Bringing International Health Home

A Guide to Applying International Health Principles to Underserved Communities at Home

From the Global Health Action Committee of AMSA

Women's group in Canton de las Piedros, El Salvador, January 1999.
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Introduction

by Molly Martin, editor

Looking for Solutions to the Failures of the United States Health-Care System: Does Your International Experience Hold the Answer?

During my travels to Mexico, Central America and South America, I saw beautiful places, met incredible people and learned a little bit of medicine in the process. But I always found coming back home to be a difficult, painful process. None of my friends or family really understood where I had been and what I had seen. They enjoyed my stories for a few days but then the novelty wore off and they expected me to go back to the same person I was before. But as those of you who have had an international experience know, it forever changes you. You cannot go back to who you were before. Too much has changed and you have grown as a person. Most of us, however, try to fit ourselves back into our previous world. We don't forget about the people, the poverty, or the issues we were exposed to in our travels, but we do lose the passion and energy we had when we first got back. The ideas and hopes to improve the world become just part of the memories.

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Does it have to be like this?

How do we maintain that energy in our everyday life after the international rotation is done? In an effort to figure this out, I began reading the book *Global Learning for Health* published by the National Council for International Health (now called Global Health Council). The book put into words all the ideas that I had been struggling with. Other people were just as frustrated as I was! But instead of complaining about it, they acted. They applied what they had learned internationally. And they applied it where it mattered the most to them—at home. While the United States health-care system provides some of the best care and technology in the world for some of the population, a huge portion of Americans still receive inadequate or insufficient health care. The system has some serious problems, many of which mirror those in developing nations.

But aren't we obligated also to acknowledge the work and successes of others? Perhaps it's time we took a look at what these other nations can teach and give us.

People from the United States have a tendency to think we know the best way to do things and that our sole obligation is to impart our knowledge and resources on others less fortunate. But aren't we obligated also to acknowledge the work and successes of others? Perhaps it's time we took a look at what these other nations can teach and give us. This idea is explained very well in the following excerpts from a chapter in *Global Learning for Health* called "Why is United States Health Care So Expensive?" by Judith Kurland, Julia A. Walsh and Gail Price.

It is clearly an error in the U.S. to believe that medicine is the answer to all health problems. In many instances, by the time a person requires medical care, many other systems have failed. Perhaps a young girl would not have become pregnant if older women in the community had given her guidance. Perhaps a young man would not have abused drugs if the educational system had provided him with self-esteem and a sense of hope for the future. Perhaps there would be less street violence if there were more jobs. Perhaps fewer poor people would contract tuberculosis if housing were improved. Perhaps fewer corporate executives would suffer heart attacks if exercise and a low-fat diet were more important parts of our culture. Perhaps fewer people would develop cancer if environmental carcinogens were eliminated. Much illness could be prevented through interventions outside the mainstream U.S. medical system, at a much lower cost.

One role of public health is to evaluate the effectiveness of interventions on population groups, rather than on individuals. In contrast, the medical model in the U.S. focuses on the individual, rather than on the social determinants which influence the health of the individual as a part of society. An individual's lifestyle-related cardiac disease may receive great benefit from high-tech medical interventions. However, this type of care does not prevent the disease from occurring in the population at large. Clearly, one major lesson from the developing world is that in order to improve the health status of the society, more emphasis should be placed on wide-reaching prevention and health education programs.

A related lesson is that within the field of medicine the emphasis on using expensive staff in highly technical settings is neither necessary nor desirable for many of the illnesses that we face as a society. The U.S. has chosen to provide highly technical care for the insured population, often in the last days life, at the expense of universal access to basic services for the entire population. Curative services, such as the intensive care provided to low-birth-weight infants, has received more attention than preventive services, such as prenatal care, which could have resulted in the birth of a normal newborn.

Health-care cost remains central to the debates about access and reform in the United States. Cost is a critical factor, but money alone cannot produce a population that is healthy. In fact, many of the causes of the high cost of medical care can be approached not from a cost-control standpoint, but with a health-promotion emphasis. Thus the elimination of poverty, inequality and racial discrimination is both cost effective and healthful for the United States. We can face these challenges, however, in the international health-care models, projects, staff and resources across national boundaries."[1]

David Werner and David Sanders, in their book *Questioning the Solution: The Politics of Primary Health Care and Child Survival,* talk about the essential elements that need to be addressed to achieve better health for the world. What would happen if these principles were applied at home in our own system?

> In order to be effective, any effort to reduce the mortality and improve the quality of life of the world's most vulnerable groups, including children, will have to be comprehensive and holistic. Citizens will need to address the issues at all levels, from the local to the international, and extending well beyond the boundaries of the formal health sector. The following suggestions for action are drawn from the experiences of various activists, advocates and community organizers from around the world:
>
> Laying the Groundwork for Change: A Strategy for Health Improvement—
>
> - Ensure that measures intended to improve the situation of disadvantaged people encourage their active participation and foster self-determination.
> - Take care that such interventions are implemented in ways that facilitate equity, power sharing, and group problem solving.
> - Beware of recommendations, technologies, or funding sources that increase dependency, subservience or unquestioning compliance.[2]

Learning from Other Cultures Can Help Us and Empower Them

As I began to explore the health-care models of other countries, I realized how much we can learn and benefit from the work of others. At first I was concerned, because I believe the United States has a history of exploiting other countries less wealthy than ours, and this could be another opportunity to take from them again. But then I started to see how powerful the recognition of their work was. People all over the world have amazing ideas and do great things; this needs to be acknowledged. When a powerful industrialized nation can benefit from ideas developed in a poorer, struggling nation, this serves as a source of empowerment for the poorer nation. Wealth can be measured in much more than currency, if we can just give recognize it.

These ideas also draw us closer and reveal the similarities we have to other countries and cultures. This will prove invaluable in years to come. The world is becoming a much smaller place since the advent of the Internet and the growing ease of travel. We need to be more aware of our neighbors because their wellbeing directly affects us. Our markets are linked and our people intermixed. We will only benefit from improved relations and understanding of other nations and culture.

> It is amazing to see what happens when poor people from around the world come together and recognize their commonalities. People come to realize that their problems are linked. A woman from Kenya visited some communities in Tennessee affected by toxic waste and said, "The problems here are the same as the ones in my village. The only difference is that there we do not know that the water is polluted until the elephants begin to die." The women from Mexico who came to visit U.S. textile workers said, "We knew that we are getting jobs from workers in the North, but we did not know that we are getting jobs from the poor people in the North." And women in the U.S. plants said, "We knew that the Mexicans were taking the jobs but we didn't know that it was people like us who were getting those jobs." The commonalities of experiences became clear. And from those commonalities, local and global empowerment follows."[1]

How Can This Manual Improve Medical Education?

To develop these ideas and feel the drive to apply them to your own communities at home, you first need to go abroad. This is much easier said than done. While some medical institutions in the United States are very receptive and helpful in planning international electives, the majority are not. They tend to see international work more as a vacation or as

an exotic, extravagant way of getting through the requirements of medical school. Not enough institutions can see the benefits international electives give to students and physicians. Many times international electives are presented as opportunities to provide assistance to people in other countries. But what requires more emphasis is that these electives teach participants to be better thinkers, to understand more about the world and the people in it, and to feel the strength and confidence to improve their own communities when they return home. If more institutions could see the direct benefits of international electives, more support would be available for students and other health professionals.

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How To Use This Manual

As you read the ***first section*** about health models in other countries, look for the similarities between the communities featured and your own. Think about how these ideas could be applied to other situations and places. Also, look at what was learned from the models that failed or had to be revised; maybe we can save ourselves a few mistakes in the future.

The *second section* focuses on the United States and ways that people are thinking globally while acting locally. You don't need to leave the United States to work in international health—it is a frame of mind that makes what you do international, not location! The United States is full of people from all over the world. You can learn tons about language and culture right here. Our own indigenous population—Native American—provides a unique opportunity to explore a fascinating and sometimes very different world. We have incredible access to literature and resources to teach us about the world or to express what we have learned.

The *third section* highlights some of the many organizations that work locally and globally to improve the lives of people everywhere in the world. A group of people is always much stronger than an individual—involvement in organizations is critical to changing the world and the politics who run it. Giving your support to these organizations can occur at a wide range of levels, including reading newsletters, attending conventions, volunteering your time, running for office, or financial support.

The *last section* is a reading list to learn more about the politics that govern our world. Many of the ideas presented in this manual are idealistic. In reality, implementation of ideas centering around empowerment and community self-sufficiency is historically plagued with resistance by governments, industry and others. You need to educate yourself on all sides of the issues to effectively fight for what is right.

Finally, you can use all this information to influence where you are by educating your institution and community on the importance of looking at health internationally. Expand the ideas presented in this manual by holding discussions, bringing in speakers, starting clinics and forming partnerships between your institution and others. This manual is only a beginning; it is only ideas. But believe that YOUR ideas and actions can change the world!

References

[1] Russell E. Morgan, Jr., and Bill Rau, *Global Learning For Health*, Washington, DC, National Council for International Health, 1993, pp. 155-156, 164.

[2] David Werner and David Sanders, with Jason Weston, Steve Babb and Bill Rodriguez. *Questioning the Solution: The Politics of Primary Health Care and Child Survival*. HealthWrights, 1997, p 62.

Selected Approaches to Health Care

Health-Care Systems in Europe— Socialized Health Care

by Scott Ryan Gregory
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To begin a informed look at differences between European and American approaches to health care, it is necessary to understand just what is meant by socialized medicine. The ideals for this concept stem from the idea of "social security" which was coined in 1935 in the Social Security Act. Soon after, Englishman Sir William Beveridge wrote his benchmark report which cemented these ideas to form England's National Health System (NHS). The more widely applied of two broad models for health care in Europe today is commonly known as the "Beveridge" or "British" model. Countries that have health-care systems of this genre include Denmark, Spain, Finland, Greece, Ireland, Italy, Norway, Portugal, England and Sweden. The less-applied second model had it roots in Germany is therefore known as the "German" or "Bismark" model which is seen in Austria, Belgium, Germany, France and the Netherlands. The generalized goals of the Bismarkean systems are to provide coverage or insurance against specific health risks or problems while Beveridge systems aim to provide public services which address the general health of the population. As one might surmise, the latter of the two is very egalitarian and distributes basic benefits to most of the population equally but is often challenged at providing specialty or "cutting-edge" care, research and education. Similarly, the Bismark system address these more complex areas very well but often places qualifiers on the equality of distribution.

Bismark System

- Private: Management of resources by non-governmental entities (which are contracted by the government to take care of patients) that are regulated by law
- Laboral: Coverage leveraged towards laborers
- Causal: Causes for health care (accident, illness, etc.) considered in determining coverage
- Need-based Discriminative: Needs or insufficiencies considered in determining coverage (similar to "ability to pay")
- Subjective: Coverage based on origins of problem on case-by-case basis

Beveridge System

- Public: Management of resources completely by governmental agencies
- Civic: Coverage provided equally to all citizens
- Contingental: Contingencies of health care (invalidity, death, etc) considered in determining coverage
- Need-based Non-discriminative: Equal coverage given regardless of need or insufficiencies (or lack of).
- Objective: Coverage given equally to all cases regardless of origins.

Here it is important to remember that these generalities are made about the systems themselves, not about the status of health care in the countries that utilize them. Obviously, the standard of care varies greatly among countries using the same basic system model as a function of the wealth of the country. Irrespective of our distaste for the idea that the well-being of humans revolves around money, we must not forget this dirty little truth when comparing health-care systems of countries, whether among European states or between Europe and the United States.

That having been said, can we make real comparisons between the United States and the states of the European Union? There may not be a straight-forward answer to this, but we can certainly make some observations as long as we keep in mind that this discussion is much too superficial to consider economic, cultural, historical and other factors that can easily change our interpretations of an observation. The Europe Community is an interesting area of the world to consider as an entity since there is probably no other confederation of independent nations acting as a community with such great diversity in their cultures, languages, economic status, etc. Northern European medicine often produces results that rival or exceed the standard held in the United States, while some of the southern European countries are often challenged to meet minimal standards in some areas of care. In spite of these generalities, examples of quality innovative research are found in many of the "poorer" EU states and there is no dearth of instances where "richer" systems have faltered. It must also be said that there are countries that neither qualify as particularly rich nor poor.

A classic representative of this latter group is France. While not traditionally considered a true powerhouse in medicine in the post-World War II era, it has consistently provided quality care and manages even still to break ground in plenty of areas of research. One very recent example of this has been the recent development of robotic surgery in France. Although this has been a tremendous success and a

boom to French medicine, the peculiar effects of politics and money cloud the potential for any direct comparisons (much of the development for this project was U.S.-based but human trials were not performed in the U.S. due to restrictions by the FDA).

Could system management schemes similar to those most commonly seen in the European Union (E.U.) be modeled for use in treating the modern-day woes of U.S. healthcare management? Yes, they could, and it stands to reason that two major problems of our system could be addressed: 1) extension of basic coverage to a higher percentage of the population; and 2) overall reduction in the cost of health care. It should be noted, however, that these solutions would not be without serious side effects and that the net result may, in fact, bring about an condition less favorable than the present.

To extend coverage to all citizens (at present about 15 percent of Americans, or 35 million, have no official means to access health care) would mean compromising the benefits of the 85 percent who presently have access to the finest care available. Considering that even the EU countries that have socialized medicine also have healthily competing private insurers, it is easy to see that the "double standard" for health care (i.e., those who can pay for private care receive better care) would be maintained as those who are not willing to have their benefits compromised would opt for private plans at any cost (assuming that present-day insurance and HMOs were not eradicated). This problem is manifested widely in Europe where medical doctors are often put into roles of conflicting interests when their duties to patients in both social and private practice compete for the their time and skills.

Finally, in considering the benefit of reduced costs of health care for a socialized plan in America similar to that in Europe, it has to be questioned how much more efficient care can be and what the proper motivators for increased efficiency would be. Simply limiting the amount available to any system or component of a system is hardly sufficient, as seen in many European institutions. More often than not, the net effect of reduced resources translates to less care to patients, not the same care done more efficiently. Given that there is little or no incentive for socially run institutions to excel, the mode of operation can easily become "just get by" rather than "reach for better."

America's dilemma is not an easy one; no one likes to think of the situation where someone is unable to get the care they need in a land as wealthy as ours, yet no one is any more willing to give up what care they have in hopes of something better for all.

Microcredit

Microcredit is the concept of extending small scale loans to very poor people (usually women) for self-improvement projects that generate income, allowing them to care for themselves and their families. Instead of giving money or supplies, providers give only a loan which allows for people to improve their own lives. This concept has incredible potential; read on to learn more about this revolutionary idea.

A Poverty Eradication Strategy That Works

by Joel Rubinstein

Imagine you are a poor woman in Bangladesh. You work hard almost every day weaving mats. In five days you can finish a mat that sells for less than a dollar. When your children get sick, there is no money for medicine. How much would it change your life, if you could borrow $65 to buy a sewing machine?

Joygon Begum was a poor mat weaver in Bangladesh. About five years ago, a worker from the Grameen Bank came to her village and explained that the Grameen Bank was looking for borrowers. The Grameen Bank inverts normal bank lending procedures: to qualify for a loan, you have to be poor. Joygon used her $65 loan to buy a second-hand sewing machine and started a small business making clothes which her husband sells in the village market. Before her first loan, Joygon and her family frequently went hungry, and never had money for family medical care. She could not afford even the very small education fees for her children. Now, the family eats three healthy meals a day in a diet that includes vegetables, grains and a small amount of meat and fish. Her children attend school, and she has money saved up for emergencies.

Joygon is just one of the millions of participants in a peaceful revolution of credit to the poor. In 1993 alone, the Grameen Bank lent to over 1.7 million borrowers. The borrowers, mostly women, are required to organize themselves into groups of five, and learn the rules of the bank before they can receive a loan. The members of the group support and encourage each other and take individual responsibility for their own loans, as well as collective responsibility for the group.

When the Grameen Bank approves the loans, usually the two poorest and neediest receive their loans first. Each week, the borrowers make their loan repayments. After five weeks, if the first two borrowers have kept on schedule with their repayments, the next two borrowers receive their loans, and after five more weeks, if the first four borrowers are on schedule, the fifth borrower receives her loan. The borrowers support each other, because the bank will not make sub-

sequent loans while anyone in the group is in default.

First loans average $30 and have occasionally been less than one dollar. Subsequent loans are larger, and the average loan size is about $100. Ninety-eight percent of the loans are repaid on schedule. The Grameen Bank has had explosive growth, roughly doubling the number of borrowers every two years. There are Grameen Bank branches in 34,000 villages, more than half the villages in Bangladesh. Here is the story that Grameen Bank founder Muhammad Yunus tells about how the Grameen Bank goes to a new village and finds the first borrowers there.

When the first Grameen Bank workers come to the village, they announce that they are looking for poor women to lend to. Usually, several women will come and say "I am poor and I could use a loan." The bank workers listen politely, but they take no action. Usually these women go away after awhile, when it seems that nothing is happening. After a few weeks, a bank worker starts looking for the first borrowers. She looks for the women who were too timid to come forward. She finds a woman in her hut, and says that the Grameen Bank is looking for poor women to lend to. The woman usually responds that they must have meant to speak with her husband. "No, we meant to speak with you," the bank worker replies. The woman then often says that she doesn't need or want any money. Coming from a desperately poor woman, this is a strong sign that the bank has found a borrower. Almost everything in her life that started out looking like good news has turned out bad, and she learned from bitter experience to avoid becoming hopeful.

Almost everything in her life that started out looking like good news has turned out bad, and she learned from bitter experience to avoid becoming hopeful.

The bank worker explains that many other women as poor as she have taken loans, started small businesses, and generated income to repay the loans and improve the quality of their lives. The prospective borrower finds the courage to seek out four others. They each decide what to do with the money, and learn the rules of the Grameen Bank. The Grameen Bank approves the loans.

Soon comes the day that she will receive the money. The night before she gets her loan, she cannot sleep. She worries that her business will not succeed and she will not be able to repay. By morning, she has often decided to cancel her loan request. But the other four women encourage her to go through with it, and convince her that with their support, she will succeed. When she accepts the money, her hands are trembling. She's never seen $30 all in one place, let alone in her own hands. She takes the money and starts her business, and her life is changed forever.

This story may seem bizarre to us. Here in America, banks don't lend to people without education, collateral and business experience. If a bank decided to do poverty lending, we might expect that they would wait for the most aggressive, dynamic personalities who might have the best chance for a successful business. But the Grameen Bank has learned that almost anyone can succeed with a little encouragement.

The Grameen Bank has succeeded in increasing the incomes of some of the world's poorest women. Are these increases in income sufficient to escape poverty? A Malaysian professor of economics took a leave of absence to study the Grameen Bank, and concluded that, of long term borrowers, 48 percent had crossed the poverty line and 27 percent more had moved close to the poverty line. The remaining 25 percent had made little progress, usually because long-term illness in the family had eaten into the savings.

Not only do the borrowers support each other in groups of five, they also support political reform in their country. Traditionally, most of the poor in Bangladesh heeded the advice of the village elders in deciding how to cast their ballots. But in Grameen Bank villages, the borrowers organize to interview the candidates, and in some cases have run for office themselves and been elected.

The Grameen Bank is the world's most successful microenterprise lending institution, but it is far from the only one. Similar banks operate in the Philippines, Indonesia, El Salvador, Mexico and many other countries. There are poverty banks in the United States, most of which offer business training and support in addition to loans. East Bay microenterprise organizations include WISE, the Women's Initiative for Self-Employment (telephone 510-208-9473) and the East Bay Small Business Development Center (telephone 510-893-5532). The economics of microenterprise make it a compelling anti-poverty strategy. With a loan of $100 in a poor country, one can start a small business and repay the loan in a year while still owning the productive assets. Over time, one can earn enough to escape from poverty. When the $100 is repaid, it can be lent to another borrower. The grassroots anti-hunger lobby, RESULTS, has pushed for microenterprise as a poverty eradication tool and promoted legislation to allocate a portion of U.S. foreign assistance to microenterprise lending programs. There was considerable White House and State Department resistance to this until they actually tried it. Agency for International Development (AID) officials now acknowledge that microenterprise are among the most successful anti-poverty programs, and AID Administrator J. Brian Atwood has committed to support expansion of microenterprise lending.

References

- This information was reprinted with the permission of RESULTS from their Web site at *action.org/microjoel.html*. RESULTS, 236 Massachusetts Ave. NE Suite 300, Washington, D.C. 20002. Phone: (202) 543-9340. Fax: (202) 543-7512. E-mail: results@results.action.org.
- To find out more about microcredit, a good information Web site can be found at *www.bus.utexas.edu/~talbotb/microcredit* or do your own search under "microcredit."

Cuba

With the United States embargo of Cuba, the discussion of politics tends to dominate all thoughts of Cuban health care. But the health care system in Cuba has been incredibly successful and should be considered in the quest for alternate health care systems. This section will address the following issues: a description of the Cuban health care system, the Sister Cities Project, a physician exchange program with Cuba, student exchanges to Cuba, and how to be more involved in the protest movement against the embargo.

