

REFLECTION IN GLOBAL HEALTH: *An Anthology*

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Foreword

By *Louise Aronson*

The two words that summarize the topic – the occasion – of this anthology, “global” and “health,” encompass an enormity of human experience: the entire planet on the one hand, and much of its well-being on the other. Put them together and you have a vast and complex enterprise of unquestionable import, difficulty, and variety. Add education to the mix and you get a window into the world today and also into the future, as the owners of the voices herein move into their careers as health professionals equipped with the aspirations, skills, and insights to make a difference.

The writings in this anthology of reflection on global health experiences reveal undergraduate students, health science trainees, and young doctors confronting both illness and injustice in health systems around the globe and their own expectations, ideals, biases, limitations, and ambitions. Each piece meets the call for reflection by demonstrating deliberate contemplation of a global health experience. Many countries and parts of the planet are represented, as are a plethora of medical conditions and specialties. An occasional essay also confronts what might be termed global health at home, as the writer considers the migrations and health tribulations of her own or another immigrant family in the United States. All strive to understand some part of their lives in a larger context and to link that experience to critical issues in health care around the world. As such, each offers insights into the realities, joys, challenges, and key questions facing global health.

Using reflective writing to demonstrate and evaluate learning is a relatively new addition to the medical education toolbox. Yet in recent years, reflection has become one of the hot topics in medical education, mandated by governing bodies including the LCME and ACGME, and applied to areas from professionalism to quality and safety to surgery. Search any of the key journals and in most issues you’ll find at least one article on reflection. This was not the case five or ten years ago, though not because physicians then had no need for reflection. Rather, as the world has become more complex and communication has increased generally and across disciplines, medicine has begun to

recognize that its traditional modes of learning and evaluation are necessary but not sufficient to train and assess the performance of medical students and physicians. A good doctor is more than a repository of knowledge. He or she is also an amalgam of essential attitudes, behaviors, and skills. Moreover, to achieve and maintain proficiency in both the art and science of medicine, a doctor must be able to learn from experience, ask important questions, and consider the origins and implications of his or her own thought processes, decisions, and behaviors. In other words, a good doctor must be skilled in reflection.

This sounds more straightforward than it is. The term reflection often is used both colloquially and in medicine to indicate thoughtful consideration of or meditation on an experience, idea, or problem. This definition is accurate but vague. As a result, the exercises and products that count as reflective in medical education vary widely in their intent, approach, and criteria for success. Being thoughtful is good, even necessary, but it isn't always sufficient to guarantee learning from an experience. Simply put, sometimes we try our best and think as carefully as we can, and it is often not enough. Sometimes we need outside input to really see something as it is, or to see it differently, and to learn from it. While this may be particularly true for trainees who lack the knowledge or experience to appreciate the intricacies of new-to-them medical culture, it is equally true for seasoned professionals who find themselves in situations that are surprising, unsettling, complex, or uncertain, or for which they didn't have the necessary knowledge or skills. For this reason, educators often distinguish between reflection and a higher-order skill called critical reflection that moves beyond thoughtfulness to learning that includes a transformed perspective.

As with most – perhaps all – skills, reflection comes more naturally to some than others. However, it is a skill and as such can be learned and must be practiced to achieve competence and proficiency. Indeed, key scholars in the area have developed a hierarchy of levels of reflection, from *habitual action*, which occurs with little thought, to *understanding*, which is mostly theoretical with few links to personal or real-life experience, to *reflection*, in which experiences and concepts are linked and explored, and finally to *critical reflection*, which includes confrontation of assumptions and assimilation of alternate perspectives to produce new viewpoints, attitudes and behaviors. Novice reflectors generally reflect at one of the first three levels in a somewhat bell-shaped distribution. Training, feedback, and guidance are required to move them along the continuum to reflection and critical reflection.

While many types of reflection prove useful to trainees and educators, the key to making a reflection useful is to be clear and explicit about its goals. With this anthology, for example, the goal was to have learners consider their experiences and create a compilation so others could get a sense of where they had been, what they learned, and how they were thinking about that experience. In that case, a general prompt for reflection on a topic such as “your global health experience” usually suffices, as this

diverse collection so eloquently illustrates. But sometimes the goal is different. In order to generate and evaluate learning in areas where traditional knowledge tests or clinical supervision aren't adequate – and to produce fully reflective health professionals with the skill to learn from experience after formal training – we must apply techniques that help learners become critical reflectors.

Studies within and outside medical education have shown that a structured approach yields higher-level reflections than simply asking learners to reflect. This isn't surprising: teach the learner a skill, and he or she will be more adept at that skill. Multiple structured approaches to reflection have been published, and while they vary in focus and approach, all offer a series of questions or tasks aimed at getting the reflector to think deeply and differently about an experience. At UCSF, we have developed one such tool called “the UCSF LEaP,” a 5-step approach for “Learning from your Experiences as a Professional.” First, the reflector must pick a suitable experience, generally a situation that remains unresolved (i.e. clearly significant but from which learning has not yet taken place). Second, they describe the experience in a way that allows others to develop their own impressions and so provide feedback that leads to new perspectives. This entails offering details about events, thoughts, and emotions at the time followed by a consolidation of their current thinking about the situation. In essence, this is ‘reflection;’ the subsequent steps transform it into ‘critical reflection.’ The third step is getting feedback or finding information that increases knowledge, questions assumptions, and offers alternate interpretations of events. In the fourth step, they identify a learning issue (often there are multiple) and discuss their transformed thinking about this issue. In the final step, they make a SMART (specific, measurable, attainable, related, and timely) plan for future professional behavior.

As is perhaps obvious, critical reflection is a tall order and not suitable for all situations. It might come down to this: do you want reflectors to process an experience, to think about it, and note their own impressions based on it? Or do you want them to move to a new place they might not be able to get to on their own? The former is ‘reflection’ and the latter is ‘critical reflection.’ Both have utility. My own belief is that we should reflect on all notable experiences, and critically reflect when we come up short or simply cannot understand or feel resolved about an experience. As we can see in these pages, global health experiences are always notable and sometimes they also might benefit from a deeper dive that results in a clear plan forward through complex and challenging situations without simple or singular answers. So what might optimal application of reflection look like for global health and trainees learning from international experiences? Perhaps they could *reflect* to help identify the important questions for the individual, the programs they participate in, and the field, and *critically reflect* to help them begin to answer those key questions.

Introduction

“Something is better than nothing.” “They have so little but they’re so happy.” “Haiti was *great*.” “Change the life of just one person and it’s all worthwhile.” “All you need is love.” “Be the change you want to see in the world.” These commonly heard phrases, true to varying degrees, are sound bites that may be heard after experiences in global health. While this array of sentiment minimizes the value extracted from experiences in global health and relegates these experiences to a certain realm of superficiality, it is amazing how quickly or easily this type of phrase rolls off the tongue of even the most veteran global health practitioner. These expressions can be protective in nature, arising out of a sense of vulnerability and inability to express fully the significance of the experience, or are representative of a lack of clarity around what content and depth is being requested of the learner or practitioner. These expressions, if they were to stand alone, would be representative of an incomplete or underdeveloped understanding and articulation of reflection.

Oftentimes, however, this type of one-liner is rooted in good intentions and serves simply to test the waters of the audience. These statements are not necessarily false, but instead, they seek permission of the listener while also allowing the learner to gauge where to begin and how deep to go. These expressions are the tip of the iceberg, so to speak, as the learner or practitioner simultaneously sorts through experiences and assesses the context in order to represent a broad range of reactions, feelings, and thoughts on a complex set of experiences in a prioritized and appropriate manner. It seems to be a somewhat common occurrence that individuals return from experiences in global health to discover that when someone asks about their experience, they expect a simple and quick response. The result of this dynamic is the development of these cliché one-liners, which try to capture one small sliver of the importance and impact of the experience. Encouraging the practice of reflection in global health serves to address human experiential complexity in a systematic and genuine fashion.

In the body of this anthology, you will find 63 essays that explore an array of topics in depth through systematic, reflective approaches to experiences in global health. An anthology on reflection in global health benefits significantly from a brief introduction to

some basic definitions of “reflection” and “global health,” as well as a general overview of one methodology of maximizing the benefits and minimizing the obstacles of reflection in global health training for students and educators. Finally, the introduction will conclude with a few words of suggestion around how to utilize this anthology in conjunction with trainee experiences in global health.

This anthology aims to convey the profound impact of experiential education in global health, particularly through the reflection pieces offered by undergraduate and graduate participants in a variety of fields and projects. For this particular project, reflections are tangible, written pieces composed after participation in a global health training experience and do not directly refer to oral reflections, individually or as a group, on the ground or upon return. As educators in global health, we believe all forms of reflection play a central role in the incorporation of experience into the lives of the participants. Reflection encourages participants to grapple with the multifactorial nature of global health and to grant meaning to these experiences personally, professionally, and systemically. What one person experiences in one isolated interaction often resonates with others who have had similar experiences and gives rise to a conversation about topics ranging from personal engagement to justice to social responsibility and often, to humility, helplessness, and inequality. These written reflections report on experience and present the opportunity to share with others, as well as to take the next steps in global engagement through feedback, mentorship, and the pursuit of further involvement in global health.

Holding reflection as a central tenet of global health, a number of educators approached the Consortium of Universities for Global Health (CUGH) in 2012 and proposed the value of convening an essay contest for trainees in the various fields of global health. The call for essays was issued:

“Over the years, students, trainees and faculty have reflected in creative ways on their travel, learning, and work experiences. Through writing, sharing, listening, and storytelling, we can begin to derive clarity about the injustice we witness, embrace the complexities of the lives we touch, decipher the ambiguity of moral judgment in widely divergent cultural contexts, and imagine constructive action in response to our experiences. All current undergraduate, graduate and postgraduate trainees are invited to submit reflective essays in response to global health experiences. These may be in a research, educational, clinical, or service capacity. Please highlight the impact of your experience on professional development, personal growth, or new insights you have gained into cross-cultural or ethical issues.”

The reflection prompt left ample space for interpretation and creativity, defining only the topic for reflection: experiences in global health. Reflections pertain to trainee involvement in research, educational, clinical, or service capacity. Within these flexible parameters, reflections offered are not simply narratives, nor are they purely structural or systematic analyses, though both of these elements are incorporated. Instead, these elements are brought to bear on one's own understanding of the world, with one's interpretive framework, merging past, present, and future in the process of meaning making. But first, *Why?* Why is reflection integral to global health training? *So what?* Before answering the *why* or the *so what*, let's explore the *what* – what is reflection?

Reflection in Global Health: Value Added

While there are many different iterations of reflection, this anthology refers to reflection that is particular to personal experience. Furthermore, this reflection draws upon experiences within training in global health at various levels: undergraduate, graduate, and postgraduate. Global health, in this context, refers to immersion within, or being completely surrounded by and engaged in, cultures and contexts outside of that of the trainee, primarily within underserved, under resourced, isolated, or excluded populations. CUGH defines global health as “improving the economic, social, and environmental conditions people live in, and eliminating avoidable disease, disability and death.”¹ While global health experiences frequently occur outside one's country of origin, the operational definition of global health utilized is not synonymous with international health. Most frequently, these experiences pertain to encounters through which students experience contrasting health systems or cultural nuances in health access in economically scarce environments. Reflection in this context, then, surfaces a range of independent and overlapping themes presented through various student experiences both close to home and internationally.

What is the value of including reflection in global health experiences? First, when a participant knows that reflection on his or her experience is an expectation, the participant may approach global health more intentionally and thoughtfully. In an ideal scenario, the participant engages in a more contemplative manner; observations are more active than passive. For the astute observer, reflection is multifactorial and is inclusive of all five senses. Everything from one's own perception and biases, to the sights, smells, and sounds, enter into the experience. From the body language of others to one's own body language, the participant is acutely aware of the variations and nuance of the encounter. The participant notices the systems in place, accounts of justice and injustice, both in one's current location, as well as previous experiences, presenting elements that are both

concordant and discordant with prior experiences. Power dynamics are observed and questioned, or the absence of a power dynamic becomes apparent. But *why*? What value does this heightened sense of presence add to an experience or, conversely, how does this heightened sense of observation and analysis *detract* from the experience?

In addition to a heightened sense of presence in and engagement with global health, reflection urges participants to further explore the notion of *extracting meaning from experience*. Experience serves as the gateway to meaning. Someone may learn or believe something to be true, but if that belief is not verified through experience, or if that experience is somehow contradicted, beliefs adjust accordingly because experience has dictated a new dimension of reality. Experiences that prompt reflection range from subtle to quite dramatic. Reflection holds a deeply personal component. Expectations regarding reflection on experience may be expanded or adjusted to include targeted learning objectives, or to highlight desired course concepts, but generally speaking the starting point for reflection, the content without which learning objectives and course objectives would be irrelevant, is first-hand, personal experience. Experience can challenge us to the fiber of our being. It can inspire enduring change in even the most deeply engrained beliefs or practices. We see that, for better or for worse, the world is not always the way we believe it to be or have thus far experienced it to be. Going deeper, asking *why* and offering one's hypotheses and observations is how we attempt to draw meaning from or make sense of the distance between reality and the ideal, or the necessary coexistence of the two.

One approach to reflection can be conceptualized by thinking in terms of one's interpretive framework, or the structure of one's values and beliefs formed by life experiences thus far, against which all experiences are tested. Dutch theologian Edward Schillebeeckx captures the two simultaneously present dimensions of reflection through the use of the term *dauerreflexion* through which new experience is critiqued by one's interpretive framework, while also given the latitude to serve as a critique of that very same framework.² *Dauerreflexion* literally means "constant reflection," and the most immediate, tangible fruit of *dauerreflexion* is the ability to extract and define meaning by way of experience in a dually functional fashion. Based on one's interpretive framework, an experience is either accepted as consistent with the values and beliefs that were present in that interpretive framework, or the experience is rejected because it is inconsistent with the framework. Determining whether an experience fits within one's interpretive framework is complex; it is often not a simple yes or no.

Furthermore, *dauerreflexion* serves as the point at which a new experience comes to bear on one's very interpretive framework, testing its validity and applicability, either universally or particularly to the given situation. There are moments when the discordance between values and beliefs represented through one's interpretive framework

causes the individual to readjust her interpretive framework. Inconsistencies cause values and beliefs to be altered, purged, or built anew. At times this change occurs at the cognitive level and inspires subtle behavioral change, scarcely detectably by even the closest of friends. Similarly, even in the presence of significant change to one's worldview, consequent behavior change sometimes appears minimal to the outside observer. Occasionally, reflection on one's experience is so dramatic, so altering to one's interpretive framework, that significant, immediate, and lasting change to one's very framework results. Transformation has occurred. The transformed individual had engaged fully with heart and mind, embracing an openness to shift values and beliefs and, on some level, to admit incomplete or inaccurate beliefs.

Finally, incorporating reflection into global health requires a desire for complete and total *personal and cultural humility*. Participants who are asked to reflect can be guided to observe and not to judge, to enter this new experience to learn and not to teach, and to maintain a decided openness to the perspectives of "the other," both individual and cultural. The multifactorial nature of nearly every situation introduces a *certain relativity*. This relativity is not an "anything goes" type of relativity. But instead, the relativity that is encouraged through reflection in global health is a realistic relativity that is not conclusive but is exhortative. The relativity encountered exhorts the trainee to delve deeper into the reality encountered, into the factors influencing experiences that the trainee has never before experienced, or practices that the trainee had previously believed to be unsound or even immoral. The expectation of reflection in global health encourages participants to venture beyond the *fact* to explore the *cause*, beyond the *reality* to encounter the *ideal*. The personal and cultural humility inspired by reflection in global health is not meant to be passive or immobilizing. Instead, this humility serves as the basis of further discovery and of responsible engagement in the global arena.

In the foreword of this anthology, Louise Aronson shares the structured approach utilized at the University of California San Francisco by way of offering a pathway through which meaning can be optimally extracted from a new experience in one's journey from reflection to critical reflection. The five-step LEaP (Learning from your Experiences as a Professional) approach encourages learners to delve deeper into experiences in the setting of medical education. This structure is paramount in extracting meaning from experience and mapping a "clear plan forward through complex and challenging situations without simple or singular answers."³ Critical reflection in global health does not necessarily provide answers, but the value of critical reflection in these moments may provide the courage and determination to move forward by way of the newly evaluated framework of meaning, or through rebuilding the thoroughly deconstructed framework now in need of restructuring and rebuilding. A path is determined, even if existing only for a moment before further modifications are enacted, and a newly transformed

individual embraces a more firmly rooted and deeply inspired manner of embarking on this utterly rich, and quite often difficult journey, deeply influenced by the process of and guideposts placed through engaging in critical reflection.

Challenges of Reflection in Global Health: Value Questioned

Reflection, while extremely valuable, is not without its obstacles. When engaging in reflection or when utilizing reflection in educational settings, there are many potential challenges to consider. The inexperienced or untrained author may be tempted to write specifically to fulfill the expectations of the exercise and lack their own personal touch or depth. Similarly, the authors may write to what they believe the reviewer would want them to think or feel, or how they should react. There may be the temptation to exaggerate or embellish, to underemphasize or exclude. This temptation is particularly strong if a reflection is associated with a graded course or activity wherein the author may fear that certain points of view could mar the evaluator's grading or, more personally, the evaluator's opinion of the author. Another possibility is that the author has not yet come to terms with his or her own opinion, or is aware that their opinion or belief is not as commonly held or as politically correct as desired and hesitates to express herself fully. Information is withheld in these instances, leaving a recognizable hole in the logic and drawing incomplete or inaccurate conclusions.

Confusion around the structure of the composition or the expected components of a reflection can jeopardize the overall value of reflection for both the author as the innate value of the exercise. Reflection can be confused with narrative, which results in an often beautiful and descriptive piece detailing a typical day, or creating an elaborate and precise scene for the reader instead of delving more analytically into the experience. A related challenge that surfaces in reflection is insufficient guidance and or vague prompts. Clear expectations of the reflective exercise provides a basic rubric for the composition of the reflection, at the least, and serves as a reflection prompt into robust reflection at fullest capacity. Even though the learner's writing and storytelling skills might play a small part in the essay contest, they generally do not influence the assessment of reflective ability (Aronson, 2010).⁴ A structured process or guide to reflection helps improve reflective ability but raises questions about best practices around providing feedback on reflection.

A framework by which evaluators offer systematic feedback to trainees could promote and develop a more in-depth reflective process.⁵ Providing students with objective feedback, or how well a student has completed the reflection process given the outlined prompts and stated objectives removes an element of subjectivity from the process. Evaluators offer feedback on the *structure* of the student's reflection instead of solely

commenting on the *content* of the reflection. The concept of providing directed feedback on the structure of reflective exercises helps transition the concept of reflection to the more directed exercise of critical reflection, or “the process of analyzing, reconsidering and questioning experiences and of making an assessment of what is being reflected upon for the purposes of learning,” as defined by Louise Aronson.⁶ Structured feedback necessitates training of evaluators on desired components for reflections, as well as style of feedback to be offered, and would require protected faculty time in many institutional settings where training occurs. Most importantly, a supportive and safe environment must be created in order for participants to be honest and open in their reflections, knowing that they will be met by their supervisor or mentor wherever they are in their journey and accompanied to the next steps as they are ready and able.

To add yet another layer to an already complex process, reflection on human interaction in any culture or situation, even one’s own culture, is susceptible to projection or misinterpretation. The way the observer understands the reality of a specific scenario may deviate quite significantly from the reality of the situation. Many factors contribute the misinterpretation of a situation. We can see what we expect to see, or we are not fully conversant in the culture or language of the encounter and therefore misinterpret or oversimplify (or make more complex) an interaction or situation. We do not have to go abroad to have this experience; it happens to us in our own cities and countries. In the context of new experiences, reflection can provide a structure for allowing these experiences to serve a role that lies in the ambiguous ground between simple observation and lasting judgment.

