

Global Health is a field of study, research, and practice that centers health equity, social justice, and trans-national health issues. Global Health is an interdisciplinary field that blends public health, clinical care, planetary health, social determinants of health, and much more. As trainees and professionals seek immersive experiences and training in the field, they encounter colonialism, bias, power imbalances, and dynamics that make walking the talk of equity and justice an endeavor that requires a lens of critical reflection - one focused both on the self and the structural elements of the world. Whitney and Clayton (in Research on and Through Reflection in International Service Learning) remind us that experiential education "all too easily leads to reinforced stereotypes, simplistic solutions to complex problems and inaccurate generalizations from limited data" without intentional practices of critical reflection. This anthology is a compilation of reflective essays and expressions that capture personal and professional journeys essential to developing authentic and transformative insights in Global Health. The contents of this book draw from the Consortium of Universities for Global Health annual Reflection in Global Health contest. This anthology is intended to serve as a resource and educational tool for practitioners and educators, alike, and to engage more with all who are committed to elevating reflection in Global Health.

To engage with this community of practice, visit the following link or scan the QR code.

www.tinyurl.com/globalhealthreflection



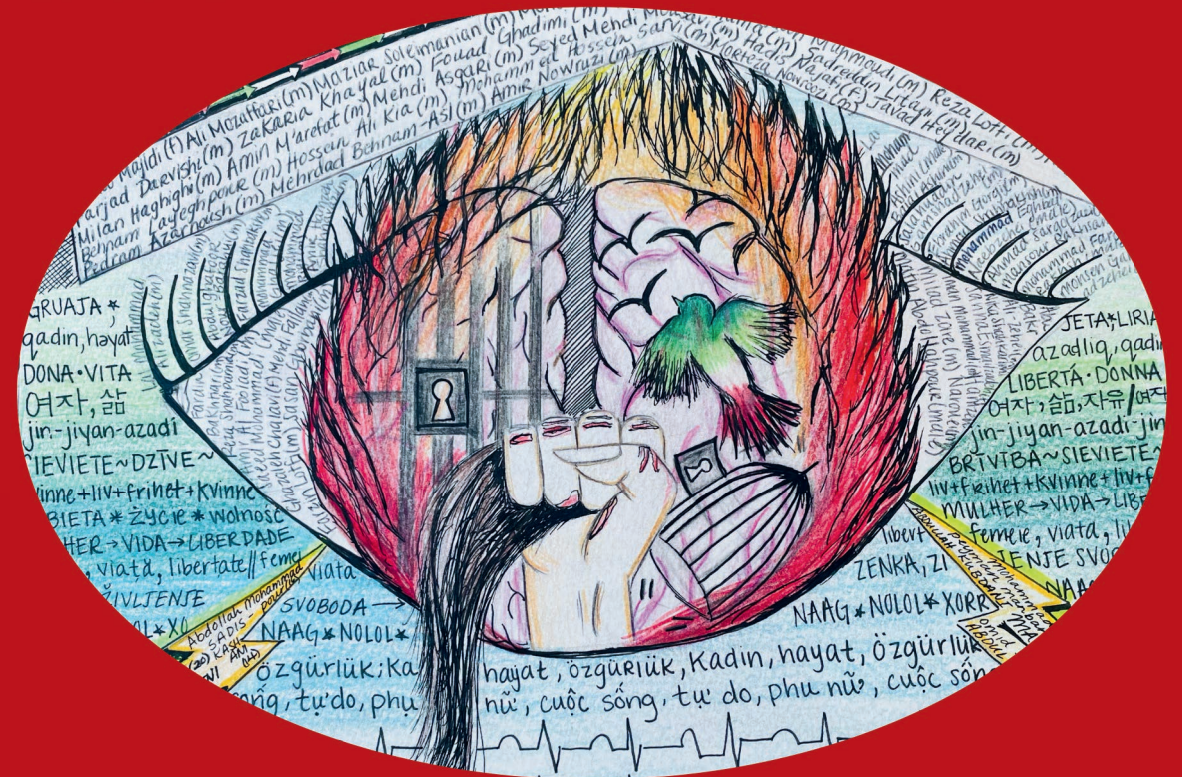
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REFLECTION IN GLOBAL HEALTH AN ANTHOLOGY

REFLECTION IN GLOBAL HEALTH

AN ANTHOLOGY

VOLUME 2



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An Anthology, Second Edition

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Reflection essay authors were instructed to use pseudonyms for all patients and select institutions.

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Table of Contents

Preface.....	xi
<i>By: Virginia McCarthy</i>	
Introduction.....	xxix
<i>By: Amy Blair and Virginia McCarthy</i>	
Enlightened.....	1
<i>By: Jean Adomfeh</i>	
Creeks Flowing into the Ocean.....	4
<i>By: Jinghua An</i>	
A Challenge in Global Health Education: Diversity.....	7
<i>By: Anu Aryal</i>	
Carrying On.....	10
<i>By: Hannah Bergbower</i>	
On Toughness and Apathy.....	13
<i>By: Clara E. Busse</i>	
Decolonizing Global Health.....	16
<i>By: Shradha Chhabria</i>	
Shared Ground vs Intervening Oceans.....	19
<i>By: Samantha J Cheng</i>	
Human Experience Shaping Medical Needs.....	22
<i>By: Jett E. Choquette</i>	
Health Advocacy through Objects: Reflections from a Refugee Medical Case Manager.....	25
<i>By: Sarah K. Clarke</i>	

Shut Up and Let the Women Speak.....	28	When Stories Are All We Have.....	70
<i>By: Mark Darby</i>		<i>By: Pooja Parameshwar</i>	
Impetigo: A Case Study.....	31	Lessons Learned from a Car Stuck in the Mud.....	73
<i>By: Jehannaz Dinyar Dastoor</i>		<i>By: Hannah Peifer</i>	
The Earth and You: Weaving Foundations in Global Health.....	34	Preoperative Preparation.....	76
<i>By: Huda El-Zein</i>		<i>By: Joseph Peterson</i>	
Life Lessons from The Dying.....	37	Dignity in Death.....	79
<i>By: Matt Evans</i>		<i>By: Aparna Ramanathan</i>	
When the Treatment is Worse than the Disease.....	41	A Tuesday in East Africa.....	81
<i>By: Lia Harris</i>		<i>By: William E. Rosa</i>	
Thy Father's Will.....	44	A Radical Act.....	84
<i>By: Amoghavarsha Havanur</i>		<i>By: Mitra Sadigh</i>	
Worth a Thousand Words?.....	47	Defining Poverty: From India to South America via USA.....	87
<i>By: Bethany Hodge</i>		<i>By: Vatsla Sharma</i>	
Till He Died.....	50	Lungile.....	90
<i>By: Dusingize Marie Immaculee</i>		<i>By: Ilana R. Siegal</i>	
One Team: Kinship Through Sport.....	53	The Touch.....	94
<i>By: Ryan Mak</i>		<i>By: Lisa Simon</i>	
A Home for Hope.....	56	"Why Are You Doing Global Health?".....	97
<i>By: Rania Mansour</i>		<i>By: Jonathan Steer-Massaro</i>	
The Imperfect Art of Medicine.....	59	The Sixth Sick Child.....	100
<i>By: David Means</i>		<i>By: Paula Tavrow</i>	
The Silent Killer.....	62	Going Gently: A Case for Palliative Care in India.....	104
<i>By: Treasure Blessings Mkalianinga</i>		<i>By: Ilika Tripathi</i>	
Hearing Aid.....	65	Beyond the Burden of Disease.....	107
<i>By: Parimala Mohanty</i>		<i>By: Jessy Uchindami Gondwe</i>	
Finding Meaningful Connection Through Problems.....	68	Lessons from a Math Teacher.....	110
<i>By: Lusayo Mwakatika</i>		<i>By: Cristina Viguera Altolaquirre</i>	

Life, death, and representation: Understanding the importance of imagery in global health through the Haitian *tranbleman deté*.....113
By: Renata Wettermann Capo

On Power: Justice, Mental Health, and Hope in the Rohingya Refugee Camps.....116
By: Julia Zigman

Beautiful.....119
By: Kristen Zozulin

Preface

By: Virginia McCarthy

As we prepared this second edition of reflection essays from global health experiences, we recognized an opportunity for a few contributions to the field above and beyond the rich compilation of reflection essays. After a decade of facilitating the Consortium of Universities for Global Health (CUGH) Reflection Essay Contest, we realized that, in addition to collecting reflections from global health trainees and practitioners around the world, a deeper dive into the theory and structure of reflection in global health would be useful. Two ways in which we hope to contribute to the theory and structure of reflection in global health are, first, by providing an overview of critical reflection theory that informs an approach and sample reflection prompts for trainees and educators in the Introduction of this anthology. The second contribution we hope to offer here is the development of a mechanism to gather information about reflective practice in global health in an open-source manner. Through this survey (tinyurl.com/globalhealthreflection), we invite responses from the community to better understand our audience and to collect additional resources on reflection in global health, ultimately creating a repository of reflection resources to share with the community through this ([Collaboration for Reflection in Global Health website](#)). We also hope to build a community of practice among those who are utilizing reflective practice through the Collaboration for Reflection in Global Health initiative.

Background

It feels appropriate to begin an anthology on reflection by, first, spending some time reflecting on how we arrived at this point. This essay competition was the product of the editors of this anthology who, through shared work and a healthy dose of coincidence, found one another and began to offer this competition in partnership with the Consortium of Universities for Global Health (CUGH). At the 2012 annual meeting of the Society of Teachers of Family Medicine (STFM) conference in Minneapolis, Jessica Evert and

Ginny McCarthy met by Ginny's poster that discussed the value of utilizing reflection in global health training for medical students at a Catholic, Jesuit medical school (where reflection is incorporated with great regularity into the curriculum and, while students can complain, the practice of participating in required, structured, purposeful, critical reflection tends to be something they miss upon graduation and proceed through residency). Preceding this conversation at the STFM conference, Jessica was already in conversation with Twee Bui, Tom Hall, and CUGH about the idea of an essay competition for reflection in global health and now, eleven years after that initial conversation in 2012, we have received *hundreds* of essays through the annual CUGH Reflection in Global Health Essay Competition, *thousands* of memories and points of reflection, from trainees and practitioners from around the world.

The first competition was held in 2013. Essays submitted were reviewed by judges from more than twenty institutions based upon four categories: originality; style and composition; critical reflection; and impact on the reader. Essays received a score between 1-10 for each category. The highest scoring 10-12 essays were reviewed and scored anew by the essay committee without viewing the first-round score. Winning essays were selected by the committee through conference call until Zoom technology entered the scene more prominently in the Covid years and beyond. Authors from the first two years of the essay contest (2013 and 2014) were invited to include their essays in the first anthology, *Reflection in Global Health: An Anthology*,¹ which was published in 2016 and included 63 essays. This second anthology includes essays from a larger number of years, with the invitation for inclusion extended to authors whose essays were selected as one of the three winning essays or were honorable mentions for their year of submission. Between the years of 2015 and 2022, 67 authors were invited to include their essays in this anthology. Of those invited, 40 authors accepted this invitation to publish their work: three authors from 2016, five authors from 2017, four from 2018, seven from 2019, seven from 2020, six from 2021, and eight from 2022.

Throughout the years, the process for compiling this anthology raised key questions for our editor group regarding reflection. The primary question raised was, "What are the ethical considerations we should be making when sharing these reflections?" And, relatedly, "Whose story is this, anyway?" As global health practitioners who prioritize ethical engagement in the world in hopes of educating future global health practitioners who prioritize the same, the ethical implications and reinforcement of power differential of sharing life details of persons met through global health encounters (often based in

¹ "Reflection In Global Health."

a private and vulnerable clinical or home setting) were central concerns for our team. These concerns have always been present and have been addressed by asking authors to use pseudonyms to protect identity, to use broader references to location and region instead of specific clinic or village names, and to make small changes to details of their accounts that do not modify the overall content of their reflection. While encounters from global health experiences (and all human interactions) are shared encounters and, thus, are able to be shared by and through the perspective of the authors of these reflections, we are also cognizant that the authors have a platform through which their stories, perceptions, encounters can be made quite public. Those featured in their reflections, though possessing shared ownership of the encounter, often lack the platform to share their personal experiences and perceptions of the same encounter. We are mindful of this power differential as we continue to call for essays and as we publish this anthology. The truth is, global health has changed significantly since its inception. The field has matured in important and meaningful ways between the beginning of this essay contest and today. While concerns of privacy are not new, privacy considerations have become increasingly more challenging to uphold through the rise of use of technologies and social media and are of particular importance in the realm of shared, personal experience. Considerations of power dynamics and privacy are elements of the broader landscape of efforts to "decolonize" the field of global health, meaning to shift power imbalances, privilege, access, agency and related considerations. Efforts to decolonize global health are multifaceted, and we hope that this collection of essays from the field can enhance these conversations and efforts to redress power imbalances and lack of equity and inclusion in all areas of influence.

Essays featured in this anthology include works authored by practitioners and trainees from low-middle income countries (LMICs) and high-income countries (HICs). While the distribution of authors and perceptions still features majority HIC work, efforts are being made to expand the call for reflection and, in 2023, the Reflection Contest has grown beyond the inclusion of 1,000-word essays to also invite multimedia submissions. The hope for this shift is to invite reflections from around the world which foster and facilitate creativity and expression beyond the reach of words alone in order to convey fuller depth and breadth of our shared human experiences. We hope you will join these efforts by sharing this work with others in the field through contribution of your personal experiences and by inviting those in your global network to join this community of practice (tinyurl.com/globalhealthreflection).

Personal Reflections

Through this anthology, we also hope to provide a small window into the life of educators and practitioners in global health through a brief reflection on the journey to and through reflection, personally and professionally, of this group of editors. These reflections share a bit about who we are and how we began to utilize reflection in our own lives and in our work. Our hope in sharing briefly about our own paths, our prioritization and incorporation of reflection into our individual and collective journeys, that both the distinct and the common threads will speak to you as a reader. We hope our reflections will invite a similar reflection from you and will encourage you to stay with reflective practice as you move through the world, changed by the process as you continue to form and inform the process itself, both for you and for others in your sphere of influence.

Naturally, once we decided to include this component, we asked ourselves why we might include something like this and discussed the components we would hope to see addressed in each of our personal reflections. Then we *drafted* an outline to guide our reflections. After we each drafted our personal reflections, we asked ourselves if anything was missing from the exercise or if there could be additional value added through the inclusion of additional questions or components. We acknowledged the variation in the reflections, which is to be expected, and continued an iterative process of writing and review until we finalized the following outline to guide our reflections:

Outline for personal reflections:

- I. Who are you? Include personal and professional elements here, as you are comfortable.
- II. What brought you to the practice of reflection?
- III. How has your practice of reflection changed over time? What has inspired or influenced this change?
- IV. Have there been any challenges or hurdles for you in using reflection for personal, professional, or educational purposes?
 - a. If so, what were they?
 - b. How did you navigate, incorporate, or overcome them to continue to use reflection as a practice?
 - c. Did this change the way you used reflection in these areas (personal/professional/educational)?
- V. What are your hopes for reflection in the field of global health or the hopes for the use of this anthology?

Virginia (Ginny) McCarthy, MPH, MDiv, DrPH

I am currently a doctoral candidate at the University of Colorado School of Public Health in the department of Community and Behavioral Health where I also work as a Research Assistant in the Firearm Injury Prevention Initiative and the Injury and Violence Prevention Center. I also work as the Director of Development for Denver Youth Program/GRASP (Gang Rescue and Support Project). Prior to doctoral studies, I co-founded the Center for Community and Global Health (with Amy Blair, co-editor and co-author of the Introduction of this anthology) and in the Health Sciences Ministry department at the Health Sciences Campus of Loyola University Chicago. My professional profile was deeply enjoyable and meaningful, as I worked with health sciences students (medical, nursing, biomedical sciences, and public health) and practitioners, as well as a host of phenomenal non-profit organizations in local, domestic, and international learning and partnership. I have been incredibly fortunate to have spent thirteen years of my life working with a talented and committed multi-departmental team to accompany hundreds of students and practitioners through global health engagements of varying durations and compositions with critical partners. It was the practice of reflection that led me to leave this work (for a moment) to pursue doctoral training in public health. Inspired by my students and colleagues over the years, I knew there was more to learn so that I could be more effective in my contributions to the field of public health (and to the world) and in my role as a practitioner, educator, and researcher into the coming decades.

My journey to reflective practice began in high school. I traveled to the U.S.-Mexico border and the following year to rural Guatemala. The structured reflection sessions really spoke to me. I found that reflection helped me detail my own immediate thoughts and I liked the combination of spoken and written reflection. The urge to take my thoughts from what I was seeing to exploring questions around why my observations might be as they are, especially the ways in which systems and structures made these realities as they are. Additionally, the action-oriented component of what to do with these realizations spoke to the “doer” in me. Finally, the idea that reflection, while perhaps shining light on aspects of global realities, was informed by (while also forming) my worldview in the process in ways that invited observation, empathy, and action was (and still is) appealing to me. The main takeaway from the process each time is that while this is my observation, in this moment, for *now*; my views can and should be subject to further refinement as I learn more, see more, am present, and even *do* more.

Perhaps my greatest learning in utilizing the practice of reflection in education is the fact that, while I believe human beings have a natural capacity - and even inclination

- toward reflection, reflection is neither a common and natural process, nor is it standardized by definition or by intended outcome(s); the practice of reflection must be taught in order to maximize benefit to the participant/learner and the process. Part of the challenge, too, is deciding what is hoped for through the incorporation of reflection and how to frame the process of reflection to provide enough space for learners to reflect on questions that are meaningful to them and in ways that begin to do justice to and support the intended learning outcomes of the particular experience as well as the practice of reflection in general. The hope, then, is to create an experience of incorporating reflection in such a way that it is meaningful in the moment and is also building a skill and a practice that the learner can incorporate into their life toolbox (as cheesy as that sounds). Reflection, I believe, is a transferable skill. While the structure and process are inherently similar from one experience to the next, the content, the observations, and the *work* of the individuals embarking on the process of reflecting will likely vary in duration, detail, meaning, and impact. But reflection is never for naught. There is always more to be learned. And reflection has a way of yielding new and refined learning over time with the introduction of new experiences, as new experiences influence and also become a part of my interpretive framework, the lens through which I see and interpret the world—the way I make meaning of experience. The meaning experiences hold, then is also subject to change as I experience new and different things. This dynamic interplay emphasizes the possibility for constantly in-motion, mutually informative, multi-layered and concurrent realities in existence in the world and my experience of it.

My hope for the practice of reflection in the field of global health (and broadly) is that we are able to enter more fully and more humbly into the realities of the world, as we encounter it, and into our own lives more fully and intentionally. My hope for the outcomes is that we feel more fully ourselves through this process and more aware of the ways in which we engage others, our work, and the world and *why* these pieces unfold as they do. I hope that we better understand our own motivations for participating in global health, what is to be hoped for through these types of engagements, and that we can facilitate these processes and experiences for others, be they learners, colleagues, family, friends. And on days when I'm feeling particularly hopeful, my ultimate goal is to introduce reflective practice to as many people as possible so that there is a greater number of well-intentioned humans who value and prioritize critical reflection so that they (we) can bring our talents into conversation with the talents of others around the world to, together, address contextual and systemic injustices and work toward the flourishing of all people everywhere. How is that for ambitious?

Thuy Bui, MD

I serve as the director of the Global Health-Underserved Populations track of the internal medicine residency program at University of Pittsburgh Medical Center (UPMC) since 2007. My official journey in global health started as a Peace Corps volunteer (PCV) and medical doctor at Kamuzu Central Hospital (KCH) in Malawi from 1995-1997, and I have since continued to teach and mentor Malawian students, interns, and registrars which is a privilege of a lifetime. For the past 22 years, I have facilitated clinical experiences at international partner sites for UPMC internal medicine residents and medical students. I strive to impart on my trainees a commitment to cultural humility, partnership, bearing witness, and accompaniment. The practice of reflection has indeed been central to my global health journey. As a PCV in the early days of the AIDS epidemic when effective treatment was not available, sensemaking was important to understand the tragedy, suffering, and deaths in hospitals in Malawi coupled with staffing shortage and lack of medication and supplies.

Reflection might have prevented me from sinking into hopelessness and deep despair, and it moderated the rage that came with witnessing injustice and blinding apathy. Reflection has allowed me to forgive myself and to grow on this journey from “helping” to decolonizing global health.