The Cuban Experience

The following is an excerpt from a chapter in Global Learning for Health, "*Preserving Humanity: Los Angeles County at Risk," by Caswell A. Evans, Jr.. Russell E. Morgan, Jr., and Bill Rau, eds. Global Health Council, formerly National Council for International Health, Washington, D.C., 1993, p 60. Reprinted with permission.*

On a recent study tour of Cuba, I was surprised to learn that the infant mortality rate in that country nearly equals that of the United States. More importantly, the Cuban experience shows no difference in infant mortality based on what we would call "ethnicity." Where there are differences in Cuba, they appear to be more related to urban compared to rural residency. Since Cubans represent as broad a mix of European and African ancestry as in the United States, the question must be asked: Why is their experience so different so as not to exhibit vast disparities in infant mortality based upon "ethnicity?" And then, what can we learn from them?

The Cuban health system targets disease prevention and health maintenance as its first and top priority. The pride and distinction for a community-based physician is in keeping the community healthy. When illness occurs which requires hospitalization, hospital care is available; however, community-based physicians refer to hospitals as "palaces of disease." Since health services are available without payment, there is no financial disincentive nor are there administrative costs related to payment and reimbursement.

A major difference is in the attitude of persons regarding their own health and the health of their families. Maintenance of health is a societal norm and expectation. The need for individuals to be healthy in order to ensure a healthy populace is widely accepted. Furthermore, government policies are crafted to ensure a high standard of health. The expectations for good health start with government policies and priorities which favor health care over other types of government initiatives. The result is a health system that works and keeps people healthy.

A Description of Cuban Health Care

The following abstract was chosen for its concise information. The paper can be viewed in its entirety at http://www.igc.apc.org/cubasoli/waitzkin.html.

Primary Care in Cuba: Low- And High-Technology Developments Pertinent to Family Medicine
Howard Waitzkin, MD, PhD, Karen Wald, Romina Kee, MD, Ross Danielson, PhD, Lisa Robinson, RN, ARNP, Abstract reprinted with permission of US/Cuba InfoMed.

Abstract:

Cuba's accomplishments in primary care, while controversial, include several developments pertinent to family medicine. These accomplishments involve low-technology and organizational innovations, such as neighborhood-based family medicine, as the focus of primary care; regionalized systems of hospital services and professional training; innovative public health initiatives and epidemiologic surveillance; universal access to services without substantial barriers related to race, social class, gender and age; and active programs in alternative or traditional treatments such as "green medicine" and "thermalism." High-technology achievements include innovations in pharmacology and biotechnology, surgical procedures, and care of patients infected by human immunodeficiency virus (HIV). Limited access to Cuban publications, impediments to presentations by Cuban health-care professionals at professional meetings, and the prohibition on importing products of Cuban biotechnology to the United States inhibit a detached, scientific appraisal of Cuba's accomplishments. Cuba's isolation from the U.S. clinical and research communities has prevented interchanges that would improve primary care services in both countries.

Sister City Program

In September 1998 at a meeting in New York, representatives from nine cities met to discuss the process of forming "Sister City" relationships with cities in Cuba. As was well documented at that meeting, the lack of normal diplomatic relations with Cuba makes creating "Sister City" projects with Cuban counterparts a very exciting but challenging task for all parties involved. Since "Sister Cities International" does not yet recognize projects with Cuba, it was decided to create an organization to share our experiences and help facilitate the special needs of those forming such relationships.

Lisa Valanti of the Pittsburgh-Matanzas Sister City project was elected acting president of this new joint venture, and Richard Gonzalas from the Madison-Camaguey Sister City project, acting vice-president. "U.S.–Cuba Sister Cities Association" is its proposed name. The first national meeting of the US-Cuba Sister Cities Association convened in Pittsburgh, March 19-20, 1999. The goal was to "network" as well as become a network, nationally, with the mission to assist all cities in achieving solid Sister City relationships.

Interested parties may contact <LisaCubaSi@aol.com> for basic information on how to choose a city, form a committee, get support from city officials, and so on.

A Physician Exchange Program with Cuba

In Pittsburgh, a program is under development to address the needs of the African-American community by using Cuban physicians. Areas of the African American community in Pittsburgh are vastly underserved by the medical profession. One solution they are looking at is having several doctors from Cuba come to Pittsburgh and work in the African-American community to help identify at-risk pregnancies and perform well-baby care. The Cuban physicians cannot practice as doctors but they could work out of the church in such a neighborhood program.

To learn more about this program, contact Lisa Valanti at LisaCubaSi@aol.com.

Work Opportunities in Cuba

Medical Education Cooperation with Cuba (MEDICC) offers medical electives in Cuba, open to all U.S. medical students, public health students, residents and students in the health sciences. MEDICC is sponsored by the American Association for World Health, which serves as the U.S. committee for the World Health Organization and the Pan American Health Organization.

In Cuba, MEDICC study opportunities are coordinated with the National Center for Post-Graduate Medical Training, under the supervision of the Council of Deans of Cuba's 24 medical schools and the National School of Public Health. Content of electives and student experiences are regularly reviewed and evaluated by MEDICC's Academic Council.

MEDICC offers students the opportunity to immerse themselves in the work of Cuba's public health system, which is based on complete coverage within the constraints of a severe economic crisis. The commitment and skill of Cuba's health professionals have been widely credited for keeping health indicators among the best in the hemisphere, despite shortages of medicines and other key resources. At the heart of their efforts is preventive medicine and special attention to primary care.

U.S. students will carry out clinical and field work, with Cuban professors of medicine and public health as mentors. This may take MEDICC participants into city neighborhoods or small towns, where 25,000 family doctor-and-nurse teams care for the communities they live in; into clinics, pediatric or maternity hospitals working with specialists and their patients; or to centers for health education, tropical medicine and environmental health.

For more information, write to MEDICC at: P.O. Box 3507, Reston, VA 20195-1507 or check out the web site at www.medicc.org.

Other Ways To Get Involved

- US–CUBA MEDICAL PROJECT, One Union Square West, Suite 211, NYC 10003 (212) 727-3247. Not only raises funds & ships medicines, but will organize medical trips on any area of interest.
- IFCO/Pastors for Peace, IFCOgc.apc.org
- Web site: http://igc.apc.org/cubasoli
- Contacts on the legislation to exempt food and medical supplies from the embargo/economic blockade include:
  - Washington Office on Latin America, 400 C. Street, N.E., Washington, D.C. 20002.
  - Oxfam America, 1511 K Street, N.W., Suite 640, Washington, D.C. 20005. (202) 544-8045, Geoff Thale, or (202) 783-7302, Bernice Romero.

Lessons Learned from Iran

The following is an excerpt from a chapter in Global Learning for Health, *"A Quiet Revolution: Primary Health Care in Rural Iran" by Carol R. Underwood. Russell E. Morgan, Jr. and Bill Rau, eds. Global Health Council, formerly National Council for International Health, Washington, DC, 1993, p 93-94. Reprinted with permission.*

The Iranian experience in primary health care over the past decade is replete with lessons for developing nations. Chief among them is the fact that at both the international and intranational levels, the goal of "health for all" is impeded not so much by a lack of funds but by the inequitable distribution of resources. As the Iranian situation demonstrates, countries need not wait for economic prosperity before they introduce primary health care.

Certain aspects of Iranian health policy can also serve as a model for the United States and other industrially developed nations. Specifically, an increase in the use of non-physician providers, the use of indigenous institutions to convey health messages, and a prevention-oriented medical school curriculum could be informed by the Iranian experience.

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Iran has relied on non-physician providers in large part, one could argue, because of an inadequate supply of physicians. While this certainly has an element of truth to it, experience in Iran and elsewhere demonstrates that primary care is most efficiently given by non-physician providers. Physicians are highly skilled professionals whose specialized training tends toward curative rather than preventive care. Given this background, physicians are inclined toward curative treatment even when preventive or primary care measures are a viable option—such as in the choice of hospitalization over oral rehydration therapy for infants dehydrated due to diarrhea. By contrast, non-physician health-care providers are trained in preventative and primary care, and their treatment of choice will reflect that training. Also, it is too costly to train physicians and use their services to treat cases for which other personnel are fully qualified. It is far better stewardship of resources to utilize their services further along in the referral system.

In addition to increases in the number of female and male health-care workers, Iranian health policy stipulates an increase in the number of trained birth attendants. In Iran, too often birth attendants are untrained midwives; by contrast, in the U.S., well-trained midwives are too often restricted and, in some areas, legally proscribed from working without a physician present. Physicians fought hard for a monopoly over the birthing process and are hesitant, at best, to relinquish that power. But the reluctance of physicians to serve in rural areas, coupled with the relatively high costs of physician-attended births, may open the door for midwives to practice more freely.

While periodic child survival campaigns have contributed to increased immunizations coverage of Iranian children, coverage would not approach universality over the long term without a primary health-care system to serve as a safety net. In rural areas, the *behvarz* knows the name of every villager, keeps careful health records of each family member, and makes home visits to families who have failed to have their children immunized. While this may be impractical in many regions of the U. S., it would be possible in rural areas covered by the equivalent of a rural health center or health house. School children in Iran are required to demonstrate that their younger siblings have been immunized. While this approach would not cover infants without older siblings, it could significantly increase immunization coverage among underserved and disadvantaged populations.

Religious leaders often enjoy social ties to people from diverse backgrounds. Muslim clergy, or *ulama,* can be found in the smallest village and most distant outpost. An indigenous system well-suited to information and policy dissemination, the mosque network has been used to disseminate health verses and Islamic traditions, and advocate breastfeeding, immunization, basic hygienic practices and literacy. While religious institutions in the U.S. are organized differently from those in Iran, the use of religious figures to promote preventive measures is one that might prove particularly fruitful. Whether in a church or mosque, a synagogue or temple, the importance of preventive health measures and how to gain access to preventive care could be conveyed. This is a potentially effective venue, since people who might otherwise remain outside the health system until their health problems become severe can be found in many religious congregations.

Finally, a prevention-oriented medical school curriculum is essential if we are to make serious inroads in the access to care among our underserved and vulnerable populations. If physicians remain unaware of the importance and efficacy of simple preventive measures such as oral rehydration solution and immunizantion, and continue to resist the use of non-physician providers for basic health care, primary care will remain unavailable to those most in need. While it is not realistic to require all newly-minted physicians to serve in rural or neglected areas, it is feasible to require that all physicians serve a public health rotation. Moreover, universal requirements for course work in public health, as well as in the social and economic factors that

influence physician and mental well-being, would benefit physician and patient alike.

As noted by Morgan and Mutalik,[1] policy commitment to primary health care models is relatively weak in the U.S. Consequently, programs that promulgate the basic tenets of primary care are underdeveloped. The role of the state in health-policy formation should not be underestimated, once the state arbitrates among contending social classes and political interest groups. States could take the lead in a commitment to a national health policy that incorporates primary care, which would help avoid partisan policies that respond to special interests but leave the needs of a growing minority unattended.

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Community-Oriented Primary Health Care: Lessons from South Africa

The following is a chapter in Global Learning for Health, *"Community-Oriented Primary Health Care: Learning From the Third World," by H. Jack Geiger. Russell E. Morgan, Jr. and Bill Rau, eds. ational Council for International Health, Washington, DC, 1993, pp 99-106.*

For decades in the post-colonial period following World War II, international health activities were characterized by a one-way flow of "technical assistance"—the phrase itself has paternalistic connotations, despite the good intentions that motivated it—from industrialized nations to developing countries. The U.S., Great Britain and other European powers exported their own models of medical education and medical care, models that increasingly were focused on tertiary care, the use of high technology, teaching hospitals and laboratory research; they gave relatively little attention to primary care, let alone to the role and contribution of nurses, paraprofessionals and community workers to health care. This model was the contemporary definition of excellence; it is not clear that developing nations would have accepted anything less.

Yet predictably, this model was wildly inappropriate to the needs of developing countries. In response to overwhelming health-care needs, it produced relatively small numbers of physicians and neglected the training of paraprofessionals. The physicians, in turn, were trained in settings with relatively ample resources—and then resisted practicing in locations lacking such resources. Inevitably, the new or "improved" health-care systems were overwhelmingly urban in societies where the needs were largely rural. They were physician-centered, when supply could not match demand. They were so expensive that they slowly devastated health-care economies, with a single medical school and teaching hospital complex consuming as much as 90 percent of a nation's health budget. In sum, they did more to deepen social inequities in health care than to correct them.

A number of assumptions, explicit or latent, lay beneath this pattern. They included the belief that there was only one model of excellence, independent of demographic, social and economic considerations, and that this model was appropriate even where there were huge differences in health problems and disease patterns. Next was the belief that reliance on complex technology and specialization, despite their high costs, was essential to improvement of health status. A further assumption was that there were no significant and relevant innovations in health care training and delivery in the Third World that might be highly effective in those settings, and certainly none of any relevance to the problems of industrialized societies.

Not until the 1970s did developing nations—and the World Health Organization and other international health agencies which assisted them—begin to abandon the inappropriate models and emphasize primary health care, rural health and community development models. By the mid-1980s, the high-cost, high-technology approach was beginning to fail in the very nations that produced and exported it. In the 1990s, "technical assistance" has begun to be replaced by "technical cooperation," a recognition that industrialized societies may have much to learn from Third World developments in health care.

The irony is that significant innovation had begun in the Third World in the 1940s—at the very height of technological emphasis—and had been adapted to address relevant problems in highly developed nations, in several instances, in the 1960s. It has taken almost three decades for the relevance of that pattern to be more widely recognized. One example may illustrate the point.

In 1940, two young South African physicians, Drs. Sidney and Emily Kark, opened a health center at Pholela, a remote, impoverished Zulu area in rural Natal Province. Under their direction, the center developed all of the core elements that came to be defined as community-oriented primary care (COPC):

- a census to define the population;
- epidemiological and environmental surveys to define health status and major health problems;

- the recruitment and training of community health workers as health educators and community organizers—key members of health-care teams, which also included physicians, nurses, midwives and laboratory personnel;
- the provision of primary care as the basis from which targeted interventions in preventive medicine could be launched;
- a focus on the community rather than the individual as the ultimate object of care; and
- ongoing surveillance, evaluation and epidemiological study to measure impact and identify new problems as they arose.

The Pholela model was so successful that it became a model for a network of some 40 health centers, established by 1948, predominantly in black communities. By 1954, it had its educational counterpart, the Department of Social, Family and Preventive Medicine at the University of Natal Medical School, the first black medical school in South Africa. Although the work at Pholela and other health centers was published in South African medical and international health journals, and supported in part by the Rockefeller Foundation, it remained virtually unknown—or, at best, ignored as irrelevant—in the United States.

In 1957, as a senior medical student at Western Reserve University medical school in Cleveland trying to learn whether the elusive concept of social medicine had any practical meaning, I stumbled across a classic account of community-oriented primary care at Pholela.[1] A variety of stratagems, and support from the Rockefeller Foundation, enabled me to take a six-month elective clerkship in South Africa to study and work at the University of Natal Medical School and the Pholela and Lamontville health centers, the major rural and urban teaching sites in the network. When I returned to Cleveland, my thesis for the M.D. degree presented a proposal for community health centers in the United States,[2] but I was sure my professional career would be in international health in the Third World.

Then in 1964, at the end of my clinical and public health training, I spent a summer in rural Mississippi as a volunteer for the Medical Committee for Human Rights. Echoes of South Africa and other Third World settings were evident. Although not at the same absolute level, the same problems were manifest in the rural African American population: high infant mortality rates, high birth rates, high crude death rates, high rates of infection and malnutrition, especially among children, and high burdens of chronic disease; abject poverty, high unemployment, low educational levels, low mobility; miserable housing, unprotected water supplies, inadequate or absent sanitation; and lack of access to medical care and other support systems.

I remembered Pholela. What worked in the Third World, I felt, could be adapted for relevant settings in the U.S. My colleagues and I proposed the COPC/community health center model to the federal Office of Economic Opportunity, the "War on Poverty" agency, and in 1965, under the aegis of the Tufts University Medical School, two centers were funded—in Bolivar County, Mississippi and Columbia Point, Boston.

They were based explicitly on the South African models. The Lamontville Health Center served an African urban township of some 12,000 people; the Columbia Point health center served an urban public housing project of some 10,000 people, mostly African American and Hispanic. The Pholela health center in rural Natal served a 500 square mile area of what was then called a Zulu tribal reserve; the Delta Health Center served a 500 square mile area of northern Bolivar County with an African American population of about 14,000. More important than the geographic and demographic similarities was the fact that both centers were designed to practice community-oriented primary care and to combine classic primary care with public health strategies.

As in the South Africa of the 1950s, the Delta and Columbia Point health centers became the models for a national network—in the U.S., more than 600 centers serving as the primary care resource for more than 6 million low-income urban and rural residents and migrant workers. In South Africa, the COPC health centers were abolished by an apartheid government; in the U.S., beginning in 1980, repeated attempts by the federal government to dismantle the community health center network failed, but did result in reducing their number and severely limiting their services and orientation to COPC. Nevertheless, the network has survived and has incorporated some features that expand on the Third World models.

In this respect, the Delta Health Center was a pioneering effort. We recognized that the most powerful determinants of the health status of any population lie in the physical, biological and social environments, not primarily in access to health care—a truism know to all public health workers. We decided to try to run that equation backwards, and to organize health services not merely to meet medical care needs but also, specifically and deliberately, to function as a point of intervention for broader social change—change in those biological, social and physical environments that created so many of the health problems in the first place.

Health services, we believed, might prove particularly useful for these purposes on two grounds. First, health services have salience—and the potential actively to involve a target population—in ways that more abstract political, economic or other approaches may lack. The evident problems of sick children, sick or elderly adults, lack of medical care and food, are very real to affected populations—much more so than abstract proposals for change—and so provide a basis for effective community organization. Second, health services have sanction from the larger society; under the umbrella of health, it may be easier to effect economic, political or social changes that otherwise might be seen as threat-

ening by the existing society and meet strong resistance.

In Bolivar County, the existing social order was relevant to what followed. The Mississippi Delta area is prime cotton-agriculture country; in the preceding decade, mechanization had doubled the average size of cotton plantations and caused widespread unemployment. One double-row cotton-picking machine replaces approximately 100 sharecropping workers. By 1965-66, a health center survey showed, the median annual African American family income was roughly $900; given the median family size, that provided about $1.25 per person per day for all basic needs: food, housing, clothing, education and transportation. In northern Bolivar County, close to 90 percent of African American homes were wooden plantation shacks, lacking indoor plumbing and often electricity. Many were unfit for human habitation. Sanitation was provided by surface privies; water came from drainage ditches (often contaminated by runoff from the outhouses), from rainwater collected in old agricultural pesticide barrels, or in containers hauled or hand-carried from protected sources up to five miles away. In winter, when temperatures often dropped below freezing, heat was provided by tin stoves burning firewood.

The median educational level for African Americans in the area was five years of schooling, abbreviated each year during the months of intense cotton-weeding and cotton-picking. The median age of the African American population was 15, but the median age of male heads of households was 57, reflecting high dependency ratios and the migration of large numbers of young adults to northern and western urban areas in search of employment. The estimated African American infant mortality rate was over 70 per thousand live births, more than three times the rate among whites. For the black population, segregation and lack of money severely limited access to physicians. There was limited access to one 44-bed black hospital through an insurance plan operated by a fraternal order, and a few white physicians ran small, segregated, severely substandard (and sometimes unlicensed) inpatient facilities for African Americans as entrepreneurial ventures.

Community organization, health education and extensive community participation are the bedrock of real COPC, but often they are neglected or done superficially—involving small and unrepresentative elites and existing leadership structures in the target population—in the rush to provide the traditional medical care services with which health professionals are most comfortable. In this respect, the Delta Health Center staff was fortunate. For nearly two years, a political struggle with the Mississippi white power structure and medical establishment delayed the construction, licensing and operation of the health center. That time was used for careful, patient and intensive community organization, public health nursing, health education, emergency assistance, and the conduct of a census and health survey. When the health center proper opened, there were already in place 10 local community health associations, each located in a small town that served a larger rural hinterland, and each representative in both membership and leadership of people in poverty. The 10 health associations in turn formed the North Bolivar County Health Council, a not-for-profit group that was chartered not merely as a health organization but as a community development corporation.

That was the key to the health center's strategy. The center offered all of the conventional elements of primary medical care: physicians, dentists, nurses, a laboratory, X-ray services, a pharmacy and the like. But the professional and technical staff worked in teams with outreach workers: public health nurses and community health workers from the target population who spend their time in case-finding, community organization and health education. To these were added the staff members of an environmental health team which—working with local residents—dug and installed protected wells, constructed sanitary privies, repaired roofs, windows and porches, and carried out continuing environmental surveillance.