One final confounding factor is that reflection brings the notion of privilege to the forefront. In global health, experience-based reflection stems from the very experience of removing oneself from one’s own day to day life in order to enter into the reality of another. This is a *privilege*. Global health participants may bemoan the expense, or increased debt loads, or the need to take vacation days for experiences that are not vacation, as defined by traditional standards, but the reality is that anyone who is able to participate in experiences in global health enjoys a certain level of privilege. It is a place of privilege, indeed, to come from a world where vacations, breaks, and daily routines are enjoyed without significant ramifications to one’s livelihood, without survival hinging on a lifestyle that is subsistence-based; to live this reality is a privilege. Remembering this privilege while engaging in experiences that are well-intentioned fosters a healthy sense of humility. Failure to remain humble in the experience one enters as a foreigner, as the other, can lead to being (perceived as) paternalistic. The “us/them” dynamic that innocently flows from the mouths of many upon exposure to underserved or under resourced communities can unintentionally reinforce negative power dynamics. Short-term medical trips can undermine the local health infrastructure as patients want to see

the pre-clinical American “doctors,” albeit supervised by attending physicians, instead of a local practitioner (to whom the visiting practitioners must ultimately defer). This challenge does not necessarily warrant the discontinuation of this type of experience, but instead, there is significant nuance to these experiences that needs to be considered carefully. Approaching these situations with deep and intentional humility, literally imagining the many factors that could negatively form the experience in some way and working to avoid or minimize negative effects, is worth all of the time and effort to neutralize crippling side effects of well-meaning experiences. There exists an ethical obligation to reflect thoroughly on scenarios created through global health experiences in order to move participants from observation to analysis, and perhaps ultimately to action. While this process takes many years, much experience, and significant guidance to engage maximally, everyone engaging in global health experiences starts somewhere. Observations are central to experience, and the structure of reflection invites participants to go beyond the *what* to the *why*. To enter into the reality of another, to contemplate root causes of difference, of injustice, and to allow oneself potentially to be transformed—which seems to be the most humble, most sincere form of lessening the power dynamic and the privilege that allows participants to witness realities distinct from their own. The belief that, when engaged responsibly, experiences in global health hold the capacity to build solidarity and serve as the foundation for positive change in the world that motivates participants and educators alike to incorporate structured reflection into global health.

Varying Educational Approaches to Reflection: Value Channeled

Reflection is a learned process. Individuals have varying skill levels when it comes to reflection, both in terms of the process required by reflection and the manner in which a reflection is composed. One value of incorporating reflection in a longitudinal manner, when possible, is observing students grow in their ability to reflect, as well as develop personally and professionally. Reflection is truly a life-long skill. One common characteristic of the essays in this anthology is that each reflection explored three necessary components of reflection: description, dialogue, and formation/transformation.

The descriptive elements set the scene for the reflection. This section often includes background information, key contextual elements and details, sensory observations, preliminary thoughts and emotions, and describes the interactions between the involved parties and their assumed roles in the scenario, perhaps even including that of the author.

The dialogue component details the interaction between the observed scenario or setting with the author’s interpretive framework. While the attraction to a particular

scenario might be initially presented in descriptive detail, the underlying depth to the reflection develops in the dialogue component. *How did the experience resonate with the author's interpretive framework and/or how was the experience discordant?* The author's core beliefs and value surface in this dialogue, incorporating all dimensions of temporality as well as various ideologies or disciplines.

Finally, a reflection involves formative or transformative elements. The formative component of a reflection involves action or change. New insight requires a new course of action, a new way of thinking, a broadened perspective. Alternatively, the formative component could serve to validate the author's current interpretive framework. In this case, the author comments on why this is the case and elaborates on the significance of her discovery. Beliefs or practices may become more deeply engrained. It is also possible for an experience to both resonate with and be discordant from one's interpretive framework. An example is when we receive confirmation on the way the world is, but we hope for more. We see the reality, but we hold out hope for the ideal, or at least more desirable conditions, and believe these more desirable conditions to be attainable. Reflections that are missing any of those elements either represent incomplete contemplation of an experience or the inability to express the fullness of the experience through reflective methods. This complexity reiterates that reflection is a learned process and requires targeted guidance.

Composition of the Anthology: Value explored

For the 2013 essay contest, 118 essays were received. Of the essays, 87 were submitted by trainees in Global Health at the graduate level and 31 essays were submitted by undergraduate trainees. There were 12 reviewers from 7 institutions in the United States. Essays were double reviewed, blindly, scoring essays from 0-10 in four areas: Originality, Style/Composition, Critical Reflection, and Impact on the reader. The top 45 essays were reviewed and ranked by the Essay Oversight Committee in order to select the winning graduate and undergraduate essays, as well as to identify 6 additional essays to be read at the Conference. Finalists and winning essays were invited to be published in the Anthology. The essays scoring in the top 50% by reviewers were selected for inclusion in the Anthology. 54 essayists were contacted and 37 accepted the invitation to publish their essays in the Anthology.

The 2014 call for essays received 166 essays. Of the essays, 142 essays were submitted by trainees in global health at the graduate level and 24 essays were submitted by undergraduate trainees. While the majority of the authors were from the United States, 10% of the essays were received from other countries. There were 22 reviewers in

total, 18 faculty and 4 students, from institutions in the United States. Essays were reviewed and scored according to the same criteria listed above. The top 21 essays were reviewed and ranked by the Essay Oversight Committee in order to select a winning graduate and undergraduate essay, as well as to identify 6 additional essays to be read at the Conference. Finalists and winning essays were invited to publish their essays in the Anthology. During the initial review process, reviewers indicated whether the essay should be included in the Anthology, should be considered for the Anthology, or should not be included in the Anthology. The editors reviewed those essays which were recommended for inclusion and consideration. The 2013 and 2014 editors selected the final essays for inclusion through a collaborative multi-step process. Each of the essays was personally reviewed by one of the co-editors, and then discussed over Skype for definite inclusion or potential inclusion. After thorough review of the invited essays, 63 entries were confirmed for inclusion in the first anthology. Those selected were edited, resubmitted to the author for approval, and included following receipt of final authorization. Special attention was paid to preserving the author's content, thoughts, and voice.

In keeping with a commitment to mentorship and highlighting of trainee capabilities, a team of five trainee co-editors (two for 2013 and three for 2014) were selected to collaborate with essay authors to refine their pieces. Ishan Asokan and Shawn Wen were the co-editors for the 2013 essays. Ishan is currently pursuing his medical degree at Vanderbilt University School of Medicine and received his M.Sc. in Global Health Science from the University of Oxford, while Shawn is conducting research at the Malaria Elimination Initiative within University of California San Francisco's Global Health Group. With direction and support from the faculty editors, Ishan and Shawn put forth a successful grant to the Arnold P. Gold Foundation for Humanism in Medicine to fund the publication and ensure its open-access status so that it could reach its wide intended audience.

The co-editors for the 2014 essays were Ambar Mehta, Kathleen Miller and Carmelle Tsai. Ambar is currently a medical student at Johns Hopkins University School of Medicine. Kathleen graduated from the University of Iowa Carver College of Medicine and is currently a pediatric resident at the University of Wisconsin. Carmelle graduated from Baylor College of Medicine and is currently a pediatric resident at University of Texas Southwestern Medical Center and Children's Medical Center of Dallas.

There is something very special about this first round of essays. There was no precedent. The reflections submitted possessed their own style and personal content. No previous anthology dictated any standard, either actual or perceived. No previous finalist or winning essays influenced the style or content of the submissions. In this regard, this anthology, this initial group of essays, is unique indeed. The essays received

were of extremely high caliber. Authors grappled with very real, pervasive topics that prove central to engagement in global health time and time again. Trainees encountered systemic injustices and the impact different belief systems have on health decisions and outcomes. The notion of global citizenship became real in a new way for participants as the many faces of global injustice surfaced, inviting participants to embrace the responsibility of reducing the global burden of disease. Trainees defined and redefined cultural humility, attempting to see their global citizenship and its consequent, enveloping interconnectedness through a new lens. Personal and professional growth blossomed as hopes and dreams of solidarity took root. In the midst of discouragement and doubt, surrounded by other-ness and despair, lessons learned and experiences garnered grounded these authors in their development of global realities and perspective. Love. Laughter. Struggle. Confusion. Bewilderment. Empowerment. Inspiration. Compassion. Empathy. Discouragement. Transformation. Solidarity. And more.

Utilizing this Anthology in Global Health Education: Value extended

The hope for this collection of expertly crafted, deeply personal, globally-situated essays is that they will affirm, inspire, and challenge the reader and, on a personal level, these essays can serve those engaged in global health experiences as a way by which to explore the world through a variety of perspectives offered, moments shared, and questions raised. It is a privilege to have the opportunity to walk alongside another, even once- or twice- removed. The authors of these essays have graciously shared of themselves and their experiences to invite the reader to join their world, if only for a moment.

For seasoned global health practitioners, some essays will *affirm* the reader, as similar experiences resonate with past experiences. Similar situations may have been experienced, similar conclusions may have been drawn from those moments.

The reader may also feel *challenged*. New perspectives on similar experiences may be demanded. Experiences offered through these reflections may draw the reader anew into conversation with her interpretive framework, to revisit conclusions drawn. Other essays may present the reader with entirely new, previously inconceivable or unexplored feelings and emotion. The reader may reevaluate the values and beliefs held in his or her interpretive framework. Reactions may range from personal consideration to systematic evaluation and discourse.

The reader may be *inspired* through this anthology to continue to work in global health, to partner globally for positive change through many related any overlapping factors: reduction of health disparities, increased health equity, mitigation of injustice, solidarity, perseverance. There is always more to learn, shared experiences to be witnessed, the

fullness of humanity to be shared—in laughter and in tears, through success and through struggle.

In an educational setting which includes an experiential component, these reflections can serve as a helpful tool at various points throughout the trajectory of the experience. These reflections may be used to *prepare* students for experiences in global health, introducing the concept and structure of reflection, as well as demonstrate the range of experiences and emotions. This anthology can be utilized *during* an experience in global health, providing select texts to encourage the trainee to delve deeper into the experiences of another to find companionship and to offer a variety of templates for reflection in the process of extracting meaning from his or her current experience. Essays from the anthology may serve as a fruitful prompt *after* experiences in global health by way of encouraging trainees to compose a reflection in a similar fashion. Similarly inviting students to select essays that resonate with their own experiences may help students identify within themselves, as well as for their fellow classmates, similar experiences, emotions, or meaning drawn from their own experience in a context of conversation or debriefing.

This anthology may be used outside the specific parameters of experiential education to reiterate concepts emphasized through coursework in global health or in related fields. The complex and interdisciplinary nature of global health practitioners invites a plurality of voices, experiences, and intertwined, often interdependent, influential factors. Essays from this anthology may complement a variety of themes presented inside and outside the classroom. In discussion around compassion and commitment to solidarity, these essays provide ample insights and a variety of perspectives for discussion.

And, finally, we welcome your feedback on how you have utilized the essays included in this anthology to fortify, incorporate, and advance the practice of reflection in global health.

Shades Off

By *Nauzley Abedini*

I recently completed a yearlong research fellowship in Kumasi, Ghana. Looking back, the research question was only a small impetus for embarking on the fellowship. A more salient motivating factor was the opportunity to live and work in an under-resourced setting and learn firsthand about the challenges underlying healthcare delivery and research study implementation. Most importantly, I hoped that by committing to live elsewhere for an extended period of time, I would avoid the ethically ambiguous ‘medical tourism’ we so frequently hear about and condemn in global health academia. I wanted to establish legitimacy as an advocate and partner by building strong ties with community members through immersion. With time, I hoped my foreignness would erode away, and I would become part of the fabric of the community—accepted, familiar, and comfortable. Additionally, the prospect of learning about Ghanaian culture and making lifelong Ghanaian friends excited me immeasurably.

My enthusiasm dissuaded me from giving significant thought to the potential obstacles I would face. My longest previous experience in a developing country had been approximately two weeks; I didn’t know how I would handle being on my own in a foreign country for so long, especially one in which the routine comforts of home, like water and electricity, were sporadically available. Second, I was working with people in Ghana whom I had never met. I had no idea whether we could collaborate on a research project for an entire year and simply, if we would even get along.

Things were certainly tolerable at the beginning. The random water shortages and power outages were new adventures. The frequent physical prodding by market sellers as I dodged goats and taxis in the bustling Kejetia Market (home to 10,000 traders and the largest market in West Africa) paired with the incessant cries of, “Hey, foreigner, come buy my things!” were survivable, even avoidable, if I planned my days properly. The swarming crowds and polluted downtown could be tolerated in small doses.

But slowly, these events started to take a toll on me. I would retreat to my tiny apartment and feel a physical and mental exhaustion unlike anything I had experienced

before. I grew wary of the constant sensory overload and the frequent reminders of my foreign-ness. It soon became apparent that I would never be seen as a co-inhabitant of Ghana no matter how much time passed nor how much I tried. As this reality set in, I escaped to the only place with familiar terrain—myself. I became more reserved. I closed myself off from new experiences to conserve or, more accurately, preserve my mental well-being.

I slowly became disillusioned. My original, albeit lofty, goal of making lifelong Ghanaian friends was progressively dispelled as I found that the cultural differences were sometimes insurmountable. Making friends became even more difficult once I started shuddering away from new experiences and attractions. My time in Ghana soon became an individualistic endeavor to survive. Work was the only thing I knew how to do well, and for a time, it was a sufficient distraction from the painful realization that I would never fit in. Slowly, my priorities began to shift. I became entirely task-driven. I lost sight of those intangible things that would have brought balance and richness to my experience.

It wasn't until I neared my three-month anniversary in Ghana that I truly came to terms with what was happening. Some issues came up with my research that made my project come to a temporary standstill. The crutch of work that I had devised for myself was suddenly knocked out from under me, and the stress caused by things that I had previously been avoiding or barely tolerating became amplified. I was suddenly acutely aware of how out of place and lonely I was. I started questioning why I was even in Ghana in the first place—I wasn't doing anything to help anyone directly. I was only thinking of myself.

Interestingly, during this time, I had started wearing my sunglasses a lot. At first it was out of pure necessity because of the blinding sunlight. Then I realized my shades could offer a sense of protection, hiding my eyes from the market sellers who incessantly vied for my attention. I even took to wearing my sunglasses in the medical student hostel where I lived. Soon I was wearing them all the time, even when it wasn't particularly sunny outside, and even when I wasn't going to the market. I didn't realize that my shades had become a barrier: a physical marker of my mental and emotional self-closure to interactions with people in the local community, the same people whom I sought to help through research, as well as the medical students with whom I lived, who could be potential friends in the short-term and potential colleagues in the long-term. I was isolating myself, and I was closing myself to the most influential and powerful experiences of living abroad: interacting with and learning from people who are different from myself.

Prioritizing work and seeking isolation are very Western practices. How many of us find ourselves in a hurry to get to work, and pull out our cell phones to falsely

absorb ourselves in a text message in order to avoid conversation with someone who is approaching? How many of us measure our success by our task-related outputs at work, and sacrifice our friendships to achieve those ends? I never realized what an oddity it must have been for people in Ghana to see me rushing about with a cursory smile or wave of the hand to my neighbors (or sometimes no acknowledgement, I'm ashamed to say) and to see me always wearing my shades.

One day, one of my few Ghanaian friends approached me and said, "Why are you so time-conscious all the time? Your work will be there for you later. If you want to make more friends, take off your shades and make some time for people." It was a subtle yet remarkably important transition point, to realize that while I may always be viewed as a foreigner, I was not doing anything to help my cause. In fact, I was perpetuating my own isolation. From that point onwards, I made a conscious effort to take off my shades as I approached people on the street or in the hostel compound. I put work out of my mind and slipped a smile on my face. Though it all initially felt completely manufactured, I had to get over my own pride to admit that my self-isolation was a poor coping mechanism. Soon, I started having more organic, meaningful conversations with people and made several new friends.

In hindsight, I realize that the interactions I avoided were actually the gateway to mutual understanding, the foundation on which those lifelong friendships I so eagerly sought are built. As a result of subtle changes in my behavior and mindset, I had so many interesting conversations that enriched my experience in Ghana, invigorated me, and granted me new and compelling purpose to the research I was doing. I interacted with the potential beneficiaries of my research and built relationships with future colleagues. It was just a matter of revising my goals and priorities and accepting the reality—that I would always be seen as an outsider, but that being an outsider is not necessarily incompatible with being accepted or familiar. My advice to anyone who is engaging with people in a new environment: take your shades off and adjust your vantage point. You'll be surprised what a difference it makes when people can meet your gaze and how much brighter everything seems.

Nauzley Abedini is a student at the University of Michigan Medical School.

Break the Silence

By *Nauzley Abedini*

A mother held a lifeless infant in her arms – an infant who minutes before had been healthy and active. Her shocked and bewildered cry hit me like a tsunami, threatening to drown me in the grief one only associates with an unexpected, devastating loss. Instinctively, I reached out to touch her arm – to comfort her – but I suddenly recoiled at the sight of my pale hand, a startling reminder of my foreignness. I resigned myself to watch from the periphery as my Ghanaian colleagues gathered, encircling the wailing woman. She sat alone in a pool of cruel sunlight, rocking back and forth to the rhythm of sorrow, still clutching her dead child to her breast. I waited expectantly, in painful silence, for someone else – someone less foreign – to provide the solace that I could not.

Finally, a senior nurse stepped forward from the crowd. My heart leapt in anticipation of a show of empathy. But no – the nurse suddenly started a soliloquy, vigorously and repeatedly reenacting how the mother had wrapped her baby too tightly, ultimately suffocating it. With each rendition, the mother's wails escalated in intensity as she endured the public shaming. In truth, she had not been responsible for her baby's death, yet she bore the brand of guilt from the nurse.

I again felt the urge to go to the woman's side – this time to shield her from the nurse's accusations – but I held back. I stared down at my white hands, taking in the irony that I held so much power, but felt so powerless. I was a privileged outsider, a guest in an alien culture. My skin color and Western upbringing afforded me an uncomfortable level of influence and constant scrutiny. Any action on my part, while perhaps temporarily quelling my own desire to provide comfort to a suffering human being, could potentially be construed as intrusive and condescending. I was terribly fearful of the consequences that could come from my interference, and thus remained silent.

I spent nearly a year in Ghana, taking in more circumstances that left my moral compass spinning: physicians wittingly turning their backs on their patients and their profession during repeated, prolonged strikes; providers making countless verbal and physical assaults on patients in my presence. I stood by, reticent and passive, adopting

a mask of unconcerned amiability. All the while, my inaction made me feel like an accomplice to social injustice. I tried to tell myself that it was right to stay out of it, and that passing judgment on such situations using a foreign ethical framework was inappropriate and unfair.

Yet I felt hatred brewing within me. I hated the providers who behaved in ways that I believed were fundamentally at odds with our professional obligation as healers. I hated the culture that condoned such dispassionate behavior towards those who, by no personal fault, had been born into a destitute and disempowered life. And, oh, how I hated myself. I hated my hesitancy to serve as an advocate. I hated my skin color and all of its social implications that kept me from connecting with others. Above all else, I hated my own capacity for intolerance and judgment.

I sought desperately to counter my disenchantment with Ghana and humanity, looking for inspiration amongst the devoted doctors crossing picket lines and the compassionate providers treating patients with kindness. I even tried rationalizing the ethically dubious behaviors I witnessed. Perhaps those providers aspired to treat patients with a tender hand, but in the face of so many environmental stressors and resource constraints, they couldn't. Perhaps they went home at night and felt remorse and self-hatred as I did.

Yet, despite these rationalizations, I was consumed by an overwhelming sense of apathy towards my colleagues and work environment. I condemned their behavior as un-humanistic and immoral. I, myself, witnessed injustice and failed to rise to the occasion again and again. I was simultaneously a self-righteous, moral bigot and a hypocrite. There is no worse sensation than holding yourself to a certain moral standard, but finding that your actions are discordant with it. It leaves you feeling deeply depraved, empty, and false.

When I returned to the States, the emotional vacuum remained. I resented the lauds I received for my work in Ghana, feeling unworthy of such praises. I met individuals who had spent time abroad and envied their elation and sense of purpose as they recounted the inspirational circumstances and people they had encountered. I wanted desperately to feel the same way, but didn't. Behind my mask, I struggled to hide the intense disorientation that threatened the lens through which I saw medicine and humanity. Most of all, I felt deeply unsettled and ashamed by what my experiences had taught me about myself. I was prone to hatred, prejudice, and cowardice.