Reflection does not need to be a solitary soul-searching activity. It does not need to be formal, especially for busy clinicians. It can be integrated into daily interactions with patients and colleagues. Reflection could be those few minutes of taking deep breaths and acknowledging what just happened. Reflection could be about sharing stories, sharing laughter and tears. In working with my trainees, reflection is when we gather around the dinner table. That's when the epiphany or realization came between the bites of good home cooking. Reflection could also be creative, putting your thoughts and emotions into poetry, arts, dance, song. Reflection is the antidote to our busy lives and the constant demand of a digital presence.

Reflection is not necessarily a passive process. As you browse through this anthology and let the words seep into your bloodstream, I hope that it will also inspire you to take action. Reflection helps us understand, broaden our perspectives, and inspire us to more just and noble actions, but often this exercise does not propel us to action or change. I hope that you can see the hope, options, choices, alternatives insinuated (or eloquently expounded) in these essays and seize this moment to inspire each other to mobilize and to organize so we don't have to witness again and again senseless death and suffering from poverty, pandemic, chronic diseases, violence, and oppression.

Amy Blair, MD

When introducing ourselves for global health education audiences, we often incorporate the places we have lived, or the programs or populations where we engage. It dawns on me that the moment in recent memory where I felt I was living my “who” and “what” the most was in the early pandemic summer of 2020 just down the street where I live in the Chicago area. Uncertainty and loss of control were the backdrop, the setting was an expedited testing event in a church parking lot in the mid-day sun, the moment included a shared sense of purpose and camaraderie, and the action and reaction felt urgent. I was doing, observing, receiving in a way that felt so reminiscent of earlier experiences in global health. It was like teleportation. Was this the event that those moments long ago were preparing me for? I returned to the comfort of my home one night with my hands still craving to be busy and was inspired to cook. I grabbed some garlic cloves and flakes of the paper-thin white peels floated in the air. I grasped the peels between my fingers, recalling a scene from the past. Children were sifting through a mountain of empty garlic peels left over from a recent harvest, sorting and searching in this mountain of peels for a few hard cloves that had escaped the processing, cloves they would take and sell for the subsistence of their family, for their own food. Why was this scene bubbling to the top today?

I realized that, to have such a clear memory, I must have spent substantial time reflecting on that scene twenty-five years ago when it first occurred. I sought my prior self in the journals I had written during my global health beginning in the undergraduate years, those first experiences immersing myself in global settings and digging deep into the realities of poverty and inequity. Reflection had clearly been my avenue for both processing and preparing. Rarely did my reflections end without searching questions about my future. It felt impossible not to incorporate the discomfort and injustice of what I lived and learned into the building blocks of my professional path. Only action felt like solidarity to me then.

Connecting the present and the past, I realized I still feel the most myself when I am doing, when there is action. I am simply not someone who keeps their hands in their pockets when there is something to be done, and it’s hard to kick that hard wiring. But reflection has helped me grow in the action of accompaniment. Accompaniment is a powerful action. It requires the awareness of when to pause, to stand still, to listen, to attend. It requires mindfulness, to forgo the next-step thinking, to forgo judgment. Connecting in this way opens the portal for true solidarity, without harm and without hierarchy.

As I guide students through their own global health journeys, I hear them wrestle with anger over injustice, of feeling called to action and frustrated with the slowness of change. I relive many moments from the long-ago journals, and I lift up that experience and my daily musings of the continued fight for equity. All of this would be impossible without an evolution of reflection, personally and professionally.

Critical reflection and situational awareness are the heart of our field and can bring harmony to those who want and need to act. The essays in this anthology illustrate how the richness of experience itself can be an agent of change. By sharing these reflections with others, the contributors have engaged us in that collective journey, with them and with ourselves.

Jessica Evert, MD

It comes into focus at unexpected moments. When the emergency room calls me to admit a patient who has a complication from a diagnostic procedure done by a licensed practitioner under ideal circumstances in terms of equipment, demonstrated skill, and oversight (I unskillfully stuck a needle into the back of a 9-year-old in East Africa while he was held down defecating and urinating, screaming and writhing in pain, pain made longer and without the payoff of a successful lumbar puncture). When I walk by my mother’s framed photo of pale me posing with black children in a short white coat indicative of a medical student on the wards of the East African hospital- a photo with patients and martyrdom dynamics that would never be taken in a US hospital because it would be tasteless, unethical, and hubris laden. When I struggle to control a patient’s diabetes during multiple visits and over a year of working on closely tracking, titrating medication, and dealing with iatrogenic hypoglycemia in efforts to get the disease in check in a way that impacts individual health outcomes (leads me to query what happened to patients when we handed out medications as students without oversight or follow up in that temporary clinic in Central America). When I care for a patient living in a shelter with generic anti-hypertensive medications because handing out the latest high-cost drug sample would only create an unsustainable and potentially more harmful outcome in the long run (I ran a free clinic that boisterously handed out expensive drug samples and claimed to be saving lives and treating the “needy”). When I precept residents and medical students revealing multiple opportunities for care to get on an accurate, safe track (the aforementioned free clinic did not provide standard of care oversight of students providing charity care). When I bristle over the community service and public health awards I received as a medical student, not realizing that I was being celebrated for care

that was sub-standard, perpetuating disparities, and treating the poor as less human than those with health coverage and deserving of accountable systems.

Reflection on experiences in global health, whether they take place locally or internationally, is a lifelong iterative process. I am 20 years out from my early experiences that were in the vain of global health and health disparities, yet I continue to deepen my reflection into the multi-faceted dynamics that led me astray. The ‘global health industrial complex’ that perpetuates power and privilege building blocks that have underscored inauthentic understandings of health systems, distant people, faraway places, disparities, and solutions was reinforced by my entres into this work. Had I not had the experience of training in a legitimate, formal health care safety net in San Francisco; had I not ventured from the block concrete biology building of my initial undergraduate major over to the anthropology department housed in an expansive, light, open minded building; had I not had a personal tendency toward critical internal dialogue and desire to hone my moral compass and challenge assumptions in many areas of life; had I not journeyed in a way that led me to a deeper, more accurate understanding of reality and of my own unconscious bias – I would still be celebrating the lumbar puncture, the medication handouts, the saviorism of those images and actions. Reflection is an ongoing process to engage in intentionally and through a lifetime of iterations. Only through this reflection can we understand ourselves and begin to chip away at understanding others.

Neeloofar Soleimanpour, MPH

Recently, I completed my masters degree at the Colorado School of Public Health in epidemiology and global health where I now serve as a research assistant and public health practice coordinator. My intention for studying public health was to further understand the greater impact of our health care system and perform research to evaluate and improve the effectiveness and accessibility of health services for chronic conditions in impoverished communities. This desire of mine peaked after traveling to Guatemala with a group of classmates and advisors to conduct a study on anemia, while assisting local health professionals. But it quickly became apparent to us that we were there for much more than a research study. As we visited each local village, the people would approach us with a wide variety of health issues, under the impression that we could fix all of them. I was in utter disbelief. Not just because I knew I could not fix their issues immediately, but because they needed more skilled professionals than we had available. This small and underdeveloped town spoke loud, magnifying words to me when I arrived. The beauty was immaculate, but poverty and suffrage were prominent

and could not be overlooked. However, it became very clear that no matter how little the people in this town had, their spirits remained abundant; their lives not filled with darkness, but instead, with the light of hope.

During each day of our trip I found it important to take time to reflect on the experiences that I encountered each day, describing the people I met, the places I visited, and the highs and low of each day. After our trip I summarized my overall experience, identifying cultural learning, global connections, and cross-cultural thinking. This was the first of many times where I implemented the practice of reflecting into my life. I believe that by reflecting and taking a moment to process and soak in impactful experiences allows us to grow as individuals. Increasing our awareness and knowledge provides an opportunity for growth not only within oneself but in understanding other perspectives and experiences.

Since that trip, I have continued to set aside time where I reflect on moments, big and small, to find not only areas where I can improve but also identify areas of my life where I have grown. I believe that self-reflection is key to broadening our understanding and awareness of others and the impact individual decisions may have. It is a skill that can help determine what the next step may be in one’s journey.

I hope that those within the field of global health find this anthology as a body of work that not only highlights personal experiences but brings awareness of the advancements we have made and will continue to make in the field of global health. For me, reading these essays ignited my passion to continue advocating for the public and it provided me a great level of respect to our authors who submitted raw, vulnerable pieces to illustrate their experiences. I hope this body of reflections inspires others to not only take action in supporting global health efforts, but to incorporate reflection into their own lives and find it useful to evaluate ourselves through a new lens.

Kimberly Sluis, EdD

As a returned Peace Corps volunteer (Ghana 2001-2004) who served on a health education project, I find the reflection components of global public health particularly compelling. As we seek to make sense of the experiences we have in settings unfamiliar to us, it is easy to go first to judgment. Reflection teaches us to start by describing what it is we see and experience. Starting there seems to give space for us to first try to understand what is happening around us in its own context before we assign value assessments to what it is we are experiencing and how it contrasts to what we have experienced before.

Since those years as a Peace Corps volunteer I have worked in educational administration, as a strategy consultant, and now in philanthropy for a national nonprofit organization. In each of these work contexts, reflection has been an important part of my practice and component of what I have helped to facilitate for my colleagues, clients, and collaborators..

When reading the reflections included in this anthology, I found myself feeling deep gratitude for the authors who so generously and vulnerably offered their own recollections of their experiences in public health and then shared their approaches to sense-making in the aftermath of those experiences. As I incorporate reflection into my own professional practice I have found that it can be challenging to share reflections publicly as I worry about offering a perspective that may draw judgment from others or even from a future version of myself who may think differently about the same topics or experiences at a future point in time.

It is brave of the authors included in this anthology to share their experiences and reflections publicly, especially as the act of reflection is so deeply personal, situational, and iterative. The way we make sense of an experience can change over time – as we learn more, experience more, are exposed to new information, and have more time to reflect. I am grateful to the authors who shared as part of this anthology. Reading their reflections pushes my reflective practice and I hope it will do the same for the students, academics, and practitioners who engage with this text.

Building a Community of Practice: A Reflection Journey from One Institution

The hope of this introduction of this anthology is to, ultimately, build a community of practice around the utilization of critical reflection in global health (tinyurl.com/globalhealthreflection). As you determine how to incorporate the resources into your learning goals or program, you may consider how larger changes in institutional mission and vision can occur through the incorporation of reflection. We will share one example of the central role of critical reflection that builds upon institutional mission and values to achieve desired learning outcomes and personal growth.

The Ignatian Service Immersion (ISI) program at Loyola University Chicago reflection guide is included as a sample reflection resource of this anthology (tinyurl.com/globalhealthreflection). As with all reflection guides, the ISI reflection resource requires some contextualization too situate its function and intended use. The Ignatian Service Immersion program began at Loyola University Chicago Stritch School of Medicine in 1993 and spent the first twenty years of its existence as the *International Service Immersion*

program. The program paired medical students with international partner organizations, often in the Catholic and/or Jesuit network. Students worked primarily in clinical settings and were accompanied by physicians who saw patients and facilitated medical learning and a chaplain from the Ministry department who facilitated logistics and reflection. The evolution of the program tracks with the evolution of the larger field of global health, namely from medical teams to multidisciplinary teams, from medicine to public health, from provision of medical care to deep learning on the social determinants of health, from international to global (meaning without borders, prioritizing local and domestic engagement), from one-way immersion to seeking experiential and professional exchange, and the list goes on. Throughout the course of the program, participants met preceding the trip, had structured group reflections throughout the trip, met with staff as a group post-trip, and gathered in their groups for at least one post-trip reflection and meal. Each of these time points were guided by questions or structured learnings that were facilitated by a student leader who met with staff for training throughout the process. A collection of reflection pages was included in participant travel folders, which then evolved into a reflection packet, and then evolved into a reflection booklet in 2017. You will find a current version and a “Covid version” on the *Collaboration for Reflection in Global Health* (tinyurl.com/globalhealthreflection) website, the primary difference between the two being the “Covid version” guided participant through “e-immersion,” or electronic immersion – experiences held at a distance due to pandemic travel constraints. These guides were developed and refined by the Health Sciences Ministry team at Loyola University Chicago and have been used to guide reflective practice throughout the Ignatian Service Immersion experience for students, faculty, and staff since the development of the first guide in 2017.

A few key features to highlight in the reflection resource. First, note that the reflection guide is built for the context of a Catholic, Jesuit health sciences campus. Not all participants are Catholic or ascribe to a faith tradition at all, and we frame this resource for them as I will frame this resource for you here: use what is helpful to you and to your process of reflection and leave the rest behind. You will even find a “How to use this guide” page in the reflection booklet itself. Second, the reflection guide features four *key themes of reflection* (which are the content of monthly meetings preceding the trip and charisms or valued in Jesuit education globally: 1) Women and men for and with others, 2) Finding God in all things, 3) Contemplation in action, and 4) A faith that does justice. These themes guide pre-trip preparation and are revisited during the trip experiences. Third, there are five *core values* that serve as the foundation of the ISI

program: simplicity, solidarity, spirituality, service, and social justice. The ways in which reflection is framed, the core values, and the learning objectives sought through these experiences guided the resources selected for this reflection booklet and are consistent with the mission and values of the University, as well as the each of the participating programs in the ISI program (nursing, medicine, public health, biomedical sciences). In fact, it was a recentering of the program on the *values* of the program instead of the *geographic locations* of the program (which had expanded beyond international, by design) that led to the renaming of the International Service Immersion program to the *Ignatian Service Immersion* program in 2015. (*Ignatian* is the adjective used to describe that which can be ascribed to the teachings of St. Ignatius of Loyola, the founder of the Society of Jesus, the *Jesuits*; hence, Jesuit education.) Finally, the cadence of reflection in this booklet divides the time on the ground into: first days, middle days, final days. These markers of time are relatively vague by design, given that trips range from one week to one month in duration. The guide builds off the pre-trip preparation scaffolding around the four aforementioned Ignatian themes and the experiences conclude with a written reflection. Perhaps already over-explained here, the context, values, and intended learning objectives guide the structure, content, intended use, and desired outcomes from the process of engaging trainees (participants) and participating practitioners, alike, in the practice of critical reflection. Please feel welcome to utilize the components of the reflection guide as they are useful to you and/or be inspired by this resource to build a value-based, contextually situated resource at the service of your particular context, process, and desired outcomes. We also ask that you consider sharing your reflection resources on this “live,” open-source website through the *Collaboration for Reflection in Global Health* (tinyurl.com/globalhealthreflection).

Acknowledgments

HUGE THANKS to Lauren Hackman-Brooks, Ann Hillman, and Julie DeMareo for your ability to transform the collection of reflection pages that was sent with participants on immersion experiences into a *beautiful*, thoughtful, structured reflection guide that has been used by hundreds of students, faculty, and staff over the years before, during, and after their immersion experiences. From the framing to the content, to the structure, to the necessary modifications made to the “Covid version” of the reflection guide made to retain relevance during Covid-19 “e-mmersion” experiences, this would not have been possible without the vision and leadership of these individuals and of this group. Thank you for making this dream a reality!

Description of Artwork on Book Cover

At times it is difficult for us to comprehend the happenings of a situation, why they occur and what they mean. Additionally, when generational trauma is at play, an individual sometimes may not have the words to articulate their feelings or current state of emotions. As a curious child for years, I was trying to comprehend the meaning of oppression, how it manifested and its implications. Upon the onset of the unfortunate civil unrest that took place in Iran beginning September 16th, 2022, these indescribable emotions that I felt for so long started appearing on television networks around the world. The once untellable pain that my family and that my people were enduring started painting itself as a vivid image in my mind. Stroke by stroke, day by day this image was getting clearer and clearer, until one day it was so vibrant that I took a picture of it with paper and an array of color pencils.

The image you see is a product of current events, my people’s tears and the profound generational story of the Iranian people.

This work is representative of the oppression endured by women in conservative theocratic nations. Even in the modern day where most westernized citizens assume this type of oppression is a thing of the past, it is a rather real day-to-day experience for women living under such regimes. While such oppression might be observed at a physical level there is a significant mental element to it. Where such consistent dampening of the spirit results in a progressive deterioration of the psyche, manifesting itself into mental illnesses such as depression and anxiety. Women in Iran have a higher prevalence of depression compared to men. According to a cross-sectional study published in the *Journal of Affective Disorders*, the prevalence of depression among women in Iran is around 35.8%, compared to 25.9% among men. Like depression, anxiety is also more common among women in Iran. According to the same study, the prevalence of anxiety among women is around 36.4%, compared to 26.5% among men.² While men in Iran have a higher overall suicide rate than women, the gender gap is narrowing. According to a report from the Iranian Legal Medicine Organization, the suicide rate for women in Iran increased by 25% between 2017 and 2018, compared to a 2% increase for men.³

The restrictions that women face in their freedoms and autonomy, such as limitations on self-expression through dressing as they choose can contribute to feelings of power-

² Hoseini, A. F., Khatony, A., Jafarizadeh, H., & Pishgooei, S. A. (2021). Prevalence and predictors of depression and anxiety among Iranian adults: A population-based study. *Journal of Affective Disorders*, 278, 338-345. <https://doi.org/10.1016/j.jad.2020.09.121>

³ Shariati, M., et al. (2020). Women and mental health in Iran: A scoping review. *Journal of Public Health*, 1-11.

lessness and hopelessness, which can impact mental health.⁴ Furthermore, the challenges such as stigmatization and discrimination, which can lead to feelings of shame and isolation can contribute to further mental health challenges and make it difficult for women to seek support.⁵ This in turn results in the complacent apathy exhibited by women who have grown up in these harsh environments.

I liken this to a caged bird longing to escape the shackles of a regressive society. In the current socio-political climate in Iran, we observe this same phenomenon where a tired and frustrated society breaks the status quo and seeks its own freedom whatever the cost.

In regard to the specific elements of this drawing, the focal point of the image is an eye, demonstrating the aspects of the human body that we do not see but still have experiences with on a day-to-day basis, being the mind in this case. Specifically, the eye symbolizes two halves of the human mind. The left hemisphere embodies the imprisoned mind of women during a regime that confined them to harsh policies and stringent regulations hindering them from expressing themselves. The contralateral right hemisphere demonstrates the current release of the fearless Iranian woman breaking bravely from confinement and releasing itself into the wild, symbolized by the colored bird. Both halves are encompassed in flames, depicting that both before the revolution and during this current revolution in 2022 womens' thoughts have been breathing with a raging fire and the mind has been burning to release itself.

The eyebrows, eyelashes, sclera, and lightning bolts contain over 70 names of the brave souls who have died fighting for the rights of women, and the lightning bolt represents the spark that has ignited a movement that will go down in history. In the background of this drawing there is the phrase, "Zaan, Zendeghi, Azadi" which in Farsi stands for Woman, Life, Freedom. This mantra paints the solid image of the basic human rights Iranians are currently asking for to reach a better quality of life and way of living.

Finally, at the bottom of the drawing is a pulse from an EKG, representing that even though some voices are silenced, the underlying message will endure as the lifeblood of a people longing for freedom.

As someone of Iranian descent and having once had the privilege of living in Iran, I am firsthand familiar with current struggles of the protesters. In addition, having heard of the horrors of the oppressive system from my brave mother I seek to share this message

of strength and solidarity. I hope that this work will bring light to the struggles of a yearning culture and the bravery and strength of will of those who simply seek freedom of thought and expression, something which is often taken for granted in westernized societies. I also hope to inspire those who struggle with mental illness to persevere and recognize that even in the confines of a jailed mind we are not alone.

B.S. is a dedicated medical student with a profound passion for global health and health on an international scale. With a keen interest in the humanities behind medicine, B.S. recognizes the importance of cultural context and patient narratives in providing holistic care. Motivated by a desire to address health disparities, B.S. is committed to increasing access to mental health services in underserved populations and promoting equity in healthcare across all levels of care, including primary, secondary, and tertiary care settings such as radiotherapy.

⁴ Sharifi, V., et al. (2021). Stigma toward mental illness among Iranian women: A qualitative study. *Journal of Mental Health*, 1-7.

⁵ Tahmasebi, K., Vazirian, M., & Bigdeli, M. (2021). Suicide trend and pattern in Iran: Findings from national suicide registry, 2010-2018. *Archives of Suicide Research*, 1-17. <https://doi.org/10.1080/13811118.2021.1905516>

Introduction

By: Amy Blair and Virginia McCarthy

Reflection as an Iterative Process

To optimize the reflective process for learners, educators must first recognize that critical reflection skills have to be taught.⁶ Personal reflections or the recounting of thoughts or events are often the default outcome when assigning a reflection. Critical reflection, on the other hand, encourages the exploration of events through a frame of reference and an examination of deeply held assumptions. Without reflection, global health service-learning and experiential education can lead to “reinforced stereotypes, simplistic solutions to complex problems and inaccurate generalization from limited data.”⁷ There are many frameworks that may be utilized for teaching critical reflection from various fields including service-learning, civic engagement, health professions, and more. Frameworks such as Rolfe’s Framework often use simple questions to explore complex realities.⁸ Additionally, the Ignatian Service Immersion program at Loyola University Chicago (ISI) offers as a value-based framework to guide critical reflection within a health sciences-based service-learning experience (tinyurl.com/globalhealthreflection) and brings this complex triad of experience, reflection and education to life in on particular context.

