire, who sold his BMW and created the BMW M5 village with 80 homes and hundreds of under-thirty billion...
Global health is one of the most important issues of our time. It is no longer solely a problem of the third world but transcends borders. To fight these challenges, global leaders in the September of 2000 adopted the millennium declaration with the aim of reducing poverty, improving health, promoting peace, human rights, and environmental issues throughout the world. The Millennium Development Goals (MDG) set out a unified commitment between developed and developing countries to make progressive, sustainable efforts toward meeting these goals. The world welcomed President Obama’s lifting of the “global gag rule” in the first week of his office which allows government funding overseas for family planning groups and clinics. But much more needs to be done. The United States has not kept its promise of donating 0.7% of its GNP, a goal set up by the Monterey Consensus in 2002, even though, according to the U.S. Global HIV/AIDS Strategy, it will take only 0.1% of the income of the rich countries to mount a decisive attack against HIV/AIDS, malaria, and tuberculosis. Although the announcement to double the budget for the President’s Emergency Plan for AIDS Relief (PEPFAR) to $30 billion from 2008-2013 has been made with good intentions, that commitment may prove insufficient. Not only that, the United States should take the initiative to convince other wealthy countries to follow the UN’s recommendations and write off virtually all outstanding hard debts to third world nations. If their debts are eliminated (or at the very least, deferred), these heavily indebted developing countries can redistribute their debt payments into more pressing domestic channels like AIDS treatment and prevention.

It was heartening to note that the Obama administration has kept the commitment to PEPFAR started by President George Bush and also has increased foreign assistance, although the details of the 2010 budget for global health are not clear. PEPFAR has been the single largest international health initiative started by the previous administration, yet it fails to take into consideration several key factors. Congress currently requires that a third of PEPFAR’s prevention resources be put toward establishing programs promoting sexual abstinence before marriage. HIV prevention accounts for about 20% of the total PEPFAR expenditure and many people have questioned the effectiveness of promoting abstinence at the expense of condom distribution. In April 2006, the Government Accountability Office (GAO) released the results of an extensive investigation of PEPFAR’s policies for preventing sexual HIV transmission. The Lancet, a leading medical journal, wrote a full page editorial calling PEPFAR’s approach “ill-informed and ideologically driven” and called for a “complete reversal of policy.” The editorial concluded that “many more lives will be saved if condom use is heavily promoted alongside messages to abstain and be faithful.” A number of prominent HIV prevention experts and societies have expressed that they are “profoundly concerned about the resurgence because of partial or incomplete messages on HIV prevention which are not grounded in evidence and have limited effectiveness.”

Global health is one of the most important issues of our time. It is imperative that our administration de-politicize its development aids. Aid to poorer countries should not be tied in with any political aims, as argued by Jeffery Sachs, a Columbia University Professor.

Another global health challenge is malaria which kills about one million children each year (mostly in Sub-Saharan Africa). The previous administration’s initiative to deliver a $1.2 billion “malaria-gag rule” has been lifted, there are other ideological provisions like the “Prostitution Loyalty Oath,” which prevents assistance to any group, organization, or nation that does not have an explicit policy opposing prostitution and sex-trafficking that has failed to protect sex workers from their clients in countries like Brazil. For that reason, many public health experts and NGO’s believe that the anti-prostitution clause is harmful and should be removed. President Obama sent the right signal across the world when he asked Mr. Dylot to step down immediately from the position of US Global AIDS coordinator. Another global health challenge is malaria which kills about one million children each year (mostly in Sub-Saharan Africa). The previous administration's initiative to deliver a $1.2 billion “malaria-gag rule” has been lifted. However, despite the positive steps taken, resources do not match the scale of need. It will be important to follow the advice of previous WHO director Dr. Arata Isozaki, who said that every home should get the bednets to poor people is to hand out millions for free.” Insecticide treatment should increase within households in order to cover the vulnerable population (children and pregnant women) in the absence of a malaria vaccine.
United States of America

Global funding that provides universal access to Coartem, a fixed dose combination therapy for malaria, to all high risk populations in Africa should also be supported. The United States should partner with local volunteer groups and NGO’s to make sure that insecticide bednets are used effectively and not for fishing nets or wedding gowns as reported by William Easterly in his book The Whiteman’s Burden. The malaria prevention program got the boost when on April 25, 2008, the United Nations Secretary General Ban Ki-Moon unveiled a powerful initiative to achieve universal access to comprehensive malaria control across Africa by the end of 2010, with a donor financial commitment of roughly $3 billion a year. To achieve this universal coverage, about 250-300 million long-lasting bednets need to be distributed in Africa. What needs to be addressed is the primary health systems and training of personnel who run these clinics and primary care centers to support the health systems for sustainable progress.

Unfortunately, another global health challenge, tuberculosis, is under-reported. WHO has developed a new initiative to achieve MDG-6 goals alone. It must partner up with all invested parties including private sectors, professionals, NGO’s, and individuals. We should take the initiative to galvanize international, establish the international status quo, and set the milestones and steps necessary toward achieving MDG-6. Investment in the healthcare programs is crucial for economic development and, ultimately, our national security. To quote Colin Powell, “AIDS is not just a health matter, but a national security issue.” We must stop the disease from infecting our child-bearing population and creating domestic and international unrest. To paraphrase another great American President, “If not now, when? If not us, who? And if not together, how?”

Gautam Sharma is currently a freshman who is majoring in psychology with a possible minor in film studies. He enjoys making films, one of which was a documentary covering a malarial bednet distribution in Kenya. In his free time, he enjoys making music, working out and playing basketball.
If you are interested in joining staff or learning more, please visit http://ssgh.stanford.edu or email ssgh.journal@gmail.com