I desired intensely to tell someone how I felt and remove my self-constructed mask. Perhaps, in the act of telling, I could repent for my hatefulness and complacency. And so, four months after returning from Ghana, I found myself sitting in a meeting with my mentors, struggling to find the words to set myself free. Surprisingly, I didn't need to say much. My mentors saw right through my guise with the practiced wisdom of those who

have borne and cast-off masks of their own. They offered simple yet pivotal advice: “Just accept. Accept the good, bad, and ugly, both within you and around you.”

Every day since then, I have endeavored to accept, and also to forgive. I have found it easier to forgive those who made me question the fundamental good within humanity and myself. Self-forgiveness has proven more difficult. I constantly question the appropriateness of my silence in Ghana and remain haunted by the notion that I could have done more to give a voice to victims of social injustice. At least, in speaking out now, I have found solidarity. I am comforted knowing that I am not alone – that others are fighting their own internal battles, questioning the silence.

Nauzley Abedini is a student at the University of Michigan Medical School.



View from inside the ‘Door of No Return’ at Elmina Castle, a former slave-holding fortress in Ghana.

Photo credit: Nauzley Abedini

The Lone Man at a Child Welfare Clinic: Making a Case for the Role of Men in Neonatal Health

By *Henrietta Afari*

It is a widely accepted cultural norm in Ghana that mothers are directly responsible for caring for their newborn babies. They are expected to feed the infants, nurse them, and ensure their overall health and well-being. At a typical child welfare clinic, there is often a crowd of mothers presenting their children for review, proudly strutting as they bring them up to be weighed and baring their children's arms and legs for yellow fever and BCG vaccines. But in all the excitement that happens following childbirth, one often wonders: where are the men? Is there a need to revisit the apparent invisibility of fathers in the fight to reduce neonatal mortality in Ghana, and is there a way to encourage greater participation from them in neonatal care?

Two summers ago, I had the privilege of observing a child welfare clinic session at a remote rural community in southern Ghana. The makeshift clinic consisted of a few benches under a tree for the clients, a desk for the nurses, and a rectangular wooden structure with a weighing scale dangling from a hook in the middle. Not surprisingly, there was a teeming mass of women waiting to be seen by the nurses. A few hours into the session, we all looked up to see a man appearing to be in his mid-40s walking up to the clinic, beaming with pride, with a baby in his arms and a green child welfare booklet in his hand. He was unaccompanied.

"Where is your wife?" Many mothers asked.

"She is busy. She is getting her hair done at home," he replied. Almost immediately, a slew of reprimands were hurled at this apparently negligent mother. Did she think she was better than all the rest of the women at the clinic? How could she sacrifice the health of her baby for something as seemingly trivial as looking nice? Surely, she needed to be punished for her slack behavior. In all the uproar that followed, no one acknowledged the laudable efforts of this conscientious father. He could have agreed to skip this week's

child welfare session with the excuse that the person tasked with doing so was busy. Or, he could have used the excuse of work to leave such matters to his wife. Instead, he realized the importance of ensuring that his child's growth was progressing at expected rates and that his immunization status was up-to-date. Despite its noble aspirations, the work of this father went unnoticed. At that clinic, the role of the father had been made invisible. The lone man said not a word. And after he got all his baby's vaccines and well-checks, he left the child welfare clinic, arguably with less confidence in his stride than he arrived with.

Every year in Ghana, 76 out of every 1000 live births die before they are five. About 29% of these deaths occur within the first four weeks of life. Neonatal deaths (those within the first month) undoubtedly account for a significant proportion of deaths among children less than five years old (under-5 mortality) in Ghana. Reports show that more than 80% of neonatal deaths are preventable with good quality antenatal, perinatal and postnatal care,¹ and child welfare clinics function as a mechanism for health staff to give regular postnatal care to infants and children. A defining feature of most of these clinics is health education where clients are educated about the importance of immunization and growth monitoring, and instructed on how to properly care for their babies. At the community level, this often takes the form of durbars and radio shows where mothers are encouraged to present their children for regular, scheduled review. Not surprisingly, fathers are rarely targeted in community education nor are the efforts of the few who care for their children commended.

In the fight to reduce under-5 mortality in Ghana, it might be worthwhile to leverage fathers' existing interest in their children's welfare and engage them early as key stakeholders. For instance, if two parents are educated on common neonatal causes of death like sepsis or asphyxia, there will be two pairs of eyes instead of one looking out for danger signs, and the chances of early recognition and timely treatment will be increased. Moreover, with most rural Ghanaian communities largely operating patriarchal systems of governance, ongoing neonatal and child health efforts stand to gain immensely from including fathers and men, as well as women, not just in final policy endorsements but rather earlier in the process to allow for richer, more empirical, and more invested discussions of effective change ideas for improvement. In the effort to accelerate Ghana's achievement of Millennium Development Goal 4 of reducing under-5 mortality by 66% by 2015, it may be worthwhile to borrow from ongoing national family planning efforts. The group's most recent campaign ad on national television runs under the banner, "Are you a real man? Real men plan their families." With similar motivations, child health

¹ Lawn, J. E., Cousens, S., & Zupan, J. (2005). 4 million neonatal deaths: When? Where? Why? *Lancet*, 365, 891-900.

campaigns should encourage fathers to become more involved in the healthcare of their children with a slogan that could say something like this: “Are you a real man? Real men know their children’s next polio vaccination date.”

Henrietta Afari grew up in Accra, Ghana, and came to the US for her undergraduate training. She is currently a 4th year medical student at Harvard Medical School, with plans to pursue residency in internal medicine next year while maintaining her interest in health systems strengthening in sub-Saharan Africa.

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My American Project

By *Stephen B. Asimwe*

Coming to America

Sometime after University, I knew I wanted to leave my country. By all standards, I was from a problematic demographic. Born and raised very poor, I had, as a child, strangely built many castles in the air — which I did not get to live in — but I had remained optimistic. I still had time. Then, childhood had come to an abrupt end. Without warning, I had become an adult. Praises had morphed into expectations, and feelings of “*missions unaccomplished*” were taking me over. I had to go somewhere or run out of time.

America though was not my first choice. The eleventh of several children, I was grateful for the scarcity, sometime back, of family planning services in Uganda, but I was the first to go to University. I would face a hard time alone in America. But both America and the University of California San Francisco were lands of opportunity, or so I had been told. I took the risk.

The first flight is the longest

The physical distance between Uganda and the US is quite large. By the time we arrived at the airport in San Francisco, I had not seen the night, but knew that I had been travelling for days. I went to baggage claim to find a chair, and sleep; I had lost interest. As I entered baggage claim, someone called my name. It had escaped my mind that this lady would be receiving me at the airport. Sitting in her car, with her driving out of the airport at an incredibly high speed, I somehow regained my interest in my American project. I began to reflect on what I had seen today — and would see subsequently.

My mental sketch

Before travelling to a new place, we usually create mental sketches of what it will be like. My mental sketch was not bad but was fraught with underestimations. As an example, I had expected long bridges, but had underestimated the size of their pillars.

I eventually concluded that infrastructure, energy, and transport, are what distinguish rich from poor countries. Infrastructure is orderly steel and concrete, and wide roads. Energy is electricity running everything, and everyone knowing that it is important. Transport is trains that allow you to live miles away from work, and airports where planes line up to take off or land — continuously. I had always criticized western systems as being a little too perfectionist. With time, I thought that maybe the perfectionism was justified. To have thousands of planes crisscrossing one another's path every day, you must get it right — all the time.

My language problems

On a connecting flight to Chicago, a United Airlines flight attendant had asked me: "What can we serve you, sir?" I had replied, "Hot water." In my rather direct accent, hot would have sounded like: "hawt"; water like: "wotta." She, rather strangely, did not seem to hear me. My neighbor then intervened and told her, "He said he needs hot water." In her American accent, which nearly got me protesting, "Hey, that is not what I said!" "Hot" would have sounded like "hat," with the "t" a little silent, "water" like "wada," with the "d" neither a "d," nor an "r," but the so-called "silent d." This conversation was a prophetic sign to me of impending problems, but I had not paid attention.

I was to later learn that people genuinely did not hear me when I spoke, a very disappointing realization. Like everyone else, part of my grand plan was to make new friends. How would this happen if they did not hear me? As time went on, I got my answer. The conversation would get strained eventually forcing one of us to pretend that they heard what the other said by nodding in agreement; a highly risky strategy. I just asked you, "Where did you eat out last Friday?" and nodding in agreement, you reply, "Okay!"

Over time, I watched educational YouTube videos, and improved my English, aiming, in part, to open my mouth more, and be a little louder, and more articulate. I eventually became more audible, although I do still get those bewildered stares going like, "*What on Earth is he talking about?*" Most definitely, they do not get my jokes. With jokes, you can tell, especially if you are sure that what you just said is funny; and they are looking at you like nothing happened.

Civilization

I have come to think about civilization differently. I think that civilization is when you hurry on the road but slow down on the door; and if someone else appears to be in a hurry (at the door), you let them go in first. It is when people feel that there is going to be enough for everyone, and that it will not matter, if they miss out, and so, see no need to squeeze against each other in order to get through first. It is also when people respect the

thoughts, feelings, and opinions of others, and admit that people are different, and that people will remain different. At times, I nearly take back my definition when someone shoves me off a line. I do also see some that hope to make everyone the same, or give no regard to the feelings, or status of others: America has got its own problems. For most people though I guess, it remains the land of opportunity.

Final thoughts

I have learned a few things about American society. I think that, compared to my country, America is more nuclear (no pun intended), i.e., organized in smaller units of family and friends. There is a private space around everyone, but (some) people, are actually nice. Contrary to what it might be in my country, in America, immediate reactions to a stranger seem to range between indifference and suspicion. Finally, I should never have worried about the food: it is okay.

Despite all my problems, my so-called American project — which really is nothing but an unrealistic plan to eventually see one of those castles that I once built — has taught me that striving for excellence, whether as an individual, or as a society, is (sometimes) not in vain. Tunnels can actually penetrate mountains, and bridges that look impossible can be built. In a way, some of these things have validated my personal optimism: even the wildest things you can imagine are not always impossible.

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Behind the Baobab Tree: A Story of MSM Culture in East Africa

By *Ishan Asokan*

The Indian Ocean's foamy mist greeted us as we arrived in Mombasa. Twelve years had passed since my first visit, and now, with a backpack filled with memories of coconut trees and shimmering coastlines, I embarked on a journey that would forever alter Mombasa's meaning to me.

Before that evening's stakeout I had spent three months studying Kenya's MSM (men who have sex with men) commercial sex industry. During my investigation, I struggled to understand how, in a country where homosexuality is condemned and criminalized, such an industry could thrive so publicly. Through my many conversations with players on both sides of the game I encountered fathers, sons and husbands secretly soliciting what belonged to them - their identity. But, these interviews were not enough; I had to see this underworld for myself. I needed to go to Mombasa's famous nightclub, Bishara.

Choking back hesitance, I entered Bishara with my very own Virgil, Saif. Saif was a member of our prevention staff, and took it upon himself to show me this dark side of Kenya. Over the course of three months, I came to know Saif very well. I learned that he was HIV+, that he struggled to adhere to his medication regimen, and that despite enduring instances of rape and abuse, Saif found solace in being a part of HIV prevention. I grew to trust him and on that particular night, I was glad to have him with me.

After wading through a maze of lust-drunk tourists, dancers, and businessmen, we secured seats by the bar. With keen interest I examined my surroundings, only to later discover that I was being thoroughly inspected myself.

"May I sit?" winked a beautiful Swahili girl. "Oh, sure" I responded. But before I could even ask her name, I felt her hand reach for my thigh. Alarmed, I pushed her away and said, "Please don't do that. It makes me uncomfortable."

"Then why are you here? Are you not a man? You are behaving like a *mshoga* (homosexual)!" she cackled. But when she saw my guide, and recognized Saif, her

countenance transformed from charming to frightening. “I *hate* gays,” she shouted. “You are ruining my livelihood. You are ruining my work, OUR work.”

This was not the first time I saw the MSM sex industry threaten its female counterpart. In visiting clinics in Kilifi and Malindi, I heard of male commercial sex workers (MCSWs) charging three to four times the going female rate for similar services. Female commercial sex workers (FCSWs), quite unsurprisingly, detest and protest the presence of MCSWs vying to dissuade otherwise curious clientele.

Though I was no client, the sex worker’s embarrassing remarks made me feel, for the first time, unwelcome in East Africa. My attention, however, was soon drawn to a male sex worker watching nearby, Masha Baanu.

“Don’t mind that silly girl, my sister,” he chuckled as he slid into the vacant seat.

“What’s your deal?” Saif responded with a giggle.

“Ha, just finished with a client in the bathroom. Had to pay the *ascari* (guard) to keep watch so we could do the deed. But still, the *mzungu* (white man) paid me so little. I can’t even buy cigarettes for the Matatu ride home,” said Masha.

“How much did he pay you? Did you use a condom? Do you know his HIV status?” I fired off the questions, attempting to mask the light buzz I was starting to feel from my beer.

“No, I got 500 shillings instead of the 300 I would have got if I’d made him use a condom. It’s pretty simple, really. And HIV, well that’s a done story,” he lamented, ordering cigarettes on our tab.

This was a common response, especially on the coast. Unlike this particular MSM, many get offered enormous amounts for unprotected anal intercourse. Despite the condom dispensers in nightclubs, clients often opt for the short-term enhanced pleasure over the long-term risk of infection. Just beyond Bishara, numerous sex houses make securing a bit of fun all too easy.

“So, *se-Ma* (tell me), why are you here with no man?” Masha asked.

“I’m here for field work,” I said. “And, what brings you here?”

“Well, that’s obvious. We all want a *mzungu* or a *mubindi* (Indian) to whisk us away. It’s hard here. We do this to eat, to drink. We get beaten, harassed, and jailed for the lives we live.”

He continued as he puffed his cigarette, “The worst part is that it is low season now. We are anxious, driven to steal, and willing to accept any payment we get. The *mzungus* come from Nairobi to drug us, have their fun, and leave without giving us so much as a shilling.”

I listened as Masha talked, but was preoccupied with worry over Saif’s now lengthy absence. Though he had assured me he would return in a few minutes, nearly an hour

had passed since his departure. Unsure of where he had dashed off to, I closed the tab and went out in search of him.

Bishara was hardly navigable for a newcomer and I was unnerved each time I entered a different room or new corridor. When I got to the ground floor, I was shocked to find even scarier surprises housed within it. As I opened the door, I saw Saif getting dressed, after finishing with what appeared to be a session with a client. He quickly scrambled to gather his things, pulling me forcefully out of the room. I had heard the rumors that some of the prevention staff engaged in transactional sex, but I was unprepared for the sadness I felt seeing that it was true.

The guilty Saif stared at me, trying to gauge my reaction. But, beyond my initial feelings of shock and sadness, I was beginning to really understand the nature of his actions. HIV prevention and sexual safety in Kenya could no longer be restricted to regular testing and distribution of condoms. The reality was that treatment as a form of prevention had to be embraced as it was clear that risky sex would continue.

From an outsider's perspective, it is easy to see the challenges impacting most at-risk communities, but it's saddening to see the challenges within them. Not taking ownership of their safety and accepting little pay for unprotected sex keeps the world's oldest profession alive and well in Kenya. But, that is what happens, when there is no other way to survive.

Ishan Asokan is a student at Vanderbilt University School of Medicine.

Love and No Other Drugs

By *Ishan Asokan*

The scorching heat of the Arabian sun greeted my frail face as I awoke that Friday in Amman, the capital city of Jordan. It had been nearly four weeks, and my research block at one of Jordan's premier hospitals was drawing to a close. I appreciated my practicum in the Middle East, since the country offered scientific luxuries I naively believed to exist only in the States. State-of-the-art labs, the newest chemotherapeutic agents, and plenty of support from Arab financiers branded this hospital as a top contender in the international healthcare industry.

My Friday that week, however, would change my perception of Jordan's health system forever. It was during this time, the summer of 2013, when the Syrian Crisis began to escalate. The *Zaatari* Camp, famous for swelling Jordan's population by nearly 20% in a mere couple of months, became the focus of the United Nations Development Programme and the world. Thousands of aid workers and troops attempted to meet the demands of the crisis, but failed to keep up with the droves of refugees freshly occupying Jordan's border cities.

My contact with Syrians was sparse until a week into my stay, when a merchant from Damascus moved into the apartment next to me. Mitra, a jeweller in Amman for nearly three years, immediately captivated the attention of our complex. His pride for his country was reflected in the fine arts he traded, but his hospitality was his greatest gift. Each night's festivities centered upon meals with Mitra, as he would dine us, entertain us, and shower us with Syrian traditions and customs. But, to our worry, Mitra's demeanour rapidly changed one morning. I recall hearing a horrific cry in the apartment next door when the city of Aleppo came under attack. While the BBC reported mounting atrocities, Mitra was informed that his family had been injured from air strikes. The greater tragedy was the lockdown that took place shortly thereafter, preventing him from breaching the Syrian border to provide help.

His only therapy, at the time, involved seeing other Syrian refugees stationed in Mafraq, a border town not too far from Amman. And, given that it was Friday and a

day dedicated to *Allah*, I felt compelled to help him in his time of need. So, I joined him as he filled his van with toys, candy and clothes for a trip to this now controversial city and haven for the displaced.

The small town of Mafraq hosted numerous refugees, many of whom were now described as insurgents by the Jordanian media. The UN labelled *Zaatari* as unsafe and a source-point for drugs and crime, further crippling the role of aid efforts. Mitra routinely volunteered, however, in the small tents flanking this fortified campsite. He made promises of bringing healthcare and medicines to the patients in need. I did not realize, however, that I was the healthcare he was then referring to.

Without even a stethoscope in hand, I ventured into the colourful UNHCR compound, routinely introduced as “the Doctor.” At this point in my career as a medical student, it was customary to blindly nod in agreement with a suspected ailment, without knowing the scientific basis for its occurrence. I thus remained a novice at physical diagnosis, which was visible at the time. Though I knew I had limited skills to offer, Mitra’s words of encouragement somehow nudged me into the first tent.

This small home featured a veiled grandmother with blinding glaucoma, to which I responded with a presumed diagnosis but failed to treat. The second tent I entered showcased a father of five who sustained five bullets to his leg. A botched procedure and series of infections following insertion of a metal rod rendered him unable to walk, possibly for the rest of his life. To this handicap, I shook my head in disbelief and disapproval. The third tent, now housing eight family members, featured a man with two wives, one of whom suffered from a bout of dermatitis. To this, I mentioned potential treatment with a topical corticosteroid. Again, a resource that was then also absent from my arsenal.

As I travelled from tent to tent, the guilt of providing nothing more than kind words weighed me down, highlighting the unforgiving inequity I benefitted from for the past four weeks. Just an hour away from this decayed, sand dune city stood a mecca of medical aid, one in which these patients could receive immediate resolution and life-altering care. But newfound racism, a lack of resources, and the challenge of a population exceeding a nation’s supply barred access to treatment. It hurt me to see Mitra’s dual expression of sadness and gratitude, further evidencing that Syrians were to remain a foreign entity, perhaps even permanently, in this land.

When I asked Mitra why he brought me to this camp, he said he just wanted me to witness the plight of his people. Even this empathy, this ‘love’, was enough to inspire awareness for the position of his community. He was convinced that through prayer and devotion a solution would come in weeks, perhaps even months. But I was convinced that these people needed more than the love Mitra spoke of – they needed basic, unprejudiced care.

Though I am unsure what may happen to the Syrians I saw that day, or in the final weeks of my stay in Amman, I know that the world's eye needs to be refocused on them. It is a crime to be gifted the skill of caregiving if this care is to be restricted and laced with prejudice. It is thus unsurprising that I worry for the people in the Middle East and simply hope they receive more than our thoughts. But, this is the story, when there is love and no other drugs.