Formal frameworks can help learners avoid common pitfalls in critical reflection in global health. These pitfalls may include the failure to center the voices and experience of partners, inadequate exploration of identity or what the learner may represent to a community (e.g., level of training, cultural or national background, representative of institution), premature and/or sweeping judgments, and superficial reasoning for disparities created by global political and economic systems. Formal frameworks also promote the use of critical reflection as a transferable skill. Exercising the mind so that it is accustomed to conscious examination, applied across settings and populations, is the

⁶ Aronson et al., “UCSF LEaP (Learning From Your Experiences as a Professional): Guidelines for Critical Reflection.”

⁷ Whitney, B.; Clayton, P., “Research on and through Reflection in International Service Learning.”

⁸ Rolfe, G; Freshwater, D; Jasper, M, *Critical Reflection for Nursing and the Helping Professions: A User’s Guide*.

ultimate application of critical reflection. Communicating that these skills will be useful in many future experiences will help students engage, both in the present and in the future, whether in a clinic or a community board meeting, policy conversations or cross-cultural engagements of any kind.

Frameworks must be applied with some degree of flexibility, recognizing that learners have different styles and methods of expression and that part of the process of evaluating critical reflection is to “meet them where they are at.” This means being open to the medium of choice, be it an electronic method such as an app or video, a group discussion, a narrative essay, or a shorthand written log. Educators who are open to the medium in which reflections are delivered and have the ability to facilitate or receive reflections through a variety of formats will decrease barriers and increase flow of depth, processing, and learning. Yet, within a creative space, educators must still apply a construct for evaluating the reflective process.

Providing feedback on the reflective process

Providing feedback on reflection is an essential step of incorporating critical reflection into professional training and personal practice. Experiences left to the internal narrator may lack meaning or remain in the “first draft” of surface level observation without proceeding to the “second draft” of critical reflection or may feel so daunting in their complexity or emotional weight that the depths of experience remain underexplored and under-processed. Failure to provide feedback on reflections in the context of learning outcomes reinforces the misconception that reflection is any collection of thoughts, feelings, and observations, rather than a structural and purposeful component of learning. Why does this lack of feedback happen? It may stem from a lack of structured and purposeful incorporation of reflective practice into an activity or learning goal, leaving reviewers to view reflections as a “check the box” requirement (We will use the term *reviewer* to refer to any evaluator, faculty member, peer reviewer, etc. who provides guidance through and feedback on the reflective process with the learner). Reviewers may also feel hesitant to challenge definitive conclusions or judgments made by learners. It may be difficult for reviewers to readjust toward a social justice framework or to respond to the personal nature of learners establishing their greater goals, which can sometimes feel like an invasion of privacy, even though the reflection has been shared by the learner in an educational context. Reviewer time and training is needed to overcome these hesitations in providing feedback, to ensure the developmental process of reflection. Providing feedback on reflection, just as we provide feedback on clinical or field-based performance, is a critical

component of advancing learner skills in this practice and both requires and invites some level of reflection on the part of the reviewer themselves throughout the process.

Time for and training in critical reflection can benefit reviewers by reconnecting them to the meaning and motivations which led them to enter their professional field in the first place. By providing feedback on reflections, reviewers can restore hope in their own endeavors and in the future of the field, hopefully leaving them more mindful and engaged. Another approach is to utilize peer evaluators when a safe space is created and has been accepted by students. Reflection that happens between learners or near-peers has tremendous potential for connection and learning. The expertise (actual or perceived) of the audience or reviewer of the reflection may not be as crucial as one thinks and expertise among student participants is often underestimated. As long as the motivation to maximize learning from an experience and practice reflecting on that experience is prioritized throughout the process, a variety of reviewer compositions and constructs are possible and even encouraged, with the caveat that reviewers (and the overall process) benefit from structured guidance and training for the review process.

Sample Reflection Prompts and Feedback Questions

We propose that there is predictable development across three stages of reflection that can be utilized for evaluation and feedback: preparation for engagement (Before), awareness in the present (During), and processing the “what now?” (After). The following sections offer reflection prompts for each of these stages and feedback questions for use by reviewers.

Before: Preparation for Engagement

Exploring how an experience impacts a learner requires an examination of expectations and assumptions prior to the experience. Preparation that includes learning about the community where learners will engage should incorporate information acquired through several resources, much like a thorough “literature review” for any publication. But preparation should also go beyond the inclusion of mere facts and include an analysis of personal assumptions, intentions, and even of why specific interests arise and hold varying degrees of perceived importance for the learner. This metacognitive moment, where a learner explores how they think, has the potential to help them manage their motivations for the next stage of their experience. It is a method for moving the needle from being a passive participant to engaging as an agent of one’s own learning path. Key to this area of pre-departure conversation is the exploration of expectations of the

learner. Learners and practitioners, alike, can be inclined to say they do not have any expectations of the experience. This is simply impossible. A little probing often yields a response and framing the entire experience as an opportunity to learn, observe, and inquire can be a helpful approach to fill a space that may otherwise be filled by judgment and premature conclusions. If not done carefully, entertaining pre-experience judgments can also reinforce some of the colonial pitfalls of global health engagement, as it prioritizes the context of the learner as dominant rather than encouraging a position of curiosity and an exploration of global interconnectedness through contextual, place-based learning.

The provision of standardized questions can assist in the exploration of the student disposition and possible assumptions at play before the global health experience begins. Sample questions are provided here for both the learner and for the reviewer of reflections, though we encourage each user to adapt the language and frame to fit their individual context(s) and intended use(s).

Sample prompts for learners:

- What led you to pursue this experience at this time?
- Have you participated in a similar experience previously?
 - If so, describe the experience and key takeaways.
 - How do you expect this experience to be similar and/or different?
- What are your hopes for this experience?
- Any fears or hesitations as you prepare to engage in this experience?

Sample evaluation questions for reviewers of this stage of reflection include:

- Does the learner express recognition of the unpredictable components of the experience prior to departure?
- Does the learner express curiosity for the elements of culture or place that will be different from their own?
- Has the learner expressed learning goals that link to past experiences or future professional paths?

During: Awareness in the Present

In many ways, the account of events captured during an experience is like the “first draft” of creative work. When reflecting critically, rather than recounting events, learners may

produce narratives that are rich in examples and peppered with the raw and challenging questions that the immediacy of the experience creates. When built upon the “Before” review of expectations, gaps may be identified and the tangible reality of the experience can activate a learner to reframe and, sometimes, even restart their reflective process. It is at this point that critical reflection elucidates self-directed learning skills, which include asking: What do I need to learn/read more about? Who do I need to talk with? How do I continue to contribute in informed and meaningful ways while learning?

One key skill in this stage is to maintain mindfulness and situational awareness. While these metacognitive moments spent thinking about how one thinks are important for growth of consciousness, constant thinking is a set-up for not listening. Particularly in cross-cultural interactions, maintaining a genuine engagement in the lived experience and daily realities of others is foundational to developing critical consciousness. This engagement needs move beyond curiosity in one’s mind; instead, it requires full, attentive presence, including the conscious engagement of the five senses, for example. Moreover, many global health students may place a premium on *doing over listening*. This inclination can often be identified in the pre-trip departure through the expectations learners express. Switching into “doing” mode rather than observing or listening can also unintentionally occur in response to the challenging disparities and structural injustices witnessed during the experience. Educators can assist students who feel called to act by discussing accompaniment as an action, not passive observation, prior to and during the experience. The greater the comfort learners display with discomfort that arises from lived realities, or the discomfort that may arise from accompaniment rather than fixing, the more likely it is for learners to see the possibility and the necessity of challenging systemic issues after their return. Indeed, the fruits of accompaniment are not always yielded in this stage. In a sense, reflecting on the unknown outcomes of being present may be the best way to recognize the outcomes when they manifest in another circumstance along a personal or professional path. In essence, we might not know the outcomes of our presence in a place until we have left it. Educators often need to assist learners in recognizing and crossing that chasm.

Sample prompts for learners:

- Describe your experience up to this point. What have been key observations and encounters? (consider walking through the five senses – sight, sound, smell, touch, taste)
- Has anything surprised you? Positively or negatively? Say more.

- Has anything challenged you?
- Has anything confirmed your expectations or hopes you held before beginning this experience?
- Have any experiences or encounters surfaced expectations you didn't realize you had?

Sample evaluation questions for reviewers of this stage of reflection include:

- How are partner/community voices and lived experiences centered in the reflection?
- When facing complexity, does the learner note utilizing trusted voices or other resources?
- Does the learner acknowledge and have a plan for challenged assumptions?
- Does the learner acknowledge and value the action of accompaniment?

After: Processing the “What now?”

The multilayered timeframe of global health education requires stepping out of one's life into another and back again. This stage or “second draft” of reflection occurs after return. At the outset, this stage may be steeped in the recognition that the ability to step away from one's daily life is a privilege in and of itself. Once learners return to their homes where cultural interactions and daily living are more predictable through lived experience, critical consciousness calls us to also recognize predictability as a privilege. Thus, this third stage of reflection can be exhausting and treacherous. Post-experience reflection may be a turning point for some learners, particularly those who have much to process but who have (or take) little time to do it. They run the risk of cementing the experience in a state of emotional complexity that remains unresolved and, to some extent, unintelligible. There is a disservice of staying in the “first draft,” where the experience remains boxed in and the learner may remain self-centered versus world-focused or globally-minded. For those whose reflections in the preparation and action states were inadequate, there is an even harder hill to climb in this stage of reflection. Structured time is the key element for overcoming these challenges upon return. Participants must be encouraged to take the time to understand what has happened, what the experience is asking of them, the “what now?” When learners connect the past self to a new consciousness and reality, this third stage of reflection can be quite fruitful.

To tie together the framework of before, during, after, there are four key questions we encourage as reflection prompts after return:

- Review: What did I expect to experience, what am I experiencing, what did I experience, and what now?
- How has this experience affected my worldview? What has it confirmed? What has it challenged or changed?
- Am I becoming the person and professional that I want to become?
- How has participating in and reflecting on this experience changed the way I engage in the world both professionally and personally?

Post-experience Checklist for Reviewers

Reviewing and providing feedback on learner experiences requires structure and guidance. The following list of prompts, held alongside stated learning objectives or outcomes of the experience, can lead reviewers through the areas within a reflection that call for additional attention and focus.

- (*Before/during/after*) Did the learner explore how their pre-experience expectations are different or are reinforced through experience? Has the learner described the impact of key moments they observed/experienced?
- (*Compare contexts*) Does the learner describe new skills in situational awareness or the ability to apply observational skills to different settings?
- (*Personal*) Does the learner discuss personal growth and change? Is there an awareness of self and self in relationship?
- (*Professional*) Does the learner incorporate personal experience into their professional path and development? What are the implications for the professional context, approach, practice?
- (*Societal/Global Citizen*) Does the learner see themselves differently in the world? How will they live, work, act or think differently in that space? What are notable shifts in worldview?

The last prompt focuses on a global consciousness that is crucial to global health. We propose that all programs consider incorporating a reflection prompt that requires participants to apply lessons learned “over there” to their own home context.⁹ Such a prompt encourages the development of skills to address challenging disparities no matter the geographic context. An open-ended question that explores differences in health care delivery systems, such as, “What did you learn about the local health care system in relation to the US health care system?” can yield rich, learner-driven reflection. An alternative prompt may be one that encourages learners to explore similarities in disparities across

⁹ Herzig van Wees and Holmer, “Global Health beyond Geographical Boundaries.”

locations, such as, “Describe an example of a health disparity you encountered during your away/international rotation and whether and why that same disparity occurs in your home context.”

Finally, to encourage the development of longitudinal reflection skills, the third stage of reflection encourages participants to think through both the personal and professional contexts, guided by questions such as, “How did and will this experience influence the kind of person and professional you would like to become?” This may prove to be a protective question given that reflective practice holds an inverse correlation with burnout.¹⁰ While the relationship between critical reflection and burnout is layered, several features of the reflection process are also key wellness strategies. First, the ability to spend time processing experiences and emotions is possible through a variety of practices, including written and oral, individual and group formats. This provides a nimble menu of strategies for wellness across development. Second, critical reflection enhances the ability to incorporate multiple temporal realities simultaneously (immediate lived experience and processing across past, present, and future). The process is action-oriented when individuals engage and embrace the possibility of change through entering into the process of critical reflection. Finally, when utilized in a group context, the incorporation of reflection introduces a certain degree of accountability and encouragement to embrace a deeper exploration of experiences and related actions. The sense that others are engaging in a similar process models through action an essential skill set and introduces a depth to the community of learners that invites conversation and a more profound and meaningful engagement with the mutually informative nature of observation, learning, and action.

Utilizing reflections as dynamic assessment tools for global health competencies

Global health educators have long recognized the richness of reflection for assessing the educational impact of global health encounters. As programs in global health are tasked with defining outcomes in order to maintain ethical partnerships and sustain support, leaders strive to demonstrate this impact through the achievement of goals and objectives. In the general undergraduate medical education landscape, this encompasses competency domains in ethics, professional practice, health equity, and social justice.¹¹ While these domains are sometimes described as “non-traditional” in medical education,¹² there exists

¹⁰ Moradkhani, Raygan, and Moein, “Iranian EFL Teachers’ Reflective Practices and Self-Efficacy”; Shirazizadeh and Karimpour, “An Investigation of the Relationships among EFL Teachers’ Perfectionism, Reflection and Burnout.”

¹¹ “CUGH-Global-Health-Toolkit-Web-Version.Pdf.”

¹² Smith et al., “Assessing Medical Students for Non-Traditional Competencies.”

a strong rationale for prioritizing these competencies among others for learner outcomes in global health.¹³

Yet, assessment of these competencies remains challenging and raises questions for global health educators. Fitting the layered lessons of a reflection into competency-based learning is clumsy at best. The use of standardized or criterion-based assessments of personal and professional development domains often falls short and may even deter the development of the very outcome desired.¹⁴ Can a number scale or grading rubric ever truly capture the professional attributes we strive to see developed through engagement in and reflection on experiences in the field of global health?

When structured such that professional attributes are defined and progressive development is observed, reflections offer invaluable insight into learning outcomes, beyond what any numeric assessment could achieve. Models of measuring competency in personal and professional development, as well as social and community context of care through serial reflection, provide guidance on this challenge of evaluation. Standardized measures such as the Tolerance of Ambiguity scale offer an opportunity for objective measurement of a key skill for health care workers.¹⁵ Requiring this scale longitudinally to demonstrate learner development in dealing with uncertainty across their training could be an approach to assessment; however, the depth of key moments of experience within narrative reflections may be missed in the use of this scale or other traditional assessment tools. Can a score on multiple choice assessment or an independent project really compare with a narrative reflection of a learner who dealt with uncertainty?

If mistakes are our best teacher, and humility an essential trait, then skillful reflection that facilitates processing events and encounters that do not go well or as expected seems to be the best proof of learning. This includes the processing of individual and systemic shortcomings in global health activities and engagement. Programs that hope to move beyond competence in global health toward a critical consciousness in global health and equity should leverage the power of reflection to “foster a type of thinking and knowing—a critical consciousness—of self, others” and the world.”¹⁶ To be able to approach global health with this level of accountability requires reflection. Particularly when considering the neocolonial underpinnings of many global relationships, critical consciousness is essential to avoid perpetuating hierarchical mindsets. Is there a method to assess the development of this critical consciousness?

¹³ Ventres and Wilson, “Rethinking Goals.”

¹⁴ Pinto-Powell and Lahey, “Just a Game.”

¹⁵ Kim and Lee, “Understanding Uncertainty in Medicine.”

¹⁶ Kumagai and Lypson, “Beyond Cultural Competence.”

Perhaps the best path toward creating a method of assessment for global health learning is to go back to the learning objectives themselves and ask learners to create their own assessments. Self-defined assessment of learning outcomes is both core to the principles of critical reflection and a unique curriculum design.¹⁷ For example, participants could be asked to review the following learning goals set out by Ventres, et al¹⁸ for participants in short-term global health experiences: 1) develop contextual inquisitiveness, 2) grow in insightful understanding, 3) nurture global humility, 4) cultivate structural awareness, and 5) critically engage in the pursuit of creating equitable and just societies. Reviewers can then ask learners to set their own assessments for each goal prior to the experience using the prompt, “During and after your experience, how will you demonstrate ...” or “Discuss your current skills in global health engagement and how you expect you will...” Feedback can then be provided on the reflections provided by the learner on their own assessment of the learning objectives they defined. Again, the emphasis here is not solely on evaluation but, instead, holds reflection and increased depth of learning as priorities throughout the process. We hope that readers of this anthology who are global health educators will gain new insight into the use of reflection in curricular design through attention to the learner experience and the incorporation of structured feedback. While imperfect and never fully objective, following a structured approach to incorporating and prioritizing critical reflection can be used to evaluate student learning in a variety of contexts.

Anthology: Next Steps

There is much to be hoped for in the expansion of the use of reflection in the field of global health. This review is by no means exhaustive and, of course, the utility or feasibility of the ideas shared here depends upon the context and relationships that comprise the particular global health landscape the reader occupies. Additional training can and should be provided to faculty, staff, and peer reviewers on the purpose and practice of reflection, as well as the key components of providing feedback to trainees and peers, alike. Greater attention can be made to addressing the application of the theory of critical reflection to particular learning experiences in order to maximize yield and to tether to learning objectives. Directors of global health initiatives can explore the feasibility and interest of partner organizations in training and incorporation of reflective practice, both in their settings and in the role of providing feedback to learners on their reflections on experience.

¹⁷ Aronson, “Twelve Tips for Teaching Reflection at All Levels of Medical Education.”

¹⁸ Ventres and Haq, “Toward a Cultural Consciousness of Self in Relationship.”

Finally, the incorporation of critical reflection into daily or “regular” professional practice in global health and as a resource in daily life highlights that, if incorporated strategically, reflection can and does serve as a protective factor against burnout in health-based and other service-oriented professions.

Sample Reflection Prompts for Learners and Evaluation Questions for Reviewers

Before: Preparation for Engagement

Sample prompts for learners:

- What led you to pursue this experience at this time?
- Have you participated in a similar experience previously?
 - If so, describe the experience and key takeaways.
 - How do you expect this experience to be similar and/or different?
- What are your hopes for this experience?
- Do you have any fears or hesitations as you prepare to engage in this experience?

Sample evaluation questions for reviewers of this stage of reflection include:

- Does the learner express recognition of the unpredictable components of the experience prior to departure?
- Does the learner express curiosity for the elements of culture or place that will be different from their own?
- Has the learner expressed learning goals that link to past experiences or future professional paths?

During: Awareness in the Present

Sample prompts for learners:

- Describe your experience up to this point. What have been key observations and encounters? (consider walking through the five senses – sight, sound, smell, touch, taste)

- Has anything surprised you? Positively or negatively? Say more.
- Has anything challenged you?
- Has anything confirmed your expectations or hopes you held before beginning this experience?
- Have any experiences or encounters surfaced expectations you didn't realize you had?

Sample evaluation questions for reviewers of this stage of reflection include:

- How are partner/community voices and lived experiences centered in the reflection?
- When facing complexity, does the learner note utilizing trusted voices or other resources?
- Does the learner acknowledge and have a plan for challenged assumptions?
- Does the learner acknowledge and value the action of accompaniment?

After: Processing the "What now?"

Sample prompts for learners:

- Review: What did I expect to experience, what am I experiencing, what did I experience, and what now?
- How has this experience affected my worldview? What has it confirmed? What has it challenged or changed?
- Am I becoming the person and professional that I want to become?
- How has participating in and reflecting on this experience changed the way I engage in the world both professionally and personally?

Sample evaluation questions for reviewers of this stage of reflection include:

- (*Before/during/after*) Did the learner explore how their pre-experience expectations are different or are reinforced through experience? Has the learner described the impact of key moments they observed/experienced?
- (*Compare contexts*) Does the learner describe new skills in situational awareness or the ability to apply observational skills to different settings?
- (*Personal*) Does the learner discuss personal growth and change? Is there an awareness of self and self in relationship?

- (*Professional*) Does the learner incorporate personal experience into their professional path and development? What are the implications for the professional context, approach, practice?
- (*Societal/Global Citizen*) Does the learner see themselves differently in the world? How will they live, work, act or think differently in that space? What are notable shifts in worldview?