Because access to hospital care was so limited, the center devised a home care assistance service, providing portable hospital beds, linens, potable water supplies, commodes, and medical equipment and supplies to families with acutely or chronically ill members. Under the supervision of visiting nurses and physicians, even seriously ill patients—a child in coma with encephalitis, for example—could be cared for successfully in plantation shacks.

Early on, the Center recognized pediatric malnutrition and infection as major problems in the area. Food stamp and commodity surplus programs had not yet come into being. For a time, health center physicians literally wrote prescriptions for food—milk, vegetables, meat and fruit—which were filled at local groceries, which in turn sent the bills to the health center pharmacy. The government objected on the grounds that a pharmacy is for drugs for the treatment of disease. We responded that in our view the specific therapy for malnutrition was food.

We prevailed, but this was a clumsy mechanism. The Pholela health center, similarly confronted with malnutrition, had organized a community vegetable garden. We suggested that—and more than a thousand families volunteered. That led to the formation of the North Bolivar County Farm Cooperative, a 600-acre farm (initially on rented land and then, with foundation help, owned outright by families in poverty), growing food instead of cotton, on which workers pooled their labor in return for shares in the crops. Next, the Farm Cooperative attempted to lease a government-owned cannery, and developed plans to market southern "soul food" in northern urban centers. The lease was never granted; the government, it appeared, was generous with palliative measures but was averse to minority capital formation and ownership.

To the medical care, outreach, environmental and farm cooperative services, the health center added social services, legal services, mental health and youth guidance programs,

a pre-Headstart program for early childhood intervention, in-service training for local staff, and—uniquely—an office of education. With its professional staff doubling as teachers under an arrangement with a nearby African American junior college, the health center offered a high school equivalency certificate program, a college preparatory program, and guidance in college and professional school application procedures.

The latter proved to be perhaps the most significant of all the health center's efforts. Through this program, 13 area residents graduated from medical school, several dozen from nursing school, a similar number with training in social work, others in dentistry and pharmacy. More than 40 others obtained college degrees and at least five earned Ph.D.s. Many of the health professionals have returned to Mississippi to practice. Even more striking, there is now preliminary evidence of a second-generation effect: a disproportionately high number of the children of the original health center staff and patients are embarking on health careers. There is even more direct evidence of social change. After passage of the Voting Rights Act, African Americans for the first time were elected mayors of eight of the ten towns in our service area; a majority of the successful candidates were former health center community organizers, who had simply applied their new skills to the political arena. Their election, in turn, meant that housing grants, water and sewer grants and increased educational support went to their communities.

Beginning in the mid-1970s and throughout the 1980s, the national health center program was cut back severely. In the Delta, the environmental health services, outreach programs and almost all of the other supplementary programs were cut from the federal grants, and the health center program was reduced to the provision of personal medical services and a minimal amount of health education—a partial parallel to the elimination of the pioneer health center programs in South Africa with the onset of Grand Apartheid. But the Delta Health Center survived, and may expand again if the national government adopts more enlightened social policies.

What are some of the lessons in this experience?

- First and most important, health care and social support models developed in the Third World may be highly appropriate for populations in industrialized nations—particularly those populations in deepest poverty, in both rural and urban areas.
- Second, the lesson of our office of education is that the most important potential for long-term change may he in the untapped human resources in the target population itself.
- Third, an intersectoral approach combining medical, environmental, social, legal, educational and transportation services is far more effective—particularly when overall support resources and funds are limited—than the separate development of such programs.
- Fourth, without economic development there are sharp limits on the potential for long-range changes in health status. In the 1980s in the U.S., the redistribution of income from the poorer to the richer, combined with the shredding of the social support "safety net," made it certain that the black/white ratio in infant mortality rates and other health indicators would remain the same—or worsen—despite improvements in the absolute health status of both populations. A similar effect in Third World nations is produced by the policies of the International Monetary Fund and the World Bank
- Fifth, professional recruitment for service in impoverished rural and urban areas becomes a desperate problem in the absence of national programs of appropriate medical education, loan forgiveness, professional support and other incentives.
- Finally, the current work of the Delta Health Center suggests the need for flexibility. The major health problems in the Delta are no longer malnutrition, infection, substandard housing and dangerous environmental exposures, though all of these still occur. They are, instead, unemployment of young people, cocaine and other substance abuse, crime and teenage pregnancy: the ruralization of urban patterns associated with poverty and social disorganization. Conversely the headlong and massive urbanization of Third World populations is likely to present similar problems.

The health center/COPC experience is but one example among many of the fact that we can learn from one another in international health. The Network of Community-Oriented Health Sciences Schools, linking universities and professional schools in developed and developing countries in the pursuit of educational innovation, is another. As "technical assistance" is replaced by more bilateral "technical cooperation," all of us stand to gain.

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Lessons Learned in Community Participation: Ceará State, Brazil

The following is a chapter in Global Learning for Health, *"Lessons Learned in Community Participation: Ceará State, Brazil," by Jay F. McAuliffe. Russell E. Morgan, Jr., and Bill Rau, eds. Global Health Council, formerly National Council for International Health, Washington, DC, 1993, pp 107-111. Reprinted with permission.*

Brazil is a very large country, both in its geographic and demographic dimensions. It occupies nearly half of the South American continent and has a total population of 150 million. The size of the country tends to conceal important differences among the five regions into which the country is divided. The Northeast Region, with a population of over 42 million, is more populous than any other country in South America. The region is distinctly poorer and less developed than the rest of the country.

The Northeast Region also is the poorest region in Brazil, as reflected by several key socio-economic indicators. Infant mortality is twice as high in the Northeast compared to the other regions. Illiteracy is two-and-a-half times greater. Families with monthly per capita earnings below a quarter of the minimum wage (equivalent to approximately U.S.$20 per month in 1992 figures) are four to five times more prevalent in the Northeast.

How often do the vulnerable of a given society feel that they have ownership in the health services they require?

The state of Ceará, located in the Northeast Region, offers a good example of how community participation can lead to significant improvements in health. Over six million people live in Ceará, a third of them in and around Fortaleza, the capital city; here, modern high-rise buildings sit among large favelas (squatter settlements). The other two-thirds of the population live in the interior, where many are subsistence farmers and poverty is the norm.

In recent years Ceará has attracted national and international attention for some major advances in the area of child health. Infant mortality—particularly when caused by diarrhea, the leading killer of infants—has declined significantly. The prevalence of malnutrition has dropped, despite the difficult economic situation of the country. Immunization coverage has also improved substantially. These achievements have been highlighted in several publications, including UNICEF's 1992 edition of *The State of the World's Children*.

These achievements were achieved because of several key factors:

- the state government's determination to make primary health care a priority;
- the decentralization of the administration of health services, making them assessable at the local level;
- the effective use of diverse channels of communication for providing families with basic health information; and
- the earlier development of appropriate community-based primary health-care models which served as the basis for health projects which changed the profile of maternal-child health in Ceará.

One program's experience with community participation is illustrative. PROAIS (Programa para Acoes Integradas de Saúde, or Integrated Health Actions Program) is a primary health-care program based at the Federal University of Ceará in Fortaleza. The program receives support from the Kellogg Foundation, and Project HOPE has collaborated with the University on this program for over ten years.

The program began in 1975, under the leadership of an obstetrician, Dr. Galba Araujo. Galba felt that the morbidity and mortality rates of mothers and newborns who were referred to the University maternity hospital from the interior of the state were excessive. He sought to identify and train traditional midwives (called parteiras) from local communities, so that they could identify at an early stage risk factors for a complicated delivery, and refer the mother more rapidly for other obstetrics care.

The need for such an alternative arose because of the limitations of the existing health services. At that time, health facilities and staff in local communities were either under the direction of the state or the municipal government, two different teams. There was no clear definition of responsibility for coverage of the population between the two sets of health facilities, and effective coordination of services was minimal. If the municipality and state were administered by leaders of different political persuasions, there could be outright antagonism between their respective health units, which had obvious negative repercussions for the health of the population. In many cases, health services served more as a commodity used for individual political gain than as an essential tool for the development of the communities.

Within this context Galba hoped to establish perinatal services where they did not already exist. Training the parteiras was a relatively straightforward task. The real challenge was how to provide a reliable, self-sustaining structure through which the newly-trained parteiras could offer their services.

In the first community in which this work was carried out a building originally built (but never used) as a maternity was donated to the parteira project. It became the first community maternity established by PROAIS. To adminis-

ter the maternity, Galba insisted that a community organization be formed with local members and an elected directorate. This model was later followed by other community maternities.

More than just a means to offer perinatal services to needy communities, the maternities offered health services which were for the first time under the control of the community. The maternities revealed the potential of direct participation of the community in meeting their own health needs in the absence of government support. Local leadership emerged to take charge of each maternity's community organization—people who lived in the rural towns and were committed to helping their neighbors and improving the conditions of their community. In most cases they were people who had some previous experience in local organizing—that is, they may have mobilized the community to construct a church—and they brought those skills to the health project. For example, when a new building was needed for a maternity, the community organization would negotiate the purchase of construction materials from the municipal government, while volunteers would provide the labor to erect the maternity. Donations were obtained from the community to stock the facility, even if people could offer nothing more than a sheet or a cup and saucer. Whatever the size of the donation, it helped provide a sense of ownership by the members of the community.

Financial support for ongoing operating expenses are often much more difficult to ensure. In this case, the community organizations were able to make some key institutional agreements to cover day-to-day costs. In most cases, the municipal authorities were persuaded to pay the salaries of most of the maternity staff. Although the eight to ten staff members would earn less than a minimum wage, they were able to negotiate with the social security system and to be paid for the services they provided. Long-term fundraising campaigns were organized by the leaders of the community organization to make capital improvements.

Twenty-five community maternities were established, with local, para-professional health staff providing prenatal care, performing normal deliveries, and offering well-child care, family planning services, and cervical cancer screening. PROAIS makes routine supervisory visits to ensure quality control and provide limited clinical support. Open 24 hours a day, the maternities commonly offered emergency services, and emergency transportation was always available, if needed. While traditional government health services were plagued with lack of motivation by their staff, multiple strikes, and chronic inefficiency, the maternities were models of commitment and never closed their doors to a patient in need. These communities were defining their needs and assuming responsibility for seeing that the needs were met.

The maternities and their community organizations have entered a new phase in recent years. In 1987, Brazil's new constitution outlined the basis for a major reform of the health system. A single health system was created where multiple, poorly-articulated elements had previously existed. Health services and funding for such services were decentralized and located in the municipalities.

Within this new structure the importance of the maternities became formally recognized. A number of maternities have been "taken over" by the local governments which, in some cases, have undercut the autonomy previously sustained by these units. Some have fallen into the same low level of functioning of many other government health units. Others are now suddenly reaffirming their independence from the municipal government. However, even in those cases where the maternity has lost the autonomy and effectiveness it had previously enjoyed, the individuals who so actively supported the maternity through its community organization continue to promote community development, even if it occurs through other entities. Their experience as leaders of the community maternities has shown them the potential of effective community organization and they have put it to use in other community initiatives.

As part of the country's decentralization of health services, municipal health councils have been created to guide local authority. The councils are made up of an equal number of community representatives and health providers. In this way, Brazil is embarking on an ambitious venture to try to institutionalize community participation. Although the councils are still in an early phase and in most cases, functioning to only a limited extent, leaders from the community maternities are playing an active role in this new structure. The potential exists for them to have an even greater impact on improving their community's health.

The lessons to be learned from the Ceará experience revolve around several critical questions about community control:

- How often do the vulnerable of a given society feel that they have ownership in the health services they require?
- How do groups maintain ownership when outside agencies want to take over?
- How do you achieve that sense of ownership in places where health services are run by the government?
- How might such ownership be achieved in the context of the United States?

At issue are the basic (and often antagonistic) roles which the community, health providers and the government play in having decision-making power over the provision of services. The example of the community maternities supported by PROAIS reveals the potential of a strong role for the community through active community participation, an element of primary health care which in most places of the world is still waiting for its chance to make a difference.

Ideas on Urban Health from Brazil

Several health programs initiated in the slums of Rio de Janeiro, specifically Vilas Canoas and Parque de Cidade, resulted in some interesting reflections on urban health.

The following is an excerpt from a chapter in Global Learning for Health, *"Lessons in Urban Health: The Vila Canoas Health Program Experience," by Daniel Becker and Silvia Reis dos Santos. Russell E. Morgan, Jr., and Bill Rau, eds. Global Health Council, formerly National Council for International Health, Washington, DC, 1993, pp 121-122. Reprinted with permission.*

Can the lessons learned in Vila Canoas, and now Parque de Cidade, be applied to urban health problems in the cities of the United States—to Chicago, New York, Detroit, Los Angeles? The Vilas Canoas Health Program (VCHP) partners believe that the answer is yes. Despite cultural and geographical differences, many of the problems are the same. Rapid, large-scale urbanization is a worldwide phenomenon and its pattern and shape reflect an international urban "culture." Global partnerships have been important in the growth of VCHP and we feel that other global partnerships are necessary if the enormous challenge of better urban health is to be met in a timely and effective manner.

One lesson that is quite clear from our experience with Vila Canoas is that some of our long-held beliefs about the promotion of health need to be revised. Specialist teams, city, national and university medical school clinics, large-scale health campaigns and legislation are not sufficient to deal with urban health problems. The routes to better urban health will not come from the top and trickle down to the communities. The solutions must come from within the communities and the sub-communities, in partnership with frontline health professionals. The higher levels of the health system must support these efforts, but the frontline partnerships must define workable, sustainable solutions. The communities and the health professional will then have the opportunity to reshape the higher levels of the system so that their needs are better met—a revolution from below.

Global as well as local partnerships can accelerate this process. As in the proposed city-wide network, it is the sharing of experience, solutions to problems, successes and failures and human and even financial resources that is so valuable. More people will benefit sooner when such transnational or global partnerships are at work. Working with The Health Foundation—one of the partners in the VCHP—we have already begun to apply the lessons learned in Vila Canoas to the United States. Specifically, one of us (Silvia Reis dos Santos) participated as a facilitator of discussions with staff of the University of Illinois Medical School (Chicago and Rockford) to identify solutions to both rural and urban health problems. The National Council for International Health annual conference in 1992 provided another forum for sharing experiences. Finally a series of workshops was held with colleagues in Ghana and Guyana.

The list of urban health problems—poverty, overcrowding, poor housing, violence, crime, substance abuse, unnecessary illness and death, broken families and lost human potential—is a global list. Certainly, it is a list shared by Brazil and the United States. Partnerships for better urban health offer the best and perhaps the only real hope for achieving effective, timely solutions.

A Model for Community Health Care and Development in El Salvador

by Molly Martin

I was very fortunate to have the opportunity to work for ASAPROSAR (Asociacion Salvadoreña Pro Salud Rural or Salvadoran Association for Rural Health) in their child development program. ASAPROSAR truly is a model for community development. Its programs are designed specifically for the needs of the people they serve and all programs are initiated and run by members of the community. ASAPROSAR is working hard to become self-sufficient and always to improve their services to the rural and poor urban communities of El Salvador. *The following information is taken from their brochure.*

ASAPROSAR:
Asociacion Salvadoreña Pro Salud Rural

In 1972, after completing medical training in Mexico, Dr. Vicky Guzman began working in remote mountainous areas of western El Salvador, treating people and training health workers in each village. Poverty, illiteracy and disease were rampant and many children died of diarrhea, malnutrition and parasites. Most people had no access to health care and preventive medicine was unknown.

Dr. Guzman believed that people have a right to basic health care and medical attention should not be dominated by political concerns. At a time of growing unrest and civil war, the government considered such a position dangerous

and subversive. In spite of personal adversity, Dr. Guzman founded ASAPROSAR in 1985. Working with three social workers, she methodically and patiently listened to the concerns of villagers, collected useful information about problems and explored possible solutions. Campesino leaders from the rural mountain areas were identified and trained as health promoters for their villages.

The mission of ASAPROSAR is to help villagers organize to improve their health and well-being. After years of oppression and exploitation, they are developing hope for a better future. The guiding principle throughout is empowerment of the people. ASAPROSAR is the story of respect and understanding of culture and traditions. It is working side by side, shoulder to shoulder with campesinos, to improve the health conditions of people living in the rural mountain regions and in the poor areas of the city of Santa Ana, El Salvador.

In the past ten years, ASAPROSAR has grown successfully. It has increased its service to approximately 80,000 people in the rural mountain districts of western El Salvador and in several poor urban regions of Santa Ana. It has grown from a staff of one physician and three social workers to a staff of more than 50. Three rural clinics and eight maternal child health centers have been formed. It has trained over 800 volunteer promoters in health, midwifery, child development and early intervention programs. The morbidity and mortality rates of children in these regions has been decreased substantially through the efforts of ASAPROSAR.

The areas ASAPROSAR focuses on include the following:

Community Health and Development

ASAPROSAR's early work focused on preventive health measures. Health promoters were trained for the communities. They taught their fellow villagers to build latrines, clean and cover wells, treat the water and improve sanitation. Infant mortality and illnesses were further reduced by vaccination campaigns, improved nutrition, treatment of parasites and the early recognition of diseases. Women, children and adolescents are often the major victims of poverty and illiteracy. ASAPROSAR places a priority on their needs. Classes in basic health, first aid and normal growth and development of children are changing the lives of people in communities all across El Salvador.

Environment

Rural life in the mountains is difficult and always intertwined with the environment. Resources of water, trees and clean air are becoming depleted. Environmental education is critical to the community. Therefore families work together in reforestation projects, soil conservation, planting of vegetable gardens and building cisterns to collect rain water for the dry season.

Eye and Dental Campaigns

Over the years the program of ASAPROSAR has expanded to include eye and dental campaigns conducted in collaboration with professionals from Massachusetts and Texas. An eye glasses distribution bank and several operating rooms equipped for eye surgeries are maintained at the ASAPROSAR multiclinic in Santa Ana.

Small Business Loans (Microcredit)

Experience revealed that the cycle of poverty can be broken if poor people have access to credit and loans to start a small business and to improve living conditions related to poverty. Illness and disease are closely related to poverty. Poor health, malnutrition and lack of education are often the by-products. ASAPROSAR has developed a rural banking program which allows an individual, a group of people or a community to get a small loan. ASAPROSAR provides training in marketing, bookkeeping and other business skills.

Post-War Programs

The war has ended after 12 long years and new programs have been added to ASAPROSAR. The "Barefoot Angels" program works with boys and girls living on the streets. These children have been orphaned, abandoned or exploited by the civil war. ASAPROSAR has rented a shelter and provides medical and psychological help for these youth. The opportunity to go to school and to learn a trade will help integrate them into the community and give them more options for the future.

Mothers selling in the marketplace are encouraged to send their children to school. ASAPROSAR teaches daily kindergarten classes in the market area for their younger children. Classes are also available for the women as they identify their own needs.

Center for Training Assessment and Community Development (CECADEC)

In 1991 ASAPROSAR opened CECADEC, the new Center for Training, Assessment and Community Development. The success and quality of the classes, conference and vocational courses are recognized throughout El Salvador. ASAPROSAR currently uses the classrooms and dormitories to conduct training on both a local and a national level. This is one step toward generating revenue to sustain the work of ASAPROSAR.

- For more information of how to be involved, please contact the ASAPROSAR Development Fund, Inc.

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Routine Systematic Home Visitation in Bolivia

The following is an excerpt from a chapter in Global Learning for Health,*"Home Visitation: Improving Access to Services and Program Effectiveness—Lessons from Bolivia and the U.S." by Henry B. Perry, III, and Irene Sandvold. Russell E. Morgan, Jr. and Bill Rau, eds. Global Health Council, formerly National Council for International Health, Washington, DC, 1993, pp 175-185. Reprinted with permission.*

Andean Rural Health Care (ARHC) is a non-govern mental organization which, in conjunction with the Ministry of Health, operates health programs for approximately 50,000 low-income people in three regions of Bolivia. Programs are located in the rural Andean highlands, in the inter-Andean valley area, and in a tropical lowland periurban slum area. Almost all the people served by these programs are of native American descent. The services provided by ARHC included child survival activities (immunizations, promotion of oral rehydration therapy, growth monitoring and promotion of breastfeeding, as well as the treatment of pneumonia), the provision of basic curative services for all age groups, health education, and training of health workers.

Routine systemic home visitation (RSHV) entails the periodic visitation of all homes in the geographic area served by the health programs. As a result of routine systematic home visitation, high priority individuals in need of specific services are identified. Strategies are then developed to get these services to those most at risk, including, if necessary, the provision of services in the home.

The impetus to begin RSHV was the need to develop a reliable methods for registration of vital events (births, deaths, and migrations) in the populations being served.[1] Since a large proportion of births and deaths in ARHC's project areas in Bolivia occur in the home without any contact with the health system, the only practical way a vital events registration system could be developed was to regularly visit all homes and to record vital events which had taken place since the previous home visit. It was with this goal in mind that the RSHC program began in 1988.