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Hacking for Human Rights: Global Health in the Age of Radical Transparency

By *Bethany Bogges*

Globalization has dramatically affected the health of populations; access to food, clean water and health care are increasingly controlled by multilateral institutions and corporations. Radical transparency is an ideology embraced by hacktivists (hacker + activist) that calls on governments and corporations to operate openly in the new global era that relies on digital information networks, often with the end goal being the advancement of human rights. Wikileaks and Edward Snowden are well-known examples of acts of radical transparency that have exposed violations of civil rights and blatant corruption with the Internet as their medium. Recently I joined an international volunteer group of investigative journalists, hackers, students, and labor rights institutions seeking justice for Bangladeshi garment workers with radical transparency as the rallying cry, and the experience made me rethink the boundaries of global health. A new intercept point for public health, human rights advocacy and hacktivism is emerging, and it is aimed at building inclusive collaborations that examine, expose and eliminate the root causes of health inequities experienced by the global poor.

In October 2013, the volunteer group I joined formed a “data expedition,” which was led by the London-based School of Data.² The data expedition was a global collaborative hacking project that focused on the horrific industrial disaster at the Rana Plaza in Bangladesh that killed 1,129 workers in a building collapse in April 2013.³ The primary goal was to connect the supply chains of the international garment industry in order to expose the companies that source from the factories that commit human rights violations. The first step was to find the factories with the greatest labor

² School of Data. (n.d.). Home page. Retrieved from <http://schoolofdata.org/>

³ Butler, S., & Hammad, S. (23 Oct 2013). Rana Plaza factory disaster: victims still waiting for compensation. Retrieved from <http://www.theguardian.com/world/2013/oct/23/rana-plaza-factory-disaster-compensation-bangladesh>

and human rights violations, then uncover the U.S. and European companies buying from these factories, and finally to disseminate that information to journalists and grassroots consumer groups to pressure corporations into socially responsible behavior. This international group of social activists, journalists, hackers, labor professionals and students spent a weekend on video calls, Google docs, and Datahub sorting and cleaning cryptic import/export data, geocoding factory locations, and researching labor violations and work-related fatalities in Bangladesh. The hacktivist approach to the ongoing assault on workers' rights in Bangladesh aimed to attack the root issues of poor working conditions for a highly vulnerable population, which focused on the global network of consumers and corporations rather than small factory owners. While hackers often have a poor reputation among academics and government officials, many have a strong social conscience and want to see their skills utilized for public benefit, including corporate accountability, environmental justice, and public access to research and scientific advancements.

I learned a key lesson from participating in this hacking for human rights project: Public health needs to keep pace with globalization. Radical transparency and hacktivism offer a chance to construct global collaborations that include participants from all levels of society and from all nations to address the root causes of poverty, disease, and despair. These root issues are not simple or singular: addressing a web of opaque multilateral trade accords, passively corrupt NGOs and blatantly abusive government policies requires the efforts of activists and advocates from all disciplines and sectors of society. But the complexity of these causes of inequity does not preclude them from solutions. The field of public health was originally built on the principle of social justice, which focuses on addressing the impact of the global political economy on health, and it is social justice that must remain our primary goal.

Tackling intricate international supply chains and the fatal consequences of political disregard for worker health and safety in global free trade is not easy. The experience I had linking U.S. corporations to collapsing factories on the other side of the globe has left a deep impression: Realizing social justice and eliminating health inequities means that action must be taken on not just the surface of those inequities, but on their deeply buried roots.

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The Investigation is Ongoing

By *Andrew Boyd*

The woman was younger than most of the women in the ward. Her brother confirmed that she was 16, but they put her in the women's ward because the pediatrician was not available to see patients. Previously healthy, the young woman had become more fatigued over the last few weeks, and she was no longer strong enough to walk to school. Then, two days ago, she began sobbing about sudden pain in her knee, which then became red and swollen. Now she was having trouble breathing. Her brother brought her by bus to the hospital in Kigali, the Rwandan capital, for help. I heard this story, I looked at this very sick young woman, panting for breath, and I panicked.

Every morning at the hospital in Rwanda, I struggled to keep my head above water. Working in the capital city Kigali's main referral center, my team was in charge of twelve patients, all young women. I was a second-year medicine resident doing an elective rotation in Africa, and I was trying, for the first time, to lead a team of local residents and interns in diagnosis and treatment of patients. The prospect of assuming that leadership position in the US, in a system I knew well, was enough to make me nervous, and now I had to do it here.

In this very poor setting, I realized that I, like the Rwandan physicians, had to make medical decisions without the ancillary information I previously relied on to help make diagnoses: CT scans, blood tests, and the advice of specialists. Instead, resource limitations forced me to make decisions based solely on epidemiology, medical history, and physical findings. Granted, these bits of information were often enough. Many of our patients suffered from HIV, tuberculosis, or malaria, difficult infectious diseases but ones that were common, diagnosed easily, and had available treatments. For these patients, we approached the patients with confidence and authoritatively wrote our plans in the charts. And then there were patients like this young woman, whose diagnoses eluded us.

"I think it's a blood clot in her leg that went to her lung," volunteered one intern.

"What about sepsis? Pneumonia plus bacteremia," another posited.

Or it could have been a juvenile inflammatory condition, or leukemia with leukostasis, or anaphylaxis with pulmonary capillary leak. I lamented, both to myself and aloud, that we could not check a lactate dehydrogenase level, could not order a CT scan of the lungs, and could not call a hematologist to do a bone marrow biopsy. If only we had the information we needed, we could get this right! The degree of uncertainty was made all the more acute by how rapidly the young woman was failing. We decided an infection or a blood clot was equally likely, and each was potentially fixable. We started antibiotics and a blood thinner. Commensurate with our uncertainty about the diagnosis and treatment, the medical student wrote vaguely in the patient's chart that "the investigation is ongoing." The patient died later that evening.

One of my friends in the US has been sick for the past year. Not sick in a dramatic or terminal way, but sick enough that she has cut back at work and occasionally avoids parties. She has fleeting but frequent episodes in which she feels lightheaded, with blurred vision and a pounding heart. She has seen a cardiologist, an endocrinologist, and a neurologist. She has had MRIs of both her heart and her brain. She has had a heart monitor, an EEG, and blood tests searching for endocrine tumors. Despite her access to multiple specialists and the availability of expensive blood tests, her physicians are unable to present her with a diagnosis, and by extension, unable to present her with a treatment plan. I am also unable to offer definitive answers, which makes me feel inadequate, both as a new physician and as her friend.

I think frequently about these two young women, but the way I think about them now that I am about to finish residency has changed. In Rwanda, I fretted that I did not have the labs, the imaging, and the consults I thought I needed to do my job. I thought the problem in Rwanda was the existence of medical uncertainty, and that if Rwanda had more testing, then more patients like that young woman would be definitively diagnosed and subsequently cured.

But in counseling my American friend, I learned that extensive lab investigations and specialists do not guarantee a diagnosis or deliver a treatment. We as health professionals, whether in Rwanda or the US, cannot eliminate medical uncertainty. What we can do is work earnestly with the information that we do have, provide a source of comfort to the patient, and do our very best to make that area of medical uncertainty as small as we can. When I was in Rwanda, it bothered me profoundly that "the investigation was ongoing." Now it inspires me to work harder.

Andrew Boyd is an Internal Medicine resident at Yale University School of Medicine.

Old Neighbors: Exchanging Values on the Reservation

By *Eric Bressman*

The dust kicked up behind me in the late afternoon of another North Dakota summer day. I'd ventured further west than on any of my previous rides, and I happened upon the pow-wow grounds just past the outskirts of a small neighborhood. My comically undersized bike rattled along as I admired the backdrop: rolling green hills meandering down toward glistening ponds and back up toward tree-lined plateaus. I was struck by the contrast to my expectations. The road west of Fargo on my drive to the Spirit Lake Nation reservation had yielded two truths about eastern North Dakota: topography is in short supply, and Jesus remains a powerful muse on the North Dakotan airwaves, second only to pickup trucks. These were no Alps, to be sure, but it felt like a veritable oasis in the middle of an endless ocean of ho-hum amber waves of grain. Another radiantly yellow meadowlark had just caught my eye when I was snapped out of my peaceful daze by the sound of a rez-dog barking up ahead, protecting its territory. I tried to continue forward non-threateningly, but the dog quickly gave chase and I abandoned all pretenses. The road curved left, and I pedaled like a mad man as the dog easily kept pace. We were in front of a row of houses now, and some of the residents looked on, laughing as I pedaled ferociously by with the dog barking at my heels. It occurred to me that I was probably in less danger than I originally thought, and as I came to a stop the dog proceeded to lick my leg and walk alongside me. Finally someone let out a whistle calling it back, and I continued on home.

In the weeks leading up to my time on the reservation, I was often asked if the people still live in tepees, and in the weeks afterward people wanted to know if I had been given an Indian name. The answer to both questions seemed to disappoint most people, although I'm grateful I was spared the moniker Soils Himself on Tiny Bike. But what struck me most was that after the few dated facts that most of us picked up in elementary school, just about everyone's knowledge ran dry. And I don't fault them for

their ignorance, either. Until I started reading about Spirit Lake and the Dakota people a few months prior to my departure, I was equally unaware. I eventually learned a great deal about the current state of affairs in Indian Country, but what resonated with me more than anything was how little I had known before. I began to wonder whether the final, and perhaps greatest, injustice committed against the American Indians was simply their relegation to anonymity.

Our job on the reservation was two-fold: to teach a class on public health and health careers at the tribal college, and to run a camp for pre-teens with a health careers theme. The goal was to encourage members of the tribe to eventually pursue careers in health. The ambitions our students expressed at the end of the summer indicated that our message had hit home for many of them. But the appreciation expressed by the people we met and worked with seemed to transcend the project in which we were involved. They thanked us graciously and profusely for coming, almost as if the greatest service we had performed was the simple act of showing up. They invited us to break bread with them and welcomed us into their spiritual community. I thought about how little the issues that plagued their community factored into mainstream American discourse, and it began to make sense. From the moment the native tribes first encountered our forebears some four hundred years ago, they'd had their basic humanity ignored time and again. Talking with the people on the reservation, it seemed that, from their perspective, the disrespect with which they had been treated for centuries was an outgrowth of the same fundamental injustice that engendered their sense of anonymity today. They simply wanted to be understood, and if people could just see the beauty of their way of life they might finally appreciate the common humanity that connected them.

After telling people about the reservation, they've asked me if it's a depressing place. Unemployment in Spirit Lake is nearly sixty percent, many small homes are occupied by ten to fifteen people, and obesity, diabetes, and alcoholism are as pervasive as ever. I think the question misses the point, though, because the atmosphere of a place is rooted in the people that inhabit it. Indeed, there are some bad people on the reservation, as well as some unlucky people. But there are also many beautiful people, individuals whose spirit and capacity to love shine brighter than the sun over the great plains on a summer afternoon. Some of them may become nurses or doctors or politicians, while others may never earn a college degree. The last question I've commonly received is what can be done to improve the situation on many reservations. The answer, in short, is that I'm hardly qualified to answer such a question. I do know, however, that at the core of our own project's success were the relationships we formed, and if any of the people we met walked away inspired, it is only because we engaged in a mutual exchange of values. For a century our forebears chased down the native tribes until they had the land they wanted, and we've spent the century and a half since running away, trying to forget the fate to

which we consigned them. If our hope is to right the wrongs that have been done, our first step must be to stop running, and simply connect to them as friends and brothers. Only when we establish a clear understanding of mutual respect and learn how to learn from them, can we hope to finally share some of our own values in a meaningful way.

Eric Bressman is a graduate of Columbia University and a current medical student at the Icahn School of Medicine at Mount Sinai. He spent a summer teaching on a Native American reservation through the Mount Sinai Global Health Department.

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Santosh⁴

By *Megan Campbell*

You never know what you have until it's gone ... I sat on the red carpet with my legs crossed listening to the shopkeeper as he lit up with pride talking about his country. We had spent the past three weeks in India, mostly in remote villages within the Himalayan Mountains. "What is India?" the shopkeeper asked. Feeling put on the spot, I looked over at friends who had also come to the shop, and was puzzled and overwhelmed with where to start. "I will tell you what India is. It is a land of magic," he answered. The shopkeeper, who had insisted we enter his shop for a glass of chai, was doing very little to try and sell anything. He simply wanted to tell us about his country, about the Taj Mahal, about the *magic*. He went on describing the regional differences throughout the country with regard to language, religion, and overall culture. As he talked, I thought back to the person I was three weeks prior and about the person I had become. *Maybe this country really was one of magic?*

I remembered the morning of July 16th and how it could not come fast enough. The excitement, anticipation, and anxiety had festered and grown and far surpassed the emotional capacity of a single person. With very limited international travel, I was travelling to the Himalayan Mountains for three weeks to do clinical work. I was going to be alone half way around the world. I was entering the unknown completely unprepared. Yet, despite all of this anxiety, there was still an unwavering excitement about the challenge ahead.

As I boarded the plane in my hometown, I looked back to my parents. Through the preparation and planning, they had been my biggest cheerleaders. Now, they were fighting to hold back tears, and surprisingly, I found myself doing the same thing. I quickly waved, gave a half-hearted smile and looked forward praying no tears would make their way down my cheek.

⁴ *Santosh* is Hindi for contentment

I spent the next 48 hours in international airports, hopping from one plane to the next until I met the rest of the team I would be working with in New Delhi. As we approached the hotel there were wooden carts hooked to bikes everywhere. I would later learn they were rickshaws. They were big enough for maybe two people to sit, yet every single one had at least one person sleeping in a contorted position. As exhausted as I was, the frustration of trying to sleep on a plane immediately went away. This was the first time I realized the difference between the society I had left and the society I had now entered.

We drove for the next three days on bumpy, narrow, dirt roads as we climbed in elevation. Each hour we drove brought us to people with less and less, from what my eyes could see. Western toilets transformed into holes in the ground, the temperature became colder and colder, and technology virtually disappeared. To fill this void I decided I would journal.

After a few days, I was amazed to see how much I had written. Stories of people I sat near on the plane, elephants, cows, food, and even general reflections. I had become so much more receptive to my environment. I was beginning to transition from feeling homesick and like I had left everything behind to a feeling of gratitude and fortune for all that I was experiencing. Contentment was beginning to set in. All of the distractions back home were gone, and now that they were gone I could see the blessing of what I had left behind. I was no longer a fixture standing in the background of my environment. I was actually participating and observing what was happening.

When we arrived at our campsite, it was the most beautiful thing I had ever seen, with snow-capped mountains, rushing rivers, and pristine wilderness everywhere. We slept in tents with sleeping bags, had holes in the ground for toilets, and 3 liter buckets of water for showers. The people here, similarly, had nothing.

Driving to clinic one day we passed through a village where a young father sat in the dirt with his children laughing and playing. This man exemplified *santosh*¹, or contentment. I again saw what I had left behind by leaving home. This father helped me get past seeing these people as having so little materialistically, and showed me how rich this culture of people are with regard to family, spending time together, and valuing life. I had forgotten about the simple things in life—the things that last longer than a battery—things that last for generations, like time and compassion. Ironically, it was not until I shed the life from back home that I realized how much of my time was occupied with email and text messages.

Clinic only further reinforced the value of time and compassion, and it extended the value from personal life into professional life. One day, my preceptor reached over and held both arms of a patient, feeling the pulse on his wrists. He then said, “Feel the pulsations, the synchronization? Medicine is an art. Touching your patient is part of that art. They won’t teach you this in medical school.” For the past year, taking a thorough

history and completing a physical exam had been the most important skills to learn. This was no longer true. The most important skills to learn are how to listen and connect. I lost the ability to speak to my patients, but in turn I was appreciating another way of communicating. I had grown a new kind of ear towards my patients. The shopkeeper was right. India is a land of magic. I really didn't know what I had until it was gone, for better or for worse. In this magical land, I was learning the *art* of medicine.

Megan Campbell is currently a third year medical student at the University of North Carolina at Chapel Hill School of Medicine. She attended East Carolina University for undergraduate studies and received a Bachelor of Science in Biochemistry and Chemistry.



Photo credit: Megan Campbell

My Own Feet

By *Natalie Cassell*

There is a scene that comes to my mind in moments of quiet, in moments of daydreams, in glimpses when I talk to patients, and when I lie down and close my eyes to sleep. My thoughts come swirling up in a spout of memories and visions, bringing with them strong emotions that keep me awake and thinking.

Not too long ago, I sat down to eat with some fellow medical students and we almost immediately started into what experiences we recently had around the hospital and clinics. On her turn, one of my friends described her repulsion at many of her patients' feet describing one particular interaction with extremely unhygienic and poorly cared for feet that she had to manipulate in her examination of the patient. And as she spoke, assuring us she dutifully continued her exam without outward signs of disgust, I could feel the solemnity slip down over my face once more as my thoughts drifted to my own feet.

In my first month in the village, my new home, I became sick. Being sick away from home is more than unpleasant, but being sick in a foreign country, when you barely speak the language, have no friends, and endure the sweltering heat with no relief in sight, is frightening. I had an infection. I was feverish, my ankles were ulcerated, and my feet were swollen and painful. The doctor in the capital, a several days' bus ride away, repeated her instructions thick with accent from a distant world away: continue to bathe my feet in salt water in one of those multipurpose ubiquitous plastic basins. My water supply was grossly dirty and even boiling it was dubious: it was probably contributing to my infection. The cholera tents were visible at the hospital as rainy season continued, and I pushed hypochondriacal notions of dreadful illnesses to the back of my mind. I tried to carry on. A young man offered to show me how to make the first of many dreadful trips into the city to run errands. This ride was more painful than any other I remember. We waited for the minibus to fill over capacity in sweltering heat to make a 5-plus-hour jarring voyage of mostly unpaved road with no stops. My legs were unbelievably painful as I tried to disembark from our minibus in the city after sitting upright for so long and

I was unable to run any of my errands in the city. Previously determined to stay stoic, I broke down crying as we arrived at the young man's family apartment where all I wished was to be back in my own home and not have to act the part of foreigner and guest, a sometimes grueling expectation.

I was fighting back tears in a small third-world city apartment with strangers and a young man who I had known, apart from the long bus-ride, for a matter of minutes. And then it happened: he began to take care of me. I had been cared for since my arrival, but never at a moment of vulnerability such as this. Without hesitation, he fetched and boiled water and gently took off my dusty shoes as I cringed in pain. He peeled off my dirty socks and began to wash my feet in hot water and salt. I did not know this man and he was washing my dirty, infected, painful feet. I was grateful. As I look back I can't help but feel absolutely in debt to such a show of humility, compassion, and service.

I was helped a countless number of times during my stay in that country without question and the cumulative effect was to create in me a dedication to returning the favor. But in particular, having my repulsive, dirty feet washed by practically a stranger has played over and over in my head, reminding me of my dedication to service as a physician, to global health, and to communities at home and abroad like those I visited. I have yet to be able to run through this story without tears welling with gratitude and shame -- shame at my unworthiness in receiving such generosity, care, and compassion throughout my stay.

Hopefully I can earn the kindness I received in that country and repay them through my service as a physician. And whenever my mind flinches when dealing with the ugly side of medicine, I hope I can remember that once, when I couldn't, a stranger washed my feet.

Natalie Cassell is a medical student at Wake Forest School of Medicine.

Demystifying the Art of Medicine in the Mayan Landscape

By *Anne Marie Chomat*

Drawn by a desire to better understand human experiences of health and illness in marginalized contexts around the world, I have worked in several countries across the global south, first as a medical student and later as a physician and public health practitioner. Everywhere, I have been moved by the remarkable healing and coping strategies of those I have encountered, as well as their silence despite the profound inequality, social injustice, and structural violence they face. These experiences have shaped my beliefs, practices, and values, often challenging the very core of my formal education. Perhaps nowhere has it transformed me more than in the remote indigenous communities of Guatemala's Western Highlands, where I am presently working.

The following narratives are drawn from my encounters with *Mam*-Mayan women and the struggles they experience in their everyday lives.