Enlightened

By: Jean Adomfeh

I contracted malaria at the age of six. My mother tugged me by my feverish arm each time I paused in the hospital corridor at the sight of a child with a stomach the size of a bowling ball, or a growth protruding from their face, or ashen red hair from malnutrition.

It was my first trip to Ghana, West Africa. My mother, brothers, and I had arrived for my grandmother's funeral and stayed a few additional weeks, because my mother wanted us to acquire a sense of the culture. I acquired a bit more than just that. My mother rushed me through the hospital, not wanting to linger in any of the corridors out of fear I would see something too difficult to explain. Sickly people lay sprawled on the steps of stairwells, dark even though it was day, clutching at the air as they waited to be treated.

After we passed what must have been the fourth bloated child, I had seen enough. Hot tears filled with sadness crawled down my face. My mother tried to calm me with, "It's not something you can control. There are just too few doctors to treat them."

She held me in her arms as we waited to be seen. I swam in and out of consciousness for hours before receiving antimalarial medicine from an exhausted nurse. With time, my fever went down, my symptoms disappeared, and I returned to the United States, but I could never forget my experience in that hospital.

As I grew older, I reflected on it regularly. I saw the faces of those sick children when I closed my eyes to sleep. My body would recall my hospital daze when I waited in long queues. There was a certain ease with which I could see my pediatrician whenever I was sick, only because I was raised in Upstate New York and not in a "developing" nation or a high-poverty, inner city neighborhood.

Ultimately, my desire to give back drove me to revisit Ghana years later. I rotated through clinics and hospitals in the same area I had been treated as a child, shadowing and contributing where possible. In my second week, I rotated through a bloodless hospital on a day when I happened to be the only student or volunteer available and willing to shadow an evening operation.

“Do something!” the OR nurse yelled to me as she and the surgeon held the patient’s abdomen closed. A patient from the village had come in for severely painful swelling of the abdomen of a few days’ duration. The ventilator stopped working after she had already been anesthetized and incised.

“Grab the Ambu bag,” the anesthesiologist boomed while he tried to counter the steady drop of the patient’s heart and respiratory rates. My actions were crisp and deliberate. I had never wanted to do anything more in my life than help in that moment.

I pressed the rubbery manual ventilator with as much careful rhythm and strength as I could muster. I did not miss a beat for about a quarter hour, before the anesthesiologist was able to get the ventilator back in order. The surgeon found and treated the intestinal perforation, then sutured the patient’s abdomen closed. The patient would live; we had saved her. From that moment, I realized improving the health of others was not just a childhood dream, but what I would be doing as a career. I wanted to be a global health clinician, contributing my work to an underserved system in a manner akin to my role, via medical service trips.

I pursued a Master’s in Health Care Management and Innovation, with the hopes of leading these service trips in the future. I developed different iterations of ideas for these trips and had my plans lauded by professors and professionals alike.

At the very first global health lecture I attended in medical school, I seated myself in the front of the lecture hall eagerly. Immediately, the lecturer described how the medical service trip model had been shown in many cases to destabilize the medical ecosystem of an area. New research at the time showed that specialties with frequent service trips had fewer local doctors willing to pursue careers in those fields, as their patient population was treated by foreigners. As a result, the need for such trips could be perpetuated given that the number of local clinicians was suppressed.

I was floored. The last several years of my life had been dedicated to this concept. In fact, I and many other idealistic first-generation immigrants of the African diaspora often believe we will arrive with our Western educations and fix what ails our mother countries. The naivete of my ivory tower ideology hinged on the misconception that those who had stayed did not have solutions to their own problems. I had unknowingly held a paternalistic view of my ancestral homeland, when, in reality, it is not that there are not enough home-grown ideas for improvement, but that the resources are often not available due to the effects of colonization.

While service trips solve the immediate problem for patients who cannot afford care or do not have access to care, what are we to do about the forces that contribute to these

conditions? While I can theorize from my comfortable medical school dormitory in the United States, I suspect that many of the most impactful solutions to the widespread poverty, poor health care infrastructure, and lack of specialist human capital lie within the collective minds of those experiencing Ghana right now. Their ideas need to be amplified and their initiatives need to be supported and funded if we want to create a world with true global health equity. While I am not sure for now exactly in what role that leaves me, I am hopeful that any work I can do to support the initiatives of local health stakeholders will be worthwhile.

Jean Adomfeh, MBA, BA, is an MD Candidate at Harvard Medical School and author of No Pain in Vain and Anything Is Possible in Sci-Fi, Including Black Girls under her pen name Akosua Amoabeng, as well as a number of academic publications and abstracts. She was a pre-medical student at the time of this essay’s experience and wrote it during her medical school education. She hopes to promote health equity worldwide.

Creeks Flowing into the Ocean

By: Jinghua An

“They’re really not on the Google map!”

In Israel, I participated in a summer global health program in 2017, during which I was able to meet some Bedouin villagers in their community tent. These indigenous people are traditionally nomadic; they now live in the Negev desert where their villages were not recognized by the Israeli government and did not appear on official maps. Under these circumstances, they were not officially entitled to water, electricity, or other essential services such as healthcare and education. Caught between modernity and tradition, Bedouins face a complex dilemma with their adherence to traditional values, their lack of flexibility, their missed opportunities, and the state’s inability to meet its obligation to provide them with basic services. For the Bedouins, health—a basic human right—was thus compromised. As I reflected on my experiences in Israel, the meaning of global health became vivid to me.

Global health matters

Earlier in 2017, I was a master’s degree student in nursing in my native China. Before participating in the summer program, I had never even heard of “global health,” as it was not then part of the nursing curriculum. Believe it or not, when I saw the program’s poster online, I thought that global health involved people going to a different country to obtain medical services.

During that summer in Israel, I was for the first time able to use my English to take classes and talk to students from different countries. I learned about critical global health topics, and we discussed both the positive and negative effects of globalization on health along with Israel’s global health innovations. I also had many eye-opening experiences that included visiting not only Bedouin villages but also kibbutz communities and elderly individuals receiving home care. Limited in my English skills, I tried my best to overcome the language barrier and learn new things. By the end of that summer, my views on health

and healthcare had greatly broadened, and I thought, “Wow, global health really matters!” However, at that time, I could not see why global health should be of any concern to me as a nursing student in China, a middle-income country. To me, the main players in the global health field seemed to consist of individuals, communities, and institutions in high-income countries (HIC) and low-income countries (LIC).

Nurses matter in global health

As I completed my master’s program in China in 2018, I had an opportunity to continue my studies in a nursing PhD program in the United States, and I started a new adventure there that fall. My understanding of global health has gradually deepened since beginning my doctoral program. In contrast to my home country, many global health seminars and courses are available here in America, and more research is conducted at an international level. Consequently, I am being exposed to health disparity issues and unequal distribution of resources both in America and worldwide. For example, the disproportionate COVID-19 incidence and mortality among Black Americans has made America’s vast healthcare disparities evident to me. Besides, in studying nursing leadership in global health, I have recognized how globalization changes nursing services and causes nurse shortages and nurse migration; my reading has enlightened me about nurses’ and midwives’ efforts to increase universal access to primary healthcare in vulnerable populations. Gradually I realized that as the front-line providers who most closely interact with patients, nurses play a vital role in global health.

Now I can easily bring the lens of global health to my research. My own research on delay in seeking consultation among patients with symptomatic breast cancer has shown me how much this delay varies worldwide—from less than 10 days in the United Kingdom to about 2 months in China to over 6 several months in sub-Saharan Africa. This disparity in delay contributes to women’s being diagnosed at more advanced breast cancer stages in low- and middle-income countries (LMIC). My dissertation study addresses individual, cultural, social, and healthcare factors contributing to this delay in China, and it will provide insights that are applicable to other LMICs. Future research on reducing delay in China will be inspired by both the solutions developed in HICs and the innovative and effective ideas in LICs restrained by resources.

China matters in global health

After becoming aware of global health in summer 2017, I noted that more departments of global health were being established in China’s universities, and global health seminars and

research collaborations have become increasingly accessible for students. With China's economy now the second largest in the world, the country has developed an optimistic willingness to engage in global health issues. The emerging engagement in global health is exploring its definition in the Chinese context and addressing the international aspects of global health. However, I think health disparities within my country have not been fully recognized. Some participants in my dissertation study do not promptly visit a healthcare provider due to lack of awareness or fear of costly cancer treatments. Unequal healthcare distribution in regions with different economic development levels is one fundamental cause of our health disparities. I believe that future global health education in China will both address international issues and acknowledge and tackle China's domestic challenges. China matters in global health, not only because it can share its wealth of experience in reducing poverty and improving people's health, but also because it must devote its enormous energies to eliminating domestic inequalities.

Final thoughts

Through continuous study and reflection, I believe that the core of global health is to pursue health equity for all people and to address health disparities wherever they occur. This beautiful idea seems unrealistic at first, but my experiences have empowered me to believe that as a nurse and researcher, I can contribute to health equity. I now see that the efforts of each researcher and practitioner are like creeks that persistently flow into the ocean of global effort and promote the health of the lives encountered along the way.

Jinghua An grew up in China and is currently a 4th year PhD student at University of Illinois at Chicago. Her research focuses on improving cancer prevention, early detection, and cancer care.

A Challenge in Global Health Education: Diversity

By: Anu Aryal

When I joined the Global Health class of 2017 last year at one of the reputed universities in the US, I was surprised to find out that none of my 39 cohort members were American-born Black students. It had only been a few months that I had been aware of the existing racial tension in the US through the BBC and CNN news coverage about Baltimore protests and the subsequent articles on NY Times and other news outlets dissecting the problem. Before then, I used to think it was "history", as Americans had elected a black president, not only for one term, but two terms consecutively. The composition of my own global health class was my first encounter with the problem of systematic underrepresentation of minority students in my own field.

I kept thinking, is it only our cohort? But no, the last cohort also had this issue. So, is it because of the expensive tuition of graduate education? But there are minorities represented in other courses. So, why is the global health classroom different?

During our first quarter of school, we were asked to do a presentation about ourselves for our cohort, so that we could get to know one another better. After listening to a number of classmates, I had that "Aha" moment: Global Health is a field of the privileged.

Traditionally, global health in the West has been associated with traveling to low-resource countries with an intention to "help". Most of the white students had traveled to low-resource countries, volunteered, or worked abroad, and some even had philanthropic parents or parents who traveled a lot. When universities post on their websites that experience working in low- and middle-income countries is required/desired of prospective students, a large group of people who haven't traveled are systemically discouraged to apply.

I am not suggesting that global health workers need not have experience in low resource settings. They certainly do. But it is a challenge that global health schools need to find a solution to. When we global health professionals say we want the voice of the unheard be heard, isn't it our responsibility to address this in our own field? If some schools are doing better than the other, let's share the best practices.

The admissions committee for our program acknowledged that this requirement for experience abroad may be preventing some students from applying and began to accept experience in low-resource settings at home as well. That should have worked, right? But that was during our admission, and our cohort didn't come out to be any different than the previous one.

It wasn't until summer of that year, when I was doing my internship that I started thinking about the career aspect of global health. Being from a low-income country myself, I can see myself going back and working in global health for my country and the region. The white Americans in my cohort will also do the same, travel often to low- and middle-income countries and impart their unique skills. It made me ponder, is this career easy for American people of color as well?

The traditional perception attached with people with whiter skin is not only in the West, but colonialism has also taken that notion to developing countries as well. In those countries like mine, people are used to having white expatriates, and the perception of them being wiser than people of color is widespread. Would they regard those with a skin tone similar to theirs as experts? Most unlikely. Because, if I go to a meeting in my own country, with my white classmates, I know people will look up to them as "experts" and me as "less". There is an inherent bias.

There is no magic bullet for this. However, I believe universities have a responsibility to address this issue as well. Mentoring students interested in this career path, hiring more faculty of color as role models, sending more students/faculty of color into the field as experts to challenge the traditional perception of color are a few of the many possible ways universities can improve this.

I also think universities' responsibilities don't end with having diverse students. A future challenge created by diversifying education, is the need to adapt the curriculum and activities to apply to all people in the world, not just the West. I remember our class doing the privilege walk, a classic activity where you take one step ahead if the statements of privilege apply to you and stay at your spot if they don't. I felt like it didn't reflect the privilege I had. One of the statements was -walk one step ahead if you went to a private school. It didn't apply to me because I went to public school, but was I really unprivileged in education? I didn't go to a private school, but I am far more privileged than many children in my country who cannot go to school at all. One third of my classmates are international students like me, all from low- and middle- income countries, and all of those I talked to expressed disagreement with some of the statements in this activity. Global health classes need to adapt to the diversity represented in their cohorts.

Diversity has become a buzzword in America, and more so in global health. But the problem is real. Universities have the challenge to make global health a career field of choice for diverse students and faculty. At the same time, they must equip themselves to offer cross-cultural educational materials for this diverse body.

Personally, going through these experiences and reflecting on them, I feel there are some issues I have to work on too. I need to challenge people's perception of skin color in my own country. I have to advocate for the inclusion of minority communities like women, different castes, sexual minorities, and the disabled in the public health workforce. And, for the broader global community, I will keep writing about the issues I care about.

Anu Aryal, MPH recited this essay as a finalist at the CUGH conference in 2017. At that time, she was studying MPH in Global Health at the University of Washington, Seattle. Currently, she is a PhD student at the department of health policy and management in the University of California, Los Angeles (UCLA). Her research interest lies in strengthening primary healthcare systems in low- and middle-income countries for prevention and management of chronic diseases.

Carrying On

By: Hannah Bergbower

Each day we make decisions about what to place on a shelf or table. We don't think much about it and know that whatever we place there will eventually be moved when the time is right. A shelf is made to hold clothes, supplies or even pictures of the ones we love. A table is made for working or writing or supporting the love of a gathering family. But what if, in some places in the world, tables and shelves are used to hold things that there is never a right time to move?

It seems peculiar to think about, but the shelf and the table only matter because of the story they carried and the ways our lives were impacted. After replacing yet another calendar while living in east Africa, I couldn't help but wonder what this shelf and table, that I thought of often, might say. So let me share how they impacted me.

It was my first day entering the labor ward. I had been in this hospital for over a year and I had avoided this ward every day. Sometimes I now think that I had held the hope that this would be the ward that was different. Maybe I wouldn't let myself walk in because the hope I had held for this unknown space was a mirage that I wasn't quite ready to stop believing in. Luckily for me, an expert midwife convinced me it was time.

That morning we walked together. For a year, I had walked to the hospital alone or with students and that day I was no longer the lonely foreign face whose Swahili was good, but would never pass for a local. We entered the ward and I looked around as if I had never seen a ward like this before. I had spent hours in many just like it, but my dreams had told me the story of a beautiful labor suite with at least reliable water, electricity, and some privacy; none of which were present.

As I was digesting this reality, an almost naked woman came running from the back carrying her buckets and cloth, screaming "mtoto, nakuja". I looked between her legs to see that, thankfully, she was wearing underwear and they were holding up an infant. A midwife, who would later become my friend, got up and with laughter said, "mama, mtoto hapa." The baby wasn't coming, it was here. With this event, my first day had begun. And as everything calmed down, I decided to orient myself to the ward.

I was walking along and entered into a small area with a newborn warmer that worked only when there was electricity, or as it saw fit. As I was checking out the resuscitation equipment, I noticed a shelf. On this shelf were beautiful kitenge fabrics that appeared to be wrapped up. I remember thinking this must be where women would leave their extra fabrics after delivery. A naïve hope, but something told me to pick one up and find out the truth. It was a moment where I realized how little I really knew.

The kitenge was beautiful, but it was housing a lifeless infant. I heard the cry of a baby in the cold warmer behind me and it was almost as though he felt the heaviness of this reality too. As I held that body, I looked back to the shelf and saw three next to it. I would, later find out that these were just the four losses from the night before and this was not a particularly unusual night. Four mothers, now journeying home, were wearing the other piece of matching fabric that would forever remind them of what they were forced to leave behind.

This ward and truth learned awoke a new sense of injustice deep in me and I knew that it was something I would never forget or walk away from. A few weeks went by and labor wardi tatu was where I was spending my extra time. Then I saw the reality of what a table might hold.

It was the middle of the day and I decided to step out for chai and chapati. As I returned, walking back through the security gates and down the concrete walkway connecting the wards, I felt a devastating sense of tragedy lingering in the air that wasn't present when I had left. I walked in and saw a pool of blood on the floor. Coming towards me, to leave the ward, was a table carrying the lifeless body of a twenty-four-year-old mother. She had hemorrhaged, and she was gone. She was already a mother of four with a new baby on the warmer. Somehow, he had lived. Yet, I knew that it likely wouldn't be for long without her.

As she was moved out of the ward on this table, her arm fell off the side and I caught a glimpse of the matching kitenge her baby was swaddled in. It felt like a moment where I couldn't imagine being where I was, but couldn't dream of where else to be. In a matter of ten minutes, she had gone from alive to breathless in a regional referral hospital that did not have the capacity to save her life. Mourning happened and then somehow the day went on.

I wondered how many lives this shelf and this table had held the burden of being a final resting place for. How many last breaths they had felt and how many more were to come. Yet I knew that the burden never actually fell on the table or shelf to carry on, but rather on those of us left behind to remember these stories and to never forget our commitment to a world awaiting a different story.

Hannah Bergbower (she/her), MSN, MPH, CNM, WHNP-BC, was a first-year Nurse-Midwifery and Women's Health/Gender-Related Nurse Practitioner student at the University of Pennsylvania when she composed this essay about her time with the U.S Peace Corps Global Health Service Partnership. She had spent several years in east Africa and later throughout the continent, working on capacity building programming for nurses and midwives before she decided to return to the United States to continue her education. Hannah is currently a practicing Nurse-Midwife with Emory University School of Medicine at Grady Hospital in Atlanta, Georgia and is beginning a PhD at the University of Alabama Birmingham School of Nursing in the Fall of 2022, with a global focus.



2014, Image captured at sunset during a clinical visit with students in Northern Tanzania. Students were providing clinic care to pregnant women in a Maasai boma who had just finished hand making this jewelry to later be sold to foreign visitors.

Photo Credit: Hannah Bergbower, MSN, MPH, CNM, WHNP-BC

On Toughness and Apathy

By: Clara E. Busse

In May, I took three planes across the world and arrived in Kumasi, Ghana, where I worked in a sphere managed almost entirely by women: childbirth. It took me only a few days of observation in the Lying-In, Labor, and Surgical Wards to consciously note the absence of men. Sure, many of the doctors were male, but they visited the wards infrequently, and mostly just to monitor the progress of labor in a particularly complicated case, or to oversee the wheeling of pregnant woman to the surgical theater for a Cesarean-section. But, usually, the delivery of the hundreds of babies I saw during my two and a half months at the hospital, was left to the almost entirely female staff of midwives and nurses. On that stage, in that Labor Ward, women, and women alone, were the actors.

In these wards, I was struck daily by the toughness of women. Unaccompanied by their spouses and partners, or even sisters and mothers, pregnant women waited and moaned in their beds against the East wall, suffering and persevering as their labor progressed. They paced and snapped their fingers. They shook their hands over their heads while laying on their sides, a demonstration of pain that looked a little like praise, maybe to God, maybe to the midwives clustered at the desk by the door. They shouted. They suffered in silence. No matter their reactions, no epidurals.

As we enrolled new mothers into our study—the triumphant ones holding fresh new babes in their arms while sitting in the beds on the West wall—I looked at their charts. Thirty, sixteen, twenty-two years old...I measured their age against mine and marveled. I don't have children. I wondered what it would be like to be whisked into motherhood—one moment laboring, the next a lucid one with a small human-being against your chest—all alone.

The midwives were respectful, and, from what I could tell, quite good at their jobs, but there was no hand-holding, coddling, or even any perceptible sympathy toward the women in labor. No, it seemed that these pregnant women were treated like lone warriors, off to fight a battle to be faced down by the woman herself.

Toughness coursed through the midwifery staff too—each day tasked with shepherding new souls into the world, many of whom did not come out crying on their own. During delivery, the midwives bravely managed the lurking dangers of prolonged labor, postpartum hemorrhage, and neonatal asphyxiation, to name just a few. In the night, when the doctor was at home and a phone call and car ride away, the lives of mother and baby were vulnerable and in the total care of the midwives on duty. It is in this resource-limited, emotionally-charged, painful, joyous place that the power of women pulsed and shook. Their grit, determination, and tenacity lay bare.