In that year, 11 community-based auxiliary nurses were trained to complement the existing staff of one physician, two rural health technicians and two auxiliary nurses. With this additional staffing, it was possible to initiate the home visiting program throughout the Carabuco health area, outside of La Paz, the capital. In the following two years, two additional project sites began the program. Over the four year period between 1988 and 1991, more than 30,000 home visits were carried out. Home visitation now has become a central focus of program operations for ARHC.

Since one-third or more of the deaths in the program area are among children under three years of age, determining which children are at greatest risk and where these children are located in one of the principle tasks of RSHV. Staff try to visit all homes in the project area at least every six months. During this routine visit, household census information is reviewed, and any vital events which have occurred since the last visit are noted. Characteristics of the household dwelling are noted, particularly with respect to water and sanitation. The vaccination and nutritional status of all children under five years of age is reviewed. Inquiry is made about any pregnancies or illnesses in the household. During the routine health visit, a simple predesigned health education message is delivered. The messages usually pertain to some aspect of health promotion and disease prevention such as oral rehydration therapy or personal hygiene.

Illnesses are treated during routine visits if possible. If a referral to a health facility is more appropriate, the visiting health worker will try to facilitate this. In most cases, the health worker actually accompanies the patient to the facility, usually with transportation provided by the program.

Most children receive vaccinations and are monitored for nutritional well-being at the time of regularly scheduled meetings of mothers' clubs or other community-wide meetings. However, if a child is behind on vaccinations and nutritional monitoring schedule, the program staff will provide these services at the time of a special home visit. A final activity of the routine visit is to determine if there is a need for a follow-up visit sooner than six months.

Most home visits have been carried out by community auxiliary nurses. They are paid program staff who come from and live in the communities they serve. These persons have received at least six months of formal training along with considerable in-service training by field staff. ARHC's field staff has been reluctant to rely too heavily on volunteers for these activities because of problems encountered with high turnover, quality of work and dependability.

Advantages to Routine Systemic Home Visitation

Home visitation is not an uncommon part of health programs throughout the world, including the United States. Staff are called to homes to provide initial or follow-up care. What is unique about the Bolivian program is that is gives program staff a means to interact with all families in the health program area and use information obtained during this interaction to prioritize future program activities. Thus the health program becomes population-based rather than clinic-based, a critical characteristic if those most in need are going to be reached with preventive services. Through RSHV and other home visitation activities, ARHC staff in Bolivia have become increasingly impressed with a number of advantages which accrue to the health program. Two of the major outcomes are *improved relations with the client population* and *improved program effectiveness.*

Limitations of Routine Systemic Home Visitation

While there are strong advantages to home visitation programs, it is nonetheless important to be clear that limitations do exist. First, home visitations take a lot of staff time. In rural areas, especially the highlands, many people live in isolated areas. To reach these areas is time consuming, thus raising the cost of providing direct service. Also, the home visitation approach requires at least someone in the family to be at home. The people served by ARHC's programs not uncommonly migrate to other areas of the country as seasonal laborers. Some visit relatives in the city, and many have farmland some distance from the house. Thus, walking some distance to visit a house and not encountering the family can be frustrating and costly in terms of staff time. Even so, the total cost of local program operations (including preventive services, child survival activities, primary care and home visitation) is only about $10 to $12 per person per year.

ARHC's field staff think that more information than is really necessary is being collected at each home visit. Finding a balance between too much and too little collected information takes time and experience. Minimizing the amount of data collected at the time of a home visit is thus a current need. In the case of ARHC's Bolivian experience, given the existing staff and the demands for other activities and services, it has not been possible to maintain in the Carabuco area of La Paz the intensity of home visitation achieved in 1989.

ARHC staff members have expressed a concern that families might become too dependent upon the provision of health service in the home and may over time be less likely to seek services at the health center or at the village "rally." There is also concern about whether the health education messages being delivered at the time of the home visit are being effectively transmitted.

Experience has and will continue to help ARHC's staff minimize these limitations. The staff are continuing to try new approaches to more effectively incorporate volunteers into program operations so that costs can be reduced. It would be possible, for instance, to limit RSHV to a small but representative area of a large health district and to apply the knowledge gained in the RSHC area to programming on a much larger scale. This would provide some, but obviously not all, of the benefits of RSHV.

Methods of evaluating the effectiveness of health education messages at the time of a home visit need to be developed, and data collection instruments need to be periodically updated as experience accrues. As each staff member becomes more knowledgeable about the daily activities of the families for whom he or she is responsible, it will become easier to schedule visits when the families are most likely to be at home.

Home Visitation Programs in the United States

Over the past decade in the United States, there has been an enormous growth in home health-care services, fueled by the cost savings to third-party payers of having hospitalized patients discharged once care can be provided in the home. On a much smaller scale, in the past five years there has been a resurgence of interest in home visitation as a strategy for improving maternal and child health outcomes, particularly among adolescent and single low-income mothers. Such programs are widespread in Europe. In England and in several other European countries, all mothers and children are visited at home by a professional nurse. In the U.S., home visitation of low-income urban or rural mothers and their children by public health nurses was widespread in the earlier part of this century. Unfortunately these programs were gradually eliminated during the past few decades as a result of funding pressures in local health departments.

However, as a result of positive evaluations of recent pilot home visitation programs—as well as growing concern about the failure of the current medical and public health system to effectively address maternal and child health problems in selected high-risk populations—interest has grown in home visitation as a strategy for improving access to prenatal care, diminishing rates of low birth weight, improving childhood immunization coverage, and improving early childhood growth and development.

Conceptually, the implementation of RSHV in selected locations in the United States could emulate the approach undertaken in Bolivia: to identify risk factors for sickness and death, and to target follow-up visits for those persons or families categorized as being at high risk. Issues such as smoking, obesity, presence of early signs of cancer, incomplete childhood vaccinations, high blood pressure, or not getting regular mammograms or pap smears could lead to further follow-up visits to address the specific risk factor identified. If car dealers in Japan find it profitable to systematically visit every home around each dealership on a periodic basis to promote their car sales,[2] perhaps there is also a health improvement benefit to be derived from RSHV!

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Oral Rehydration Therapy

ORT has revolutionized health care around the world and dramatically reduced the deaths of children from diarrhea. But today in the United States, we routinely choose intravenous fluids instead of ORT. This is a highly political topic that must be addressed.

The following text is from: Alan Meyers, "Modern Management of Acute Diarrhea and Dehydration in Children," American Family Physician, *Vol 51 (5), April 1995, pp.1103-1115. Reprinted with permission.*

Dramatic changes in the treatment of diarrheal disease in children have occurred during the past 20 years, but physicians in the United States have been among the last to apply these advances to the care of their patients. Many of these therapeutic innovations have been pioneered in the world's poorest countries, where dehydrating diarrhea is the leading cause of mortality in children under five year of age and is responsible for as many as 4.5 million deaths every year.

The morbidity and mortality rates for acute diarrheal disease are much lower in the United States than in most other parts of the world. However, it is estimated that the average child in this country has 1.3 to 2.3 episodes of acute diarrhea each year during the first five years of life and that 10 percent of these episodes are severe enough to prompt a visit to a physician. Furthermore, 6.5 percent of all children are hospitalized for diarrhea during the first five years of life. Diarrheal illness is responsible for 10.6 percent of all hospitalizations in this age group, or some 220,000 admissions per year, as well as 500 deaths.

The major advance in the treatment of diarrheal disease has been the development of oral rehydration therapy. In view of the global magnitude of the problem of diarrheal disease and the simplicity, low cost and effectiveness of oral rehydration therapy, an editorial in *Lancet* referred to this treatment as "potentially the most important medical advance of this century."

While oral therapy for diarrhea has been used by traditional cultures for centuries, the origins of modern oral rehydration therapy date to the 1940s, when Harrison at Johns Hopkins and Darrow at Yale began using an oral electrolyte solution that approximated the ion losses in the stool, with glucose added because of its protein-sparing effect.

The finding that this cotransport mechanism also mediates water absorption in the human gut and is preserved in patients with diarrhea led to the formulation of a sodium- and glucose-based oral rehydration solution, which was first used on a large scale when cholera broke out among refugees fleeing into India during the Bangladeshi war of independence in 1971. Supplies and personnel for administering intravenous therapy were scant, but the use of oral rehydration therapy reduced the mortality rate from over 30 percent to 3 percent.

Subsequently, the World Health Organization (WHO) developed and began to promote the use of a single oral rehydration solution (ORS) to treat dehydrating diarrhea in children and adults of all ages. The WHO-ORS consists of sodium (90 mEq per L), glucose (2 percent), potassium (to replace the inevitable stool and urinary losses) and bicarbonate (to help correct acidosis). The dry ingredients are distributed in packets for reconstitution with water. More recently, trisodium citrate has replaced bicarbonate as the base to prolong the packet shelf life.

Today, oral rehydration therapy is being used to treat an estimated one-third of the diarrheal episodes in children living in poorer countries in the world. As a result, 1 million lives are being saved each year.

The following is an excerpt from a chapter in Global Learning for Health, "*Cereal-Based ORT" by Ronald G. Wilson, A. Majid Molla, Syed Mizan Siddiqi, Helen Murphy, and A. Bari. Russell E. Morgan, Jr., and Bill Rau, eds. Global Health Council, formerly National Council for International Health, Washington, DC, 1993, pp 206-207. Reprinted with permission.*

Cereal-based oral rehydration therapy (ORT) has powerful implications—both for more cost-effective child survival and primary health-care programs in developing nations, and for major cost-savings in pediatric and geriatric care anywhere in the world, but particularly in the United States where health-care costs are higher than in most, if not all, other countries.

In the United States, diarrhea in children under age 5 years accounts for up to 3.7 million physician visits and more than 200,000 children are hospitalized annually for rehydration therapy.[1] Diarrhea among the elderly in the United States has only recently been recognized as a large health problem and one that has a case-fatality ratio higher than diarrhea among children.[2]

If inpatient care for diarrhea is $600 per day and outpatient care for diarrhea costs $50 per visit to a physician, the use in the U.S. of cereal-based ORT for home treatment of acute diarrhea in children under age 5 could save up to $527 million in hospital care costs alone. Another $185 million can be saved in outpatient care costs for a total annual savings of $712 million in health-care costs. As these were 1985 data, in 1992 this figure might be closer to $1 billion per year.

The widespread use of ORT—and most particularly cereal-based ORT—in the United States is perhaps one of the best examples of how the costs of health care can be substantially reduced without any compromise of efficacy or standard of quality care. It is also one of the best examples of reverse transfer of technology, in which cereal-based ORT, after being developed and field tested in the Third World, could then be broadly used in the United States to substantially benefit the general population and reduce health care costs.

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Medical Schools in Zimbabwe, Thailand and the United States

The following is an excerpt from a chapter in Global Learning for Health,"*Lessons from International Health for Medical Education in the United States," by N. Lynn Eckhert and Louis E. Fazen, III. Russell E. Morgan, Jr. and Bill Rau, eds. Global Health Council, formerly National Council for International Health, Washington, DC, 1993, pp 259-260. Reprinted with permission.*

Public funding for medical education offers the linkage between the national health-care agenda and the mission of the medical school. Funding can be the lever which ensures that the needs of the nation's citizens, its health plans and the resulting health-care policies are incorporated into the goals and educational objectives of the public medical schools.

Apart from the United States where 40 percent of the 126 medical schools are independently sponsored, most medical education across the globe is government sponsored. Governmental investment in the training of physicians, nurses and other health personnel sets the stage for a population-based strategy of curriculum design and health workforce production aimed to train individuals to become attuned to the health needs of the nation.

Examples from Zimbabwe and Thailand offer lessons for medical schools in the United States. Following independence in 1980, Zimbabwe inherited a medical care system inequitably distributed throughout the nation, with health institutions, resources and personnel clustered in urban areas serving a small minority of the population. New policies were formulated in response to popular demands.[1] The health plan for the new nation called for reallocation of health resources, facilities and personnel to rural areas where 70 percent of the population live. Following delineation of the national health plan, the Ministry of Health, and the medical faculty reexamined and reorganized the curriculum of the nation's only medical school, the University of Zimbabwe, to reflect the new health agenda. Rural attachments to local districts were established in each medical school curriculum year to encourage medical students to learn of, participate in and become knowledgeable about the national priority of rural health.

In Thailand, National Medical Education conferences have been conducted every seven to eight years since the mid-1950s. In recent years, Thailand has moved toward education that would enable medical graduates to have experience more relevant to the needs of the community. Policy makers have attempted to place training within the context of the health needs and problems of the community, at the same time fulfilling the national goals of social justice and social equity. At the most recent conference in 1986 it was determined that medical education policy should be formulated along with the national health policy and should be more responsive to national health plans. Four major medical and public health groups would work collaboratively in developing the medical education agenda. [2]

In contrast, the absence of a well-defined, coherent, universally accepted health agenda in the United States to address issues of access, cost, available health workers and resource distribution, and health priorities reflects and contributes to a fragmented approach to health care and medical education. While developing nations adapt medical education programs established jointly between the Ministries of Health and Education and the medical schools, United States medical schools advance specific programs designed to further their own distinctive agendas. Opportunities for cooperative undertakings between the public section—the Department of Health and Human Services and the state and local departments of public health—and the medical schools in the United States are meager in comparison to the developing world.

Health professional education in the United States embodies a fundamental conviction that medical schools should be granted ultimate flexibility in curriculum design so long as specific basic standards of education are met. Promises of independence and incentives to encourage creativity enable medical schools to conduct innovative courses for medical students. Yet the disparity between the number of primary care physicians needed in the nation and the number

completing their residency training programs commands national attention. The Federal Physician Payment Review Commission has attempted to narrow the gap in salaries between primary care and specialist physicians, but the plan is too new to evaluate any impact on career choices. In addition, training at ambulatory sites and in primary care has to date not been well recognized in academic medical centers, which predominate as sites for medical education.

Unchallenged by a clear, well-conceived, publicly-debated, accepted national health agenda, medical schools will continue to respond to their own priorities, which may or may not correspond to those of the nation. A federal mandate for curricular change is unlikely, but the Department of Health and Human Services has sought to provide direction for training for generalists. At the state level, greater creativity is evident. As part of their concern for access to health care, some state legislatures mandated family medicine as part of the curriculum. Vermont's Health Reform Law calls on the University of Vermont College of Medicine to work with the state to train more primary care providers.[3] In the 1980s, Texas legislated a family medicine clerkship in the state-supported medical schools, but failed to provide funding for such a change. Departments of family medicine, pleased by the new teaching opportunities, were nonetheless constrained by insufficient funds to effectively implement new curricula.

The call for innovation has come from numerous philanthropic organizations and voices within the faculty challenging medical schools to become more responsive to the needs of an ever-changing health-care environment. The Pew Health Professions Commission[4] has set an agenda of action for the nation's health professional schools; the Kellogg Foundation has established Community Partnerships; the Robert Wood Johnson Foundation is supporting generalist education; and Area Health Education Centers have offered successful models. The stage is being set for change and models are available to be tested, tried and redefined.

The developing world is far ahead of the United States in setting an agenda for health and applying resources which make sense for educating physicians for the health problems of the population. Now is the time for a bi-directional flow of expertise, ideas and personnel. The exchange of faculty and health policy makers between the United States and those developing nations with clear health plans and strong educational connections can stimulate the restructuring of a more responsive medical education system. Incremental change, carefully planned through dialogue within the medical schools and distinctively designed by each school, is likely to be the means by which restructuring occurs. Thus, school-to-school international exchanges can facilitate not only the generation of new ideas and concepts, but the needed dialogue within U.S. medical schools.

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International Health Projects within the United States

Indian Health Service

by Bill Trost
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The Indian Health Service (IHS) is the closest thing the United States has to a true civilian national health program. This distinction has made the IHS the focal point of much debate on both sides of the national health-care issue. It provides a possible model for the design, effectiveness and pitfalls of a broadly inclusive, centralized national health-care model as it might take shape in the U.S. In addition, the IHS serves as an example of a culturally exotic health-care system being superimposed on an indigenous people with historically very different views of health and illness from those developed in Europe. What does the IHS have to tell us about the effectiveness of public health initiatives in the U.S.? What about the perennial question in the U.S. regarding "mainstreaming" of cultural minorities vs. multiculturalism? What of the effectiveness of a medical system in which the medical paradigm is not in agreement with the culture it serves on key issues? All these questions make the IHS a fascinating experiment in U.S. medical history. Obviously they cannot all be addressed even superficially in this paper, but we will present a brief history of the IHS as well as some of its triumphs and challenges and resources for further research on the topic, as well as information about possible employment opportunities for health professionals in this challenging and highly rewarding field.

The seeds of the modern Indian Health Service were planted in the early 19th century by military doctors who provided medical care for Native Americans in the vicinity of government outposts to fulfill both treaty obligations and also the government's role as trustee. In 1849, the Bureau of Indian Affairs (BIA) and its responsibility for provision of health care to the Indians was transferred from the Department of War to the nascent Department of the Interior. Indian health care remained under the auspices of the Deptartment of the Interior until 1954, at which time it was transferred from the BIA to the U.S. Public Health Service (now part of Health and Human Services). The transfer of Indian health care from the BIA to the PHS was influenced by multiple political currents as well as mounting evidence from government studies which showed the poor health status of Native Americans under BIA supervision. The transfer was generally viewed favorably, both by those who felt that the health status of Native Americans would be improved by a centralized public health initiative and by those who supported assimilation of the Indians into broader US culture, since the transfer would weaken the BIA. Indeed, it is interesting to note that, at its inception in 1954, the purposes of the IHS as stated by Sen. Edward Thye of Minnesota included furthering "our long-range objective of integration of our Indian people in our common life." This sentiment is one which is currently quite foreign to the goals of the Indian Health Service and underscores the sometimes contentious debate regarding assimilationism vs. multiculturalism as it relates to Native Americans.

The transfer to the PHS marks the inception of the IHS as we currently know it. So what exactly is the Indian Health Service? The IHS provides a broad range of medical services to Native Americans free of charge based on their membership in recognized tribes. Contrary to what many believe, however, the IHS is not considered an entitlement like Medicaid or Medicare. This means that the IHS gets a fixed budgetary allowance each year and that expenses beyond this allowance are not covered except in rare circumstances. In addition, the IHS is designed to serve as a residual provider of health care, meaning that other sources of health-care monies, i.e., Medicaid, Medicare or private insurance, must be exhausted before IHS funds are tapped. This has become an increasingly important point as IHS funding dries up. The IHS is further differentiated from other national health-care models in that it is not an entirely self-contained system. IHS funding is not sufficient to provide comprehensive medical care in all cases, therefore the IHS relies on contracts with other health-care systems to provide some medical services. Increasingly, these other systems are private HMOs and hospitals.

Since record-keeping was begun in earnest in 1954, the health status of Native Americans has improved dramatically. Much of this improvement can be attributed to the effectiveness of the IHS, particularly in regards to public health initiatives. Life expectancy among Native Americans has improved from roughly 60 years at birth in the 1950s to 73.2 years in 1989-91. In 1990, the life expectancy of Native Americans was only 2 years less than the U.S. average. Since 1973, infant and maternal mortality have decreased by 54 percent and 65 percent respectively. Morbidity and mortality due to infectious disease has also been addressed successfully by the IHS. Mortality from tuberculosis, historically one of the scourges of reservation life, has declined

by 74 percent since 1973. Better sanitation and improved ambulatory health care provided by the IHS have contributed to significant drops in mortality due to gastrointestinal infection and influenza (reduced by 81 percent and 50 percent respectively since 1973, according to the IHS Web page). Deaths related to violence and alcohol have also declined, although these still exact a heavy toll on many reservations. Indeed, "accidents and adverse effects" are the second leading cause of death among Native Americans, and an unusually high rate of alcoholism contributes to the appearance of chronic liver disease and cirrhosis in the top five causes of death among Indians. Behavioral risks now present the largest threat to the health of Native Americans, who overall show a death rate from alcoholism of five times that of the general population, develop diabetes at a rate 154 percent higher and commit suicide and murder at significantly higher rates as well.

It is noteworthy that these significant improvements in Native American health have been achieved with very limited funding, with a per capita expenditure of $976 per person covered by the IHS vs. $2,629 for the average U.S. citizen. Even with other insurance and out-of-pocket expenses added, the average per capita Native American expenditure on health services is only 60-65 percent of the US average.[1,2]

The IHS has contributed to a significant improvement in Native American health, but there are obviously serious issues that remain to be resolved. What will be the IHS's role in upcoming years in regard to Indian health? What are the challenges and changes currently facing the IHS?

One area that has been a sticking point since the inception of the IHS and which continues to shape policy today is the degree to which the federal government should be involved in Indian affairs. Where is the balance between Indian autonomy and the benefits of a large, centralized organization with its incumbent political and financial clout? Self-determination is a catch phrase that often surfaces in discussions of Native American health. Certainly few would argue that placing control of a community's health into its own hands is not a worthwhile goal, but the best way to accomplish this without entirely dismembering the significant accomplishments of the IHS is a subject of some debate. Since the civil rights movement of the 1960s, the IHS has actively trained and recruited Native Americans to serve as employees. There is also a long-standing movement afoot to decentralize the IHS so that regional systems can be more responsive to the needs of their catchment area. Nonetheless, friction between Native and non-native staff continues to be a sticking point in the IHS, according to a recent survey of IHS employees (*Public Health*, vol. 113 p.22-33).