September 2, 2012. Lucia hands me her newborn in a dark, crowded room of her family's adobe hut. I gently remove layer after layer of swaddling cloth, bright in color of the typical patterns worn in this remote mountainous area. A sash fastens half an onion against the baby's small stomach. Below the onion, a large bandage imbued with an herbal ointment covers his umbilical cord. These are local remedies given to newborns with "pujo," a culturally perceived illness often affecting newborns in this area. The skin around the bandage is red and swollen, but I am unable to examine it well. I ask if I may remove the bandage, explaining my concern for an infection, but Lucia and the *facilitadora* (community health worker) accompanying me state that a traditional healer had placed it there, and that it has to stay on until it falls off; otherwise, the baby may die. As I hold her infant, Lucia asks what more can I do to cure him of "pujo."



Mam-Mayan woman with newborn infant
Photo credit: Anne Marie Chomat

The scarcity of resources blended with local *Mam-Mayan* narratives of health and illness, create a landscape foreign to me through which I attempt, when asked, to traverse using my best practices, within the “art of medicine” as dictated by Western medical traditions. Local health workers often prescribe tea brewed with medicinal plants. But I am often left feeling helpless. No diagnostic tests are readily available. Medical cabinets, supplied by the government’s Ministry of Health, are mostly empty. Treatment plans are reduced to informed guessing games, and in the absence of any symptoms of concern, I shy away from making prescriptions, opting instead to listen intently to the women’s struggles and concerns, and to learn about the tried and tested traditional remedies often used in such remote areas.

December 5, 2012. Roselia, a 15-year-old first-time mother, lives with her family in a large brick home on the hillside; a dusty, red pickup truck is parked outside. Roselia delivered her baby via C-section, though she is unsure why. She has been unable to breastfeed her three-week old infant. The formula she gives her, only an ounce a day mixed with water, is not enough to sustain life. Her baby appears profoundly malnourished. Even with the help of the *facilitadora* who speaks the local dialect, it is hard to communicate; the mother avoids eye contact, and her answers are monosyllabic. I

feel uncomfortable in her father's presence, hovering, clearly disturbed by us being there. Perhaps they have decided to let the baby die. The mobile clinic serving the area had already come by several times and advised Roselia to take her baby to the hospital, but she and her family have not followed suit. Like many others, they believe the hospital is a place where people go to die. They would rather the baby live or die at home, according to God's will. We advise Roselia on adequate nutrition for her newborn and urge her again to visit the hospital. We continue to check in with Roselia; her infant continues to grow, albeit very slowly. At 6 months of age, her baby is severely stunted.

In Guatemala, roughly 54% of children are chronically malnourished, with the country having the fourth highest rate in the world. Chronic malnourishment, measured as stunting, or small height-for-age, is a strong determinant of early mortality and adversity throughout a lifetime. In the indigenous communities where I work, the rate of chronic malnourishment reaches nearly 80%. Out of the 155 women who have given birth in these communities since I arrived, five have lost their newborn in the first month of life. Forcing families such as Roselia's to engage with the formal health sector places at risk the tenuous trust that many have of Western medicine. Because some families feel threatened by or reject Western concepts of health and illness, local health workers who have exerted such pressure to seek formal care have sometimes experienced violent repercussions.

Roselia's situation may be complex. Perhaps she did not want the child. Perhaps her family was ashamed by a pregnancy out of wedlock. Perhaps the situation could have been prevented with contraceptive options, but birth control is not readily available and when it is, many men oppose its use. Abortions are illegal. There are few effective social programs to provide much needed support.

I am aware of the global and national statistics on maternal and infant health and well versed in the Millennium Development Goals and the interventions considered most effective in reducing maternal and infant mortality. But despite impressive scientific and technological advances in global health interventions, many questions remain. How do these advances trickle down to individuals and communities such as those that I work with? Moreover, aside from addressing the problem of inequitable distribution and access to these resources, how do we navigate through diverging beliefs about life, health and illness, and through diverging preferences in health care utilization? How do we empower individuals and communities, including the most marginalized, to secure their health and well-being, and to be able to do so in harmony with their own beliefs and traditions?

After a decade working as a clinician, the diagnostic and treatment modalities once so familiar to me now seem abstract and foreign, as I struggle to find solutions that work for mothers in these Mayan communities. The little that can be done sometimes feels only like a Band-Aid solution to a much deeper and largely invisible wound plaguing the most

vulnerable. In Guatemala, rural indigenous populations, deeply scarred by years of civil war, remain entangled in a vicious cycle of food insecurity, extreme poverty, limited access to basic resources, dispossession and land loss, violence and marginalization. Systematic disempowerment of traditional, community-based health systems by the formal medical establishment further deprives poor, remote communities from the only health resources to which they may have access. A legacy of gender inequality further adds to existing cultural and linguistic barriers, leaving many women helpless in sustaining proper care for themselves and their infants.

What is a health practitioner to do when health and illness are as much, if not more, tied to socioeconomic, cultural, and infrastructural factors as they are to biomedical ones? The stories of Lucia and Roselia call us to take a humble approach to healing and care, one that combines a deep awareness of local realities, gentle trust-building, and a constant effort to link public health action to locally defined need and priorities. When our own knowledge, tools, and skills are lacking in their power to heal and fail to address underlying determinants of health, we, as global health practitioners, have a great deal to learn from local actors and realities. We ought to only proceed through open dialogue and through active and genuine engagement and collaboration with the very people we hope to heal.

Anne Marie Chomat holds a PhD in Parasitology and Environmental Sciences from McGill University.



Adobe house in Mam-Mayan community.

Photo credit: Anne Marie Chomat

The Thrill is Back

By *Michael Clark*

More than halfway through a busy residency program in pediatrics, I signed a one-year contract to work as a medical officer at a district hospital in South Africa. In addition to my clinical responsibilities, I intended to carry out a research project on tuberculosis in young children. Within months of being there, I realized that I would never complete my research, as I became bogged down by clinical duties and in-house calls. Long hours in a hospital were nothing new, but it was hard because of all the unexpected horrors and injustices. It was even harder when I awakened one day, surrounded by pain and suffering, feeling like I was part of it. When I returned home, I became ill with depression and sought help. Here, I should quickly add that some of my closest friends and fondest memories come from that year. It was a life-changing experience. I believe an adventurous heart is required to embark on such a journey, but the true experience is not an adventure. It is a commitment, and the most important prerequisite for this commitment is a solid personal foundation. I had to learn this the hard way.

The reality of practicing medicine in a resource-poor setting takes a while to sink in. Before this year abroad, I had completed two electives at the same hospital, each only a month in duration. Encountering late presentations of illnesses I had only read about, more HIV and tuberculosis cases in one week than in ten years back home, and the opportunity to perform countless procedures made the previous experiences exciting. Working as a foreign medical officer – licensed under their authorities, receiving their wages, registered to pay taxes to their government – is a completely different experience. A heavy burden of disease, HIV/AIDS, and preventable death took the thrill away swiftly. At first I felt sick, and later, cold and numb, as we played God with ventilators (the HIV-negative child gets it). I struggled to remain motivated. It was challenging, but rewarding too at times. I remember smiles on the faces of children who once looked like skeletons, hugs from their parents, and the angelic voices of nurses singing at 7AM every morning.

There was one thing, however, that I was not at all prepared for: experiencing a horror and knowing it will return tomorrow and the next day. That feeling is nothing like reading about it or having a brief glimpse of it. Before my year abroad, I had fully assessed and managed only one childhood sexual assault, a seven year-old girl raped by two young adult males. This isolated experience did not prepare me at all for the phenomenon, or rather the epidemic, of childhood sexual abuse in South Africa. Sexual assault was a chief complaint in the pediatric outpatient department everyday. When I later reviewed the clinic register, I found my name scribbled beside six visits for alleged sexual assault in a single shift. On call, I would see them between admissions and emergencies, while managing children on ventilators. It was a horror. The belief that raping a virgin could cure HIV still circulated in some corners, and I did diagnose previously uninfected young girls with HIV, having acquired it from their uncle or neighbor. As I wondered why so many children were being raped, I only had enough energy to provide care the best I knew how and to not ask too many non-medical questions.

“Before we can take care of others, we must take care of ourselves.” Repeated attempts by my seniors to drill these words into my head had been unsuccessful. I needed to learn this lesson the hard way, through firsthand experience. My time in Africa was filled with the unexpected. I did not expect the excitement to fade into routine, or a daily horror of sexual abuse. I felt sad, guilty, and weak. One day, I jokingly told a colleague I was in need of an SSRI for depression. In a stoic yet understanding tone, he said he had been on one for years. He added that I looked pale and had been working too much. He was right. I had become obsessed with my job. I worked through it, transferring to a different position with fewer hours for the second half of my year there. Soon I began to see that depression, post-traumatic stress, and substance abuse were common problems among my colleagues. Overwhelming disease burden, perceived impotence in dealing with it, shocking inequity and violence, and the intense dilemma of “playing God” were taking their toll. I wanted to know what it felt like to be a resident there. Now I do.

I did not rid South Africa of HIV/AIDS, tuberculosis, or childhood sexual abuse, nor should I have expected to. However, my commitment to global health is now stronger than ever, and just as importantly, so am I. Rather than regret this experience, which came at a personal cost, I am grateful because it taught me an invaluable life lesson. Statistics from the World Health Organization and UNAIDS still paint a grim picture, but in it, I also see hope. A myriad of opportunities can arise from seemingly infinite need, for the student or trainee to learn new skills and help build capacity in resource-poor countries. I would encourage such initiatives at every turn, but always with a degree of caution. We must build solid, sustainable partnerships, setting forth objectives that benefit both learners and their hosts. Although it is impossible to guarantee, we should do our best to maximize safety and remain mindful of our limitations. Finally, let us

be respectful of our colleagues in other countries. I often reflect on the daily struggle I witnessed – their struggle – and remember that after I boarded my airplane home, they remained. A foundation of good health, realistic expectations, and empathy is vital, if we are to be effective partners in global health.

Michael Clark is a post-doctoral fellow at University of Ottawa.

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The Voyeurism of Global Health

By *Bayle Conrad*

“We have visitors coming this afternoon.” I inwardly groaned hearing these words. In the weeks I had been interning as a global health graduate student at the HIV/AIDS pediatric care organization located in the Kibera informal settlement of Nairobi, Kenya, I had come to dread the arrival of tourists visiting the facility. The routine was the same during every visit. The visitors would arrive, the staff would greet them with a tour of the facility, and they would be taken to visit homes deep within Kibera. I had become used to the preparation surrounding these visits: the announcement at the beginning of the work day, the rearrangement of staff schedules to accommodate the visitors’ site tour, and the strategic discussion among social workers of which families in the slum to visit with our guests. A few weeks into my internship, the social workers began asking me to come along as they escorted visitors around Kibera. When I asked one of the social workers whether my presence as an additional white Westerner would cause greater disruption in the slum, she answered honestly, saying, “Please come. We don’t know what to say to them (the visitors).”

That comment stuck with me for the rest of my internship in Kibera. What do you say to foreigners, coming to visit a Nairobi slum in between their Kenyan safari and Mombasa beach vacation, shedding tears over tea in a tiny home where an HIV-positive woman lives with her four children? I found myself consistently annoyed by the presence of visitors and their disruption of daily work. But even more, I found myself disgusted at their voyeuristic presence because it reminded me of my own unease, the exploitation inherent in my observations in Kibera. I often felt uneasy just being in the slum, as though I had no right to be there, to see the people and their homes. While I was warmly accepted as a fellow coworker by the clinic staff, I knew that my existence there for a short summer had little measurable impact and was not necessarily needed by the organization, which hosted an endless rotation of Western interns. Even though I was a global health graduate student interested in working at the community level in East Africa, how different was my presence there from that of the visitors I scoffed at? I pondered this on my frequent

visits with clinic social workers to homes within the informal settlement. To residents of the area, was there a difference between me and any other Westerner coming to “tour” the infamous slum? Where was the line between “voyeur/exploitation” and “witness/experiencing”? When I asked my Kenyan coworkers this question, one replied by saying “It’s different. You are one of us.” When I responded by saying that I could just as easily be a fellow Westerner on a slum tour, my coworker gave me a confused look, replying, “But you aren’t. You are here, working beside us, teaching us as we teach you. You are not here to simply gaze.”

It is now months later, and I still have not shaken the unease I feel when thinking about the privileged voyeurism inherent in global health. As global health practitioners, we work in some of the worst, most impoverished conditions in the world. We spend our trips abroad observing these conditions and those who live in them, even in places we may not belong, and then have the privilege to leave once our projects are over. In my struggle to come to terms with this unease, I am reminded of what it has brought me. By remaining aware of my own position as a Westerner in Kenya, and the power and privilege inherent in such a position, I was better able to connect with coworkers, clients, and community members, much more than I would have by presenting myself as a Western “expert.” I was able to have several frank, critical discussions with coworkers in Kenya about the field of global health; its domination by young Westerners wanting to make a change in the world; and how it blurs the edges between voyeurism, aiding, and witnessing. These conversations became one of the most valuable aspects of my internship, and have altered the way I view myself and global health.

My experience working in Kibera threw me into an ethical conundrum that I had previously grappled with but had never felt so acutely. There is not much to differentiate myself from the constant stream of tourists at the clinic, other than a graduate degree in global health. In trying to find a solution to my unease as a global health practitioner and the power differentials inherent in the field, I have come to realize that there is little to no solution. My unease and discomfort will continue as I pursue a career in global health, and more importantly, *should* continue. This is the greatest realization I take away from my experience in Kibera. The blurry line between voyeurism as an outsider and observation as a global health practitioner will always remain because, in reality, my role encompasses both.

Bayle Conrad is an MPH student at Emory University Rollins School of Public Health.

The Outsider

By *Rebecca Cook*

Warning! To pursue an experience in global health is inevitably to become an outsider. By leaving your own racial and cultural training group and going to learn and serve in another, you are taking on a new identity. It is this experience of being the outsider that leads to some of the greatest self-growth, moral distress, and opportunities for change. How we handle it makes us who we are.

Growing up in Kenya, I was accustomed to the experience of being in the cultural and racial minority. Sometimes walking down dirt roads in rural areas, children would shout “Mzungu!” (White person!). Neither threatening nor personal, their call was simply an announcement that an outsider was walking through their neighborhood. Even my close childhood friends found my hair and freckles fascinating, just as I thought it was odd that they didn’t seem to get sunburned in the hot equatorial sun.

As I spend more time in the United States for training, this “outsider” identity adds more layers and complexities. It’s no longer just the difference in skin color, language or accent; now I must grapple with the reality of coming from different training experiences, standards of medical care, professional cultures, privileges, and resources.

Returning to Kenya as a college student to do summer research and again on clinical rotations in medical school, I often found myself in the uncomfortable position of patients and families assuming that I was the most educated or qualified member of the team, when in fact the opposite was the case. My colleagues were incredibly gracious with these misunderstandings, but much vigilance was also required on my part to work in clearly established roles and stay within my scope of training even in settings when there was less supervision.

More recently, rotating as a resident on the medicine wards of a teaching hospital in Uganda, I have found this outsider identity becomes even more challenging the more advanced I am in my clinical and professional training. I could not have asked for a more accommodating group of Ugandan faculty, residents and medical students; yet the vast gap in resource availability and differences in medical systems made it impossible to

ignore my outsider status. Watching a previously healthy adolescent girl progressively decline in hypoxemic respiratory failure from a likely reversible pneumonia simply because there was no oxygen that day, I felt alone in my urgency and desperation. One of my Ugandan colleagues said, “You seem angry.” I was horrified. Knowing from my experience growing up in Kenya that anger is a grave cultural offense, I quickly apologized and explained I was not angry at anyone but rather frustrated and sad at the harsh reality that this girl may not survive. In that moment I realized that while my perspective as an outsider on what medical care should be available was not wrong, my indignation at the inequity of health resources and inefficiency of systems could easily be misinterpreted as anger at the individuals who worked there.

Based on these experiences I developed a “code” to help guide my interactions as an outsider during global health rotations:

- I will never undermine a local provider in front of a patient/peer.
- I will approach points of clinical disagreement with humility and an eagerness to learn.
- If I am concerned about the clinical judgment of another provider, I will *ask* a question, and only directly intervene when there is a risk of immediate and serious harm to the patient.
- When in doubt, I will *ask* ... and if no one at my site can provide a satisfactory answer I will seek information from outside experts.
- I will *not* perform procedures alone that would require supervision at my own institution.
- I will *not* handle medical emergencies by myself and I will not be the team leader in emergencies.
- I will defer all final decisions about referral, payment, discharge plans to local clinic leadership.

The most interesting thing about the experience of being the outsider in global health is that you ultimately return to your “home” and find you are an outsider there as well. The experiences you have and the relationships you form have made you a different healer and a different person. Immediately after return you experience “reverse culture shock” – suddenly there is an obscene number of cereals in the grocery store and incredible waste in the hospital. Yet even after the initial shock fades, you will discover you have been changed in more profound ways. It is almost impossible to return to practice without a deeper awareness of systems and resources. You will rely more on your history and exam, you will assess whether the diagnostics you are considering are really necessary, and when you do order tests or treatments, you will be grateful that they are available.

You will have more understanding for the “difficult” patients and families – those who require multiple interpreters, or those who have a different set of priorities or values than your Western medical agenda.

There is no question about it. Being an outsider, while challenging at times, changes you. Multiple studies have found that trainees who spend time abroad are more likely to go into primary care and work in underserved communities. Now consider an even more important question - how might it change someone else? Even in the current economic climate where funding for global health programs in our own graduate medical education is threatened, can we really say we are travelling internationally to pursue global health equity and ignore the unequal training opportunities for our colleagues? If the experience of being an outsider has so many positive effects on our personal and professional growth, what impacts might these experiences have on retention and systems improvement in low resource settings? Are not our East African colleagues equally entitled to the experience of being the outsider?

Rebecca Cook was born in Kenya and received her undergraduate degree at Wake Forest University. She has a master's degree from Oxford University and attended the Vanderbilt School of Medicine. She is currently a Med-Peds resident at Massachusetts General Hospital.

An Interesting Clinical Finding

By *Siddhartha Dante*

Year 1. “Lub-woosh-dub, lub-woosh-dub, lub-woosh-dub ...”

I raised my stethoscope and searched anxiously for my clinic preceptor. I found him outside, bundled up for the cold, looking out over the picturesque Andean valley. He always left the room when his medical student examined the patient – later I would learn it as a technique to let students gain confidence in their exam skills.

The sound was a heart murmur, so loud that it was obvious even to my second year medical student untrained ears – the ‘woosh’ occupying the space between the heart beats as we listened again and again suggested a Ventricular Septal Defect (VSD). My 9 year-old patient was sitting with her mother when we returned, with her jacket back on to protect from the cold as it was not much warmer inside. Her mother knew about the murmur; it was identified at birth and referred for follow-up. As her daughter had grown well, the follow-up had never happened. But with the Americans now here and her daughter quickly becoming comfortable with us – playing in our crafts sessions, asking us questions over meals, dancing during the traditional festival, adopting our undergraduate students as big sisters – asking the American doctor for a checkup at our free clinic was easy to do. With our exam and working diagnosis, we explained and reinforced the need for her to have follow-up with the imaging tests that could only be done in a hospital and the requisite evaluation by a cardiologist.

Year 2. “Lub-woosh-dub, lub-woosh-dub, lub-woosh-dub ...”

The murmur was still there. This time I could compare it to what I had heard during my student rotations – it was not like the atrial valve regurgitation I had heard the week prior on an adult during my medicine clerkship or the machine-like murmur of the patent ductus arteriosus in a newborn I heard on pediatrics the previous fall. This murmur was different and I could hear why we knew it was a VSD.

But no, she and her mother had not traveled to the nearest city to seek evaluation at the state hospital. They knew it was important but the obstacles were challenging – the

distance, the time away from the fields, the waitlist at the clinic – and she was still growing and seemed healthy. But yes, they were concerned. She had less energy and she was not keeping up with the other kids – signs that perhaps her murmur was beginning to affect her. She needed an echocardiogram and an expert opinion.