One afternoon, I stopped by the Labor Ward to borrow the delivery book for my project, as was my routine. The midwives were gathered in the front of the ward, chatting in Twi while one midwife sat filling a chart. I watched, confused, as a woman took slow, agonized steps toward the door, holding her skirt in her hands. The midwives' steady stream of chatter continued while the woman painstakingly lowered herself down onto a stretcher parked outside the ward, her face contorted and wincing. I turned to the midwife seated closest to me and asked what was going on. She replied that the woman had a uterine prolapse, so she was being transferred to the referral hospital. Stunned, I replayed what I had just seen: the woman had given birth just moments earlier and she was walking in spite of a severe complication. She would be wheeled over the bumpy sidewalk to the parking lot, where she would be loaded into the ambulance, which would drive twenty minutes over roads riddled with potholes. It all sounded horribly painful and lonely.

The juxtaposition of the midwives' nonchalance and the woman's suffering really bothered me. This isn't an indictment of those midwives. After a few months of daily interactions at the hospital, we had built a good rapport and I had grown to like and respect them quite a lot. No, this is a quandary regarding the systemic apathy that I noticed at the hospital...and now see all around me. Somehow, at the hospital, it had become normal to ignore the suffering of the woman with the uterine prolapse—no one seemed to mind too much—which reminds me of the way I ignored the Vietnam veteran begging for change on the side of the highway exit this week. It is odd and striking that we can be so physically near a person and so separate from their pain at the same time. Somehow, across culture and locations, apathy toward the suffering of the other has been normalized, transformed into the status quo.

To an extent, I believe, these apathetic applications preserve us, protect us from absorbing too much of the hurt and harm in the world. I know that the midwives were accustomed to birth complications, used to referring patients they themselves could not treat, so it seems likely to me that their apathy could be a form of self-protection. Maybe

avoiding the gaze of a homeless veteran functions similarly? Perhaps we form callouses to preserve our stores of compassion for something more noteworthy?

It is probably easiest to notice systemic apathy in an unfamiliar culture and place. Realizing my own contribution to this often-damaging system is much harder, requiring both perspective and humility. I am not so naïve to suggest that we eschew apathy altogether, but I do believe that we owe it to each other, as decent human beings, to notice and consider more carefully the instances in which acknowledgement, even compassion, could buoy a person drowning in pain. Toughness is admirable, but does it need to be demanded quite so often?

Clara E. Busse, MPH wrote this essay when she was a Master of Public Health student studying Global Health Epidemiology at the University of Michigan School of Public Health. She had just completed her summer-long research practicum related to infant health at a hospital in Kumasi, Ghana when I wrote this essay. Currently, Clara is a PhD student at the University of North Carolina at Chapel Hill in the Department of Maternal and Child Health.

Decolonizing Global Health

By: Shradha Chhabria

During an undergraduate study abroad semester in Ghana doing health research, my peers and I huddled with other *obrunis* in the chilling dungeons of Cape Coast and Elmina Castles, where West Africans of various tribes were stripped of their ethnicities and brought together to await either slavery or death. Here, we heard the gut-wrenching stories of how colonizers robbed wealth and dignity alike, and we learned how narratives across the world vary in assigning blame. As we neared the end of the tour, our guide brought our attention to the particular stench in the air and the smoothness of the dungeon floor. He told us that we were standing on and smelling the actual remains of those who perished--their flesh, blood, urine, vomit and feces paved the brick floor under our feet smooth. As I looked around, my disgust with the smell intensified as I imagined women who had survived rape in the officers' quarters bleeding here during childbirth, men coughing up sputum as they died of pulmonary infections, and children defecating in the corner, creating rivulets flowing through the crowded room.

Soon after, I had a week off and found myself at the Monument to the Discoveries in Lisbon—a large statue depicting Henry the Navigator, Vasco de Gama, and others navigating the seas during Portugal's Age of Exploration. Outside was a world map made of red and white marble, circumscribed by a compass rose. All of the various places that the Portuguese had discovered were marked with a celebratory star and named. There it was—in the Western curve of Africa, a bright gold star with the words “El Mina”. My stomach clenched. That smell, those dungeon walls, the dehumanization of millions, and the disparities that their descendants still face all over the world—that is what we commemorate as a “great discovery”?

Colonial history makes it clear that it is not an inherent fault of formerly colonized countries, or the color of their people, that leads them to struggle through development today. However, my visceral history lesson left me wondering why the nations who created these conditions are still the ones entrusted to solve them, in a power dynamic referred to in political philosophy as neocolonialism. The global health I know does not intend to be colonial and perpetuate the white savior complex, or to eliminate cultures

and traditions. Those of us dedicated to this field are driven by the humanitarian intention to translate ideals of social justice into health equity. We consider suffering due to preventable causes senseless, and the disparities unforgivable. However, I worry that we are willing to pay any cost, including the erosion of traditional concepts of well-being, to achieve our Western standards of health equity all over the world. With these exogenous standards as the benchmarks for a whole country's success, neocolonialism can easily invade even the heart and soul of communities—their culture and identity. Even in my limited experience, I have seen that with the best of intentions, we tend to value traditional medicine practitioners primarily for patient referrals, we teach mothers to rely on nutritional supplements instead of foods indigenous to their land, and we tend to believe that only the standards and solutions set by the developed, and once colonizing, world are the legitimate and universal goals. Given our history, what is and what should be the role of developed countries in global health?

During a recent month-long research internship in Rwanda, I marveled at the efficiency of the team of East African clinicians running the hospitals and research centers, and I wondered if there was and should be space for me there at all. If a local person can do the same task, but with a stronger understanding of cultural nuance, why would a foreigner do it instead? I was particularly struck by the way that the Rwandan community-based health insurance scheme, *mutuelle de sante*, was explained to me not just as an economic theory, but as a natural manifestation of culture in rebuilding and developing a grieving society in the late 1990s. While its implementation is certainly imperfect, it is centered on traditional Rwandan values of interconnectedness and social support, which naturally lend themselves to an inclusively affordable scheme, providing care for \$3 USD per person per year, and less for the indigent. No foreign consultant could be the one to integrate community values and health equity so seamlessly, let alone that in the US, health insurance is still considered a luxury rather than a human right. If we, as Western medical practitioners, continue to center Western medicine without considering the rich culture and history of holistic well-being that was eroded by colonialism, we too are missing out on novel approaches to healing our public health challenges.

At the end of the recent film *Black Panther*, a “Wakanda Outreach Center” is established in Los Angeles. The idea of any external development NGO, let alone an African one, helping Americans seems unimaginable, yet the tremendous domestic health disparities in the United States indicate that our own vulnerable populations could benefit from some of the aid we donate abroad. This shockingly reversed flow elucidated to me how racist and neocolonial the norm of global health remains. Perhaps a day will come when we can begin to decolonize global health simply through discussions and humility—where lessons about health systems can be shared bi-directionally instead of

a one way transfer of knowledge and resources, and low- and high-income nations alike can exchange lessons about how to truly care for people, at the level of populations. A framework for controlling HIV in high-risk groups in Kigali might be useful in Baltimore. Cutting edge updates to EMR systems from Bangalore could improve longitudinal patient-physician relationships in Accra. We cannot undo mistakes of the past, but it is our duty as healthcare professionals to examine the wider narrative and ensure that we are not perpetuating them in the 21st century.

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The upper two photos depict a map highlighting global sites of Portuguese exploration including Elmina, Ghana, circumscribed by a limestone compass rose in front of the Monument to the Discoveries in Lisbon, Portugal. The bottom two photos show Elmina Castle, including the preserved dungeon grounds in which thousands of West Africans were enslaved and deported.

Photo Credit: Shradha Chhabria, MPH, BS

Shared Ground vs Intervening Oceans

By: Samantha J Cheng

On my first day, I remember being taken aback as I watched the presentation about him. As the slides rotated through images of our mentor at different stages of his life, one of my teammates stood next to the screen and described what she had learned while visiting his family. She described his disposition, his hopes, his insecurities, and his illness. In the US, we would not think to learn about our donors on such an intimate level. Yet, whilst engaging in such unique methods, this Buddhist institution was reputable for an extraordinary level of respect and gratitude towards those who gave their bodies to science. I had assumed that even across the Pacific Ocean, the universal humanitarian sentiment of medicine would keep me oriented; however, I was immediately confused by the level of intimacy my teammates had with our donor.

The most difficult day of my month in Taiwan was the opening ceremony of this program. As the beneficiaries of such generosity, each team was to introduce themselves and pay respects to their mentor's family. This was a hard task as the mentors had only died one to three-months prior, and the wounds of loss were still fresh. It seemed intrusive of me to enter the lives of my donor's siblings, children, and grandchildren. I could only assume that these efforts would help bring closure and understanding to both family members and students.

Ceremony proceedings began at 6AM. After several hours of Buddhist chants and prayers, we led the family members to the operating theater, where they bid farewell to their recently deceased loved ones. On command, my two team members at the head of the table pulled down on the sheet covering his face. I will never forget the heartbreak that ensued. Our mentor's daughter and son dropped to the ground and prostrated themselves before him, sobbing, praying, grieving. His grandson, who looked no more than 10 years old, stared wide-eyed at the rigid, lifeless face of his grandfather, and slowly broke into tears as well. My two team members were designated to provide tissues to the family members, while I stood at the foot of the table without any other duties and held my hands in prayer. Afraid to break out of formation and disrespect the ceremony, I could

only watch the grief play out. I had to wonder if the family members would look back on this ceremony and appreciate or regret this moment. Was I doing harm by bringing the family members to such a stark confrontation with their loved one's decision? After a few cruel minutes, we led the family out of the operating theater and concluded the ceremony.

Following the ceremony, we joined the family members in a large cafeteria for lunch. Each team was seated with the family members of their mentor. I wanted to show the family sympathy and respect for their acceptance of the sacrifice their loved one made. I wanted them to feel like he was falling into competent hands, but I knew neither how to compose myself nor express these complicated feelings in Mandarin. Yes, I looked like my other peers and I dressed in the same clothes, but I knew that the family sensed I was not like the other students. As I looked down at my meal, I wondered if they were disappointed to be the only family assigned a mumbling foreigner to work on their loved one. Were they disappointed in me for falling short of the cultural and linguistic mastery of the other students? I watched my two teammates laugh congenially with the family members, while I just wished to myself that I could express the same level of ease.

I lied in bed that night feeling more out of place than I knew I could. I felt as though the requirement for providing emotional support had risen to a higher threshold; yet I was handicapped in my language and cultural knowledge to provide that service. In Taiwan, in the US, and across the globe, medicine is a profession grounded in humanitarian services. Is it possible to carry out these intentions across such isolating barriers? I felt unsure if my actions had truly helped the family manage their loss. I also wondered what my capacity and responsibility was as a medical provider in this unfamiliar culture?

I found that my role and my mission did not change. Despite this rough start, I eventually realized that the shared ground exceeded the intervening oceans. Over the course of the week, I came to understand why we went through such pain-inflicting processes for the family. Before we began and ended each procedure, we made sure to bow deeply and thank our mentor. We closed every cut we made with careful suturing. Actions such as these made it so that when it came time to meet the family members at the closing ceremony, I felt better knowing that I had paid more gratitude and respect to their loved one than I had previously known how to. The time our team spent with our mentor's family members helped the family feel closer with their loved one. Because of their intimate involvement in the program, they were also able to grasp that his ending is truly a legacy that lives on through the generosity he gave. I was able to speak up about my appreciation for their sacrifices, but also found that gratitude does not just live in the language. Through my efforts and the help of teammates, I realized that kindness

could be communicated despite my barriers. Rather than feeling limited by my ignorance in a foreign setting, I now know to embrace all that we share as medical practitioners, which is ultimately a shared mission of justice and compassion. In addition to teaching me procedural skills, my mentor also succeeded in reminding me that the medical mission is universal, even if there is variety in its execution.

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Human Experience Shaping Medical Needs

By: Jett E. Choquette

The patient sat slouching. Baseball cap slightly to the side and pants riding low. The physician and I (a medical student) prepared to conduct our interview through an interpreter. I speak the patient's language as a second language but still use an interpreter with complex patient interactions to ensure that nothing is lost in translation. This often puts me in a position where I understand all parties in the conversation and gives me a front row seat to the game of telephone that is translation. On this occasion, the patient was following up on uncontrolled vaginal bleeding. They had tried multiple regimens with minimal relief and, at the time of our consult, had had their period for over a month. As the patient explained how long they'd been bleeding, their face was drawn, their jaw clenched, they made minimal eye contact, and they slouched deeper into their chair. I imagined I'd also be upset if I had vaginal bleeding for a month straight. However, somehow, the patient's distress about the bleeding was greater than I expected.

The conversation unfolded. We started to explain the options that were left before we considered surgery. The patient didn't have health insurance, so surgery was not a financially viable option for them even though it would have been definitive treatment. One option was to try oral birth control, again, at a high dose for a short time. The patient's lips drew into a tight line, and they spoke louder as they emphasized their frustration that birth control pills had not worked in the past. They did not want to repeat a treatment regimen that had previously failed. As the patient explained their stance, they stated clearly in their language, "You see, I've always felt like a boy."

The interpreter translated into English, "You see, I want to have a boy child."

I interrupted and asked that the interpreter clarify. The patient was forced to repeat themselves several times. Each time the interpreter got it wrong. I watched the patient's frown deepened each time they had to repeat themselves. After several failed attempts by the interpreter, I turned to the physician and said, "The interpretation is incorrect. The patient identifies as a male and finds the vaginal bleeding distressing. Can we discuss the other treatment options we have for them?"

The physician responded swiftly and began discussing other interventions that might stop the patient's vaginal bleeding entirely. Once the patient saw we took stopping their vaginal bleeding seriously the lines on their face softened and they spoke more quietly. As we continued to talk, the patient asked about starting gender-affirming hormone therapy once the vaginal bleeding was under control. I wondered if this was the first time that they'd ever asked a healthcare professional about gender-affirming hormone therapy.

I've thought back to this patient interaction many times because it goes to the heart of my education as an aspiring physician. It illustrates how healthcare access and experience are influenced by language differences, economic resources, and the cultures of patients and their healthcare teams. It also shows how specific identities and life views can act as barriers to care or, conversely, as ways of connecting healthcare professionals with their patients.

I doubt that the interpreter was intentionally misconstruing what the patient was trying to say about their gender identity. I believe that the concept of identifying as a gender divergent from the one assigned at birth was so unfamiliar to the interpreter that she simply could not understand what the patient said even though they spoke in plain language. Therefore, even though the interpreter and the patient spoke the same language, they could not understand each other. Similarly, even though the physician and I were not native speakers of the patient's language, our backgrounds had given us more exposure to various gender identities, and we were familiar with treating transgender patients.

While speaking the same language can help with understanding each other it does not guarantee it. The case above emphasizes the importance of education in cultural humility not only related to different national identities and language but, also, regarding diverse aspects of the human experience such as gender identity. I believe that training in cultural humility around gender fluidity for the interpreter would have empowered her to better serve our patient. As our world becomes more and more interconnected and the right of respectful, excellent healthcare for all people remains a core value of the healthcare system, it is of growing importance that healthcare professionals strive to understand disease as well as how various identities influence health needs. And while it is impossible for one person to be versed in all languages and identities, it is possible for physicians to cultivate a team culture where all team members can ask questions about situations that they find challenging and contribute their life knowledge to the team's expertise. Interconnectedness necessitates that we continue to push ourselves to learn about people different from us.

Under one cause, global health unites many languages, cultures, and experiences as we seek to solve health problems. As the world becomes more interconnected, these differences don't only occur when healthcare professionals from one country visit another country; they also occur within a single country. On one hand, cultural and language differences can make healthcare professionals miss key aspects of their patients' stories. While, on the other hand, the unique identities of healthcare professionals can allow them to be allies. As a result, there is a need for healthcare professionals to be medical experts and scholars of the human experience. We are called on to understand the world more deeply, not just through language. We are asked to carry the knowledge that human identities such as gender, race, and religion (to name only a few) are complex and not limited by country boundaries. And with the understanding of this complexity, it is our duty to provide the best treatments and medical advice we can to all patients regardless of what identities they have.

Jett Choquette is a MD degree candidate at the Larner College of Medicine at the University of Vermont where their anticipated graduation date is May 2025. The experience that inspired their reflection essay occurred during their third year of medical school while training in the Nuance Health System in the state of Connecticut in the United States. Jett is currently transitioning from their third to fourth year of medical school and continue to train in the US states of Connecticut and Vermont.

Health Advocacy through Objects: Reflections from a Refugee Medical Case Manager

By: Sarah K. Clarke

What do a woman with stage IV cancer, a man with a wooden prosthesis, a woman requiring a liver transplant, and a boy with a congenital heart disorder all have in common?

All were refugees resettled in the United States within the last few years. All were clients. For three years, I was a medical case manager for a refugee resettlement agency. Throughout those years, family, friends, insurance representatives, and medical providers continually asked what exactly was a "refugee medical case manager". My reply always changed: patient liaison, public health professional, social worker. No answer seemed to adequately convey medical case management's breadth. On my last day, looking at the objects I had accumulated, I contemplated how they represented my work. In each, I saw clients' faces.

Insurance cards: Seven plastic insurance cards were clipped above my computer. During my second meeting with new clients, I would fan out the cards in my hands like we were playing "Go Fish". I then began the daunting task of distilling information about the U.S. healthcare system, Medicaid, secondary insurance companies, and health benefits to clients in an understandable yet succinct explanation. Many had never heard of insurance and did not have a corresponding word in their language. At the end of the session, clients would select a secondary insurance. It was one more complication in a sea of confusing U.S. mechanisms to which they were struggling to acclimate. To make the decision more manageable, I helped prioritize their health needs and identified the company whose benefits covered those needs.

Between client sessions, I displayed the cards as a reminder of those plastic rectangles' power. For some clients, these cards signified that they had finally gained admittance to an exclusive club: access to appropriate and timely healthcare. For many clients this access came too late, like the 35-year-old client who succumbed to her stage IV breast cancer shortly after arrival. However, for the client suffering with liver disease, it meant

accessing a network of doctors who manage her conditions so she can live to see her teenage daughter graduate high school. For thousands of other refugees, these cards meant access to prenatal care, eyeglasses, medication, mental health services, cancer treatments, surgeries, and prostheses to replace limbs stolen by mines and car bombs.

Sticky notes: On the side of my desk was a rainbow of sticky notes. Written on the notes – in either my quick scribble or a client’s flowing script – were a seemingly random assortment of words in varying languages with English translations. Fragments of languages from a rainbow of ethnicities, cultures, and countries. I showed clients how to navigate our labyrinth of a health care system. In return, they shared pieces of their language, culture, trauma history, resilience, and humanity.

My favorite note translated the word for butterfly. A client had lost his leg from a land mine; the amputation took place in a field. When he arrived at the refugee camp, they had run out of adult prostheses and had only children’s sizes. It was made of wood. It rubbed against his knee, causing great pain and preventing him from walking far or standing long. For four months, I would drive him to his weekly early morning prosthetics appointment. In the office was a picture of a butterfly. While at doctors’ offices, I always asked clients to tell me words in their languages, trading the name in English. Whenever there was a lull in the prosthetics appointment, he and I would attempt to communicate and inevitably end up laughing at our misunderstandings. We would then point at the picture of the butterfly and quiz each other. The butterfly became our connection.

Sketch of a heart: A cardiac surgeon at a leading children’s hospital drew a heart as he explained to the mom how a heart pumps blood, thus illustrating what was wrong with her youngest son. He had been born with a serious congenital heart disorder. As the doctors explained, if her son had been born in the U.S., he would have quickly undergone a moderately complicated surgery. At seven years old, open-heart surgery was now extremely risky. His heart had massive holes, the muscle was stiff from overexertion, his skin was tinged blue from oxygen deprivation, and he had to be carried everywhere. At any given moment he could have a fatal seizure or heart attack. Her son was without choices. After fleeing her home and traveling to multiple countries in pursuit of doctors to treat her son, his mom well understood. But she had been told, “Only American doctors can save your son.”

The surgeons were concerned by this promise, and we tried to hedge her expectations. “We cannot do everything. We have never seen someone as sick as your son is still alive.” His mom listened intently and spread her arms wide. “It is in Allah’s hands and your hands.” The consent was signed, and her son was prepped for surgery. In defiance of the

doctors’ concerns, her son not only survived but is also flourishing. He and his mom, I decided, are resilience personified.

On my last day of work, I took the sticky notes and the sketch home. These represent my most treasured moments of medical case management and lessons learned. I witnessed the ramifications of health care access inequities and realized that working in global health does not require traveling abroad. Now when I am asked to describe medical case management, I say, “I am a cultural bridge. I am a supporter of health care access as a human right. I am a global health advocate.”

Sarah K. Clarke, MSPH is a global health professional with 10 years of experience with organizations in the United States, the Netherlands, United Kingdom, Canada and Mali. She was early in her career when she wrote this essay synthesizing her experiences as a refugee medical case manager. Sarah is now coordinator of the Society of Refugee Healthcare Providers which organizes the North American Refugee Health Conference, and is technical advisor for health promotion at the International Rescue Committee.