While contributing in some positive ways to self-determination and community responsiveness, decentralization has also created some new problems. It seems to have led in some instances to competition between tribes for already strained funding, and could potentially lead to a fragmented and uneconomical system replacing the once unified IHS. According to Stephen Kunitz in his paper in the *American Journal of Public Health*, some patients presenting to clinics on the Navajo reservation are being turned away because they do not live in the area served by that clinic.[3] In his words, "Self determination is a double-edged sword. If supported adequately, it may in fact permit the freedom to develop locally unique and responsive programs. But if supported inadequately, as seems to the case at present, it may lead instead to fragmented, expensive programs that will require the expenditure of tribal resources that might better be used elsewhere...."

Other challenges facing the IHS include inadequate funding and difficulty recruiting doctors and other health professionals. These issues are not likely to be improved by fragmentation of the IHS, as individual tribes will no longer enjoy the economy of scale imparted by the IHS in negotiations with contracted health-care providers, and may no longer be able to afford loan re-payment programs for employees, who must already deal with relatively low pay and sometimes harsh conditions on reservations. Nonetheless, decentralization of the IHS is seen by many as an essential step in the continued progress of Native American health, both physical and spiritual.

Proponents of decentralization include the Indian Health Design Team, a team which included many tribal representatives. This team recommended that the IHS serve more of a supporting as opposed to a controlling function in the future, with greater funding being sent directly to the local level. The support of the IHS may remain critical for some time in order to maintain the health of Native Americans at a level consistent with that of the rest of the country, as the median salary of Native Americans is reported to be more than $5,000 less per year than that of the general population ($13,700 as opposed to $19,000). [1]

The future of the IHS is hardly written in stone, and I highly encourage interested health-care workers to research the topic and draw their own conclusions. Further information on the IHS may be obtained at the IHS Web site at http://www.ihs.gov.

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Health Care for the Homeless

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This manual, which was prepared with the assistance of AMSA and the Bureau of Primary Health Care, Department of Health and Human Services, can be viewed in its entirety along with other materials on health care for the homeless on AMSA's Web site at www.amsa.org/programs/homeless.html.

Introduction

Homelessness is a continuing problem in our country today. However, many of us do not know the first step to becoming part of the solution. In order to clearly define an effective role for ourselves, we must first be familiar with the root causes of homelessness and the efforts currently being made to confront it. Unfortunately, many health professions schools do not necessarily educate their future health-care workers to care for this unique population. It is important, then, for students to take the initiative to seek out educational experiences with the homeless population in order to learn to provide quality care.

Students have been at the forefront of numerous social movements over the last 40 years: the civil rights movement in the 60s, the anti-war movement in the 70s, divestment from South Africa in the 80s. The anti-poverty movement, begun in the 1960s, has been an ongoing interest of students throughout the country. As the number of homeless people in this country have grown dramatically in the last 15 years, students have again come forward through volunteer efforts, organizations and alliances with those living on the streets.

For the last 10 years, students have been an integral part of the formation of a number of organizations that specifically address the issue of homelessness, e.g., Campus Outreach Opportunity League (COOL), Students Together Ending Poverty (STEP), Empty the Shelters, and the National Student Campaign Against Hunger and Homelessness (NSCAHH). Students have also been active members of other organizations working to end hunger and homelessness in this country, such as the National Coalition for the Homeless, the National Alliance for the Homeless, the National Law Center on Poverty, the National Welfare Rights Union, and Bread for the World. At the local level, health professions students are running free clinics for underserved and homeless patients as well as volunteering at agencies all over the country. These volunteer efforts are significant, but health professions students have a more permanent, future role in the fight to end homelessness. Planning a rotation/elective along with volunteer work can assist students in preparing for a career working with the homeless population.

The hundreds of clinics and agencies that address the health concerns of our nation's homeless are necessary adjuncts to the meal programs, shelters, job training and transitional programs that exist. Thousands of homeless people in our country have little or no access to health care except the care and resources provided by these Health Care for the Homeless Projects. Whether you are training to be a pharmacist, nurse, dentist, nurse midwife, podiatrist, physician assistant or physician, the services you will be able to provide are critical for those living in poverty and those without homes. As clinicians providing direct service, or as advocates working alongside those living in poverty, health professionals should take an active role in addressing homelessness as an emergent public health concern.

The Homeless and Their Health Concerns

The images we may have envisioned of homeless individuals 15 years ago are not accurate pictures of those living on the streets today. The "hobos" who hopped freight trains "enjoying" a life free from responsibility have long since ceased to be the faces that characterize those living in poverty. The idea that one chose this path is no longer valid. In fact, homelessness in our day and age is a culmination of the root causes of poverty, i.e., inadequate income, lack of affordable housing, decreasing public benefits, limited access to health care, and a vulnerability to becoming homeless, due to mental illness, substance abuse problems, domestic violence, history of abuse or neglect, chronic physical problems or disabilities, or any combination of the above.

During the 1980's, the United States experienced the largest increase of homelessness in recent history. Numerous reports and studies confirm what is painfully obvious as we walk down any city street in America: homelessness is a pervasive problem throughout this country. Contrary to our notion that homelessness is just confined to our urban areas, it is a problem that now plagues communities where in the past it would have seemed unthinkable—our nation's rural communities.

Who Are the Homeless?

While single adults still constitute the largest proportion of people who are homeless, it is the increasing visibility of families, especially children, that has brought homelessness to America's consciousness. Single adults represent roughly 60% of the homeless population, but families with children are the fastest growing subgroup of people who are homeless. In late 1986, the U.S. Conference of Mayors conducted a survey of hunger, homelessness and poverty in 25 major cities, resulting in the conclusion that families with children made up 28 percent of all homeless people. By 1996, the same group was reporting that families made up 38 percent of the people who were homeless. It is reported that

these percentages are even higher in rural areas where families, single mothers and children make up the largest subgroup of people without homes.

Homelessness affects a number of populations. Minorities, particularly African Americans, are overrepresented in the homeless population just as they are overrepresented in the number of people who live in poverty. According to Blau in *The Visible Poor* (1992)[1], slightly more than half of the homeless population is made up of people of color. Those who are addicted to alcohol or drugs and those who are mentally ill are also overrepresented in the homeless population. Based on the U.S. Conference of Mayors (1986) synopsis of data[2] gathered from studies completed in 30 cities, roughly one-third of the homeless population is addicted to alcohol or other drugs, and approximately one-third of the homeless population is mentally ill. However, these subpopulations are often difficult to quantify due to the numbers that may have dual diagnoses, both an addiction and mental health problem, and the challenge of identifying whether the addiction or the mental illness is a cause or a result of the homelessness. While these numbers may perpetuate common stereotypes about people who are homeless, the National Academy of Science conducted a study[3] demonstrating that 45 percent of homeless people have high school diplomas or GEDs, refuting what many of us may believe about the education level achieved by homeless people.

Placing exact numbers on the size of the homeless population in the United States is an ongoing challenge for numerous reasons. First, studies attempting to count homeless people vary in their definition of homelessness. Some include only the "literally homeless" who are on the streets or in shelters, while others also include the "hidden homeless," those who live doubled up with family or friends. These studies also differ in the period of time used for counting, such as a one night "point-in-time" count versus a one-year "period prevalence." The most problematic aspect of any study, however, is the attempt to count a population that is not static, with people moving in and out of homelessness, as well as changing locations within cities, states or regions.

These inconsistencies and difficulties in counting have resulted in widely varying estimates of numbers and characteristics of people without homes. The most commonly-cited estimate of a point-in-time count comes from a 1988 study[4] by The Urban Institute. During one week that year, researchers estimated that approximately 500,000 to 600,000 homeless people stayed in shelters, ate at soup kitchens, or congregated on the street. If a projected annual rate of increase of 5 percent is applied to this estimate, by 1996 approximately 760,000 people might be homeless on any one given night, while 1.2 to 2 million would experience homelessness during one year. According to a study published in the *American Journal of Public Health* in l994[5], approximately 13.5 million adult residents of the U.S. have experienced homelessness at some point during their lives.

Why are People Homeless?

A useful framework for understanding the causes of homelessness is to consider the distinction between structural causes and personal causes and the interaction between the two. Structural causes, such as the lack of affordable housing and extreme poverty, are the context within which personal characteristics, such as physical or mental disability, substance abuse, domestic violence or social disaffiliation, can increase vulnerability to homelessness. Individuals and families with these characteristics are at a disadvantage when competing for scarce resources like housing or employment.

At times, many of us feel distanced from the *real life* effects of most public policy. However, the thousands of people every year who experience homelessness are directly impacted by these policies. We cannot have an honest discussion about homelessness and its causes without analyzing our housing policies, minimum wage, race relations, welfare reform (mainly a decrease in the amount and availability of benefits), and the economic decline of our inner cities. Those who are homeless may only be a small fraction of the populations that are affected by each of these policies, but when trying to prevent or eliminate homelessness, all of these issues must be discussed.

Although the increasing numbers of those living in poverty and the declining prevalence of affordable housing are the most common causes of homelessness cited, health-related problems are also causes of homelessness. Health related problems may include severe mental disorders, domestic violence, substance abuse, physical or mental disabilities, chronic physical problems, or disabilities that preclude working, including serious illness such as HIV/AIDS.

What Are Common Health Concerns of the Homeless?

Homeless individuals represent a disadvantaged population at significant risk for physical and mental health problems. Homeless individuals have been found to experience more health problems than those who are not homeless in 24 of 27 diagnostic categories, such as upper respiratory infections, circulatory problems, fungal infections, and gastric problems. It is important to acknowledge that the state of homelessness also causes health problems. People who live on the streets are often susceptible to health problems as a consequence of poor nutrition, lack of adequate hygiene, exposure to violence and the elements, increased contact with communicable diseases, and fatigue that accompanies the conditions of homelessness and the struggle to acquire food and shelter. The state of homelessness exacerbates the vulnerability of homeless individuals' health. Common problems include skin infestations, hypertension, ulcers, respiratory diseases and heart problems.

In an effort to clearly identify the health problems of homeless individuals, medical students, working with the N.Y. Academy's Urban Health Initiative/Homeless Shelter Program, have put together the *Homeless Health Topic*

Manual. The students have compiled a list of common health problems of homeless individuals and included a discussion about the presentation, diagnosis and treatment of each condition. The students categorized the health problems into nine topics: common communicable diseases, oral and dental problems, chronic medical conditions (cancer, diabetes, heart disease, hypertension), substances of abuse, physical abuse, podiatric problems, exposure conditions, mental health issues and nutrition.

Chronic health problems requiring significant health care may, in fact, contribute to the cause of homelessness. One study found that 46 percent of homeless males in the sample indicated that health problems prevented them from being employed. Homeless individuals are among the most underserved populations in terms of accessing and using health-care services. Interviews with homeless individuals indicate that most use the emergency room or the veterans administration hospitals as their primary source for care and that illnesses often reach severe stages before care is sought.

While the actual health problems that homeless people experience may not be unique or require a specialized knowledge of treatment, other barriers to effective health care—such as mistrust of the health-care community and the problems of limited resources—require health professionals to develop unique skills. Health professions students need to educate themselves about these health-care concerns since they are not appropriately integrated into formal education. Didactic training will not be enough to learn to creatively maneuver through our health-care system and assist homeless individuals in getting necessary services. Time spent with knowledgeable, "seasoned" mentors in outreach or community clinics will best train the future health-care workers to provide proper care to a growing population of the underserved.

The McKinney Act

In 1987, the Stewart B. McKinney Homeless Assistance Act, Public Law 100-77, was enacted to provide relief to the Nation's rapidly increasing number of homeless individuals. The McKinney Act originally provided funding in 15 programs for emergency food and shelter, education, and transitional and permanent housing, as well as to address the multitude of health problems faced by homeless individuals. Title VI of the McKinney Act added Section 340 to the Public Health Service (PHS) Act, authorizing the Secretary of Health and Human Services (HHS), acting through the Health Resources and Services Administration (HRSA), to award grants for the provision of health care to homeless individuals. The addition of Section 340 to the PHS Act established the Health Care for the Homeless Program, the only Federal program with the sole responsibility of addressing the critical primary health-care needs of homeless individuals.

Skills That Can be Acquired from Working in a HCH Program (clinical skills, mentoring, personal growth, health education, etc.)

The barriers to health care for those living in poverty are numerous. Because homelessness is often a product of social conditions—such as lack of transportation, few resources for obtaining treatment, distrust of the health-care system—health-related work with the poor and the homeless is usually accomplished outside of traditional medical settings. Because most formal health-care professions education has not yet integrated experiences in proven methods for care of homeless individuals—such as outreach and an interdisiciplinary team approach—students must seek out these learning experiences on their own. In other words, it is difficult to gain the skills useful to working with the homeless without spending time in a clinic that includes the unique methods that effectively provide care for the homeless.

Few health care for the homeless clinics resemble typical ambulatory care settings—in fact the McKinney Act was a response to "typical" clinics not reaching the homeless population. The preferred encounter is actually the street itself or an outreach clinic and, unfortunately, unlike the growing popularity of the ambulatory clinic as a teaching facility, the outreach clinic is not extensively accepted as a valid teaching environment.

The skills acquired when working with homeless people in health-care settings are unique compared to those gained in traditional health-care training. An interdisciplinary team approach has been proven to work when caring for a population that has difficult life situations. Ideally, people would be trained at providing medical care, nursing and social work, but we all know that these disciplines are quite segregated with little interaction during their separate training. Working in a Health Care for the Homeless Project, however, is a crash course in the obvious connection between health problems, treatments and providing social service. The health-care providers, i.e., physicians, dentists, nurses, nurse practitioners, certified nurse midwives and physician assistants quickly learn a great deal about linking their clients with social service benefits, trying to find clients safe housing, making referrals, or, more importantly, learning what happens to people when these resources aren't available or identified. The most important factors in teaching students about working in an interdisciplinary team are a preceptor who will teach the student the importance of working with the other disciplines and the opportunity to talk with or shadow other preceptors of other disciplines in order to appreciate their contributions. Homelessness is a multifactorial problem that requires a multidisciplinary approach.

Clinical skills are gained spending time in health care for the homeless clinics. Students have the opportunity to work on their ability to communicate and sharpen their interview skills. Learning to conduct a complete interview in order to identify the many factors that may contribute to a person's health problem is a skill that is not easily mas-

tered. Learning to approach patients holistically may help you and your client determine the most effective plan of action. Students will also be able to work on their diagnostic assessments and treatments.

Homeless individuals are susceptible to some conditions that are not as prevalent in the non-homeless population. Common communicable diseases often seen in homeless individuals include scabies, ringworm, HIV/AIDS, syphilis, gonorrhea, hepatitis B, chickenpox/shingles and tuberculosis. Homeless individuals often have oral and dental problems, including tooth decay and abscesses, and many health problems that are related to the conditions of living on the streets or in shelters, i.e., podiatric problems (bunions, calluses, ingrown toenails, flat feet), hypothermia, heat exhaustion, and lack of nutrition that could exacerbate chronic conditions (diabetes, heart disease and hypertension.)

Students are not often trained in effective ways of delivering health education. Most health professions training includes information that should be shared with patients either about their condition or in order to prevent health problems. However, the means by which we impart this information is often not discussed. Working with a health-care for the homeless project can give you experience in providing health education to a needy population. Many homeless individuals do not have choices about very basic aspects of their lives and this situation presents challenges for us as health professionals to provide meaningful advice. For example, if we discuss dietary habits with a patient, we must realize that they may be eating at meal programs for the majority of their meals and may not have choices about the food they eat.

Although most of us have seen homeless people as we walk down the street or have been pan-handled at some point in our lives, very few of us have taken the opportunity to spend time with homeless individuals. The stereotypes of those living on the streets still convince us to walk right by without acknowledging their presence or decide that "they must have done something" to end up in that situation. As students spend time in a health care for the homeless project and meet more and more homeless individuals, it quickly becomes very clear that each person has his or her own story to tell—the stereotypes are replaced by names, faces and personalities. While they may never completely empathize without being in the same situation themselves, students learn to appreciate their station in life and begin to understand what life may be like living in poverty. Challenging these stereotypes and spending time with people who are homeless will only make students better health-care providers to all their patients, but especially to those who are homeless or living in poverty.

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3 See the National Academy of Sciences Web site at http://www.nas.edu

4 See The Urban Institute Web site at http://www.urban.org

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Student-Run Volunteer Clinic in Richmond, Virginia

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All across the United States, medical students are supplementing their medical education by running clinics for the underserved. They are reaching out to their communities and learning not just about medicine, but more importantly about how disadvantaged people in the United States live and feel.

History of the Clinic

Prior to the Student-Run Portion

The Cross-Over Ministry began in 1982 as an all-volunteer medical care ministry to the uninsured and working poor of the inner city of Richmond, Virginia. From 1982 until 1986, services were provided every other Saturday morning in a storefront church. From 1986 until 1990, services were offered by full-time professional staff and volunteers in the Daily Planet building. In 1991, $200,000 was raised to purchase and renovate the current building at 108 Cowardin Avenue. All medical, dental and office equipment was donated, making the Cross-Over Health Center one of the only facilities of its kind in Richmond.

A full-time staff of 17 is augmented by a group of volunteer professionals, including physicians, dentists, optometrists, podiatrists, nurses and others. The Medical College of Virginia rotates its medical students, family practice residents, dental professionals and nursing students through the Cross-Over Health Center as part of their educational experience. Student nurses from J. Sargeant Reynolds Community College and Bon Secourse Memorial School of Nursing are also rotated through the center.

In the fall of 1987, through volunteer services provided by several dentists along with donations of dental equipment and supplies, the ministry was able to provide dental services.

There were more than 7,000 patient visits to the Cross-Over Health Center for primary medical, dental and eye care in 1997. Of that number 6,175 were medical visits, 660 dental visits and 138 eye exams. Patients visiting for the first time totaled 1,644 persons.

The operating budget for Cross-Over Ministry in 1998 is $584,000 and is raised from voluntary contributions and grants.

The Cross-Over Health Center serves as one of two anonymous testing sites in Richmond for the HIV virus, having been so designated by the Virginia State Department of Health. More than 200 people were tested for the antibody of the HIV virus in 1997.

Cross-Over Ministry is a 501(c)(3) organization whose purpose is to provide uninsured/working poor patients with quality and compassionate health care.

If you have any questions, need more information about the Cross-Over Health Center or would be willing to make a donation of time or money, please call (804) 233-5016.

Beginning of the Student-Run Clinic

The effort to begin a student-run clinic was spearheaded in 1997 by Joanne Simon, then a third-year medical student at the Medical College of Virginia. She had spent a third-year rotation at the clinic, and expressed an interest in exposing more students to the clinic, its mission and the services it provided. Dr. Vivian Bruzesse had recently been hired as an Outreach Coordinator for the Medical College, and she helped design and staff the student-run clinic. The initial plan was to open the clinic on alternate Saturdays for a half-day, to be staffed by the medical students and one or two physician supervisors. This design allowed for first-year medical students to fill the clerical, triage and nursing duties. Second-year students shadowed an upperclass (third or fourth year) student, who performed a problem-based history and physical exam on the patients. The student team then presented the patient to the volunteer physician, who assisted the students in developing a treatment plan and follow-up recommendations.

Initial concerns included: 1) finding sufficient numbers of student volunteers, and 2) finding patients who would utilize services provided by students. These concerns were alleviated during the first months of the clinic and are no longer issues.

Continuing the Student-Run Clinic

The student-run clinic is now in its second year of existence. As it is now well established, there are student waiting lists (in all class years) to participate in the clinic. Each clinic includes four first-year students, four second-year students, and four upperclass students. There are volunteer coordinators for each of the first- and second-year students, and one coordinator for the third- and fourth-year students. These coordinators are responsible for scheduling and recruiting student volunteers. Services are now being provided two-to-three Saturdays per month, and students have begun to pursue similar experiences at other medical clinics in the Richmond area. Due to clerical concerns, the first-year students no longer provide clerical duties, but maintain their roles as nursing and triage personnel. Other volunteers during the student-run clinic now include one clerk and one nurse. Ongoing concerns include: 1) personnel resources (i.e. clerical, nursing and MD volunteers); 2) duration of wait-time for patients in the lobby; and 3) continuity of care for individual patients.