Year 3. “Lub-woosh-dub, lub-woosh-dub, lub-woosh-dub ...”

She smiled as our routine was familiar. I listened, more confident now. My residency match results would come the following week and seeing patients in the remote Andean clinic was a welcome tonic for my nerves. I had read the report – the VSD was small, less than 2 mm and fortunately unlikely to cause her long term problems.

After returning from my second trip, we scoured the internet and sent emails across the US and Peru. We were able to arrange for her and her parents to travel to Lima, get an echocardiogram, meet with a pediatric cardiologist, and return in the course of three days. We paid for their trip, their stay and even supplies for their home that were only available in Lima. My preceptor and I had partnered to transform our initially simple medical and educational trip into a global health group that was incorporated with non-profit status, formalizing our work with this town and health post. The check reimbursing our Peruvian partners for her trip and medical evaluation was the first I wrote in my role as Treasurer.

Year 4. “Lub-woosh-dub, lub-woosh-dub, lub-woosh-dub ...”

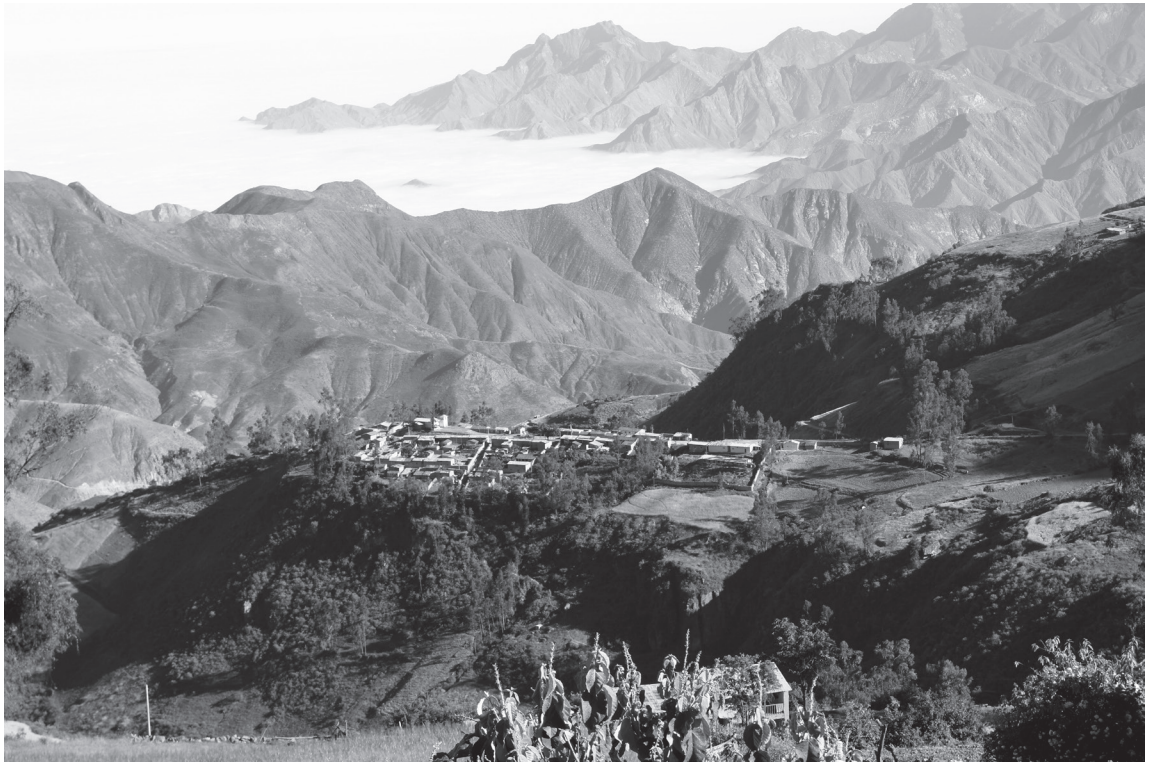
I recognized her immediately but was taken aback – we were 3 hours down the mountain at a school running a clinic in one of the far-flung towns in the health post’s district. She was a teenager this visit – more reticent, but she let me listen and let me teach. I was a doctor and had survived my intern year of early wake ups and an incessant pager. This time, there were medical students listening to me. I quizzed the students on the inverse relationship of murmur intensity and the size – the answer: the smaller the murmur the louder it can be.

Afterwards, I sat and asked her about school, how her brother was, and why she was in this town. Her family had moved in search of new jobs in the summer and she was in school here, but they still returned to the town up the mountain for the winter and harvest. Her friends called for her as our clinic was wrapping up. I extended greetings to her family; she smiled and shyly left to join her friends.

What could have simply been an interesting clinical finding on a one-time trip has, through commitment and persistence, become a profound lesson of systems and care. The girl has become my longest standing continuity patient in my short medical career and her care taught me about the external factors in healthcare both globally and locally. I could know the pathophysiology of her disease, learn to write prescriptions, or provide

the proper instructions, but still not affect the desired health outcome. My approach has to broaden from just learning the skills to diagnose and prescribe to include the know-how to build effective systems of care and eliminate barriers. My next trip to Peru will continue to involve the personal connections in clinic but will also include strengthening our partnership with the community and local physicians. Our next patient that needs a referral will not need to wait two years for care.

Siddhartha Dante is a graduate of Princeton University and Virginia Commonwealth University School of Medicine. He is currently a third year resident in Internal Medicine and Pediatrics at the University of Chicago.



An isolated village at 10,000 feet in the Cordillera Negra.

Photo Credit: Siddhartha Dante

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Hauntings

By *Mark Darby*

In my career as student, I am haunted. Haunted by my trips to Rio De Janiero or to Santiago De Los Caballeros, Dominican Republic. The experiences which seem neatly packed away in Facebook postings suddenly come full and alive to change the way I work. For example ...

1. I sit in a neighborhood health clinic with a small sign informing passers-by that we offer free STD screenings. It is a busy clinic. As we wait for the results of the rapid HIV, a 13 year old boy tells me he stopped playing basketball because he doesn't want to "spread AIDS by sweating on people." I want to chuckle.

Then I remember the favelas. Buildings built with red bricks crowding the hillsides overlooking Rio's beaches. On first glance, the buildings look like shanties, poorly constructed without electricity or water. Then I went into one of the homes, built by hand by a man with a name. He has built his family a home out of nothing. Pride does not come with readymade doors from Home Depot. He teaches me that in every situation there is always something worthy of respect.

So I imagine this young man's perspective. He is someone who cares enough to give up something he loves to save his friends. In that light, we speak of his sexual encounters, condoms, his desire now to be abstinent, and how AIDS is spread.

2. I say *hola* to the woman who cleans the bathrooms in my workplace. She is patient with my Spanish. One day she tells me that the hospital used her 10 year old to translate when she had an allergic reaction to her last dose of chemo. I am embarrassed that my Spanish is so poor I did not even know she had breast cancer.

Then I remember the first Spanish school I attended in Santiago. I struggled to learn nouns and verbs. The teacher looks like Erik Estrada and speaks very little English in class. I am glad that at least one other person has trouble with a foreign language. I want

to go to with the others to experience the local beers rather than work in the language lab. Professor Estrada seems to understand and says in perfect English, “Don’t let your fear of inefficiency prevent you from developing your effectiveness.” Rather than being further embarrassed, I study. I become if not an expert than certainly better.

So I forgo my embarrassment and speak to this woman about her treatment, which is lacking. She says she needs help but is fearful. I teach her to assertively ask for changes in her care. She asks me to attend her chemo sessions, which I do. I resist urges to step in when she questions the doctors and watch her grow in self sufficiency.

3. I am part of a group of experts that want to address the issues behind a mass shooting at a shopping mall. The group brainstorms very traditional answers that have been tried before. A suggestion to hold local meetings and listen to community members is met with skepticism.

Then I remember sitting in a Rio classroom for a lecture on urban architecture from an animated Brazilian professor. He shows a picture of Rio from the ocean with its beautiful beaches and shimmering hotels. Going three miles inland, he shows us the same picture from the other side. Behind the hotels, are densely crowded favelas populated with talented people busy making a living. “It is safe looking from the Ocean,” he says. “In order to know the real Rio you have to stand where the people live and look around.”

So I agree to work with a group that goes to where people live. We hold community conversations—in churches, homes and schools. We have hundreds of conversations. Change occurs. A new employment office with trained and friendly staff, programs for youth held where kids are living, and more relationships across racial and ethnic lines are built that did not exist before the shooting.

4. I attend an extracurricular activity on how narrative can improve how I care for patients. The teacher says that writing a poem can increase self-reflection, and clarify goals and values. We are asked to recall a meaningful story and write a poem.

Then I remember a retired teacher who volunteered with young mothers in a Rio favela. I recall one particular door and I write this:

The door had breathed its last yet a
wire still crucified the door to a post

Knobby mulato hand, fingering a pen, pounded the door,
causing
a groan from wire and door.

Pounding woman yells “Criaaaaaançaaaaa Pastoralllllll”
Portuguese vowel sounds echo over door to exhausted
window and wall
Would the worn streets awaken and attack me, the
American-protected only by a bony Brazilian teacher?

As we wait, the teacher says, “Pastoral da Criança (Pastoral
Care of Children)
Help mothers and young children
With information, food and love

A woman’s face appears
“Anna Louis” yells the teacher,
Teacher and mother skitter like two squirrels

To business
Child is eating, gaining weight. Going to school, reading,
being active
Very much unlike other children I have seen

The teacher and I say good bye,
As we go down the crumbling street the mother waves to
us, one hand on sagging door.

So now as I think of my future career, I am haunted by this poem. Because I wanted a feel good ending I left out the other child. I had not written of the developmentally delayed 5 year-old that only wore diapers and crawled. He was not enrolled in Pastoral da Criança. Two children two blocks apart and the only difference was a dainty retired teacher who worked in their neighborhood.

I finally learn my most important lesson. Healthcare, whether global or local, occurs not in large buildings and laboratories but in homes and neighborhoods where the sick live and need care.

Mark Darby is in the Family Nurse Practitioner Program at the University of Nebraska Medical Center in Omaha, Nebraska.

Moving Forward

By *Danielle Dougherty*

The five women in my car laughed and chattered in Setswana as I drove through their village in Northwestern Botswana. I had just picked them up from the outskirts of town where they had spent the day in the hot sun interviewing other women about domestic violence. Despite the long day of trudging through the sand and talking about rape and abuse, they cheerfully asked to stop by the river, where they helped me splash water on my muddy car. I adored these women and although I knew the stipend I was giving them was tempting, it was moments like our impromptu river car-washing session that made me believe that they cared about much more than the money. I was convinced that they were passionate about the issue of domestic abuse in their culture. Whenever I think of my team of five interviewers laughing and washing my car by the river, I wish that we could empower every woman to be as independent, strong, and zealous as them.

The project this summer lasted seven weeks and was implemented in collaboration with a local organization supporting women who had been raped. It was the same organization where I had served as a Peace Corps Volunteer years earlier and still remained in close contact with. After every long day of interviewing, the five ladies often came back with terrible stories, filling the margins of the questionnaire with horrendous anecdotes that often left me feeling hopeless. As a safety precaution, American Institutional Review Board ethics requires that the subjects remain de-identified, and although every interviewee was informed of resources to seek help from at the end of every interview, we always worried about the fate of each participant. Our hope was that by trusting us and being willing to open up, the interviewees would provide statistics that would help identify risk factors to help the local organization with its programming and potentially result in policy change that could increase access to assistance and protection services. But at the end of each day, the women we interviewed still went back into their often-abusive homes.

I frequently wondered if what we were doing was far removed from the actual problem, but my interviewers assured me otherwise. The oldest interviewer on the team

of five, who I will refer to as H, was also the most diligent worker. She worried about the women she had surveyed and followed up to make sure the organization's counselors had visited the ones who had asked for assistance. H was a self-sufficient woman, raising several nieces and nephews on her own, crafting and selling homemade jewelry, and was proudly independent. She was always the first to arrive at the office in the morning, often before I did. When two of the other tired interviewers started complaining about the work and appeared irritated when I requested them to do something, I heard H, as the respected elder, address them in Setswana. "Be considerate of her," she said, referring to me. "Answer her nicely." And they did. She believed in our project because she cared deeply about this issue and wanted to make a change.

By the end of the summer, we collected more surveys than I had expected. I gave the women more money than I had originally agreed to, and I wrote them all letters of reference and promised to hire them again the next time I made it back to Botswana. I went home determined to quickly finish the data entry, get the statistics back to the local organization, identify the risk factors, and work on program implementation. I wanted this research to make a difference.

But plans change in unexpected ways. I got caught up in my second year of medical school. I wasn't thinking so much about violence against women in Botswana when I received a terrible phone call in October that abruptly thrust me back into the anxious mindset of the issue. The friend who called tearfully told me that H had been killed by her ex-boyfriend late the previous night. H became a victim of the very issue she worked so diligently against. How could this happen to such a strong and independent woman? I thought we were trying to change policy for the women who didn't have resources, who were stuck, who were helpless, who didn't know there was another way. But I was wrong. It could happen to anyone. At the funeral service, the speaker talked about how much H cherished her participation in our research project and saw it as a way for her to "move forward."

I still see H as an empowered woman who continues to make a difference. Despite any cruelty she suffered in her own life, she worked endlessly toward ending it for others in the future. I hope that the data she helped me collect will help the collaborating organization to influence policy change and shed more light on the situation of rampant gender-based violence. But more importantly, I hope that every woman who participated, whether interviewer or interviewee, uses this experience to move forward in her own life, just as H always aimed to do.

H had lived a good life working hard, inspiring others, and taking each day in stride despite any setbacks. Her passing made me briefly feel hopeless about the situation of violence against women, but I believe the strength of the women in the village will turn tragic emotion into power and change. I think back to the interviewers laughing and

teasing and carrying water from the river to wash my car, even after a long day in the sun tirelessly writing down stories about abuse. It reminds me that we must continue to plough ahead and aim for change, and this is possible with a strong group of women, like the ones in my interviewing team, who demonstrate such hard work, such solidarity, and such drive to always move forward towards a better life.

Danielle Dougherty is a medical student at University of Michigan.

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Learning to Listen: A Reflection on Global Health in the United States

By *Erica Mukai Faria*

Swinging on a hammock at a typical university-students home in southern Brazil, I can hear the excitement of my friends chattering around the samba drum that is also a coffee table. While shaking canisters of rice and tapping knives on plates, they talk about the country's future with a rhythm that is uniquely and decidedly Brazilian. As I listen to their hopes and frustrations, their strategies to gather, energize, and persevere in the work ahead, I realize that their struggle is nourished by a fierce love for the place they call home and the people who live there.

Two months before I was born in the State of São Paulo, universal and equal access to healthcare was enshrined as a citizen's right by the Brazilian Constitution of 1988. Around the same time that my family moved to the United States, Brazilian municipalities began offering comprehensive healthcare through a decentralized model with community clinics and lay health workers. While my mother faced numerous logistical and financial barriers trying to get me vaccinated for school in New Jersey, my cousins in rural Brazil, some of whom were raised without electricity or running water, obtained vaccinations for free with a visit to the nearest health post. Even today, despite strides made by the Affordable Care Act, millions of low-income Americans are left uninsured and at risk for poor health outcomes. It reminds me how much we can learn from other countries where healthcare is defended as a human right.

Global does not mean foreign. If one of the tenets of global health is to provide equity for disenfranchised people, I wonder how we can reevaluate national policies that incriminate behaviors of our most fragile populations? Earlier this year, I helped facilitate a women's health course at a jail in Philadelphia. When I led a class on non-violent communication, I was moved by a simple partner exercise in which one person shared a story for five minutes and the other person listened. After the listener repeated back what they heard, the person who shared often began to cry. The world we live in is so loud that when we take the time to really listen to each other, we heal each other.

American students and educators committed to global health can listen to the cries in our own backyard. We can stand up for underinsured citizens, poor families, women's bodies, veterans, elderly people, folks trapped in dangerous cities or isolated in rural America— these are our neighbors and our friends. Remembering that America is a country of immigrants, we can brainstorm ways to be better listeners to the 60 million people in the United States who speak a language other than English at home. As global health advocates, we can speak up for the voiceless victims of environmental injustice and discuss candidly the role we play in climate change. As global health scholars, we can initiate conversations about doing research with vulnerable populations rather than on them.

As the Global Health Ambassador at my school, I've been trying to encourage honest conversations among students who plan to go abroad for their cultural learning experience. My hope is that there are more discussions about the privilege of being able to leave home, to travel, and to be welcomed into cultures that are not our own. When we go abroad, I hope we share what we have in a lasting way and bring back all that we have learned. Above all else, I hope that global health advocates earn a reputation of being good listeners.

Sustainable work is fueled by efforts that encourage and invigorate! One such effort that inspires me is the training of community health workers across the United States. Programs modeled from developing countries have reduced health disparities among refugees, rural communities, and people with chronic disease. I also admire the nurses from the United States and Canada who marched across the Golden Gate Bridge last summer in protest of the Keystone XL Pipeline. By speaking up for the hundreds of communities across North America affected by poisoned water systems, they advocated for the wellness of our planet and all the creatures that live in it. It was global health in action.

We want the things we love to be their best, so we work on bettering them. Every now and then, I think about my friends in southern Brazil, gathered around the coffee table that is also a samba drum, discussing how to make their country better. I think about the systems in the United States that I want to be better so that we can make more people better. If we put in the work to make home a better place, our work elsewhere will be meaningful too.

Erica Mukai Faria (BS, BSN) is the Global Health Ambassador at-Large at the University of Pennsylvania School of Nursing. She is also a member of Put People First! PA.

The Love Thing

By *Susan Folsom*

I've always loved to sing. When I arrived in Romania to begin my volunteer internship at a children's hospital, I couldn't keep my music inside of me. I was singing from every particle of my body. Cobble stone, ancient monasteries, gypsies, trains, remnants of history that I'd only ever encountered in books. I was in Europe. I was in Romania. I was sure that I was going to change the world.

Then I saw poverty, but I didn't understand it. I saw illness, but I didn't comprehend what that meant in this new place. People approached sickness differently here. I encountered hardened souls and bitter memories. It was hot. The hospital looked and smelled like something out of a horror film. In America, falling ill was usually an inconvenience. In Romania, it was a matter of life or death. Sometimes coming to the hospital was a death sentence.

We were commissioned to help care for abandoned children at the hospital. It was a product of communism, one book told me. Someone else said it was because of people's poverty. Whatever the cause, every children's hospital in the country had its fair share of orphans. "Copii fura mama (children without mothers)," is how we were told to refer to them.

Soon, without even realizing that it had happened, I stopped singing. I couldn't any more. Children without mothers didn't have a chance here. The nurses were overworked. They had more patients and longer hours than humanly possible to manage. Together, we watched children die every day.

One day there was a baby with hydrocephalus. I'd read about this in one of my neuroscience textbooks. It was usually a pretty simple fix, if caught early. But this was a baby without a mother. So we changed their diaper, watched their head swell, and waited for the day when the nurses said the room no longer had any, "Copii fura mama."

Too many sweaty rooms, packed with children, some groaning, others screaming, others just staring blankly at the ceiling they stared at every day, all day. It was loud,

but my soul was quiet. All I was good for any more was changing diapers and waiting until the beds were empty again.

I liked the ICU. It was different there. Most of the children were small, still babies or toddlers. They were too sick to groan or scream. They were too sick for us to even change their diapers. I knew there was very little we could do there, but it was quiet. It matched my soul. I needed quiet.

One day, one of my favorite babies from the cardio wing was in the ICU. She didn't have a name. She was a baby without a mother, but her sweet, scrunchy little face and wild hair earned her the name, "peanut baby." Looking back, I don't know if it was really all that fitting, but my mom always called tiny babies "peanuts." So she was peanut baby.