Shut Up and Let the Women Speak

By: Mark Darby

The priest had gathered the women in a tumble-down yard cleared of rubble next to the tin roof church. Mothers all, grandmothers many, sat in a circle – polite and staring.

The women waited, expecting the priest to lead even though he told them he would not. He merely stood behind their circle, arms crossed, staring down at the ground patiently. He did not even say a prayer. More importantly, he didn't introduce me. How would the women know who I was?

His only instruction to me was, "Shut up and let the women speak."

I thought this visit to a Dominican slum with a priest, famous for his work amongst the poor, would look good on my resume. I imagined being at a party back home, standing in a circle of friends, and dropping this experience into the conversation. I would say, "When I was in the slums in the Dominican Republic, I worked with Fr ____." Everyone would stop and hang on my every word.

I stood beside the priest thinking that this small circle would not make a great party story. There was no action. But this gentle priest was emphatic in his instruction, "Shut up and let the women speak." So, I shut up but not because I thought he was right. I did it because I didn't want to piss him off. Without him, I could not find the way back to our house.

There was silence for an interminable time. Then one woman with knuckle-bent hands made the sign of the cross and said "Nuestro Padre...". It was a prayer I understood. Then more silence.

Suddenly, a second woman talked in rapid Dominican Spanish, the kind of Spanish that baffles everyone but her neighbors. The only words I understand are Clinica de Salud—health clinic. This breaks open a flood of women speaking rapidly. Occasionally one person speaks to the whole group. She is asking a question and the women all nod.

I notice at these times a small smile comes to the priest's lips. The women can't see this as he hides the smile behind his hands. He returns my glance and his eyes remind me "Shut up and let the women speak."

After an hour or so, the torrent of words stops. Every woman looks at each other. Then all look at the priest. He uncrosses his arms and says in Spanish "Let us pray." His lips mumble in silence and then he blesses all with upright hand. All the women bow their heads.

On the walk back through the slum, I ask the priest what happened? "Every woman I meet in this parish wants a doctor for their children." He says to me. "They looked to me to provide one. I told them they would have to work together and make it happen. They started meeting months ago. This is the last one before they meet the health minister with their plan."

I thought of that party back home. I could say, "When I was in the slums of the Dominican Republic I helped these women get a health clinic." They would hang on my every word.

I said aloud, "I want to help. Can you get them to let me go with them to the meeting?"

He stopped mid stride. His expression grabbed my attention. He said, "Don't take this away from them."

The only thing I could think to say was, "Shut up and let the women speak, right?"

"Yes," he said. "Remember, people have their own hope and power which they need to discover."

"Will they get the clinic?," I asked.

"I don't know. It is not my concern. It is their clinic. My concern is the people themselves. They will take care of the clinic." I left the slum the next day. Many things have happened since. I gave up doing such work to impress people at parties. At least most of the time. I heard the priest later died. I don't know if the women got the clinic. Soon, that day became an old memory. Until last week.

I had been working on an obesity initiative for 3 years. I was meeting people who were overweight and teaching weight loss. People were having success. I spoke with some women who were concerned about their community and asked them if they would like to implement a community wide program. Many wanted to try. One Saturday, I gathered these women in a dingy room in the community.

Before the meeting, I was fretting. What if the meeting goes wrong? How can I implement this program alone? Can these women pull this off? What happens if something bad happens? Questions were coming in my head rapid fire. So rapid fire that it reminded me of Dominican Spanish uttered by women with knuckle-bent hands, looking to get a health clinic.

I suddenly remembered the voice of a priest, "Shut up and let the women speak." When the meeting started, I did just that.

Mark Darby, RN, APRN, MSN, FNP C, PMHNP BC is a Clinic Director at North Omaha Area Health Omaha NE. Darby was in undergraduate philosophy, hoping to be a Priest who helped people, when he had this experience. Darby gave up the first part of that dream but not the second. Darby is a Nurse Practitioner at a free clinic in Omaha where he spends his time helping people, but mostly shutting up and listening to his patient's wisdom.

Impetigo: A Case Study

By: Jehannaz Dinyar Dastoor

She sat as still as a statue, staring directly ahead with a blank face. You would have sensed that something was off, even if she hadn't presented with a raging fever and a thick cap of white, barnacle-like growths running from the crown of her head down to her ears and out of her nose—after all, what four-year-old could ever sit that still? Even in the cacophony of the hall where we had set up our mobile clinic, I heard the first “snip” of the scissors. And as her thick tufts of hair began falling around her, she still didn't move a muscle.

In medical school, I learned that impetigo was a contagious yet mild bacterial infection, with red sores that ooze and scab, mild itchiness, and resolution with antibiotics. But what happens when you shift this textbook definition of impetigo to the context of a rural mountain community with no access to hospitals, healthcare, or antibiotics?

We had to cut off all her hair. As we neared her scalp, the progression of the infection became more evident. The crusted sores clung to her scalp, nearly covering her entire head. Bursts of white powder clouded the air as we cut off hair closer to her infected skin. We were all breathing quietly through our mouths, as the smell of the infection was so potent. And still she remained unmoving. When we led her outside to wash her head with a bottle of body wash (since we did not have shampoo), she stood up and followed us without a word. But this time she reached for my hand and grabbed it tightly.

Impetigo has some risk-factors: young age, crowded conditions, humid weather, and broken skin. Let's check our patient history. Our child is four years old (age? check). She lives in Haiti, and plays with her friends outside (climate? check. Broken skin from scrapes or bug bites? check). She lives in a house with one room—and 12 relatives. Her mother, younger brother, and grandmother also came to the clinic presenting with varying progressions of impetigo. (Crowded conditions? Double check).

The doctor quickly mumbled in Creole about the next steps. First, we'd remove all the growths. Next, we'd wash her head again. Finally, we'd apply a salve of topical antibiotics

and prescribe oral antibiotics. Thankfully we were camping in this rural community for three days, so that we could schedule her follow-up visit with us immediately.

If not treated, impetigo can cause deeper infection and organ damage. In medical school, these consequences only ever occupied the bottom of a single lecture slide. Perhaps, in America, the idea that such a visually apparent infection would not receive immediate medical attention was unthinkable.

For our patient in Haiti, it had been over three weeks since her family noticed the sores. The nearest hospital would take a full day's journey and a treacherous climb down a mountain to reach, a feat made impossible by the torrential summer downpours and frequent mudslides.

The infection was even more deep-seated than it appeared, and I found myself rummaging through our meager supplies so our doctor could remove the infected growths with a scalpel, taking some of our patient's skin along with it. Her sores turned out to be excruciatingly painful ulcers. I couldn't do much but shine my phone flashlight over the treatment areas, hold her hand, and pray that the scraping of the scalpel against her bare scalp didn't hurt as badly as it looked. After about two minutes, I felt her hand twitch, and then gently leave my hand. I looked over in time to see her swipe her arm across her eyes, and then place her hand back into mine.

Her silent tears turned to sobbing, and then heartbreaking screams as the scalpel was forced to dig deeper into her head to remove the stubborn growths. Now, little dots of blood appeared where the infection had been removed. Unfortunately, the most painful part was yet to come. We had to wash her head with a stinging solution of hydrogen peroxide and iodine, and then again with our makeshift shampoo. We moved to the "pharmacy", a smaller room with our medications. We applied topical antibiotics, bandaged her head, and searched for a prescription of oral antibiotics. She was still crying.

When I learned about impetigo in medical school a year after this experience in Haiti, I found it difficult to reconcile the lecture images of small, well-demarcated pink sores with memories of this girl's raging fever and white outgrowths. It is taught that impetigo "typically" isn't dangerous. But for even the mildest illnesses, its pathogenesis hinges on factors beyond just the biomedical, and can make a disease far from "typical".

A "typical" presentation of a pathology is a privilege afforded to us by our socioeconomic status and immediate access to healthcare, information, and medication.

Our patient still had a high fever. We urged the family to keep their follow-up appointment and take antibiotics, to prevent the possibility of developing cellulitis or postinfectious glomerulonephritis.

These conditions sounded ominous enough to strike fear in my heart then, but it wasn't until a year later that I understood the sobering reality of how intimately associated these complications are with follow-up care and access to a full course of medication.

Our patient came back the next day afebrile, smiling shyly and even giggling when we redressed and re-bandaged her head. We counseled the family and saw them one more time the following day before we had to leave for the next site. She was okay.

Even with a background in public health, it was during my third summer in Haiti that I received comprehensive education on how deeply socioeconomic factors impact not just a patient's healthcare, but how their illness manifests and progresses. The relationship between a patient's environment and their illness is critical to understand, and essential to the practice of global health.

This case study has a happy ending. Not all do.

Jehannaz D. Dastoor holds a BA in Anthropology from Northwestern University, and she is currently a second year MD/MPH student at Northwestern University Feinberg School of Medicine. The experience discussed in her essay occurred during her third year of work in Haiti, while she was obtaining her Anthropology degree.

The Earth and You: Weaving Foundations in Global Health

By: Huda El-Zein

“The land knows you, even when you are lost.”

Robin Wall Kimmerer, *Braiding Sweetgrass: Indigenous Wisdom, Scientific Knowledge, and the Teachings of Plants*

Since beginning my undergrad, I have been on a peaks-and-valleys filled journey of self-discovery, academic knowledge, and maturation. Originally embarking on a more traditional scientific pathway, it was not too far into my degree that I made the switch into global health, and since then, my interest in this field has only grown; I found it perfectly amalgamated my values and academic background. It seemed that the pieces of the puzzle that represented myself, my strengths, and my ambitions were becoming more apparent everyday, but I struggled with the idea of where I belonged, whether the wicked problems that comprise global health made it a field worth continuing to pursue, and how all these seemingly unrelated pieces would eventually come together. As I have continued on in my academic endeavours, I have been fortunate to cultivate new perspectives in my personal life, in my interpersonal relationships, and in the field of global health. However, as much as this growth has been mystifying, it has been counterbalanced by an overwhelming sense of fear; it has often felt that for every step forward, three steps were taken back. In all these unknowns, I again found myself feeling lost and without a clear image of the ‘big picture’. *What is the point?* became a haunting thought that I found myself ruminating over, time and time again. As I struggled with these unknowns, I felt as if I needed a sign telling me that I was on the right path, that global health was progressing, and that my ambitions and endeavours would somehow all line up.

In a *Deus Ex Machina* fashion, my answer finally came to me in the form of the book, “Braiding Sweetgrass”, by Indigenous author and scientist, Robin Wall Kimmerer. When I reflected on what I was reading, I realized that the answer I longed for was staring

right back at me: *Sweetgrass*. As a direct extension of the earth, on whom life relies, Sweetgrass has always been there for me: Going back to the summer of 2016, I had set off on a cross-country journey from my native Alberta, en route to Toronto for school. On this journey, I had been gifted a bundle of braided sweetgrass in a small community in Northern Ontario. A sweet gift, both literally and figuratively. Since then, Sweetgrass has sat untouched on the dashboard of my mum’s car, waiting patiently for me each time I returned home, a timeless symbol of stillness, generosity, and strength. As I set on to new things on to new things in London, Ontario, Kimmerer’s book had brought the presence of Sweetgrass to the forefront of my attention once again. I realized that even after all this time, Sweetgrass has remained the only constant in my life since I had begun my post-secondary education, thousands of kilometres from the place that I call home. Despite my lack of awareness of her presence, she had always been supporting me throughout my long and often challenging path in academia.

Finding the answer that I had longed for, and truthfully, had taken for granted, I faithfully turned to her. Her gentle entwined structure had created an unmovable edifice that continually supported me, as she demonstrated that by nurturing my own fibres, they could weave their way into the earth, and keep me grounded for as long as I let them. Sweetgrass showed me that I am right where I am supposed to be, connected to the earth. She taught me that the growth, progress, and answers I have been searching for would come through remaining firm in my roots, keeping honest to the earth below, and through embracing all the unknowns, what-ifs, and unpredictability life has to offer.

But Sweetgrass is growing weary. In our modern era that has been ravaged by climate change, the crumbling earth that has long supported Sweetgrass is fading away, as the consumerism and greed that dominates the Anthropocene slowly tears apart her once resilient fibres, threatening all of life on earth. I look to Sweetgrass and imagine the years yet to come, and I find myself fraught with those familiar feelings of anxiety about the unknown. She is right to be afraid. We all are.

In the last decade, we have seen optimistic improvements in the World Health Organization’s (WHO’s) Sustainable Development Goals (SDGs) through international collaboration and interdisciplinary leadership. However, the one thing that stands in our way towards achieving the SDGs, and more importantly, a more equitable society: climate change. We struggle with what degree is too hot, and how much CO₂ is too much CO₂; but, in all our analyses, and in all our efforts, we have failed to reconcile our obsession with blind consumerism, capital gain, and unfettered individualism. Collectively, we must all learn and grow alongside the only community that has demonstrated the utmost respect for, understanding of, and reciprocal connection with Earth and her Sweetgrass – our Indigenous people.

If we hope to continue progressing in the field of global health and holding promise to the SDGs, it is imperative that the global gaze shifts towards approaches aimed at protecting our earth, perpetuating a culture of environmental sustainability, and handing the reins of leadership over to our Indigenous people.

I hold onto Sweetgrass, feeling strong, feeling rooted in the earth below, and affirm that as she was once there for me, I will be there for her. I am certain my future endeavours in the field of global health will pay homage to all that Sweetgrass has offered to me, through advocacy, empowerment, and unfailing support for the Indigenous communities across Turtle Island. Through a lens focused on planetary health, and under the guidance and compassion of our Indigenous people, not only will we have a chance at overcoming climate change, but we will have a renewed ability to progress towards achieving the SDGs, thus galvanizing change in global health for the next 25 years and beyond.

“Action on behalf of life transforms. Because the relationship between self and the world is reciprocal, it is not a question of first getting enlightened or saved and then acting. As we work to heal the earth, the earth heals us.”

Robin Wall Kimmerer, *Braiding Sweetgrass: Indigenous Wisdom, Scientific Knowledge, and the Teachings of Plants*

Huda is a graduating student from the University of Toronto where she is completing her Honours Bachelor of Science (HBSc.), specializing in Global Health and minoring in German and Physiology. Currently, she is the Director of Health and Research at Kali United, a Canadian incorporated non-profit aimed at promoting the health of marginalized groups in need, and creating barrier-free access to medical care and medical education. She is further involved in her community as a research assistant with Access Alliance Multicultural Health and Community Services in Toronto, Ontario and she is also a Wellness Ambassador with University College Student Life, at the University of Toronto. She hopes to continue on her current trajectory into a career as a physician-scientist, focusing on equitable health care access and the burden of congenital diseases in Indigenous communities in isolated parts of Canada.

She has always held an interest in public health policy, community health, and medicine; in light of her education and experiences, Huda wrote her piece “The Earth and You – Weaving Foundations in Global Health” to juxtapose her own growth and future as a global health changemaker, with the path of the field of global health. She laments the current state of climate change, and the need to shift the global gaze towards one focused on Indigenous leadership in order to make substantive change in the field of global health.

Life Lessons from The Dying

By: Matt Evans

They say that the dying are the ones who have the most to teach us about life. Two years in Laos taught me the truth in this, and the importance of a good death.

Children’s hospitals in resource-poor settings can be tough places to work, in turns both uplifting and brutal. In an uncertain environment, countless people throw their hearts and souls into work that takes them a long way outside their comfort zone. The Lao staff, long term international workers, and volunteers are all thrown headlong into a melting pot of heated opinions fueled by fatigue and idealism.

The hours are long, the situations wildly unpredictable and the resources minimal. In stressful situations tempers flare and occasionally bad decisions are made. Most staff have never encountered medical emergencies with such regularity in their professional lives before. And yet with minimal training they have rapidly grown from bearing witness to medical dramas to becoming leading actors in them.

Each day was an intense amalgam of experiences – running through the whole gamut of risks and triumphs, frustrations and breakthroughs. We would come face to face with death on a daily basis and stare it in the eye, unblinking. It was intense, it was tough, but it was an experience that pulled us together like glue.

In an odd way, I was grateful for those terrible yet beautiful moments. No parent forgets the birth of their child, and any subsequent death is an equally pivotal event that will be seared into their memory. Families look to clinicians for help, guidance and hope. Sadly, all three are not always available. But if doctors and nurses meet the gaze of parents with honesty, clarity and a refusal to shy away from the difficult questions, I am convinced the memory of this stays with the family. Being with a dying person in these uncomfortable moments has its emotional costs, but also its rewards.

Occasionally when I’m cycling or running, vivid memories of hard times in the hospital suddenly snap into sharp focus:

A father touching foreheads with me in silent thanks for the care his dead daughter received.

The wail of a mother clinging to a nurse's leg after attempts to resuscitate her child are finally stopped.

The shrill sound of a ventilator alarm though the bedside vigil of a night shift.

The relief of hearing a baby cry, knowing it is, after all, breathing.

The wall of heat and smell of closely packed bodies in our crowded ward on a summer day.

The sound of children crying reaching me on my bicycle before I'd even set foot in the building.

A mottled blue baby arriving wrapped in cloth, the teenage father helplessly offering his half-dead child to the nearest nurse, pleading for help.

Children arriving after three days of seizures, brains already damaged, because the rain-damaged roads were too bad to get there sooner.

Parents whisking their infant away home from the hospital bed, IV drips still attached. The family mistrustful of western medicine and seeking help from the village shaman. A child gasping for oxygen once the mask has been removed, only to be thrust onto the back of a waiting motorbike to race away into the night.

The joy and surprise of seeing a child, previously sent home to die, walk smiling through the door six months later.

The look of disbelief on a father's face when told our western medicine couldn't cure his son's terminal condition.

The proud smile of a mum breastfeeding for the first time, after watching nurses feed her baby through a tube for months.

This often hurts deep in the pit of my stomach, followed by the dull ache of helplessly watching a parent grieve as their child slips away. As it should. And yet I don't want that slow deep sadness to disappear or become diluted with time, for that is what spurs us on as nurses and keeps us accountable. The intensity of being side by side with death motivates us, not by making us more zealous to preserve life, but to ensure a good death. A death free of pain, fear and chaos. To provide families with honest answers, to set realistic expectations and to allow them time to be with their loved one in a way they will remember fondly.

Mortality lurks beneath us all, waiting to catch us when we finally slip and fall from life's slippery staircase. But those of us who are given the opportunity to ease that final descent for others should embrace that chance and hold it close, for the moment is a rare one. To be able to seize this instant, to make it memorable for peace and dignity, is the chance to do something honourable that will linger in the minds of the family long after the event.

Both birth and death are on the edges of existence where the flame of life is both ignited and extinguished. It is a sombre honour to be present when someone dies; this is the most visceral and raw of moments, when the protective skin of wealth and opportunity is peeled back, and the great leveller of mortality renders us all equal. This moment provides an opportunity for the nurse or doctor to ensure it occurs painlessly, with dignity and compassion.

Ultimately our work was a daily act of holding both life and death in balance with joy and pain, while ensuring that meaning could be drawn from both. Those times were compelling, tragic and often distressing, yet I would never swap them for more pleasant soft-focus memories. The reality of death helped us feel the importance of life more keenly. It showed us how privileged we are in being able to ease the pain when life's flame is finally blown out.

Matt Evans has been a Registered Nurse for over twenty years. Evans qualifications include P.G. Dip. in Tropical Nursing, Non-Medical Prescribing and an MSc in Community Specialist Practice. Evans is currently studying for his Masters in Public Health and the experience in the essay relates to four years ago working as the Nursing Director in an NGO-run hospital in Laos. Evans continues to work there today.





Photo Credit: Matt Evans

When the Treatment is Worse than the Disease

By: Lia Harris

Pandemic response is wasted in low resource and conflict-affected health care settings. As a humanitarian, have I lost my sense of humanity? Possibly. Nine months ago, I would have been horrified to hear myself suggest any integrated health care response was useless for needy populations. Nine months later, reflecting on conversations with friends in Bangladesh, colleagues in Yemen, and experience in Afghanistan, I would like to make a case that the treatment is worse than the disease. People in fragile settings are preoccupied with so many misfortunes, pandemic response is too trivial to consider, or frankly, an interference in the daily struggle.

Social distancing is a luxury. While waiting for food rations, would you ensure the appropriate distance, or ensure your family is fed this month? How do you distance when you live 14 to a tent? Handwashing? It is sensible, if you have safe running water. In the IDP camp in Ma'rib, Yemen, they must leave the camp with containers to fetch water simply for consumption. Who would waste it to hand wash, when the water itself transmits acute watery diarrhea?