Student volunteers are requested to fill out feedback forms at the end of each session in order to assess and refine the experience. Overwhelmingly, the student responses have been extremely positive. Students enjoy the opportunity to interact with other class years, as well as the early and further clinical exposure. The focus of suggested improvements varies based upon the class year of the student. In general, first-year students express a desire to be more involved with the clinical aspects of the clinic (i.e., seeing the patients beyond obtaining the vital signs and chief concern). Attempts to resolve this include asking patients' permission to include the first-year student during the history and physical examination. Second-year students express concerns that patients wait a long time to be seen by multiple providers. Attempts to resolve this include scheduling patients at 9:00 a.m. and 10:30 a.m., rather than scheduling all at 9:00 a.m. Third- and fourth-year students express concerns that first-year students don't see the patients very much and express frustrations with teaching and seeing patients simultaneously.

Future of the Student-Run Clinic

As the clinic is now well established, there do not appear to be any pressing concerns regarding patient or student volunteer recruitment. Each year, new student volunteer coordinators for each class year need to be appointed. The "rate limiting" step in the clinic remains finding sufficient numbers of volunteer physicians to provide supervision (for both medical and legal reasons). For further information regarding the student-run clinic, call the clinic directly at (804) 233-5016.

The SHARING Clinic — A Student Run Clinic

[Student Health Alliance Reaching Indigent, Needy Groups]

by Darcy Silver
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Introduction

- The SHARING Clinic was opened September 7, 1997, by the medical students at the University of Nebraska (UNMC).
- Administrating and staffing are done completely by students, and volunteer UNMC physicians sponsor the clinic.
- Only physicians within our system can be used for liability reasons.
- Open one night a week, the clinic is located in a poor, racially diverse urban neighborhood.

Goals: By opening this clinic the UNMC students will—

- Provide high quality primary care to uninsured or underinsured individuals at no or minimal cost to the patients.
- Allow students of many disciplines to interact in a patient-care setting in which they can learn about social, cultural and economic factors affecting the health of a community of underserved patients.

Clinic Structure

- Open one night a week, 6-9 p.m., the SHARING Clinic utilizes an existing clinic space free-of-charge.
- A board of 10 second-year medical students run the clinic. Their duties include student and physician recruitment and scheduling, financing, pharmaceuticals and community relations. This board meets twice a month with the sponsoring physicians.
- The student board rotates as administrators week-by-week. The administrator must orient new students visiting the clinic, orient new physicians, record all prescriptions, properly order lab work and tests, record patient demographics for the evening and attend to patient follow up.
- Students attending the clinic are responsible for performing a directed history and physical of the patient and presenting this to the volunteer physician. A physician then helps direct the student in finishing the case.
- The student is responsible for writing up the proper H&P or SOAP note to be reviewed and signed by physician and student.
- Participants are second-year and late first-year medical students and nurse practitioner students. Lab technician students also participate by running the lab work each night.
- Students who have come to the clinic were surveyed about their experience. All felt it was the best clinical experience they had been able to participate in thus far and felt that their history taking, physical exam skills and chart write ups were what benefited most.
- Medical students fluent in Spanish currently provide all translating services at the clinic.
- Patients are charged a $5 fee which goes to the facility. The majority of patients come to the clinic by appointment but drop-ins are taken.
- The SHARING Clinic is spending approximately $12.50 per patient visit.

Patient Care

- The SHARING Clinic has had 552 patient visits in its first 15 months. 69.3 percent of patients visiting the clinic report having no insurance. Most patients, 65.0 percent are between the ages of 19 and 60 and the majority are seen for acute care, although some patients are managed for chronic illnesses by the clinic.
- Demographics are recorded each night so that the students can assess if they are reaching the target populations as laid out by the original mission of the clinic.
- Prescriptions, lab work, radiology, and pathology services are provided by the clinic at no cost to the patient. Except for simple lab work, patients must travel to the hospital for these services. Accounts have been set up with local pharmacies so that when a patient goes to one with one of our prescriptions we are billed at a discount. In order to keep costs down we do ask the patients if they have the ability to pay for any of these services.
- Meetings are periodically conducted with leaders in the community where the clinic is located in order to better evaluate the needs of the community and what the SHARING Clinic can do.
- The major clinic expenses include payment of prescriptions, lab work and radiology, and paying the receptionist.
- An operations budget, which covers the cost of prescriptions and one clinic employee, was granted by the University of Nebraska Medical Center, Business Services department. The Chancellor of the medical school supports the project. As long as costs are contained and the community and students are benefiting from the project, funding will continue to be provided.
- Once the operations budget was established, the students requested a separate budget from the president

of Nebraska Health Systems, the parent company controlling the medical center and another hospital, for radiology, pathology and more extensive lab work. When these services are utilized by patients from the SHARING Clinic, the cost is deducted from the clinic's appointed budget. The amounts being charged are at a discount, similar to what is charged for research projects.
- Private donations and funding are also sought from local physicians, the alumni association and the Omaha Community. Television stories and radio interviews about the clinic have helped to aid this cause.

Conclusion
- While the clinic seems like a lot of work, it is very manageable with a supportive faculty and a group of students who are committed and who follow through with their jobs.

If you are interested in starting a student-run clinic and have some questions for us, please feel free to contact Darcy Silver at ddsilver@unmc.edu or write us at:

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Community Health Centers in the United States: Training Ground for International Health

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Community Health Centers (CHC) in the United States are great sites to learn principles applicable to international health. Clinicians at CHCs deal with relatively limited resources for the United States, mainly because of patients' lack of insurance. Inadequate transportation and housing interfere with follow-up care. Often patients and clinicians don't share the same social class, educational attainment or language. This can complicate the relationship between the clinician and patient. Frequently, preventable disease presents late for care. Confronting these issues "at home" can prepare clinicians considering international service for the greater challenges abroad.

Federally-funded Community Health Centers in the United States started in 1960's out of the Office of Economic Opportunity—as employers in underserved areas. Clinical leaders like Jack Geiger (see article on page 11) focused on community-oriented primary care: reaching outside the clinic walls to identify the health concerns of the community, modifying clinical policies to address those concerns, and gathering data to measure success.

In the 1970s, CHCs were integrated into the U. S. Public Health Service. A more traditional biomedical and administrative model developed under the leadership of Edward Martin, former AMSA president. Funding cuts in the 1980s resulted in decreased supply of clinicians from the National Health Service Corps and quotas at CHCs for numbers of patients to be seen by clinicians.

In the 1990s, many Community Health Centers have matured into integral members of the standard health-care systems in their regions. Currently about 600 local non-profit agencies sponsor Community Health Centers with an average of two to three clinic sites each. CHCs care for more than six million patients.

To receive federal funds, Community Health Centers must serve "Medically Underserved Areas" defined by the number of poor people in an area and the relative lack of physicians. Despite this stipulation, a minority of operating funds for CHCs come from the federal government. Most funding comes from patient-care revenues like Medicaid, Medicare and out-of-pocket payments from uninsured patients.

Community Health Centers serve a world of immigrants. Many Mexican farm workers receive care from Migrant Health Centers, which are closely related administratively to CHCs. Refugees from Central America and Southeast Asia often end up living in urban areas serviced by CHCs. Many CHCs highly value staff with experience in the cultures from which their patients come and who can speak the languages of their patients.

Some Community Health Centers have a tradition of staff regularly doing international health activities. In such clinics, the supportive atmosphere among clinician colleagues provides a home base and recharging before the next international experience. For their colleagues, such as myself, who stay at home base, the experiences of international colleagues are inspiring and occasionally very applicable. One internationally experienced colleague of mine taught me how to painlessly remove a live insect from a child's ear by applying a vibrating tuning fork to the child's mastoid and waiting for the frightened arthropod to flee out the ear canal.

Clinicians who find personal and professional satisfaction in working at Community Health Centers share core values with clinicians experienced in international health.

We value caring for that person right in front of us right now. That benevolence brought us into primary care, and brought me especially into family practice. We value caring for those people who are very different from us. That universalism pushes us to look outside of our hospitals and clinics to see what is needed in our communities and in the world. We value caring for ourselves, our partners and our families. We realize that hedonism is what keeps us going and allows us to give to those patients of ours in such great need.

For more information on Community Health Centers:

- National Health Service Corps Web site: *www.bphc.hrsa.dhhs.gov/nhsc*
- Bureau of Primary Health Care Web site: *www.bphc.hrsa.dhhs.gov*

National Health Service Corps: A Peace Corps for America

by Brian G. Morse
sfbmorse@yahoo.com

What is it that attracts someone to international health? After all, medicine is medicine, no matter where it is practiced. Or is it? Certainly travelling abroad is an adventure, something out of the ordinary. And leaving the country to practice medicine certainly can make even the dullest tasks seem more exciting. But I would say the main reason people enjoy their international health experiences so much is that they know they made a positive difference in other peoples' lives. This is especially true of those medical students and doctors who travel to regions of the world in desperate need of medical care.

While travel adds flavor to routine tasks, travel to these areas adds meaning to tasks that can seem pointless in a health-care system bogged down by medical loss ratios, profit margins, and a veritable alphabet soup of acronyms from HMOs to PPOs. Everyone has images of what it would be like to travel on a medical mission to a third-world country or a crisis area: images of starving, naked children somewhere in Africa; images of villagers lining up for immunizations somewhere in South America; images of refugees huddled around first-aid tents somewhere in Europe. When one considers the altruistic character of medicine in general, and the adventure offered by travelling outside the country, it is no surprise that so many medical students and doctors are interested in international health.

But what about the drawbacks to an international health experience? Travelling across the world and spending a few months helping people may be rewarding, but it makes demands on a person's time and resources. And what about the time spent away from family and friends? Here are some common concerns for someone considering international health:

- Financial: expense of travel and income lost by taking time off from work.
- Personal: time away from family and friends, disruption of family life, personal safety concerns, finding time in a busy schedule to travel.

Most people think that there is a trade-off inherent in an international health experience; that is immensely rewarding but not very practical. They would love to have the experience of travelling and of helping those truly in need, but they just can't afford to do it. But what if there was a way to overcome these obstacles? What if you could experience the unique setting and patient population that international health provides without disrupting career or personal life? What if you could even pay off your student loans at the same time? There is a way: the National Health Service Corps.

Background

The National Health Service Corp (NHSC) began in 1970 to address critical shortages of health-care providers in certain parts of America. From its inception, the NHSC included all types of health-care providers: midwives, physician assistants, dentists, physicians, nurse practitioners, etc. The NHSC encourages a team approach to solving the health-care problems of underserved communities. There are approximately 45 million people who do not have access to primary care services in America today. The federal government designates areas that do not have access to adequate primary health-care resources as "health professional shortage areas" or HPSAs. These areas can be found all over the country—both in small towns and rural areas and in the inner cities and urban areas. These HPSAs are where the men and women of the NHSC do their work.

History

The National Health Service Corps was created in 1970 as a program of the U.S. Public Health Service under the Emergency Health Personnel Act. It was set up to address the critical need for health care in certain areas of our country. In 1972, Congress amended the Emergency Health Personnel Act to authorize scholarships for health professionals in return for service to underserved communities. In the years following this legislation, Congress also authorized a loan

repayment program for those who served in the Corps. More than 21,000 health-care providers have served with the NHSC since 1972.

Opportunities

NHSC Scholarships for students:

These scholarships help finance education for future primary care providers committed to serving the underserved.

- **Community Scholarship Program**: Full-time health profession students who are residents of underserved communities serve their home communities in return for financial support.
- **Student Experiences and Rotations in Community Health (SEARCH), formerly Fellowship of Primary Care Health Professionals**: In cooperation with regional and state partners, the NHSC offers students and residents the opportunity to serve on interdisciplinary teams in underserved areas. Program details vary from state to state.

Opportunities for clinicians:

- **Loan Repayment**: Fully trained health professionals with qualified educational loans are offered repayment of those loans if they choose to serve at an eligible site.
- **State Loan Repayment**: The NHSC provides matching funds directly to states to operate their own loan repayment programs.
- **Career Opportunities**: Opportunities exist nationwide for clinicians interested in dedicating at least part of their career to serving those in need.

The above information is reproduced from National Health Service Corps Web site.

Why NHSC?

The National Health Service Corps offers many of the benefits of an international health experience without many of the drawbacks. You can work in any type of environment you wish, from rural to urban. You will be part of a health-care team providing essential primary care services to a community. Working in an NHSC field placement offers the most rewarding aspect of an international health experience, the chance to know you have really made a difference by providing medical care to underserved people. You can have all this without the financial and personal burdens that travelling abroad can involve.

You don't have to put your life on hold while you work for the Corps. The NHSC offers scholarships and loan repayment programs that allow you to work in an underserved community and become financially solvent. And you will have the support of the NHSC in the community where you work. A field placement with the NHSC isn't just a six-week or two-month long chance to help the needy; it can blossom into a lifetime of helping those who suffer from lack of medical care. Around one-third of the health-care providers who participate end up staying in the community where they practiced for NHSC.

How to Contact the NHSC

The NHSC has different programs set up in various states. The best way to find out about these programs is to contact resources at your medical school or your state's public health department. You can also contact the NHSC directly at their Web site at http://www.bphc.hrsa.dhhs.gov/nhsc/

References

This document was compiled from information obtained from the National Health Service Corps web site:
www.bphc.hrsa.dhhs.gov/nhsc

Texas–Mexico Border

by Claudia Miller, M.D., M.S.

The U.S.–Mexico border provides a unique environment for learning about cultures and health. The impacts of United States foreign policy can be seen first-hand, and the line that separates one of the richest nations in the world from its developing neighbor gain new meaning.

Laredo is the site of a teaching program about environmental health issues along the U.S./Mexico border. The university-level elective course lasts four weeks and is designed for medical and dental residents and students, as well as nursing and public health students. The sponsor is the South Texas Environmental Education and Research (STEER) Center, a part of The University of Texas Health Science Center at San Antonio. The course is led by Dr. Claudia Miller, associate professor of environmental and occupational medicine at the Health Science Center. Free student housing is provided through the Mid Rio Grande Valley Area Health Education Center.

The area is medically underserved and the problems with living conditions, sanitation and poverty are very similar to those of developing nations. Spending time at the border is a great way to gain exposure to the issues of international health while staying near home.

For more information, contact: The University of Texas Health Science Center at San Antonio, Department of Family Practice, 7703 Floyd Curl Drive, San Antonio, Texas, 78284-7794; or the South Texas/Border Region Health Education Initiative, telephone: (210) 567-7762; fax: (210)567-7764; e-mail: bourdeau@uthscsa.edu. Web site: http://steer.uthscsa.edu.

Current Projects

STEER is currently working on several projects—one to study asthma in children, and another to reduce illness caused by drinking contaminated water.

Drinking water. Untreated drinking water threatens the health of the 225,000 people who live in colonias in Laredo, Texas, and Nuevo Laredo, Mexico. Colonias are underdeveloped, unincorporated subdivisions where about 90 percent of homes have no sewers or running water. Such services are unlikely to appear for years, so intermediate steps are being taken. Under the name Agua Para Beber, Spanish for "water to drink," our center and a binational alliance of health agencies are helping teach colonia residents how to treat their own water. Volunteer residents known as "promotoras," or health promoters, who live in the colonias, receive training in environmental health and help educate other residents about how to chlorinate their drinking water and take other precautions against gastrointestinal illness. The initial phase of the project, approved in October 1997, involved 500 families in the two Laredo cities. Each family received eyedroppers to chlorinate water, and a five-gallon receptacle to store the water they treated. The program was inspired by one in El Paso, Texas, and its sister city, Ciudad Juarez, Mexico. The Center for Environmental Resource Management at The University of Texas at El Paso, which created the program in 1994, provided guidance in Laredo. The Environmental Protection Agency funded the project. Partners in the program included the Texas Department of Health's Office of Border Health, Primary Health Care Services for Webb County Colonias, and the Department of Health and Asssistance of Nuevo Laredo.

Respira, the Laredo asthma study. An ongoing study to determine the prevalence of asthma in Laredo, Texas, is examining the effect of air pollution on children's breathing. Based in the city's schools, the study will involve 1,000 fifth-grade students and their parents who will answer questions about the children's health history, home environment, and demographic and socioeconomic conditions. In a pilot project, students recorded symptoms in diaries and took daily peak-flow measurements of their breathing for two months. An educational program about asthma also is under way for school nurses, teachers and the children. In the second phase of the project, parents may elect to have their children undergo skin testing for common allergens and request a visit at home by South Texas Environmental Education and Research Center students who will help identify environmental factors that contribute to breathing problems.

The University of British Columbia Centre for International Health: International Health Course for the Internet

by Kevin J. Chan, M.D.
KevinJChan@aol.com

We hope to introduce you to the ABCs of international health and development. In 12 lessons taking approximately three hours each, we hope to provide you with the skills to deal with multi-disciplinary and cross-cultural problems, and basic skills to get you ready for your international experience abroad. Included in the course is an extensive section for further reading. There will be an extended database to allow students easier access to opportunities abroad. There will also be an evaluation component both upon completion of the orientation course and the elective experience itself, so you can tell us how to make the course better.

Learning Objectives

- To learn basic concepts of international health and development.
- To adopt an inter-disciplinary approach to solving problems.
- To consider differences in cultural values and be able to apply this knowledge both overseas and at home.

Evaluation

- A description of your elective program experience (6 pages)—35%
- Elective paper—a publishable report on a topic of your choosing based on your elective experience (10 pages)—50%
- Your evaluation summary (3 pages)—15%

Description of the Course

The instruction will be given by distance learning methodology through the Internet. Discussions will be available through e-mail and chat sessions. The session will be available two times a year. There will be the opportunity to discuss issues with colleagues and content experts.

The sessions will be supported by books and papers made available once the individual is registered with the University of British Columbia. The course will run through the Centre for International Health at the University of British Columbia under the auspices of the Office of the Coordinator of Health Sciences (OCHS), as well as through the

Department of Distance Education and Learning. Other courses will be run depending on local expertise and interest. The course will have at least one tutor to help organize discussions and to give feedback on specific ideas, as well as different tutors for different sections as required.

In addition to this course, it is highly recommended that all students learn at least some words of the local language.

Module 1: Introductions to International Health and Development and the Globalization of Health
Module 2: The Determinants of Health
Module 3: The world abroad; cross-cultural learning
Module 4: Primary Health Care and the Strategy for Health for All
Module 5: Child Health
Module 6: Nutrition
Module 7: Women's Health Issues
Module 8/9: Infectious Diseases (part I)
Infectious Disease (part II)
Module 10: Pre- and post- transitional health problems
Module 1l: War/Violence/Peace/Humanitarian Emergencies
Module 12 : Aboriginal Health

For further course information—
Contact: Kevin Chan
Canadian International Health Education Network
Web: *cihen.cstudies.ubc.ca*

Child Family Health International Reading List

Suggested Reading and CFHI Bibliography provided by Safeena Husain.

Child Family Health International (CFHI) is an organization that facilitates medical rotations for students and health professionals in Ecuador. Before leaving for Ecuador, participants are given a reading list to help prepare them for the experience. Most of the following list is specific for Ecuador and Andean Communities. If your interests include different communities, keep in mind that reading lists can be extremely useful and an idea from one community can still prove useful in understanding and assisting another community.

Child Family Health International
2149 Lyon Street #5,
San Francisco, CA 94115.
Phone/Fax : 415-206-1905
Website: www.cfhi.org

The articles in this section have been carefully selected by CFHI volunteer Sunjya Schweig to provide CFHI participants with material to begin to understand cross-cultural health issues. For the most part, these are articles which explore the variety of existing health systems in Ecuador, as well as the interaction between biomedicine and the indigenous healt-care system.

One goal of CFHI is to expose students to the ways in which Western biomedicine is culturally specific to the U.S. and other modern industrial countries. Although this biomedical system has much to offer other cultures, one can see also that it sometimes does not fit the specific cultural beliefs of the local peoples. It can be reinterpreted and reorganized, sometimes in potentially harmful ways (see Laurie Price's article, #13 below).

These are important issues for a health-care provider to explore, and it is recommended that students use these references prior to their clerkship to begin to understand some of the complex situations that exist in the field.

1. Bastien, Joseph W. The Exchange Between Western and Andean Medicine. *Social Science and Medicine*, 1982. Vol. 16: 795-803.

This article points out how Andean medicine is reflected in the cultural patterns of exchange. The idea of verticality (a system of exchange based on specialized production at various altitudes) is representative of the economic system. Farmers in the Andes harvest from limited ecological zones and thus must trade for goods and services provided by other altitude zones. This specialization is mirrored in the healing system (e.g., diviners are from Kaata, herbalists are from Curva and Chajaya). This dispersed specialization (both in healing and trade) has led to a system of rotating and dispersed debt. This is unlike the capital-concentrated economics that exist in societies focused on biomedicine. Bastien addresses some problems this creates and provides a few potential solutions that might lead to a more successful interaction between the two healing systems.

2. Bastien, Joseph W. Qollahuaya-Andean Body Concepts: A Topographical-Hydraulic Model of Physiology. *American Anthropologist,* Sept. 1985. Vol. 87 (3): 595-611.