That day, in the ICU with peanut baby, was the first day I sang again. It was a quiet place so my voice was different. It wasn't belting show-tunes or singing along with the radio. It was a different kind of singing. It was a children's hymn. I didn't know any songs in Romanian yet, so I sang quietly in English. My friend who was holding the hand of a baby in a nearby bed joined in with harmony. Our voices resonated through the quiet wing. We weren't singing loudly, but I'm sure you could hear us all the way down the hall. We finished the song and it was quiet again, except for the soft weeping of a mother sitting on the bed next to us, holding her baby. For the first time I looked at her baby and realized her baby was dying, too. Even babies with mothers often died. She whispered, "Multumesc (Thank you)." We smiled, I kissed peanut baby's head, squeezed the mother's hand, and proceeded to the next floor.

After that day, things changed. I couldn't do much, but I could sing. I could smile. I played tag with the kids from the 7th floor. I played cards with the ones confined to a bed. We began having games of catch between the 6 beds in the room on the 5th floor. The parents there would often join in. We laughed, we taught them some English, they taught us some Romanian. I learned Romanian songs and sang them often.

People often asked how I felt about my experience in Romania. At first I couldn't bear the thought of trying to encapsulate what had happened that summer into a few trite words. "It was great, I loved it," just didn't seem appropriate when one considers what we saw everyday. We saw horrors. We watched helplessly as children died from diseases I knew were treatable under better circumstances. But when I began to sing again, I knew it wasn't what I couldn't do that mattered. I realized that I may never have the resources or knowledge to help everyone, but I could always, and forever will, give love.

Susan Folsom is a second year medical student and Air Force HPSP scholar at the University of Utah in Salt Lake City.

Political Bodies: A Charitable, Unjust World

By *Shiyam Galyon*

I didn't think, at age 17, while hugging my Syrian grandmother goodbye, that the next time I would enter Syria would be at age 22 and through a refugee camp. I travelled there this past March to work on a humanitarian relief project and to make connections with workers on the ground; the journey was as much personal as it was work-related. Those five days marked a change in how I understood international power relations, the political nature of human existence within a state, and the construction of privilege.

For the first year of the Syrian revolution, I watched, powerless. I was the only Syrian-American in my social circles and didn't have a support network. In hindsight, I should have immediately sought out a support network, a team, to keep up with the news and work on projects together. The first step to being politically active is joining the conversation, but finding the American conversation on Syria was difficult. There would be no mainstream conversation to join until Obama was forced to act on his Red Line policy in August 2013.

Eventually, after months of asking around, I connected with an activist online. She in turn connected me with other activists on Facebook, and a few months later, 17 of us planned a relief project to deliver aid inside Syria. In a little over one week, we were able to fund-raise \$105,000 online with Syrian Sunrise Foundation, a registered non-profit. At the Syrian-Turkish border, we partnered with another NGO to help us allocate our money, mostly towards food baskets and one development project.

The Syrian borders are congested with tents. I saw more refugee camps than I can name. Refugee camps are spontaneous cities that emerge without an infrastructure or economy whose residents are more or less impoverished. We invested money towards a sewer to prevent the spread of water-borne diseases. Driving through the various refugee camps, you will see the occasional UNHCR-stamped tent. It's bewildering how the UN has invested time, money, and media to raise the alarm about the refugee crisis while members of its Security Council protect Bashar al Assad from being sent to the International Criminal Court: we live in a world that will hand out charity but withhold justice.

At the refugee camp, I played with the children and spoke with the women, and was ashamed that I could not offer more than just my company and promises to write about them in the media (which I later fulfilled in an online photo story and article). With just my Biology degree, I was unskilled and couldn't offer something useful, like medical care. Everyone knew we had travelled long distances to be there and expected us to be powerful or influential people. My taking up their airspace only benefitted us, the North Americans, who wanted to ensure the honesty of the relief delivery system. In a way, it was like walking in on domestic violence ... and just watching and handing the victim a blanket instead of calling the police.

Americans feel a disconnect with Syria because the Obama administration sidelined the issue and made Syria appear irrelevant to the average American. Many Americans forget that the United States has a seat on the UN Security Council which is blocking political justice for Syrians. When the August 21 sarin gas attacks happened, Obama abdicated his responsibility as commander in chief to the uninformed, indifferent American population. Suddenly, Syria was relevant, and a frenzy ensued as 300 million people tried to catch up on 2.5 years of revolution in 2.5 weeks. They failed.

Children, who are simple and innocent by nature, speak of death in Syria. One million of Syria's refugees are children while five million are in desperate need of assistance according to UNICEF. The UN estimates 1 million people are at risk of starvation. Nine million Syrians have lost their homes, and everyone has a story about death. "We were walking in a protest and both my cousins on either side of me fell to the ground, shot dead by a sniper," a relief worker told me. Conservative estimates say 191,000 people have died in Syria, and hundreds of thousands more are missing or are being tortured in detention. The residents of opposition strongholds of Ghouta, Moadamiyah, Yarmouk Palestinian camp, and Douma are imprisoned in their own neighborhoods by the Assad regime's medieval siege policy — no food, water, or medicine goes in and no one gets out. As of this writing, Yarmouk Refugee Camp has been without water for 14 days.

Individual health within the state is to certain degrees at the mercy of state policy, a reality that is evident to absolute extremes in Syria. The Assad regime responded to populist demands for reform with disproportionate force, as many Youtube videos of bleeding and dead civilians will attest. When the people persisted, the regime escalated, bombing bakeries, hospitals, schools, and homes, destroying Syria in an effort to save its rule. Lack of food takes its toll on the body while bombs take their toll on the mind. When the regime drops SCUD missiles, TNT barrels, thermal bombs, and cluster bombs, they always seem to land on civilians and never on Al Qaeda-affiliated groups fighting to control parts of the country. Yet it's the Al Qaeda groups, much like roadkill, who generate morbid fascination thanks to a decade of fear-mongering from the Bush administration in its fallacious post-9/11 "Global War on Terror."

On my third night in Syria, I slept under rocket shelling in Kafranbel. On my fourth day, I had a nervous breakdown in Aleppo. Everybody I met was wounded in some way by the war, and open to sharing their stories. And every young child reminded me of my cousins, every young man of my uncles, and every old woman of my grandmother, all of whom were a few cities away and inaccessible to me. These moments added to the well of emotional distress I carry privately with me to this day.

In America, I would write op-eds, organize political and educational events, and donate money to Syria, but it didn't stop the violence. I became acutely aware of "first-world culture" and our privileges as American citizens. I realized how two groups I used to be apart of, the "do-good" and "life-enthusiast" sub-cultures, are failed attempts by the privileged to both "save the world" and grasp the full extent of "living." Furthermore, the "radical activism" sub-culture has its own problems practicing the very ideas they preach, particularly in recognizing intersectionality and creating safe spaces (many advocates for Syria have initially been shunned by the political Left due to the latter's inability to accept that another entity besides the US could damage a Middle Eastern country). Deconstructing privilege, pushing past our isolationist xenophobia, and developing an intersectional view of the human condition will be necessary to grasp as we strive for a more balanced world.

As I began to see how political structures create and perpetuate violence, I quietly committed myself to becoming a doctor. There is a chance that by the time I'm a practicing doctor, the violence in Syria will have stopped. But unless a major shift in political and social values occurs, there will continue to be casualties at the intersection of health and human rights.

Shiyam Galyon was born in Houston Texas and attended school at The University of Texas at Austin. She's currently the President of the Houston Chapter of the Syrian American Council, a non-profit pro-democracy advocacy group, and hopes to attend medical school in the future.



Syrian NGOs, who often partner with international organizations, deliver food bags filled with staples to IDPs and vulnerable families inside Syria. The UN's Office of Coordination of Humanitarian Affairs is \$5 billion underfunded for Syria, despite estimates that 10.8 million people are in need of humanitarian assistance.

Photo credit: Shiyam Galyon

An Unexpected Journey

By *Samantha Gammel*

December 26, 2004.

A word was re-introduced into vocabulary and languages around the world. For most, the word simply means “a large wave of water.” For those in a small fishing village in Sri Lanka and thousands of others like it in southeast Asia, the word inspires terror, fear, and death.

Tsunami.

A word that changed the lives of millions of people, mine included.

The 2004 Christmas season began just the way we had planned. My friends and I were at our families’ houses in Texas after holiday celebrations eagerly anticipating the New Year and all it would hold. None of us imagined how our lives would suddenly change the following Sunday morning. A massive 9.0 earthquake in the Indian Ocean occurred off the west coast of Indonesia. The earthquake induced a massive wave that affected eleven countries. Initial news reports suggested the death toll could reach 150,000 people. This figure eventually doubled. It soon became apparent that this was no ordinary natural disaster, but something much greater, more powerful, and much more devastating.

Three days later, through our local church, we decided to respond to the disaster in Sri Lanka. Immediately, volunteers began working around the clock mobilizing resources, money, and people to respond to the needs of those we would encounter. Everyone contributed what he or she could. Teachers wrote curricula for the children who were no longer able to attend school. Construction workers, businessmen, and medical personnel offered their expertise. Counselors gave their talents to help relief teams better understand the situations and emotions we would experience. Others gathered supplies, packed crates, and did whatever else was necessary to ensure we were prepared.

On January 1, we left for what was planned to be ten days of relief work in Sri Lanka. We didn’t know exactly where we were going or what we would be doing, but we

went to offer whatever aid we could to those who were desperately in need. A few days later, we reached a small coastal town in the southwest that suffered much damage and lost many people to the deadly wave. For days we immersed ourselves in projects ranging from helping people clean their homes to picking up trash along beaches and roads.

Soon we were led to a small fishing village. At the entrance, a grave was being dug for a member of the village who died in the tsunami. Her husband found her in a lagoon six days after the tsunami and was preparing to bury her and their first child, with whom she was six months pregnant. One of our team members helped him bury his wife and unborn child before we entered the village for the first time.

Beyond this new grave stood four cement buildings, which now served as temporary housing for displaced people. The buildings stood directly behind their old village, which had been completely destroyed by the tsunami. All that remained were piles of bricks that served as reminders of the life that once was.

The need was great, and we did what little we could. We distributed kerosene stoves, cutting boards, pots, and other essential kitchen supplies. Medical staff assessed the physical status of the people and dispensed first-aid kits. Small construction projects began, including fixing doors, building shelves, and installing a community laundry line and a much desired volleyball court.

Perhaps the most significant contribution, however, was establishing a daily school for the children in the village complete with curricula, coloring, dramas, exercises, songs, and puppet shows. The school brought life to the children and many of the parents commented that this was the first time they had seen their children smile since the tsunami. More than anything else, the school gave us access to the hearts of the people. We gained their trust as we played, taught, and spent time with their children. Soon we found ourselves in their homes drinking tea and listening to them share about their lives before the tsunami. They spoke of where they were when they heard the wave coming and how they climbed the coconut trees and held on as the water raged underneath them. They cried and told us about those from the village who were lost. Through sharing in their fellowship, we soon learned they were just like us, people who were hurting, people who just needed to be heard and loved.

Our hearts broke for them. We knew our resources and words of sympathy were limited. And more than anything tangible we could offer them, we wanted them to be restored. As we questioned what we had to offer these people who had lost everything, what hope we could possibly give them, a local architect told us, "If you really want to see them restored, you have to build them homes."

And so it began. We again had to adapt our initial plans. What began as a week of relief work turned into four years of rebuilding. We moved to Sri Lanka and helped build 85 homes with these people we had come to love. The village was relocated away from

the ocean, away from the memories that still caused fear and sleepless nights. Nine years later, the people, and their homes, are still there and continue to remain in our hearts.



Completed Sri Lankan village rebuilt after the 2004 tsunami.

Photo credit: Samantha Gammel

I never imagined I would live in Asia or do something of such personal significance. But I saw a need and responded. I was asked, and I said yes. The best things that have happened to me have been things I didn't plan. They made me the person I am now and led me to where I am. I am thankful my plans were interrupted that holiday season. And I look forward to many more interruptions as I work to gain new skills to be of better service to those I encounter.



Gammel shares a laugh with Sri Lankan children.

Photo credit: Samantha Gammel

Samantha Gammel is pursuing a Master's of Physician Assistant Studies at University of Texas Medical Branch, Galveston, Texas.

Life Portrait

By *Thomas Golden*

The surgeon grasps his patient's hand and pulls it to his chest. His patient lies on the blood-soaked operating table beneath lights that illuminate every painful detail of the open gash stretching from her forehead to her cheek. She pays no notice to the blood pouring out of her wound, or the nurses hurriedly preparing suturing material. The moment in which her fingers interlocked with the surgeon's, her eyes widen in cold horror and fix on his unwavering gaze. In a strong whisper of Chilean Spanish, he delivers the world-shattering news that the woman feared most: "Your daughter is gone." These words hang in the air, momentarily taunting the mother as she processes the meaning and finality of the statement. In what is certainly a more visceral reaction than a conscious decision, she screams with the pain only a mother can know. The surgeon holds tightly onto her flailing hand. I hear her cries. I retreat within myself, and I do not wish to ever come out.

This time, the patient takes my hand. This time, dim light from a single bulb traces a heavily lined face that is free from any visible gashes or scars. The deceptive stillness of an urban slum in Peru has replaced the chaos of the Chilean operating theater, yet similar emotions permeate the lean-to made of corrugated iron in which we sit. The external calm masks the storm raging within the woman whose hand I now hold. I see no terror in her eyes, only resolute determination. She makes one request of me in exchange for sharing her story, an account of her unfaithful husband who infected her and their unborn son with HIV before abandoning the family: "When you become a doctor, do what you can to help. Not for me, but for the children. I have hope that my son and others like him will lead a normal life. Please, do not forget us." I look from her to the toddler sitting on her lap. He smiles, too young to understand the conversation. This time, I do not retreat. This time, I feel my own storm brewing within, calling me to act.

These memories sealed themselves in the deepest confines of my consciousness several years ago, during a summer in which I retraced the path of the young medical student Ernesto "Che" Guevara, a path detailed in his memoir *The Motorcycle Diaries*. Throughout

his travels, Ernesto Guevara witnessed systemic exploitation and disparity, which prompted his transformation from Ernesto, the doctor, to Che, the revolutionary. While my physical journey mirrored that of Ernesto's, my emotional one deviated substantially from Che's. Che viewed the suffering he encountered as a call to revolution and armed conflict in order to reverse the established social power dynamic in favor of the exploited. Ultimately, his dwelling on the extremist fringe of the political spectrum enabled a penchant for violence and retribution to supplant the love of humanity that first called him to medicine. When I witnessed such tragedies, I also concluded that action is necessary to address suffering. Yet I possess neither the hubris nor the longing for notoriety necessary to instigate social revolution. What, then, do I make of my time in South America?

I long to derive meaning out of the seemingly senseless phenomena of pain and tragedy. What can I learn from witnessing the devastating effects of an automobile accident in Chile, or from the heart-wrenching story about mother-to-child HIV transmission in Peru, besides concluding that the world is a cruel place? To answer this question, I must not treat these experiences as discrete pieces of memory from a different time and place, but as dynamic components integrated with my own life experiences. When I think of the pain these mothers endured, I realize that true suffering is only possible in the shadow of love. I think of the love my mother has for her children, and the shackles of cultural relativism break free when confronted with the universal ties that bind, the shared love that unites us all whether we reside in Chile, Peru, or the United States. However, this realization alone does not present a true evolution of thought. While I observed testaments to the commonality of humanity in my time abroad, I must maintain the humility to understand that I know almost nothing about these women and their children in the context of an entire human life, a portrait so multi-faceted that even the artist fails to register all of the details. I will maintain this perspective after I graduate from medical school and begin to see patients of my own. I aspire to a clinical practice that never succumbs to stereotyping, that most insidious of injustices. Stereotyping bars physicians from truly connecting with their patients and strips patients of their complexity. When physicians refuse to understand the patient's perspective, they fail their empathetic duty as health care providers.

Years hence, that boy with HIV may realize that the true scourge of society resides not within the T-cells of those positive for infection, but instead within the minds of those who pass judgment upon the infected. A mental health provider may dismiss that mother in the automobile accident as another patient undergoing the five stages of grief. As a physician, wherever in the world I might practice, I will connect with my patients through shared experiences. I will adopt their perspectives to the best of my ability, but I will never feign to understand all of the joys and sorrows, as well as the victories and

defeats, that have brought them before me. Above all else, I will endeavor to enhance their autonomy, to enable the fulfillment of their dreams, and to increase the number of strokes in their life portraits that neither subject nor artist nor observer will ever fully comprehend.

Thomas Golden is a medical student at University of Medicine and Dentistry of New Jersey-Robert Wood Johnson Medical School.

In Her Honor

By *Karina Haber*

I have traveled to twenty-six countries on five different continents. I have found myself delivering babies by candlelight, wrapping newborns in pieces of old cloth, and sterilizing my instruments in boiling water. I have operated on women's prolapsed uteri from which they had suffered in silence for years. I have done PAP smears on women never before screened for cervical cancer; and performed surgical excisional procedures for those harboring pre-cancerous lesions. So, by the age of thirty, I thought I understood the hardships of the world.

However, working in the labor and delivery unit at the largest national referral hospital in Uganda revealed to me I had much to learn about the consequences of poverty.

The sound echoing from that room was one I had never heard. Was it the beeping sound of fetal heart rate monitors or the whirl of epidural pumps? No; the only sound was of thirty-five women moaning and groaning to the pains of childbirth. Laboring women covered the ground, their amniotic juices and bright red blood saturating the plastic tarps spread to protect the floor.

Midwives were hard at work but none were smiling. They seemed defeated by the number of patients and the lack of access to necessary life saving resources. Desperation radiated from every laboring woman's face, each pair of eyes sent a silent plea to allow her and her unborn child to survive the journey.

On my first day, still in shock from the sights and sounds, I patiently coached a new mom in the birth to her daughter. After her perfect little being was born, the mother asked me my name.

"Karina", I responded. She looked down at her precious newborn and said "So is hers." I was not prepared for the extreme contradictions before me; I was moved by this mother's choice and the beauty of a healthy birth, yet, I was also aware that we were surrounded by serious complications, limited resources, preventable tragedies, and overwhelming desperation.

I went to the hospital with the intention of being an observer. I had a professional interest in how obstetrical and gynecological care differed in a low-income country from my practice in the United States. I wanted to understand why one in every 12 women in this country had to die in childbirth, and hoped to identify ways the willing hands of American physicians might help minimize the current inequalities in medical care. However, as I saw what was happening and witnessed the dire need of a competent health care provider, it was impossible to stand on the sideline. I couldn't let the woman in front of me suffer from an obstetrical emergency if I had the ability to perform the necessary surgery. I felt compelled to engage and I did.

I will never forget Mrs. Jane Doe, mother of seven, who arrived to the hospital seizing from eclampsia. I took a deep sigh of relief when I found a reassuring fetal heart rate but the mom was clearly unstable. We had to stabilize the patient before doing a cesarean to save the baby. It took me fifteen minutes to locate a functioning blood pressure cuff and another ten minutes to find a working pulse oximeter. I immediately ordered magnesium sulfate to protect the mom from consecutive seizures, but it arrived more than hour later.

Meanwhile, the patient continued to convulse. Her blood pressure was severely elevated but there were no available anti-hypertensive in the hospital pharmacy. The family dug through their satchels but couldn't gather enough money to purchase the necessary medication. I handed the son a few shillings from my own purse and he sprinted out of the hospital in search of this life saving remedy. Finally, we got the blood pressure out of a dangerous range, her seizures stopped, and thankfully, there was still a fetal heart. The patient was ready for surgery. But, as always, there was a long line of extremely sick women waiting for a cesarean section and the patient with immediate life-threatening issues took precedence. A patient with a ruptured uterus was taken back to the operating room, followed by a women and fetus suffering from a cord prolapse. The emergencies never stop. Twelve hours later, I finally performed a cesarean section on Mrs. Jane Doe. I delivered an alive but struggling baby boy. Mrs. Jane Doe never opened her eyes to see her newborn child; she died from a hemorrhagic stroke that occurred as she waited for treatment.

In a country like Uganda, misery comes in many guises: lack of medications, lack of anesthesia or mandatory operating equipment. At other times it's the inability to efficiently monitor vital signs or because there just aren't available physicians. The hospital has fifteen hundred beds but its average occupancy is greater than four thousand. Neither the thirty Ugandan house staff obstetricians nor the hospital resources can keep up with the overwhelming number of acute emergencies. I learned that the complexity of the many chains of causation are hard enough to comprehend let alone interrupt. I quickly realized that easy solutions simply do not exist for complex problems.