Here in Afghanistan, where there are so many more ways to die than by pandemic, COVID-19 prevention measures are a nuisance, at best, but a compromise to the already weak health care system, at worst. With exceptionally limited testing facilities, patients admitted to hospital are simply triaged as "COVID suspect", or not. COVID suspect signs and symptoms are sufficiently general, virtually every patient with fever and cough should be under strict isolation, or not. As a consequence, the dedicated COVID Ward remains empty, stealing beds from patients who are dying of scores of other causes.

Meanwhile, millions of donated "COVID response" money is not funding extra beds, ventilators, staff, or even testing resources. Staff here are provided with one mask per week. We have not otherwise seen this COVID response money.

Beyond the hospital, pandemic prevention and treatment measures are also useless in the community because they are distrusted. In conflict and persecuted minority settings, the myths surrounding COVID management are actually deterring people from accessing

health care services. Many displaced people believe if you have COVID symptoms and go to a clinic, they will take you away and kill you.... deport you.... lock up your family.... or it is a biological weapon developed by China (USA... Russia...) to commit genocide. After their experience of persecution, who can blame them? The same can be said for faith practices. One of the few comforts in low resource and conflict settings, faith, meant to protect and heal, in a pandemic paradoxically threatens the health of the community. Yet, who would attempt to convince a community of 1000 faithful not to pack the mosque shoulder-to-shoulder for the funeral of their beloved Imam, dead, ironically of COVID-19? To discourage the congregation is to question their faith.

What of the “lifesaving” health care services? If resource-rich countries like Italy, Spain, and America run out of beds and ventilators, countries who do not have access to basic health care services have no hope. I have seen fundraising campaigns purchase 5 ventilators for a hospital in Syria, to save 5, maybe 50 people, at best, considering the continued high mortality rate of ventilated patients. At what cost? How many could receive mosquito nets, routine vaccines, or nutritional supplements for the same money?

Meanwhile, because testing cannot happen for various reasons, there is no accurate measure of COVID cases or deaths. There is no way to determine the impact of the pandemic on vulnerable populations. Even the proxy of excess deaths is inaccurate where people routinely die without seeing the inside of a hospital.

As a pediatrician, I acknowledge COVID-19 affects kids less severely, but I have seen first-hand how the pandemic response is adversely affecting children. Daily I see children dying as casualties of conflict, malnutrition, vaccine-preventable diseases, unsafe water, or simply accidents. The social distancing measures in the hospital have restricted the bed occupancy to one child per bed, from 3 children per bed when admissions were unlimited. The pediatric mortality rate in the hospital has risen, not decreased, not just because the denominator is smaller. The absolute mortality is increased because the children are now turned away with milder illness, only to be admitted in critical condition. Measles, tetanus, meningitis, sepsis, tuberculosis, complications of malnutrition; all the same conditions which were killing kids before COVID, are killing them at a higher rate now. Yet, the hospital has no COVID, of course, because we cannot test, and the COVID ward remains empty.

Pandemic prevention measures are a privilege of wealthy countries we impose on conflict-affected and low resource countries, without consideration to the adverse outcomes of these measures. The billions of dollars donated to the COVID response in fragile countries would be better spent on strengthening current health care systems and improving the social determinants of health.

Addendum

Vaccines, of course, are the exception. I wrote the essay before COVID vaccines were widely available. Vaccines may be the only answer to a pandemic in low resource settings but must be free and widely accessible. So, this is my plea to the vaccine companies and wealthy nations, including my own, Canada; for the health and safety of the global community, vaccines need to be urgently distributed to low resource and conflict-affected countries. In the words of Dr. Mike Ryan, Executive Director of WHO Emergencies Program, “no one is safe until we are all safe”.

Lia Harris, MD, FRCP(C), is a general pediatrician who has been working and volunteering overseas for several years. The tragedy she witnessed while working in Afghanistan at the time she wrote the essay prompted her to return to school, now in the Master of Science in Global Health Policy program at London School of Hygiene and Tropical Medicine. She hopes to work in global policy for health care of civilians in conflict settings.



The emergency department in an Afghanistan hospital, where patients are treated two to a bed, and COVID distancing measures cannot be observed.

Photo Credit: Lia Harris, MD, FRCP(C)

Thy Father's Will

By: Amoghavarsha Havanur

Two days after I landed in Ethiopia, my preceptor arranged for me to shadow at the local hospital where he occasionally referred children in need of orthopedic surgery—particularly clubfoot corrections. Nestled in the green foothills at the northernmost edge of Addis Ababa, this Christian missionary organization was dedicated to eradicating pediatric disability in the developing world, one surgery at a time. An expatriate surgeon on staff there, Dr. T., was to guide me upon my arrival.

The next day, decked out in oversized scrubs, I drifted from one operating theater to another, ultimately sampling a dozen different procedures. With practiced ease Dr. T. sliced through tissue and bone, maneuvered orthopedic clamps, offset valgus and varus stresses, and supervised the handiwork of rotating orthopedic fellows. *There is literally no deformity on Earth that a skilled surgeon can't fix*, I marveled.

Above all, the anchoring presence of faith in the lives of the staff was unmistakable. Before every operation, during the surgical timeout, they bowed their heads around the patient and joined hands—myself included—as a resident quietly recited the Lord's Prayer in Amharic:

Abattachin boy besemayi yemitinor, simib yekedes, he began. *Our Father who art in Heaven, hallowed be thy name.*

*

The following morning Dr. T. held outpatient clinic—an easygoing day of follow-ups, intakes, and post-op assessments in which he took obvious pleasure. *"Salaam, no?"* he greeted parents, pinching their babies by the cheek.

A new patient, Yonas¹, had arrived with his family from distant Gondar: a solemn boy under ten, with wiry copper-black curls and a watchful, ruminative air. His father, a weathered farmer wrapped in a thick woolen scarf, wheeled him in, followed by his mother, siblings, and an uncle. I stood up to offer the father my seat.

Yonas's condition was immediately obvious: *right fibular-tibial hemimelia*. Simply put, he'd been born without a right ankle. A malformed foot stump protruded directly from the right kneecap, then curved inward and up like the handle of a cane made of flesh. Had he stood up, the foot would have dangled uselessly several inches off the ground.

But of course he could not stand up.

Dr. T. studied the radiographs: *"Quite operable,"* he announced briskly—a matter of amputating the foot and inserting a prosthesis at the kneecap. Fully paid for by the organization, the procedure could take place as soon as next week. Yonas might take his first steps in under a month. Did the family understand?

The father nodded, his expression impassive. He understood.

Did they wish to proceed?

Ai, he murmured. *No*.

Yonas watched on as his father explained that his people's beliefs prevented him from disfiguring his son's flesh.

"There is another option," Dr. T. suggested, glancing at the interpreter. They might instead connect the prosthesis to the foot stump itself—a much riskier procedure. "And he'll have some trouble putting on his trousers..."

The father hesitated, then nodded his assent.

Dr. T. continued. He was happy to take this approach, he said, but if complications arose and the operation could not continue as planned, then he would have no choice but to revert to amputation. Did the family accept this risk?

Now the father shook his head even harder. *Ai, ai*. Only if Dr. T. could guarantee a successful outcome, free of the possibility of amputation, would he consent. Nothing else would suffice.

"Well, I can't promise that," said Dr. T. gently.

Yonas began to cry. Or rather, he had been crying for several seconds already and only now did we notice—the face screwed tight, the mounting rasp of his sobs, the ragged and tremulous breaths. His mother hugged him from behind, enveloping the back of his wheelchair in her arms.

"It's all right, son," said Dr. T, placing a hand on Yonas's right knee. "It'll be all right." To the father, he added, "You and your family are welcome back at any time if you reconsider."

They shook hands. The conference was over. I reclaimed my seat as the next family, a successful post-op, sidled in. The last image I have of Yonas is the look he gave his father as he was being wheeled out, a look of sullen anguish.

Later, as he finished up his notes, Dr. T. spoke to me, not looking up from his screen. “We’re actually conducting a study on parents’ attitudes towards various surgical procedures. You understand, to better characterize impact on the child’s eventual treatment decisions.”

“Do you think they’ll come back?”

“No,” he said. “For his sake, I hope he can forgive the father.”

*

In the months afterward, after I’d returned from Ethiopia, I kept reimagining this encounter, focusing on the five radiant minutes during which it must have appeared to Yonas that the operation would in fact, proceed, that he would soon be able to walk. Just enough time for him to envision, in his mind’s eye, the prospect of life without a wheelchair. Perhaps even to anticipate the joy of running and jumping and playing soccer.

Which is crueler—to live without the possibility of recovery, or to experience *five minutes* of hope before life snatches it away?

It would be easy to blame the father for what happened; for a long time that’s what I did. Yet in the months since I reflect instead on how he must have traveled for days, wheeling Yonas in and out of buses, onto carts and platforms, up and down stairwells. All for a ten-minute meeting with a surgeon—what desperate hopes he must have pinned on Dr. T. to answer his prayers! At that instant it must have taken unbearable resolve to refuse the procedure, to ignore his boy’s weeping. To steel himself for the long journey back to Gondar with his family, empty-handed and thinking to himself: *My boy cannot walk. And he hates me for it.*

That summer taught me much about global health. In global health, infrastructure and expertise and selflessness must all come together for genuine healing to occur. But the difficult truth is that sometimes even these are not enough. Sometimes there are deformities, however operable, that no surgeon will be able to fix.

What remains then? Only what I hope Yonas someday finds the strength to do: *to forgive*. I suppose that too is a form of healing.

¹ Names and initials have been altered to preserve anonymity.

Amogh Havanur is a medical student in the MD/MPH program at the University of Miami Miller School of Medicine. The experiences detailed in his essay occurred during his MPH capstone field experience in the summer of his first year. He is currently in his fourth year of medical school and applying to combined internal medicine-psychiatry residency programs.

Worth a Thousand Words?

By: Bethany Hodge

I spent hours reviewing my photos on social media and removing some beloved faces and precious memories. It was surprisingly hard. Deleting them from the online albums seemed harsh—like I wanted to exclude brown and black faces from my posts or hide something shameful. But really the shame is mine for posting them in the first place.

Throughout in my career as a pediatrician (going back to residency in 2009), I have been able to work in clinical and academic settings overseas. The most beautiful places I have seen are in Tanzania, Kenya, Ecuador. So of course you take pics! It’s too simple with a smartphone in your hand. Frame, crop and make it artsy. Put yourself in good light. Easy to upload and share your exciting adventure with everyone back home. It’s almost required to show pictures to give your mom and financial supporters reasons to think they made a good choice to let you go on this trip. Perhaps it’s even your job to showcase these opportunities. And there are the likes and endorphin hits from people noticing what you are doing and admiring your “selfless” work. Pictures are proof you were temporarily part of something big and talismans to hold on to that adventurous identity.

The personal reasons for wanting to share photos of charming African babies, elegant Ecuadorian women or local health providers intently listening to a wrinkled old man’s heart may involve preservation of memories and warm feelings. It may even extend to feeling like you are promoting the partner or local people in some way. You justify that you are giving them recognition through showing their lives and work on your feed. And you see it as a counterbalance of “reality” to offset the usual stream of perfect faces/hair/clothes that you may see following celebrities. You are reminding everyone the world is bigger than that sorority sister’s baby shower or whatever the famous are doing. You’re the good kind of “influencer.”

You can even go to the extreme of showing the “worst of the worst” as medical volunteers. Photo-op the many pit latrines you have visited. Show the starving naked baby with a fly creeping in the corner of his eye. Document the oozing, ulcerating wound that “totally wouldn’t have happened in the US,” the goiter that has gone unchecked for

years or a rare manifestation of a tropical disease. We are allowed into intimate places as volunteer medical providers and there are words to describe those kinds of social media posts: Poverty Porn and privacy violations.

Poverty Porn—such a striking name—is the graphic depiction of a person to serve the photographer’s interest to evoke a psychological reaction from viewers. It often plays on stereotypes and “artistic license” may emphasize a skewed aspect by showing only the images that fit a predetermined narrative. The usual themes are raw (such as hunger, dirtiness or “doing without”) and it is expected that the viewer feels pain when seeing it. The pain could be channeled into something ostensibly good—like donating to causes that alleviate suffering or advocating for better policies for affected groups. But it also reduces the people in the photos to caricatures and does not represent people or cultures as multidimensional and dynamic. At best, it is “photojournalism lite” but at worst it is outright exploitation that may perpetuate racist, classist, and colonial prejudices.

If I had approached my photo-taking and posting while overseas from a perspective of equity and dignity going all the way back to 2009, I would not have posted many of the things I did. The charming baby is not MY baby; I do not have the right to publicize his photo without his parent’s permission. The healthcare providers doing their jobs deserve recognition, but all patients are owed privacy when seeking care. It violated the sanctity of the exam room to put people on display while being tended to. US-based laws like HIPAA passed prior to social media and violating a patient’s rights through posting their medical history is illegal here. Why would international patients deserve less dignity and protection?

Language barriers, power differentials and simply not having social media as part of everyday life may all make seeking permission from international patients seem difficult. And the consequences of their disapproval of me, a white foreign visitor taking and displaying their pictures, are likely minimal. Though my mandatory modules on HIPAA remind me every year of doctors and other workers who have lost their jobs in the US due to inappropriate social media posts of protected health information, I have never heard of someone facing legal punishment due to posting inappropriate mission trip mementos. In fact, striking photos are used in marketing materials published by sending organizations and fundraisers. Health professionals could face scrutiny when trying to publish case studies where informed consent forms are not properly signed by the person whose oozing, ulcerating wound is featured, but it is more seen as a lack of proper paperwork than a major violation of human rights.

Possibly the mothers of the babies I took pictures of or a patient receiving a heart check-up might have agreed to having their photos displayed. But I didn’t take the time

to ask. Feeling that their images and stories were mine to display as I pleased was an act of aggression. It puts my desire for recognition above their rights to dignity, privacy and autonomy. It makes them a part of my crafted “self-story” without upholding their abilities to represent themselves as they desire.

Erasing social media posts is a start. Committing to be more thoughtful and self-critical in the future is better and leading students in ways that promote equity is my duty. Staying humble when someone points out I’ve slipped up again or have more work to do is necessary. Finding respectful ways to cherish the partners, patients, places, cultures and stories that make up the best parts of my work as a global health physician is the next step.

Dr. Bethany Hodge is an Associate Professor of Pediatrics and Director of the Global Education Office at the University of Louisville School of Medicine as well as a pediatric hospitalist. She completed medical school and pediatric residency at Indiana University, where her formal experiences in academic global health began in Kenya. During her tenure at the University of Louisville, she has also led student service-learning trips in Burundi, Ecuador, and Tanzania and this essay represents her personal reflections over more than a decade of work in global health.

**“It all starts at the root. What children become
is determined by what they face
during their childhood.”**

Till He Died

By: Dusingize Marie Immaculee

“Forgive me mother,” A boy cried to his mother who was unapologetically beating him.

I knew the boy from the street. Every morning, he was carried on a bicycle, the cheapest mode of transportation in my neighborhood, to his usual seat on the street. The boy lived by begging, and the seat was the center for people who could help. I wondered why he spent his money to come by bike, while he was coming to beg. Ignorance is bliss- I later learned that he had hydrocephalus; he could not support his head’s weight. He appeared scary; he seemed to fear himself too. At an extremely young age, the age of ten, he was already facing a stigma from children of the same age. Whenever they went home from school, other children made sure they left the boy crying, by name-calling and laughing at him.

Nobody knew his real name, everybody called him ‘RUTWE’, meaning ‘big head’. I would anticipate that all he wanted was money; but he never asked for money. Instead, in a sluggish voice, all he could ask for was a piece of paper. His mother sold bananas on that same street. However, no one had ever noticed that the woman was his mother, until she appeared upset after she saw an old woman passing a paper to the boy. She then violently exclaimed: “RUTWE, shall we survive by papers? I asked you to beg for money, not papers,” and she hurriedly ran to punch him. This is when the boy’s voice was a bit louder, “Forgive me, mother.”

I was a high school graduate, volunteering at a community high school to help students comprehend chemistry. To witness all the boy’s sufferings, I spent 3 months walking past him heading to/from the community high school. It is a pity I was just a witness; I never helped the boy. I was old enough to have taught the children not to shame him, but I did

not do so. I had longed to know the boy’s name to avoid name-calling him, like others did, but I never asked. I, as well, ached to comfort the boy’s mother, who I knew never demonstrated pride and support for her son, referring to the way the mother had adopted beating and name-calling him. But I did not. I, however, felt certain that what I observed the mother doing to his own son on the street, portrayed what she did to him when they were at home.

Unfortunately, the point of realization only came when I heard news from my mother, “Nganji is dead.” Nganji was the boy’s name. The shame of never having helped someone who needed me while I could, kept me standing in disappointment. I felt sure that if I had done only one good thing for him, I would have relieved one in the load of pains he felt; I would have created a smiling memory in his life, at least to die with. I regretted never having had strength to help him. It took me his death to know that empathetic advocacy is not just an act by leaders understanding, standing up, and speaking for their people; like we used to learn in high school, but even everyone’s will to use their capabilities and equitably support others, not because they have become a responsibility, but because they deserve to live enjoying their rights.

Paying him tribute seems to be the only way to gain peace of heart. It still haunts me, to never have called him by his name; Nganji! An extreme self-humiliation crawls down my vessels when I reflect on the pity I felt whenever everybody abused him, and I am aware I did nothing to help him. Guilt loads my mind and soul when I flashback to the way I never gave him a paper, while my work bag contained a full ream. Fortunately, all this is what grows in me a zeal to conquer my fear and shyness, so that in the future, I will not just empathize, but I will also stand up for those who are like Nganji.

The world, in addition to his own mother, hated Nganji for what he looked like. But leave Nganji aside, no one in this world chooses their looks. Nganji, like other children, hoped to get joy from the children’s universe, but he was not granted what he deserved. Today, I realize that he faced ‘*innocent violence*’ from all the people he encountered; his mother, the children from school, people who name-called him, and the ones who never did a thing to help him, like myself.

Nevertheless, days advise me that the children who humiliated Nganji on their way to/from school. Do not deserve the blame, because they were not taught morals to treat everyone considerably. More to that, they did not know that hydrocephalus was a disease that could be managed to allow Nganji to lead a normal life. Otherwise, they would have brought a smile to Nganji’s face, instead of humiliating him. Too, they would not grow up to become passive bystanders, just like myself, ignorant of the application of human morals.

The ignorance I grew up with made me normalize the stigma that Nganji faced. I perceive that, unless they are well introduced to the basic human values, children will grow with this same ignorance. This perception is what grows my desire for advocacy: the children do not merely need the awareness of someone different from themselves, they also need an education that allows them to behave and care for their disabled colleagues. This can be met by incorporating children's cognitive and mental health education, not only in primary education but also in society sensitization, all where there could be the prevention of innocent violence. This would serve the certainty that children grew up respecting everyone's rights, while recognizing that the disabled ones are as deserving. Not to forget, the incorporation of children's cognitive and mental health education can encourage special attention to the disabled children, contributing to the management of both their physical and mental health.

NB

'Nganji' is not the character's real name. The name was changed to respect the character's privacy.

Dusingize Marie Immaculee, a third-year medical student at the University of Global Health Equity (UGHE), Rwanda. Dusingize was fortunate to embrace global health experiences when they were waiting to join medical school. At the time of composing this piece ('Till He Died') that showcased one of the global health problems at the community level, Dusingize was already a medical student at UGHE (September 2020). Dusingize had been exposed to different community problems through the Community Based Training (CBT), module that instills in students the skills not to overlook minor community problems, since they are the grassroots of even wider catastrophic health challenges observed in the world. Dusingize aspires to keep using different platforms to expose the world to things that are most of the time overlooked, *while they maggot the castle from the foundation*, i.e., while they derange the whole world starting with the community.

One Team: Kinship Through Sport

By: Ryan Mak

"What's the average age of death?" asks Coach to the boxing team. "18" yells one kid, and another, "22!" Coach continues, "How many of you know four or more people who have been killed on the streets." Immediately half of the twenty or so youth gathered raise their hand. Boxing Out Negativity is a youth boxing team in the North Lawndale neighborhood on Chicago's West Side that strives to help at-risk youth realize their potential. North Lawndale is one of "those places" known for its high unemployment rates, gang activity, and homicides. When I tell people that I live in Chicago, North Lawndale is one of "those places" people picture while they ask me if I am safe because of the number of individuals killed each year. It is a neighborhood filled with "those people" who get written about in the newspaper and reported as yet another young black man killed on the streets -- another statistic.

These certainly were not the conversations I was having with my youth basketball teammates growing up in San Francisco, California. I was fortunate enough to attend a good school playing on multiple athletics teams through many years of grade school and high school. I was privileged enough to live in a safe neighborhood that allowed me to shoot hoops whenever I wanted on the street in front of my house. These years of experience were not only fun, but shaped me into the person I am today. However, my childhood was not without hardship and just like any other person, I had my share of struggles.