Qollahuayans understand the body as a vertically-layered axis with a system of ducts through which air, blood, fat and water flow to and from the sonco (heart). Qollahuayans live in Bolivia but their body-health concept seems to have a lot of similar models in the Andean region. They see the health relations of their body in the same way as they view the ties (kinship and trade) of verticality, which in turn is the same as their view of the mountain. The fluids of the body flow in centripetally and then flow outward centrifugally. The article provides a great synthetic of health belief in context.

3. Bastien, Joseph W. Exchange between Traditional and Modern Medicine. In *Healers of the Andes*, p. 86-93. 1987. University of Utah Press, Salt Lake City.

This chapter in Bastien's book details the relationship between Qollahuayan traditional healers and modern medical practice. The system of pay for modern medical services has created a situation where modern medicine has become inaccessible to the peasants it is meant to serve in rural areas. The government requires that the doctors collect cash for services rather than fees under the anyi (obligation) system. This system of obligation would generate reasons for doctors to stay in touch with the community. Personalized care is a crucial part of healing in Andean tradition. The chapter also discusses several programs which were and are being tried in order to improve health care.

4. Bernand, Carmen. The Many Deaths of Manuel: Illness and Fate in the Andes. *History and Anthropology*, 1985. Vol. 2: 145-152.

This article consists of an Ecuadoran woman's tale/explanation of her husband's death. Bernand illustrates how the woman's husband's sickness is mediated by her constructed health belief model. Her explanations of epilepsy are draped over the framework of her cultural beliefs.

5. Davis, E. Wade and James A. Yost. The Ethnomedicine of the Waorani of Amazonian Ecuador. *Journal of Ethnopharmacology*, 1983. Vol. 9: 273-97.

The Waorani are a small group native to Amazonian Ecuador whose exposure to Western culture began only recently (in the 1950s). They seem to have extraordinarily low illness prevalence, the common cold being unheard of until recently. Their pharmacopoeia is small but seemingly well selected. The author hypothesizes that this is a result of their coming to a sort of plant-to-sickness-to-effectiveness equilibrium. They also propose that this may have been more the natural state for native groups prior to the arrival of western diseases. Many of the plants the Waorani use have alkaloids or bioactive chemicals of some sort. One point of the article is that the native curing system has scientific elements to it and has true healing potential.

Ruthbeth Finerman completed eight seasons of fieldwork in the Andean highland community of Saraguro, Ecuador, during the years 1978-1993. She has spent a great deal of her time examining the health-care system of the local population. Of major concern to her is the mother's role in health. Mothers are an often unseen source of healing. While they may be less colorful than the curanderos (shamans), they are involved in approximately 90 percent-plus of health transactions. Finerman's work suggests that mothers and women in general actively seek out and manipulate health knowledge for their family's betterment and improved social status. One of Finerman's additional concerns, like Bastien's, is the meeting of traditional and Western medical styles. Finerman argues that creating a system where native values can reside comfortably within Western medicine is critical. Subsidiary to this point, but never stated outright, is the idea that creating a meaningful way for participation by women because of their community position as healers is the key to success in the health-care arena.

6. Finerman, Ruthbeth. Experience and Expectation: Conflict and Change in Traditional Family Health Care Among the Quichua of Saraguro. *Social Science and Medicine*, 1983. Vol. 17 (17): 1291-8.

This article was written to illustrate the problems with transferring Western-style medicine to a non-Western health community. Finerman shows how some basic health beliefs are compromised by basic hospital policies. The result is severe under-utilization of resources available to the populace. Basic policies need flexibility if they are to work in variable cultural climates. Some examples are given for food taboos, women's participation (or inability to participate in) health actions, and issues of privacy. The article is thorough in that it discusses both structural and cultural concerns, analyzes the implications of these, and gives alternate solutions to an effective health system.

7. Finerman, Ruthbeth. A Matter of Life and Death: Health Care Change in an Andean Community. *Social Science and Medicine*, 1984. Vol. 18 (4): 329-34.

The interaction between the Western-style hospital and the beliefs surrounding birth and death among the Saraguro Indians are in conflict. Finerman details the ceremonies surrounding birth and death and examines problems that arise due to the health systems interaction. For example, autopsies are performed mid-burial ceremony next to the open grave. This leaves neither party satisfied. For the Saraguro, dangerous spirits could influence their health because of the situation. For the physician performing the surgery, a makeshift surgery area is obviously less than optimum.

8. Finerman, Ruthbeth. The Forgotten Healers: Women as Family Healers in an Andean Indian Community. In *Women as Healers: Cross-Cultural Perspectives*, ed. Carol Shepard McClain, p. 24-41. 1989. Rutgers University Press, New Brunswick and London.

This chapter briefly discusses the various health agents available to the population of Saraguro. It describes the basics of curanderos, herbalists, midwives, pharmacists, nurses and physicians. These all play lesser or secondary healing roles to that of the mother. Healing becomes the domain of women, as role definition begins in childhood. Boys may be taken out to start helping their fathers outside the home at age six. Girls, on the other hand, begin to help their mothers prepare and administer remedies at an early age. The chapter includes a discussion in which Finerman presents an argument against cultural conservatism as the reason that the Saraguro have not entered fully into the Western medical system successfully.

9. Finerman, Ruthbeth. Tracing Home-based Health Care Change in an Andean Indian Community. *Medical Anthropology Quarterly*, June 1989, N.S. Vol. 3 (2): 162-74.

The article relates various changes in health-care practice made in Saraguro Indian communities of the southern Ecuadorian highlands with the introduction of Western style medicine. Here women, especially mothers, are responsible for treatment of up to 90 percent of family health complaints (Finerman 1985). Finerman argues that changes in health practices occur because of the structure of local health relations. The changes that do take place are ones that fit easily within the culturally predetermined roles of women. For instance, a great deal of the women's days are spent visiting each other, discussing new remedies and sharing tales of recent sicknesses. Because this information-sharing structure is already in place, knowledge has diffused successfully to some extent. However, because a great deal of the women's role in the family is maintaining the health of her family, women are reluctant to use hospitals and clinics as anything other than a last resort. Therefore, while information is diffusing, a lack of consistent participation in the Western medical system has led to a number of misconceptions. For example, the idea of dislocated shoulders and fin-

gers has been reinterpreted, leading to cures for roaming organs. Bloodtyping has led mothers to examine their family's blood to see if it is thick or thin, hot or cold, in order to determine the appropriate herbal. The article gives several examples of cultural confounds that occur at the intersection of Western medicine and Saraguro culture. Additionally, Finerman's argument about how and why medical practices are gained/changed could provide a useful methodology for doctors trying to communicate a new health practice.

10. Finerman, Ruthbeth. Parental Incompetence and Selective Neglect: Blaming the Victim in Child Survival. *Social Science and Medicine*, 1995. Vol. 40 (1): 5-13.
The paper is critical of the application of terms like parental incompetence. One major reason is that parents may be giving child care in a culturally normative fashion. There are also confounding factors that can occur in the application of this term. For example, in an oral rehydration therapy campaign in Guatemala, women were seen as acting in an incompetent manner. Many women would not use the ORT packets for structural reasons. The women were only allowed a few packets per visit. Thus, the repeated absenteeism could become a burden which the family could not sustain. Finerman warns that keywords that do not have a cultural, political, economic and social framework can easily lead to victim blaming. This will dead-end progress in the health arena.

11. Kohn, Eduardo O. Some Observations on the Use of Medicinal Plants from Primary and Secondary Growth by the Runa of Eastern Lowland Ecuador. *Journal of Ehtnobiology*. Vol. 12 (1): 141-52.
This article provides a several page long list of plants used among the Runa and what they are used to treat. The table provides a scientific name, several common names, use and the habitat from which the plant came. It is not a particularly revealing article, but the data collected is fairly thorough and provides an interesting view of a native pharmacopoeia. If a doctor was working in this part of Ecuador, the article could also aid in overcoming linguistic or cultural barriers to diagnosis. For instance, if the patient had been treated with asna huaranga, the doctor could then guess that the patient had been having diarrhea. The article also serves to impress the well-articulated magnitude of some healing systems among more primitive cultures.

12. Larrick, James W., James A. Yost, Jon Kaplan, Garland King, and John Mayhill. Patterns of Health and Disease Among the Waorani Indians of Eastern Ecuador. *Medical Anthropology*, 1979. Vol. 3 (2): 147-89.
This article consists largely of the results of a medical survey of the Waorani Indians. Approximately 60 percent of the small population was examined. This isolated Indian group seems to be in fairly excellent medical condition. However, the effect of Western society is beginning spread. The Waorani provide an excellent view of the meeting between Western and native culture with regard to health belief and practice.

13. Price, Laurie J. In the Shadow of Biomedicine: Self Medication in Two Ecuadorian Pharmacies. *Social Science and Medicine*, 1989. Vol. 28 (9): 905-15.
Laurie Price studied patterns of drug sales in two pharmacies and found that greater than 50 percent of prescription drug sales took place without a prescription. This is of critical import for local and global health. These drugs are being distributed without any markers of their dosages, contraindications or side-effects. Antibiotics are being sold by the pill. Treatment with these low levels only selects for resistance rather than curing. This self-medication is creating more problems than it is eliminating. The poor are spending 75 percent of their health dollars on medicines, many of which are unnecessary. This article consists of a detailed discussion of the problems and solutions to this shadow of biomedicine.

Medical Books—

Agee, Philip, *Inside the Company: CIA Diary,* 1975.
A look at U.S. intervention in Ecuador's political affairs. Written by a former CIA agent.

***Amazon Crude*, Natural Resources Defense Council, USA, 1991.**
Environmental look at some of the impacts and problems caused by oil drilling in the Amazon.

Corkill, David and Cubitt, David, *Ecuador-Fragile Democracy*, Latin American Bureau, London, 1988.
Historical patterns and current trends in Ecuadorian politics.

Darwin, Charles, Voyage of the Beagle, Penguin.

Di Lorenzo-Kearon, Maria Antonia & Kearon, Thomas P., *Medical Spanish–A Conversational Approach.*
This may not be easily available in stores. You can order it by calling (800)-777-0112.

Gradwohl, J. & Greenberg, R., *Saving the Tropical Rain Forests*, Earth Scan.

Hassaurek, Friedrich, *Four Years Amongst the Ecuadorians*, South Illinois University Press, 1967.
Written by a U.S. diplomat. First published in 1867.

Kantrowitz, Martin, et al. *¿Que Paso? An English–Spanish Guide for Medical Personnel.* Fourth Edition, revised. University of New Mexico Press.
Available from the American Medical Student Association Resource Center, (800) 767-2266, ext. 217.

Linke, Lilo, *Ecuador: Country of Contrasts*, London, Oxford University Press.

Meizel, Janet E., *Spanish for Medical Personnel*, UCD Family Practice Program, Skidmore Roth Publishing.
General reading.

Miller, Tom, *The Panama Hat Trail*, Vintage Departures, NY, 1988.
Travel journal.

Urrutia, Virginia, *Two Wheels and a Taxi, The Mountaineer*, Seattle, 1987.
Travel journal of a 70-year-old woman who cycled around Ecuador accompanied by a taxi!

Werner, David, et al. *Where There Is No Doctor: A Village Health Care Handbook.* 1992, revised edition. Berkeley, CA: Hesperian Foundation.
Available in English from the American Medical Student Association Resource Center, (800) 767-2266, ext. 217. Also available in Spanish, Portuguese, Swahili, Vietnamese, Italian, Indonesian, Hindi, Arabic and French from the Hesperian Foundation.

Novels—

Mueller, Marnie, Green Fires, *Assault on Eden*, Curbstone Press.
A novel about an ex-peace corps volunteer who returns to Ecuador to confront her past. While she is there she stumbles upon a hidden war being fought against the indigenous of the jungle over their land.

Vonnegut, Kurt, *Galapagos*, Grafton.

If you will be in Ecuador, we also suggest that you take a look into the Libri Mundi bookstore located in Quito for a good selection of Ecuadoran books and literature, some bilingual.

Organizations and Contacts

The following is a list of organizations and institutions that provide opportunities to be involved in international health. This list is not meant for finding rotations abroad—better sources exist for that. Instead, it highlights organizations that can help you be involved in international health from your home institution. A majority of these contacts and the abstracts describing them were taken from the following sources: 1) *The Directory of Global Health: U.S.-Based Organizations Working in International Health*, Global Health Council, formerly The National Council for International Health, 1997; and 2) *Diversion*, Vol. 25/No. 5, April 15, 1997, pp. 129-143. Reprinted with permission.

Albert Schweitzer Institute for the Humanities
Box 550
Wallingford, CT 06492
Tel: 203-697-2744
Web: www.schweitzerinstitute.org
The Albert Schweitzer Institute for the Humanities was founded by Harold Robles, M.D., and Schweitzer's daughter, Reyna. It provides clinical services and conducts teaching seminars in Suriname and eastern Europe. Clinical volunteers serve for at least a month; the stints for teaching volunteers can be as short as one week. Volunteer needs vary, but public health specialists, epidemiologists, emergency physicians, anesthesiologists, oncologists, internists, ob-gyns, pediatricians and surgeons are frequently sought.

American Jewish World Service
989 Avenue of the Americas
New York, NY 10018
Tel: 212-736-2597
E-mail: jws@jws.org
Web: www.ajws.org
American Jewish World Service is dedicated to providing non-sectarian, humanitarian assistance and emergency relief to disadvantaged people in Africa, Asia, Latin America, and the Middle East, as well as Russia and Ukraine.

American Medical Student Association (AMSA) and the AMSA Foundation
1902 Association Drive
Reston, Virginia 20191
Tel: 703-620-6600
Membership Hotline: (800) 767-2266
Email: amsa@www.amsa.org
Web: www.amsa.org
The American Medical Student Association (AMSA), with nearly a half-century history of medical student activism, is the oldest and largest independent association of physicians-in-training in the United States. Founded in 1950 to provide medical students a chance to participate in organized medicine, AMSA began under the auspices of the American Medical Association. Starting in 1960, the association refocused its energies on the problems of the medically underserved, inequities in our health-care system and related issues in medical education. Since 1968, AMSA has been a fully independent student organization. Today, AMSA is a student-governed, national organization committed to representing the concerns of physicians-in-training. With a membership of nearly 30,000 medical students, pre-medical students, interns and residents from across the country, AMSA continues its commitment to improving medical training and the nation's health.

AMSA Global Health Action Standing Committee
Web: www.amsa.org
This is a division of AMSA that focuses on international health, environmental and occupational health, and human rights. Students participate in online discussions concerning all areas of international health. Information is shared through the bimonthly online newsletter. Global Health Action now has the capability to support projects initiated by students, such as this manual.

American Refugee Committee
2344 Nicollet Ave. South, Suite 350
Minneapolis, MN 55404
Tel: 612-872-7060
Web: www.archq.org
Each year, 40 million people around the world are uprooted from their homes. The American Refugee Committee assists one million of them annually, providing primary health care, medical training and public health services in areas torn by war or natural disaster. Long-term volunteer opportunities last a year or more. ARC also needs physicians who can offer their services for at least a month during times of crisis.

Canadian International Health Education Network
Web: cihen.cstudies.ubc.ca
The Canadian International Health Education Network is an organization comprised of Canadian Institutions in education, government, business and NGOs. Our focus is on the development of Canadian leadership in international health education. Some resources available off their website include The University of British Columbia Centre for International Health Seminar Series Guidebook by Kevin Chan, and the International Health Youth Internships Program - Canadian Society for International Health.

Case Western Reserve University
Center for International Health
10900 Euclid Avenue
Cleveland, OH 44106
Tel: (216) 368-6321
E-mail: asr7@po.cwru.edu
Their mission is to encourage academic medical training in international health, and reciprocal linkage with Third World health institutions.

Center for Disease Control and Prevention (CDC)
MS K01, 4770 Buford Highway, NE
Atlanta, GA 30341-3724
Tel: 770-488-1085
Email: MYM5@ihpod1.em.cdc.gov
Web: www.cdc.gov

Child Family Health International
2149 Lyon St., No 5
San Francisco, CA 94115
Tel: 415-673-6234
Email: cfhi@cfhi.org
Web: www.cfhi.org
CFHI specializes in surgery and health care for needy children and their families in the United States and Ecuador. The organization is always in search of doctors and other medical professional able to contribute their services or donate medical supplies and equipment. A commitment of at least two months is desired. The group prefers to hear from interested physician via email, if possible.

Christian Medical and Dental Society
Box 5
Bristol, TN 37621
Web: www.gocin.com/cmds
This religion-minded organization sends dentists and physicians of all specialties on missions worldwide.

Department of Health and Human Services
Office of International Health
5600 Fishers Lane, Room 18-75, Parklawn Bldg.
Rockville, MD 20857
Tel: 301-443-1772
E-mail: Ivogel@osophs.dhhs.gov
Policy and coordination of international activities of the agencies of the DHS (CDC, FDA, HIS, NIH, HSRA); representation to other governments; liaison for USG with multilateral organizations, including WHO and PAHO; and promotion of relations in health with other countries.

Doctors of the World
375 West Broadway, 4th Floor
New York, NY 10012
Tel: (212) 226-9890
Web: www.doctorsoftheworld.org
Except in emergencies, Doctors of the World asks volunteers to serve for at least a month in foreign posts. Projects have included building clinics for Indians in Colombia's Amazon jungle; providing health care for homeless and neglected children in St. Petersburg, Russia; tending to the mental health of women and children on the West Bank; and operating a number of large projects. Doctors of the World also runs two human rights clinics, providing medical affidavits for torture victims seeking political asylum in the United States. The organization relies on physicians in all specialties, including internal medicine, pediatrics, ob-gyn, plastic and general surgery, and public health.

Doctors Without Borders USA
(Medecins Sans Frontieres)
11 East 26th St., Suite 1904
New York, NY 10010
Tel: (212) 697-6800
Web: www.dwb.org/index.htm
The world's largest independent nonprofit emergency medical aid organization has served in 65 countries, helping victims of war, disaster and hardship. Founded in France, the international group has more than 2,000 medical professionals stationed all over the world. All assignments involving primary care last six months to a year; however, members of quick response teams such as surgeons and anesthesiologists may make commitments as brief as six weeks. Primary care professionals are always needed, as are physicians in other specialties, including ob-gyn, general surgery, anesthesiology and tropical medicine.

Esperanca, Inc.
1911 West Earli Dr.
Phoenix, AZ 85015
Tel: (602) 252-7772, ext. 109
Esperanca takes primary care physicians and ophthalmologists who are willing to make commitments of three weeks to three months. Volunteers see patients at a clinic alongside Brazil's Amazon River. Esperanca sometimes needs orthopedic or plastic surgeons to serve two weeks or more working with children.

Global Health Council
(formerly National Council for International Health)
1701 K Street NW, Suite 600
Washington, D.C. 20006-1503
Tel: (202) 833-5900
E-mail: ghc@ghc.org
Web: www.ghc.org
Global Health Council is a non-profit association that represents more than 100 private, academic and public organizations and associations. GHC is committed to increasing public awareness of the importance of global health issues. GHC works to educate and inform policy makers about the impact of foreign assistance on the health of people residing in the U.S. by providing action alerts of impending Congressional decisions, background pieces and fact sheets on international health topics, and guidelines on how to contact and present information to decision makers. GHC also holds an annual conference to gather the leading voices in international health to explore and present different themes, from the rights of people living with AIDS, to new and re-emerging infectious diseases. GHC sponsors an annual job fair to advance the careers of both recent graduates and seasoned health professionals.

Global Volunteers
375 East Little Canada Rd.
St. Paul, MN 55117
Tel: (800) 487-1074t
Web: www.globalvolunteers.org
Global Volunteers is a non-profit organization whose volunteers serve one-, two- and three-week stints in Asia, Africa, the Americas, the Caribbean and Europe. Much of the volunteer work is non-medical—teaching English, repairing buildings and planting gardens, for example. However, the group recently began a medical partnership in Quito, Ecuador, with Fundacion Campemento Cristino Esperanza (Camp Hope).

Habitat for Humanity International
121 Habitat Street
Americus, GA 31709
Tel: (912) 924-6935
Web: www.habitat.org
Involved in the generation of low-cost housing in the U.S. and in developing countries. Volunteers from various backgrounds are accepted to assist in construction and administration in 10-week to 3-year assignments.

Harvard University School of Public Health
Department of Population and International Health
665 Huntington Ave.
Boston, MA 02115
Tel: (617) 432-0866
The department offers both doctor of science and doctor of public health degrees, as well as a two-year master of science degree. The department also is responsible for the one year master of public health degree concentrating on international health.

Health Volunteers Oversees
c/o Washington Station
Box 65157 Washington, D.C. 20035
Tel: (202) 296-0928
The idea behind Health Volunteers Overseas is that when its volunteers move on, they leave their expertise behind. One of the larger private nonprofit groups, HVO endeavors to improve health care in developing countries by training local health personnel. At 34 sites in 19 countries in Africa, Asia, Latin America and the Caribbean, the group's volunteers now work side-by-side with local physicians and other health personnel. They give lectures, conduct ward rounds and demonstrate techniques in classrooms, clinics and operating rooms in the areas of their specialty: anesthesia, dentistry, general surgery, internal medicine, oral and maxillofacial surgery, orthopedics, pediatrics or physical therapy. Most assignments last one month.