As an individual, I was overwhelmed when facing the enormity of the inequities and sufferings of Ugandan women, but I was comforted remembering that we are all part of something bigger than ourselves. As such, when we have the opportunity to take the first steps in being the change we want to see in the world, we should take them. Hopefully, others will see the impact we are capable of creating for those less fortunate, and join the journey towards positive change.

Karina Michelle Haber is the Chief Resident of Obstetrics-Gynecology at Danbury Hospital.

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Silence

By *Roxane Handal*

“My body went limp as the fifth one penetrated deep within me. The other four chuckled as they held me down. Gang rape. They had taken turns ripping me apart, stripping me of my innocence, and then leaving me naked in the street to die. Alone and helpless, I lay there because nothing I did could change my situation. After all, they were part of the government, and as a poor woman, my voice meant nothing.”

Speechless, I listened to the woman before me tell her story. Only six weeks had passed since she had escaped from her native country Haiti in an attempt to give the baby girl she was expecting opportunity-granting citizenship. She had blocked out the memory for 12 years, but today the scars were reopened. Late to prenatal care, at 21 weeks of pregnancy, her symptoms revealed something far more ominous than a complicated pregnancy. Her weakness, neutropenic fever, dysphagia, and genital lesions were a direct result of a weakened immune system, a CD4 count of 47, and newly diagnosed AIDS, the disease the men who had raped her promised would represent their mark. She had never told anyone about that day, not even her husband, and refrained from getting tested for fear that the threat of disease would become reality. But she knew. She showed no signs of surprise at today’s diagnosis. This was the first time she had told her story, and it was clear that in a way, she felt liberated.

As I reflected on my patient’s years of suffering, I felt grateful for being able to speak her native tongue, allowing her to break from this bondage of silence. But what if I had not had the time as a medical student, nor the ability to speak Haitian Creole? Would she still be having unprotected sex with her husband and potentially bring a child with AIDS to this world? How many other patients have we failed because we no longer have the time as physicians to really *speak* to our patients? As a medical student I had been naïve to the weight of silence in my patients’ diagnoses. For the first time, I realized the power of silence, its critical role in disease, and the importance of providing a safe environment in which a patient can speak freely, free of fear and judgment. Whether it resulted from rape, abuse, shame, misconception of disease, lack of education, or the mere existence as a

woman with limited rights, fear drives the reluctance to break the silence. We frequently forget how silence continues to ravage many countries around the world, often presenting as an undetectable disease even to the brightest and most able physicians.

As physicians and physicians-in-training, it is our duty to treat silence and to palliate its related symptoms. However, we remain crippled by administrative affairs and short visits. When we pledge the Hippocratic oath, we promise to treat all who sought our aid without exception. We pledge to do no harm, but fail to act dutifully when we do not take the time to listen to our patients. To comprehend the physiological consequences of a disease, we need to immerse ourselves in the patient's cultural and social existence. In essence, to fully understand the complexity of the entire human physio-psychological palate, the burden of silence must be unveiled, because silence is a disease that can ultimately lead to death, and it is our responsibility to arrive at its cure.

Roxane Handel is a medical student at Boston University School of Medicine.

Catalyst

By *Lily Horng*

When asked about global health, I recall one particular hospital in Uganda and try to explain how witnessing this hospital as a medical student was terrifying, paralyzing, fortifying and ultimately transformative. I spent four months at this hospital over the course of my training, and I still often reread my initial reflections from 2007:

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These past six weeks taught me life is precious but so very cheap. It's unbelievable to see the end of this rotation approaching so quickly. The truth is that I am *scared* to leave. After all this hospital has given me – motivation, perspective, a sense of justice, a new work ethic – what if I disappoint? What if this “potential” within me is wasted? How can I even begin to repay what I took this summer?

My initial impression of the hospital was one of utter chaos. One-third of patients die in the hospital, and another third die within two months of discharge. Interns are so overburdened and poorly equipped that they are like firefighters using thimbles of water to put out the sun. Interns work for six months straight with zero days off, get two weeks of vacation, then work six more months straight.

But there was order, however foreign, within the chaos. Our first day rounding with my favorite intern Robert, we came to a bed I thought was empty. After a few minutes of conversation between Robert and the attendant, I was shocked to realize that under the small bump of blankets was actually a patient: an emaciated woman dying of AIDS and cryptococcal meningitis. Her attendants had no money, so the hospital was providing whatever it could for free. The average Ugandan earns US\$1/day. Certain medicines are free while they are in stock; a CBC costs US\$3, chest x-ray US\$6, echo plus EKG US\$37, and mortuary services US\$50. Residents and interns minister to these dying patients with everything they have. Residents actually pay to be residents at this hospital and, amazingly enough, they also personally contribute to a small free care fund. As a medical student, I've always wondered how I can contribute to patient care. Here, I wonder even more.

Perhaps my greatest contribution was to one patient, Mr. S, a 55 year-old man with six months of shortness of breath, wheezing and cough, and anasarca. Our only tests were our physical exam and a bedside echo showing right ventricular hypertrophy. Mr. S was diagnosed with CHF and renal failure and put on the Cardiology service. We gave him free furosemide and a nasal cannula to a communal, chronically empty oxygen tank. A chest x-ray was ordered, and the hospital waived his fees because he was so poor. Unfortunately, Mr. S had no way of getting to Radiology. He could not walk without getting short of breath and falling. He had no family or friends to act as attendants. He could not afford the US\$3 bribe for hospital transport.

After six days of waiting for a chest x-ray to be done, I decided to get Mr. S a chest x-ray. I talked to three nurses, a receptionist, and an emergency room staff member before I found Peter, a tech in the plaster casting room, who had a key to the wheelchair storage closet. Armed with a wheelchair, I took Mr. S into three different partly-functioning elevators to get to Radiology where I talked to the receptionist, billing, and x-ray techs to jump the queue to finally get Mr. S's chest x-ray. The long-awaited x-ray? It showed Mr. S had TB! The next day, he transferred to the Pulmonology service. The next week, after positive sputum samples, he moved to the TB ward to begin treatment. Mr. S's first, only, and last English words to me were "Thank you, Madame."

When I told this amazing success story to my brother, he just asked, "Shouldn't this be standard of care for everyone?"

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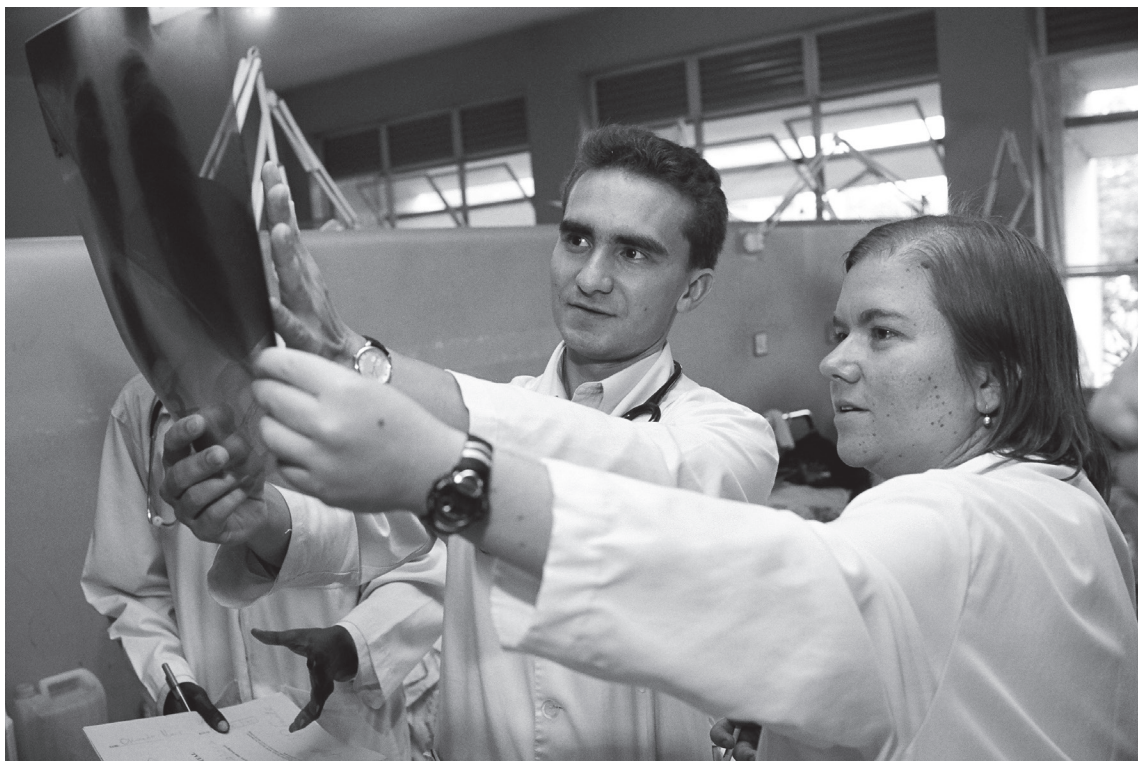
Coming back to the U.S. has been so unsettling and disquieting – I feel like everything and yet nothing has changed. Roads are too smooth, people are too mean, people are too fat, and things are way too expensive. These reactions are something I expected. What I did not expect is this feeling of being lost, disconnected, unhappy, and angry. I am hyper-critical of everything and everyone. I am thoroughly disgusted by so much waste, so much excess, and people being clueless and ungrateful. Friends and family have already called me "misanthropic" because I have little patience for people here. When someone asks "How was Uganda?" I only become more irritated.

How could these people possibly understand all that I saw? I have constant flashbacks of roads that were more potholes than roads, of men bicycling towering mountains of pineapples for sale, of neatly-stacked pyramids of battered skulls from genocide victims in Rwanda, of one skeletal, unattended, paralyzed patient reeking of feces on whom we *practiced* our neuro exam, and of a young orphan named Maska who rubbed her tummy and swallowed rocks to show me how hungry she was. I find myself wanting to either not talk about Uganda at all or take everyone I meet to Uganda. The hospital burns into my eyelids when I close my eyes to sleep.

My sister pointed out that my newfound negativity stems in part from guilt and self-disgust. I see how privileged I am. In the eyes of every person I meet in the U.S., I see how oblivious I was before Uganda. Even after Uganda, I find myself inexplicably wasting time and money on stupid things. My inability to change myself frustrates me so intensely! I deeply miss being in Uganda; I felt so alive there. Those six weeks were hyper-stimulating in every aspect of life: food, culture, friends, classes, travels, and medicine. Being in the U.S. is like life without color. I want to go back. I will go back.

So ... who should go to this Ugandan hospital in the future? Someone who is willing to be changed. Someone oblivious, but not purposefully ignorant. Someone who can survive the death and despair to then see the beauty and lessons beyond.

Lily Horng is currently a third year fellow in Infectious Diseases at Stanford University. She completed medical school and Internal Medicine residency at Yale University.



Rasikh Tuktamyshev (left, medical intern, Kazan State Medical University, Russia) and Allison Arwady (right, medical student, Yale University School of Medicine, USA) read chest X-rays.

Photo credit: John Curtis, Editor at Yale Medicine, Yale School of Medicine

Canada's Indigenous Population: A Forgotten Nation

By Rebecca Hrab

It is well known that many people are living in poverty and struggling to meet their basic needs in developing countries around the world. However, few are familiar with the dire circumstances in Northern Canada. I was quite naïve when I entered Nursing school. I had participated in a couple of short volunteer trips in the Caribbean during my time in high school; trips that I thought had opened my eyes to the disparity in the world. I chose nursing as my career so I could dedicate my life to the field of global health. I had my sights set on working in Africa, but much to my surprise, flying halfway across the world was not required to work in global health. Leaving my own province was not even necessary!

Learning about the health disparities between Indigenous Canadians and non-Indigenous Canadians during my University career shattered my sheltered view of my country. How could people living in the same province have such different health outcomes? After securing my fundamental nursing skills, I made a drastic career change. I left my job at the hospital, boarded a tiny plane that fit no more than ten people, and landed into a whole new world.

I had taken a job at an agency that provided nursing relief to remote Indigenous communities in Northern Ontario. These communities had limited resources and physicians were often only available by phone. I worked within an expanded scope, diagnosing and treating common illnesses. I provided emergency care, administered routine vaccinations, performed preventative health checks, and provided mental health care, among many other tasks. I worked long hours, often on call overnight. I developed rapidly in my professional career, and matured in my personal life. The experience was truly life changing.

Some communities lacked potable tap water, were food insecure, had limited access to job opportunities and education due to remoteness, lived in overcrowded

houses in need of repair, and suffered from illnesses related to these conditions. Before boarding that tiny plane, I thought I was going to make a difference. I soon realized how inexperienced I was, how interconnected the determinants of health are, and the impact these determinants have on individuals. Improving health in these communities was a more complex task than I knew how to handle.

Needless to say, the situation in these remote Indigenous communities shocked me. The circumstances are dire, and I was heartbroken to see this happening in my own province. I was not prepared for this experience. The history of Indigenous communities and how they came to be in their current state is long and complex. It reaches back through generations and harshly echoes today. But that is for a separate discussion.

After working in Canada's north, I finally embarked on my dream of travelling to Africa. I volunteered at a clinic in a remote, rural town in Kenya, with no running water or electricity. But, somehow, I felt prepared. Using a latrine was new, but working with limited resources was second nature to me after working in Northern Ontario.

Community members lived in overcrowded houses and had limited access to health care and education. The town was food insecure, and many people suffered common ailments not seen in Canada due to low immunization rates, environmental conditions, and various other complex reasons. I saw simple conditions go untreated because the clinic lacked the supplies to intervene. Sadly, this was of no surprise to me.

We see the situation of many countries in Africa in the news, portrayed in movies, on television, and over the Internet. We see the unjust circumstances that some people are forced to live in, and are aware of the poverty. With this exposure, combined with my experience working in Indigenous communities, I was not completely overwhelmed as many other volunteers in Africa were. Of course there was the usual culture shock, but I quickly adapted to my surroundings and found the clinic to be somewhat similar to Northern Ontario. Upon returning home, I was able to reflect and compare my two experiences. Why did I know about the hardships many people endure living in Africa, a continent so far from home while remaining almost completely blind to what was happening in my own backyard? Canada's Indigenous Peoples have been forgotten. The Indigenous people I worked with were kind, welcoming, and had a strong sense of family, community, and justice. Unfortunately, many of their voices go unheard by the public, and people are unaware of their situation.

My invaluable experiences have urged me to help make a change. I believe that these communities deserve better. More emphasis and interventions are required upstream, at the public health level. Focus on improving the social determinants of health is crucial to the future of Indigenous communities. Collaboration with members of the Indigenous community is imperative for success. I am currently studying to obtain my Master of Public Health, with a specialization in Nursing. I hope to use my broadened skillset to

make an impact in these isolated communities and improve the overall health. I wish to be involved in current public health programs, and help advance them to the forefront of Canadian global health initiatives, shedding a light on the current situation for all to see. If more people knew about the developing country within their developed country, more change may occur and people's lives could be drastically improved.

Rebecca Hrab obtained her Bachelor of Science in Nursing at the University of Ottawa, and is currently pursuing her Master's degree in Public Health with Specialization in Nursing at Lakehead University.



An aerial view of a remote community in Northern Ontario

Photo credit: Rebecca Hrab

Discovering India's Water Crisis in the Alleys of a Slum

By *Neil Issar*

A 500 mL bottle of water. While North Americans are often more concerned about the global overabundance and negative environmental impact of water bottles, ubiquitous in every grocery store and gas station, my view of them changed dramatically when I volunteered in India. I was teaching Hindi and English to children in the Ashoka Bindo Sar slum in New Delhi through *Prayas*, a local non-profit organization. The problems of lack of electricity and the inability to combat the sweltering heat were secondary to the slum's alarming shortage of water. Every family's routine revolved around the arrival of a water truck, the only source of potable water, which came three times a week. The appearance of the truck would cause temporary havoc in the slum as everyone ran to fill any empty water bottle they could find.

It was cruelly ironic, then, when a flash rainfall flooded the undeveloped roads leading to the slum and prevented the water truck from arriving. Collecting the rainwater itself was unsafe as runoff from fertilizers, septic tanks, and sewage, exacerbated by inadequate wastewater treatment facilities, has contaminated most of New Delhi's water sources. As such, many families were left with only a few 500 mL bottles of water, if even that much, to sustain themselves until the roads could be cleared. I cannot imagine how a family could survive in such meager conditions, with barely enough water to drink, much less to bathe or wash clothes.

I discovered that India, despite being a country that has trumpeted its economic and technological achievements over the past few decades, still reveals many enduring images of extreme poverty: open sewers framing the narrow lanes of the slum in which I was teaching; crippled vagrants rummaging through garbage heaps, vainly searching for food or something to sell; malnourished children vying for the opportunity to touch my foreign clothes, flashing rare but bright smiles for the camera; and families subsisting for days on a few bottles of water.

The wave of industrialization that began in the late 1970s certainly changed the economic landscape of India, but many industrial structures were built along riverbanks for easy water availability and waste disposal. As a result, rivers and groundwater have become laced with toxic heavy metals and chemicals such as acids, alkalis, and dyes, all of which greatly impact the pH of the waters. The effects of this contamination are being rapidly felt across the country, both by rural farmers attempting to tap into groundwater through wells and by citizens living in urban slums. The problem is continually worsened by the expanding tendrils of the nation's urban sprawl, which is replacing ponds, lakes, marshes, and mangroves – the natural sponges of Indian cities – with economic development and construction. And when rainfalls or monsoons hit, as they did when I was in the country, they come in short unpredictable torrents. Thus, instead of replenishing groundwater reserves and being welcomed by farmers and slum residents alike, they flood riverside villages and wreak havoc on fragile infrastructure, transforming waterlogged city streets and slum alleyways into breeding grounds for dengue fever, cholera, and other water-borne diseases. The very resource around which the lives of slum residents revolve and depend becomes the source of life-threatening illness.

I had previously seen the uncertainty and fragile emotions of the impoverished suffering from illness and isolation when I volunteered in the emergency ward of a rural hospital in Ontario, Canada. I travelled to India familiar with the statistic that over two million Indian children under the age of five die each year largely due to a lack of clean water and that 700 million Indians lack adequate sanitation or access to basic healthcare. However, it was in that New Delhi slum that I truly realized and witnessed firsthand the profound disparities of healthcare and economic status still far too prevalent in the world. My experiences in India solidified my passion for providing underprivileged people with healthcare and the resources to influence both policy and legislation. This passion, in turn, has motivated me to pursue a joint degree in medicine and law.

Depressingly, the situation for New Delhi and the rest of the second most populous nation in the world is only expected to deteriorate. India's water demands are growing exponentially, and this demand is being stretched by an economy that is pushing ever forward and an agricultural sector that still relies heavily on water-intensive crops. However, the country's water crisis is frustrating, as the root of the problem is not availability but instead distribution, encumbered by feeble administrative oversight, government corruption, a lack of pollution regulations or legislation, and industrial and human waste. While many politicians recognize the severity of the water shortage, and students and activists continue to send strongly worded letters and emails compelling government officials to action, the only ones suffering on a daily basis are the lower-class

citizens and slum residents, who are left with nothing to do but tackle the crisis one water bottle at a time.

In the end, I am left with the image of slum children and adults clutching empty plastic bottles and frantically running towards a water truck. It will serve as a reminder of the Indian government's staggering failure to deliver the most basic services to its people while the nation simultaneously attempts to assert itself as a major economic player in the global arena. The problems of water management and environmental injustice that I witnessed are threatening India's ability to sustain its economic growth, support its sagging agricultural industry, and maintain habitable cities. At stake is not only India's international image but also the very fabric of Indian society. I fear that the water crisis, among a multitude of other problems facing the nation, is causing this social fabric to unravel.

Neil Issar is pursuing an MD/JD at Vanderbilt University School of Medicine.