HealthWrights
964 Hamilton Ave.
Palo Alto, CA 94301
Tel: (415) 325-7500
E-mail: healthrights@igc.org
Web: www.healthwrights.org
HealthWrights is a small non-profit organization committed to advancing the health, basic rights, social equality and self-determination of disadvantaged groups. We believe that health for all people is only possible in a global society where the guiding principles are sharing mutual assistance and respect for cultural and individual differences. Publications include "Where There Is No Doctor," "Helping Health Workers," "Disabled Village Children" and "Questioning the Solution: The Politics of Primary Health Care and Child Survival."

Heart to Heart International
13849 South Murlen Rd., Suite F
Olathe, KS 66062
Tel: (913) 764-5200
Web: www.uab.edu/hearttoheart
Heart to Heart sends drugs and medical supplies to areas of need, both domestic and foreign. Volunteer physicians accompany the supplies. In missions lasting about ten days, the volunteers offer drug updates and continuing medical education, making sure that the hospitals and on-site physicians know how to use the drugs and equipment.

Human Rights Watch
485 5th Avenue
New York, NY 10017
Tel: 212-972-8400
E-mail: hrwnyc@hrw.org
Web: www.hrw.org
Promotes internationally recognized human rights worldwide.

InterAction
1717 Massachusetts Ave., N.W., Suite 801
Washington, DC 20036
Tel: (202) 667-8227
Web: www.interaction.org
InterAction: The American Council for Voluntary International Action is the nation's largest coalition of international development, disaster relief and refugee assistance agencies. InterAction's members include more than 150 U.S.-based non-profit organizations, large and small, including secular and religious groups. Member organizations all share the same basic goals of easing human suffering and strengthening people's ability to help themselves. InterAction coordinates and promotes these activities and helps to ensure that goals are met in an ethical and cost-efficient manner. Their areas of focus include disaster relief, sustainable development, ethical standards and public policy.

International Health Medical Education Consortium
IHMEC Secretariat
M200, 1001 West 10th Street
Indianapolis, IN 46202
Tel: (317) 568-1109
E-mail: info@ihmec.org
Web: http://www.ihmec.org

IHMEC is a consortium of faculty, administrators, students and residents interested in promoting international health education in medical school in the U.S. and Canada. Its mission is to foster international health medical education in four program areas—curriculum, clinical training, career development, and international health education policy.

Johns Hopkins University School of Public Health
Department of International Health
615 North Wolfe St.
Baltimore, MD 21205
Tel: (410) 955-3934
E-mail: rblack@ihl.sph.jhu.edu
Conducts research and academic programs on the health problems of underserved populations in the world.

MAP International
P.O. Box 215000
Brunswick, GA 31521-5000
Tel: 912-265-6010
E-mail: E-Hay@MAPINT.MHS
Web: www.map.org
Map International is a non-profit Christian relief and development organization that provides medicines, emergency relief, and health education and training to meet the needs of hurting people throughout the world. The MAP-Readers Digest International Fellowships provide medical students with clinical experiences in settings that will enable them to become familiar with the cultural, social and medical problems characteristic of developing countries. A minimum of eight weeks must be spent on location to fulfill the requirements of the fellowship.

Pan American Health Organization (PAHO)
525 23rd St., NW
Washington, D.C. 20037
Tel: (202) 974-3000
Web: www.paho.org

Partners of the Americas
1424 K St., NW, Suite 700
Washington, D.C. 20005
Tel: (202) 628-3300, ext. 206
Web: www.partners.net
The organization partners physicians in the United States with outreach projects in Latin America and the Caribbean, assigning sites based on the state in which the volunteer lives. For example, volunteers from Alabama serve only in Guatemala, whereas those from Wisconsin serve strictly in Nicaragua. In the Nicaragua project, doctors specializing in ob-gyn and pediatrics train local health-care workers in basic screening techniques. Medical missions last ten days to two weeks.

Peace Corps
1990 K St., NW
Washington, D.C. 20526
Tel: (800) 424-8580, ext. 1
Web: www.peacecorps.gov
The Peace Corps has only one site that requires volunteer physicians—Malawi, Africa. However, the organization welcomes doctors willing to work in AIDS awareness, health education or areas unrelated to health worldwide. The Peace Corps asks for a commitment of two years.

Physicians for Human Rights
100 Boylston St., Suite 702
Boston, MA 02116
Tel: (617) 695-0041
E-mail: phrusa@igc.apc.org
Web: www.phrusa.org
Physicians involved with this group investigate human rights abuses, looking into reports centering on torture in Turkey, prisons in Cambodia or land mines in Mozambique, for example. Volunteers operate large forensic programs in Bosnia and Rwanda, examining mass graves. In the United States, physicians screen people seeking political asylum for signs of torture. They also do advocacy work, lobbying for human rights legislation and teaching human rights awareness in medical schools.

Physicians for Peace
229 West Bute St., Suite 820
Norfolk, VA 23510
Tel: (757) 625-7570
This nonprofit group was founded to promote international health and peace through medical outreach projects. It has conducted more than 100 educational missions, usually ranging from ten days to two weeks, in countries throughout the Middle East, Central America, Africa and eastern Europe, as well as in the Caribbean and parts of Asia. Its volunteers teach instructors at local medical schools. Specialties involved vary with the requests of the host countries. The group's ultimate goal is to teach itself out of a job; for example, Cairo no longer needs basic cardiology teams and is now requesting volunteers in such highly specific areas as electrophysiology.

Physicians for Social Responsibility
1101 14th Street Northwest, Suite 700
Washington, D.C. 20005
Telephone: (202) 898-0150
E-mail: psrnatl@psr.org
Web: www.psr.org
Understanding that nuclear war continues to be the most acute threat to human life and the global biosphere, PSR reaffirms its commitment of over thirty years to the elimination of nuclear weapons and the reversal of the arms race and the national budgetary priorities which fuel that race, sacrificing our nation's health, social and economic needs. With a reduction in East-West tensions, PSR sees a chance for our nation to address more insidious environmental threats to human survival, such as global warming, ozone depletion, toxic chemicals, and the world population explosion. Recognizing that neglect of social problems and emphasis on militarism has resulted in a crisis of societal violence, PSR also seeks to reverse our domestic arms race and to encourage ways of finding peaceful solutions to interpersonal and local disputes, as well as international conflicts.

Project Hope
Millwood, VA 22646
Tel: (540) 837-2100
Web: www.projhope.org
Project Hope's physician volunteers teach modern medical techniques to health care workers in the developing world. The training usually takes place in a university or hospital setting. Need for specialties varies. The organization has placed physicians in long-term (one year or more) and short-term (less than six months) volunteer positions in 70 countries over the years, and is currently active in almost two dozen areas around the world.

RESULTS, Inc.
440 First St., NW, Suite 450
Washington, D.C 20001
Tel: (202) 783-7100
Fax: (202) 783-2818
E-mail: results@action.org
Web: http://results.action.org
RESULTS, Inc. is a grassroots citizen advocacy organization whose purpose is to create the political will to end hunger and poverty and to break through the idea that "I can't make a difference." Through citizen action on public policy and working with elected officials and the media, we seek political and other solutions to the problems of hunger and poverty.

Rotary International
One Rotary Center
1560 Sherman Ave.
Evanston. IL 60201
Tel: (847) 866-3000
Web: www.rotary.org
Rotary International sponsors student exchanges all over the world. They are also working to eliminate polio worldwide.

Save the Children Foundation
54 Wilson Road
Westport, CT 06880
Tel: (203) 221-4000
Web: www.savethechildren.org
Goal: To make positive change in the lives of disadvantaged children in the U.S. and over 40 other countries. Focus places children in the center of activities and women as key decision makers and participants. Key principles are: child centeredness, women focus, participation and empowerment, sustainability, scaling up, and maximizing impact. Programs aim at community empowerment and institutional development, working with disadvantaged groups as they identify problems and solutions. Primary development sectors are health/population and nutrition, education/early childhood development, and economic opportunity development. SC/U.S. also manages major refugee programs and emergency response with a special focus on children who are victims of conflict and displacement.

Tulane University School of Public Health and Tropical Medicine
P.O. Box 13, 1440 Canal Street, Suite 2200
New Orleans, LA 70112
Tel: (504) 584-3655
E-mail: tcih@mailhost.tcs.tulane.edu
Web: www.tulane.edu/-inhl/inhl.htm
(1) Educational institution providing graduate level, long- and short-term training at the masters and doctorate levels; (2) management center providing expertise to overseas projects, grants and contracts.

University of Arizona Summer International Health Course
Ronald Pust, MD
Department of Family and Community Medicine
University of Arizona College of Medicine
Tucson, AZ 85724
Tel: (520) 626-7962 or (520) 626-7822
Email: aheimann@u.arizona.edu
The University of Arizona Department of Family and Community Medicine offers this free four week course in July every year. The course is for all health professionals and students. It provides exposure and training for basic health work in underserved communities in addition to emphasizing politics and ethics. The course is a good orientation to all the joys and hardships of international medicine.

United Nations Children's Fund (UNICEF)
3 UN Plaza
New York, NY 10017
1775 K Street, NW, Suite 360
Washington, D.C. 20006
Tel: (212) 326-7000 or (202) 296-4242
Web: www.unicef.org

World Health Organization (WHO)
525 23rd St., NW
Washington, D.C. 20037
Tel: (202) 861-3200
Web: www.who.org

World Vision International
Box 9716
Federal Way, WA 98063
Tel: (206) 815-2562
Web: www.worldvision.org
The world's largest Christian relief and developmental organization, World Vision operates medical programs in Africa, Asia, and central and eastern Europe. Volunteers work in the areas of pediatrics, public health and tropical medicine.

Youth Service International
301 North Blount Street
Raleigh, NC 27601
Tel: (919) 733-9366
Web: www.youthservices.com
Places people aged 17-24 in three-month voluntary service projects overseas. Projects are primarily in the areas of scientific research and community service.

Key Readings Relevant to The Politics of Health

Compiled by the International People's Health Council and HealthWrights

HealthWrights
P.O. Box 1344
Palo Alto CA 94302
Phone:(650) 325-7500
Fax: (650) 325-1080
E-mail: healthwrights@igc.org
Web: www.healthwrights.org/polhlth/index.htm

Note: This is a short list, mainly of books and magazines, most of which are accessibly written and should be fairly easy to find. With few exceptions, it does not include articles from journals. We recognize that this list is very incomplete, but we have tried to limit it to key writings, mainly for the concerned student or lay reader. Some of the writings are published recently, others are older but still represent some of the best, most relevant writings in their field. HealthWrights and the International People's Health Council are constantly developing more complete lists and would appreciate suggestions of new and important readings. As you come across such materials, please keep HealthWrights informed by e-mail. (The following list was last updated in October, 1997. Reprinted with permission.)

Primary Health Care and Determinants of Health

Werner, David, Sanders, David with Jason Weston, Steve Babb and Bill Rodriguez. *Questioning the Solution: The Politics of Primary Health Care and Child Survival*. HealthWrights, 1997.
Questioning the Solution analyzes why 13 million children die every year from preventable causes, and challenges conventional primary health-care and child survival strategies. Too often, health and development planners try to use technological fixes rather than confront the social and economic inequities that perpetuate poverty, poor health and high child mortality. As a case study, the authors show how marketing Oral Rehydration Therapy as a commercial product, rather than encouraging self-reliance, has turned this potentially life-saving technology into yet another way of exploiting and further impoverishing the poor.

Macdonald, John. *Primary Health Care: Medicine in Its Place.* University of Bristol, UK. 1993. Available through Kumarian Press, 630 Oakwood Ave., Suite 119, West Hartford, CT 06110-1529.
Traces the development of primary health care (PHC) since its inception at Alma Ata in 1978 to the present, providing strong arguments for the rationale of PHC. Emphasizes the need for equity and strong community participation.

Navarro, V. "A Critique of the Ideological and Political Position of the Brandt Report and the Alma Ata Declaration." *International Journal of Health Services*. Vol. 14, No. 2 (1984): pp 159-172.

The Debate on Selective or Comprehensive Primary Health Care. *Social Science and Medicine*. Vol 26, No 9 (1988): pp 877-878.
Introduction to and historical background of the debate. Editors question whether there is really a fundamental conceptual conflict between SPHC and CPHC. They assert that donors should support nations to develop national health systems based on primary health care. Several good papers by key critics.

Werner, David and Bower, Bill. *Helping Health Workers Learn*.
A people-centered guide to teaching community health workers. Intended for those who feel that their first allegiance lies with working people and poor people. Discusses and simplifies the awareness-raising methodologies developed by Paulo Freire.

Halstead, SB, Walsh, Julia A, and Warren, Kenneth S, eds. *Good Health at Low Cost.* New York: The Rockefeller Foundation. 1985.
An important study investigating why certain countries—China, Kerala state in India, Sri Lanka and Costa Rica—have attained widespread good health despite low GNP per capita.

Daly, Herman. *For the Common Good: Redirecting the Economy Toward Community, the Environment and a Sustainable Future*. Boston: Beacon Press, 1989.
Daly, a former World Bank economist who left in disgust, argues for an eco-economic model of development based on equilibrium , not growth, with full cost pricing that builds in human and environmental costs.

***UNICEF: The State of the World's Children*. Oxford, England: Oxford University Press.**
Annually updated progress in child survival. Has useful statistics and graphs on health, education and economic indicators in most of the world's countries with year-by-year comparisons. Clearly presented.

McKeown, Thomas. *The Role of Medicine: Dream, Mirage or Nemesis?* Oxford, UK. Basil Blackwell Publisher. 1979.
A superb review of how medical interventions had relatively little to do with public health improvements in Europe and the U.S. between 1800 and 1950. Challenges myths about the contribution of biomedicine.

Sanders, David. *The Struggle for Health*. Hampshire, UK: Macmillan Education. 1985.
A perceptive overview of the causes of widespread poor health and early death in situations of underdevelopment. It demonstrates clearly that far-reaching improvements in health depend more on social factors than on biomedical advances.

Ehrenreich, J. ed. *The Cultural Crisis in Modern Medicine*. Monthly Review Press. 1978.
This book is a collection of writings by 14 authors divided into three parts: the social functions of medicine, the historical and contemporary roots and devastating impact of medical sexism, and the use of the art of healing in promoting and maintaining imperialism.

Kent, George. *The Politics of Children's Survival*. New York. Praeger. 1991.
This book provides a clear, trenchant analysis of how "structural violence" impacts the lives and mortality of children in the Third World. Kent makes a strong case for equity-oriented development and strategies that empower the poor.

Werner, David. *The Life and Death of Primary Health Care, or The McDonaldization of Alma Ata.* 1993. Available from HealthWrights, 964 Hamilton Ave, Palo Alto, CA 94301.
Talk given to Medical Aid for the Third World. Reprinted in *Third World Resurgence* (see below). Gives a cogent history of the three major attacks on primary health care (PHC) since Alma Ata: Selective primary health care, user financing and cost-recovery schemes, and the World Bank's *Investing in Health* report.

Development and Social Change: Issues That Affect Health

Isbister, John. *Promises Not Kept: The Betrayal of Social Change in the Third World.* West Hartford, Connecticut: Kumarian Press. 1991.
Reveals how world leaders rose to power on promises for social progress and how they blatantly broke those promises. Packed with hard-hitting facts, the book gives a chronology on how poverty evolved.

***UNDP Human Development Index*.**
Provides important, useful data on distribution of wealth and resources within and between countries, along with social indicators (rather than merely economic ones) of a population's progress and well-being. Presents a more honest (people friendly) description and analysis of global trends than does the World Bank's *World Development Report*.

Watkins, Kevin. *The Oxfam Poverty Report*. Oxfam Publishing, BEBC Distribution, PO Box 1496, Parkstone, Poole, Dorst BH123YD, UK. 1995.
A comprehensive analysis of the state of poverty in the world today, this well-documented book identifies the structural forces that deny people their basic economic and social rights. It outlines some of the wider policy and institutional reforms needed to create an enabling environment in which people can take self-determined action to reduce poverty.

Magazines (monthly)

***Third World Resurgence*. Published by Third World Network, 228 Macalister Road, 10400 Penang, Malaysia.**
Perhaps the best periodical critique and analysis from the Third World on development, environmental and health issues. Aims at "fair distribution of world resources, and forms of development which are ecologically sustainable and fulfill human needs." If you subscribe to just one Third World periodical, consider this one.

***The New Internationalist*. Subscriptions: PO Box 79, Hertford, SG14 1AQ, UK.**
"Exists to report on issues of world poverty and inequality; to focus attention on the unjust relationship between the powerful and the powerless in both rich and poor nations." Each issue focuses on a different theme relevant to development and basic needs. Quality varies, but many issues carry important debate on "the radical changes needed within and between nations if the basic needs of all are to be met."

***Multinational Monitor*. Subscriptions: PO Box 19405, Washington DC 20036, USA.**
Excellent, balanced, well-documented articles that expose the unscrupulous actions of transnational corporations, their influence on national and global politics, and their violations of international codes. Some articles are directly related to health concerns; almost all are at least indirectly related.

Global Power Structures, Financial Institutions and Transnational Corporations That Impact Health

World Bank. *World Development Report,* 1993. Investing in Health. Oxford, UK. Oxford U. Press. 1993.
This is the position paper for the World Bank's take-over of Third World health policy planning. It calls for more equitable and efficient health systems. But stripped of its Good Samaritan facelift, it is a rehash of the conservative strategies that have derailed Comprehensive Primary Health Care, but with the added shackles of structural adjustment, including privatization of public services and user-financed cost-recovery. A masterpiece of disinformation, this market-friendly version Selective Primary Health Care has ominous implications. By tying its new policy to loans, the Bank can impose it on countries that can least afford it. In sum, the Report promotes the same top-down development paradigm that has perpetuated poverty, foreign debt, and the devastating impact of structural adjustment policies.

Critical Reactions to the World Bank's *World Development Report 1993: Investing in Health*: Various papers assembled in 1993 by Health Action International—Europe. Address: Jacob van Lennepkade 334T, 1053 NJ Amsterdam, The Netherlands.
This is a packet of extremely important analysis and criticism, including responses from Save the Children Fund (UK), Tony Klouda on behalf of the PHC-NGO group (IPPF, UK) and an article by Dorothy Logie and Jessica Woodroffe from the *British Medical Journal*, July 3, 1993.

Legge, David. Investing in the Shaping of World Health Policy, Prepared for the AIDAB, NCEPH and PHA workshop (Canberra, Australia, Aug. 31, 1993).
Long, in-depth review of *Investing in Health.* (Available from HealthWrights.)

Epprecht, Marc. The World Bank, Health and Africa, *Z Magazine*, Nov. 1993, p. 31-38.
Lengthy in-depth review of harm caused by World Bank health plan in Africa.

Danaher, Kevin, editor. *Fifty Years is Enough: The Case Against the World Bank and International Monetary Fund*. South End Press, Boston MA, USA, 1994.
A revealing collection of essays, country studies and statements by marginalized groups of the reversals in social progress and deepening of poverty caused by structural adjustment and other lopsided development policies pushed by these powerful financial institutions.

Meeker-Lowry, Susan, *Investing in the Common Good*. 1995. New Society Publishers, PO Box 734, Montpelier, VT 05601, USA.
Alternative development strategy which calls strongly for equity and the participatory democratic process. Critical of the top-down, status-quo preserving strategy of the World Bank's *Investing in Health* report.

Tan, Michael. *Dying for Drugs: Pill Power and Politics in the Philippines*. Published by Health Action Information Network (HAIN), 1156 PO Box 1665, Central Post Office, Quezon City, Philippines. 1988.
One of the best books from the Third World exposing the exploits and abuses and double standards of the multinational drug companies. HAIN also puts out an excellent bulletin, *Health Alert,* which looks at many health-related issues, Philippine and international, from a pro-people perspective.

Chetley, Andrew and Allain, Annelies. *Protecting Infant Health: A Health Worker's Guide to the International Code of Marketing of Breastmilk Substitutes*. Published by International Baby Food Action Network (IBFAN) PO Box 19, 10700 Penang, Malaysia. 1993 (revised).
An excellent, well-illustrated booklet for awareness-raising in community groups.

Korten, David. *When Corporations Rule the World*. Kumarian Press, 630 Oakwood Ave. Suite 119, West Hartford, CT 06110-1592, USA. 1995.
"A searing indictment of an unjust international world order," together with a very rational alternative strategy for "People Centered Development" (the title of his first major book). Korten is the founder of the People-Centered Development Forum, based in New York City.

Acknowledgments

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Global Health Council (formerly the National Council for International Health) published several great resources on international health and they were very generous to allow me to reprint some of their material in this manual.

HealthWrights provided their reading list for reprint in this manual. They have published several books that have been essential in my self-education process.

Molly Martin, Editor

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