When I was in the 5th grade, my good friend teammate was shot and killed by his father in a bout of mental illness. I had no idea what to do, what to say. All I remember was crying and simply going to school that morning. Although I cried all day, eventually I picked up the basketball and started to play because that was all I knew how to do at that moment. It was my safe place; it was the only means of expressing myself when I was at a loss for words and numb to the situation. So I continued playing through the years, striving to be the best student-athlete I could because I felt that would somehow heal the brokenness I felt from losing a friend.

I did not grow up poor, black, and in one of the country's most notorious cities for gun violence, so naturally when I began my work with Boxing Out Negativity leading fitness training sessions and camps for youth, I wondered how I would fit in and how I could help. I started by simply attending some of the team's practices to get to know them and to see how the program operated. I remember first walking up to the small office converted into a gym. The music was blasting, jump ropes were spinning, and a couple teens were bent over on their knees, sweating profusely trying to catch their breath. There was a palpable energy in the air, one that even though I was far removed from my teenage years and high school teammates, I recognized. It all felt so familiar -- the camaraderie, the physical work, the sweat and struggle of improving in an athlete craft, the heart beating, and the air filling the lungs.

A few sessions later while I was attending the team's practice, the coach called everyone in a team huddle. He talked about the upcoming boxing competitions in the Chicago Park District. He talked about some of the youth's social media accounts, chastising them to be accountable and to stop posting material that does not reflect well on themselves and the team's image. He then introduced me as a new fitness coach that is going to help the team in their training. While this was my first formal introduction to the team, once again something about that moment felt quite comforting. How many times as a grade-school or high-school aged kid did I gather at a team huddle at the end of practices? How many times did I take-a-knee with my friend, my teammate who I considered a brother as coach implored us to be better, to strive to realize the greatness that lay inside of each of us individually and collectively? How many times did we conclude a hard day of training by acknowledging our efforts and then turning towards the next day with an attitude of getting better? The team huddled -- it's a safe space, a sacred space.

I have been fortunate to work with the youth of Boxing Out Negativity as a fitness trainer because through many sessions together, I realize how similar I am to these kids. Yes, we grew up in different cities and different circumstances, but we want the same thing: an opportunity to be better, to be the best versions of ourselves and transform the circumstances surrounding us. We want to be better as athletes and as individuals. We want a team to belong to, a way to express our moments of joy, anguish, and all those moments that render us speechless. We want a place where we feel we belong, a place in which we recognize that we are in kinship with one another.

I recognize how exhausting it can be to combat socioeconomic health disparities and advocate for youth who are often overlooked by society. However, I learned that the only way I believe I can sustain my desire for achieving social justice in community and global health is to begin not looking at the disparities present, but to first recognize

the common humanity I share with those on the margins. If I let those I work with change me, if I recognize those I work with as my own brothers and sisters on the same team growing through similar struggles and striving for common dreams, then everything about working in global health becomes not about "me and them," but about us, and our team.

Ryan Mak recently graduated from Loyola Chicago Stritch School of Medicine in May 2022. He is now a Family Medicine Physician at Northwestern McGaw at Humboldt. When writing this essay, he was a second-year medical student at Loyola Chicago and a Schweitzer Fellow using his background in athletics and fitness training to work with the youth of Boxing Out Negativity in the North Lawndale neighborhood of Chicago.

A Home for Hope

By: Rania Mansour

It's a cold winter evening. Makeshift fires are burning in strategic locations to keep the people warm. I look around with my orientation leader. I see children playing in the snow wearing sandals. I see teenagers lighting cigarettes. I see the Arabic words "God is Great" painted in black ink on a nearby wall. On another wall, I read "There is no humanity." I spot a woman leaving her designated container. She is the only woman in the vicinity. As I track her figure, my companion says: "Time her." Confused, I look at my watch and glance back at her, waiting. It took her 7 minutes and 22 seconds to walk, quite briskly, to her destination: the nearest bathroom. I had a sudden urge to speak about how outrageous this was, that the bathroom should obviously be closer. Seeing my facial expression, the leader immediately said: "If you cannot fix it permanently, for everyone everywhere, do not try to fix it here." I continued the introductory tour, but my mind remained with that woman and my ears rang with the words of my superior.

Her story was like that of most refugees in Northern Greece: she was awaiting a verdict on whether the decision to flee her home, trek mountains filled with landmines, and cross the Mediterranean Sea in an inflatable boat, was warranted. I later learn that she is a mom of 3 boys, has been suffering from chronic bronchitis, and is a rare visitor of the Women's Space: the local NGO's dedicated time and space for women. I was to be assisting with this initiative. As a global health student, I was prepared to listen and learn from the local women to deliver a sustainable Psychosocial Health Program. As an Arab woman who wears the Hijab, I was ready to relate to the women and understand how best we can make the program fit for them. What I wasn't fully prepared for, was the hopeless demeanour among fellow humanitarian practitioners.

My first week was spent visiting families, requesting I speak to the women about Women's Space, and being politely rejected. It was frustrating. We had thought my similarity would facilitate conversations with families. When walking through the refugee camp, I was treated like a local refugee: told to return to my container at curfew, suspiciously looked at by owners of the Greek supermarkets, and regularly asked for my

Refugee ID at restaurants. To the refugee families however, my foreignness was evident. Given my slow progress, fellow volunteers dismissed the program, and I was asked to help teach English. My love for sports made me a great fit for the teenage class. Within a few days, I built immense rapport with them. I also learned that these boys, each with the character and charisma of great politicians, had enormous influence on family dynamics. I began floating the idea of Women's Space, compiled flyers, and encouraged these boys to inform their parents and siblings. Next week, three women showed up asking for Women's Space.

I spent the following week marvelling at the power and bravery of women. One woman brought her sister, another woman brought three neighbours. Soon enough, Women's Space was bustling with the laughter and tears of friends who were once strangers. Together, they built a program incorporating activities tailored to their interests and needs. We escalated major complaints regarding better housing for women with bronchitis. We ensured appropriate transportation for those who couldn't walk in the snow. And yet, a week later, the program was cancelled, citing budget constraints and complaints from "people".

I understood the potential for cultural constraints, but I couldn't understand how women's psychosocial health could be considered less of a priority than other initiatives. For the time it had been operable, the Women's Space was a success. The local refugee women built the program, they decided how often to meet, they decided what trauma to speak about and what triumphs to celebrate. They discussed depression, anxiety, and suffering. They learned self-defense. They planned English classes, knitting sessions, and potlucks. It was again frustrating that leaders and fellow volunteers were unwilling to advocate for its continuation. I spoke to my leader, conveying the WhatsApp messages I had received begging for the return of Women's Space. They took the opportunity to remind me: "If you cannot fix it permanently, for everyone everywhere, do not try to fix it here."

The remainder of my time involved coordinating video calls with women and setting up online fundraisers. We conducted wellness sessions through WhatsApp. Some women were able to get together and continue the program on their own time. Others looked forward to cooking food for their neighbours, just to spend a few minutes speaking about their most-recent coping mechanisms when dropping off the food.

On my final day in Northern Greece, I visited the designated Women's Space. I wanted to take a mental image of the potential that had been missed. I found three men sitting on the front steps. I recognized them to be the husbands of the local women who had spearheaded the Women's Space. They appeared quite sad.

One mustered the courage: “Miss, can we ask you a question?”

“Of course, how can I help?”

“What can we do about these feelings we have...like...depression.”

“Sometimes we get nightmares, very bad ones.”

“Our women need us to be strong, but I swear to God they are stronger than us.”

“Did you tell your wives?”

“Yes...They said we need Men’s Space.”

Sometimes, the very obstacle we are attempting to overcome is an opportunity to tackle a new need. I returned a few months later. Hope had been renewed, and so was the Women’s Space. The once-disheartened volunteers now work with a newfound energy to make all space a safe space. My leader changed their quote: “If you cannot fix it permanently, for everyone everywhere, do not try to fix it here. But do try to help them fix it.”

Rania Mansour completed her Masters of Public Health at the University of Pennsylvania Perelman School of Medicine where she took time between semesters to volunteer at a refugee camp in Greece – the inspiration behind this essay. She is currently a second-year medical student at St George’s University of London and aims to pursue a career in academic global surgery.

The Imperfect Art of Medicine

By: David Means

The x-ray machine is nonfunctional, the flow cytometer has been “down” for 3 months, and the very idea of acquiring a CT scanner is some far-fetched reverie. The premise of low resource medicine is especially appealing to a second-year medical student. There are few confirmatory tests and no resources; instead, you have an often-incomplete patient history and a physical exam to figure out the exact pathogenesis of what may be causing the observed symptoms in a patient. It is an admirable ability that provides the foundation on which modern medicine is built, and it makes for an exceptional learning environment. When I first signed up for my trip to Uganda, I envisioned it would allow me to build upon the concepts that I learned in first year while also boosting my awareness and understanding of medicine in a low-resource country. Instead, I gained an invaluable insight into the practice of medicine that rings true regardless of the resources available.

A patient was admitted overnight complaining of abdominal pain, vomiting after eating, constipation for several weeks, and motor weakness. His blood pressure was 100/60, and my immediate impression upon entering his room was that he was severely ill. He claimed these symptoms had only been present for 1-2 weeks, but this man looked chronically wasted with his ribs showing, eyes sunken, and arms with the circumference of a broom handle. He was put on IV fluids and tests were run for every disease that could possibly be tested for in the closet-sized laboratory. Malaria, TB, H. Pylori, and brucellosis came back negative, but his blood glucose was elevated to 262 mg/dl. The elevated blood glucose and slight jaundice lead us to believe there could be liver problem, and his bloodwork was sent to a nearby lab. It would be 24 hours before his results came back positive for Hepatitis B, but even with this new diagnosis, no progress was able to be made. The drug used to treat Hepatitis B in the clinic is a potent antiviral called lamivudine, but it was only available in the oral form. The patient couldn’t stomach the medication, and no IV drug was available. Even if the viral Hepatitis was able to be treated, this still did not explain the vomiting and constipation that indicated some sort of

bowel obstruction and possible malignancy. It was apparent there was nothing more we could do for this man, and the family was informed that he would need to be transferred to a missionary hospital nearly 3 hours away by car. The family was visibly discouraged by this news. With no ambulances in the area or any kind of community transport insurance in place, it again fell on them to transport their loved one to another far away facility.

It would be three more days before the family could gather the funds and means of transporting him to the hospital, which meant that by the time this man left our clinic, his condition had deteriorated even further. He had still yet to keep any food down, his abdomen was distended, and he had slid into a delirium, unable to answer questions or follow commands. Part of me wondered if referring this patient was even the right thing to do. The cost of this journey to the hospital could very well cripple the family's finances, as it seemed like even getting this man to our clinic was a burden. The hospital he was referred to is a missionary hospital that provides "low-cost medical care", although just how low-cost, I do not know. Additionally, there was no guarantee that this man would even survive the journey, as his condition had rapidly declined in the past few days. I soon realized that I was facing the same dilemma which physicians all over the world face every day when they ask themselves, "Is it worth it?". Is it worth it to operate on this 90-year-old patient? Is it worth it to treat this cancer with aggressive chemo despite a relatively low cure rate? Is it worth it to order this CT scan and subject the patient to unnecessary radiation? These are the infamous "judgment calls" of medicine that no amount of preclinical studying can prepare you for. There are no definitive answers and no guidelines to consult; instead, each situation is treated individually by letting prior experiences and ethical considerations lead the way. In this specific situation, I found myself asking if it was worth referring this man if it means a child in the family can no longer attend school? Is it worth referring if other members of the family will go hungry? These questions are similar in nature and just as difficult to answer if one does not have the correct experiences. I deferred to the judgment of the local doctors in this case, as they deal with these issues on a daily basis and have the ability to speak with the family about their financial situation. Yet, I still couldn't help but wonder if this was the right call.

As a second-year medical student, it is natural to want a single transparent answer for each clinical question. After all, our lives and even sometimes our worth seem to be dictated by multiple choice exams in which there is only one correct answer. This trip revealed to me just how abstract the art of medicine is across all socioeconomic contexts. There is a delicate balance between treating each new patient as an individual and letting

prior experiences guide your clinical thinking, and it is a skill that is only developed over time. Sometimes the only "correct" answer is to talk to the patient and figure out what is best for him or her. As future physicians, we may make judgment calls along the way that seem incorrect at the time, but it is how we react to these situations and adapt our future practice that defines what kind of physicians we will be.

David Means earned his B.S. degree in Biology at the University of Mississippi. He had this global health experience at the start of his second year of medical school while attending the University of Louisville School of Medicine. He is now a fourth-year medical student who is pursuing a career as a Diagnostic Radiologist.

The Silent Killer

By: Treasure Blessings Mkalianinga

I am Mphatso, a 13 years old girl. I am the first born in a family of 6 children. I am surrounded by sad faces. When I look at mom, her eyes are full of sorrow. My dad is trying to comfort me, telling me everything will be alright, but through his eyes, I can see his pain. My 6-month-old baby sister is also here, for there is no one to take care of her at home. She's now at risk of acquiring other infections in the hospital. We have been here for over a month now, with no sign of progress. Every day is a struggle to breathe. It frightens me that I can now count my ribs. I understand we are waiting for lab results, but the biochemistry machine is broken-down. The next option is to get my blood tested at a private laboratory, which will cost \$10, and my family will need to sell some of their chicken to find that sum of money, so we will keep waiting for the machine to be fixed, by an engineer from a distant country. I am currently admitted at a tertiary health care facility, where I am slowly getting to understand what is really happening to me ...rheumatic heart disease.., but I have been sick for a few years now.

It all started 6 years ago, when I was about 7 years old, when I had a sore throat. Our nearest facility is about 8 km away from home, and it is a paying facility. My parents could not manage the luxury of traveling all this distance, to and from, and paying a sum of money, for a simple thing as a sore throat. So they just bought me some Tylenol, to kill the pain, and advised me to take plenty of water, to soothe the throat. A few weeks later I started having joint pains, followed by chest pains and fevers. I kept being treated at home. We can only afford to go to hospital when things are really serious. We went to the hospital one of the other times, and I was treated for malaria, but did not get better. We returned to a local traditional healer, in order to save some funds.

My condition kept getting worse. I started coughing, losing weight, getting tired easily and getting short of breath, but my granny advised us to keep going to the native doctor. At some point we tried to go to the hospital again. I was told I have asthma, and received some medication for that, but things didn't get any better. I started to have

swollen legs, and could wake up in the middle of the night due to shortness of breath. I couldn't lie down on my back without being short of breath. I needed to use 3 pillows if I was to sleep at all. That was when we decided to go to the hospital again, and they referred us here. On arrival here, I was admitted and discharged a week later. I was told that I will need to take 3 drugs for my heart, including a monthly injection, which is very painful. I missed classes most days due to my sickness, which has greatly affected my education. I couldn't participate in play with my friends, and I couldn't take part in household chores, as I was getting tired easily. My nearest hospital didn't have some of the required medication, so we kept coming to the tertiary hospital, which is over 100 km away from home, which drained our funds. Sometimes we needed to sell some livestock to travel that long, and sometimes we couldn't manage to travel. So I would run out of drugs and get even sicker.

Now I am back here in the hospital, because I was swelling a lot, to the extent that water was dripping from my foot sores that had developed, and I needed hospitalization to manage the swelling. I have been told that my heart valves are damaged, and not functioning well. I was told I could be referred to other countries for heart valve replacement, but sadly, I'm only getting worse. I am on my bed in the hospital, waiting for my lab results, which will decide how I am going to be managed. I have missed my classmates, I have missed my friends and relatives, my young siblings. How are they? What are they doing? Could they also have a similar condition like the one I have? How best can I help so that they shouldn't be in my shoes one day? Am I going to die? Will I get better and see them again?? I am Mphatso, and I am from Malawi, Southern Africa, and I am dying of rheumatic heart disease (RHD).

Mphatso lost her battle with RHD after spending a month in hospital. According to the most recent Global Burden of Disease data, there are 160,000 cases of RHD in Malawi alone (1). RHD can be prevented by treating sore throats with penicillin, yet many children, especially girls like Mphatso present in late stages. There is a need to improve prevention and case detection of RHD in Malawi to treat and prevent progression to severe RHD and death, like Mphatso.

Reference:

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Treasure Blessings Mkaliinga is a dynamic Physician Assistant and upcoming clinical researcher, working and helping solve global health challenges since 2010. He holds a Diploma in Clinical Medicine and a Bachelor of Science Degree in Paediatrics and Child Health (Honors), and is looking forward to pursuing a Master of Science in a research related field or implementation science. His Reflections in Global health essay on Rheumatic Heart Disease in 2019 won the hearts of many, and he is currently working on a project set to investigate and improve mental health challenges in children with chronic illnesses, including rheumatic heart disease.

Hearing Aid

By: Parimala Mobanty

When I was working as an Ayush Medical Officer in a RBSK program I had the privilege of observing children as I was assigned to screen them in both school and Anganwadi centers of Sheragada CHC, Odisha, India. Looking back, on those days I had a one-time experience while embarking on a girl child named Lali. Typically, in an Anganwadi center, there is often a hassle passel of children for screening, proudly strutting as they come up to be weighed and height measured.

A 13-year-old quiet, unsmiling girl with kohl-lined eyes, cuddled a two-year, malnourished baby boy and sat in a corner. I called her to join the queue, for screening the baby she held, suddenly I noticed scalds and several injuries in her hand and my inquisitive mind forced me to inquire about her injuries. I asked her but she was apprehensive, she had kind of locked herself in some hopeless cocoon. I could sense something was grave and needed attention, so I humbly asked my counter medical officer to carry the screening, while I moved out holding her hand to the adjacent room. I motivated her to speak her heart out to me.

Her sudden bewildered cry hit me like a hurricane, threatening to drown me in the grief as I associated with an unexpected, devastating pain. Instinctively, I reached out to touch her arm – to comfort her – but she hugged me tightly and ultimately the distressed, timid girl allowed me to peep into her life. Lali's father was a drunkard and a hardcore bidi smoker and her mother was a farm laborer earning minimal wages. Lali's mother was the one who ran the house but her husband would take away all the money for alcohol. Her father was emotionally and psychologically abusive, threatening and belittling her mother; he kicked, punched and caused black eyes, while even trying to strangle her once. One of the worst attacks of physical abuse was when he raped Lali in drunken condition. To outsiders, it was just a financial crisis, but behind the doors, Lali was trapped with domestic violence and physical abuse and forced to lead a life of curse. Despite her mother knowing the truth, she always defended Lali's father just to safeguard the family's reputation and fame in the name of FAMILY STATUE and begged Lali to keep quiet, as he was the birth giver. Lali constantly condemned herself with a low self-

esteem. In the absence of her mother, Lali had to look after her younger sibling and even the cattle, since often her mother was at work all day struggling for their basic needs and father in an unconscious drunken condition, a kind of apparent invisibility of her father has often led to many traumatic situations for her. In fact, she once even burnt herself while cooking, but was luckily saved by a bystander.

She knew that her life was very different from others, a life full of miserable situations and experiences, and at times the dreadful events shook her emotions which amplified her thoughts of committing suicide, but the warmth and concern for her brother stopped her many times.

My heart leaped in a show of empathy. She was no doubt from a problematic background, born and raised very poor. She never built castles in the air, but just dreamt to be happy, to live a peaceful and garrulous life. She never wanted a lot of everything, everything she wanted was just love and a normal family, a teetotaler for a father and a better environment for her as well as for her brother. I hated the culture that condoned such dispassionate behavior towards those who, by no personal fault, had been born into a destitute and disempowered life: I hated my own capacity for tolerance and incapacity to induce change.

There has been a constant trend of misery and sorrow for a girl child born in underdeveloped rural India, most parents generally want their daughters to manage households as she was from a very young age, being trained with the age-old expectation that she is destined to be a wife and daughter-in-law and is not expected to earn a living.

I couldn't help Lali in great regards but I consoled her with every motivating word possible and calm down the turmoil within her, I became a Hearing Aid to her agony, she opened up and was much better than before. I asked her to pursue education and chase her dreams as that was the only way to get out of this trap. I requested the Anganwadi worker to help her by taking care of her brother, so she can go to school. I called her mother from her working site and counseled her to let Lali live and breathe in the open air and to raise a voice against her drunkard and rapist husband.

For the spectators, it would seem that Lali is living a normal and healthy life but none would understand the pain she went through and the scars that are embedded in her soul are hard to erase. She might start a new life but she will always be fearful of the things around her because her childhood experiences had left her confidence shattered. Now it's a big question to the world, will society ever forget the plight that happened in the life of a girl like Lali? Will the stance of a girl ever improve in INDIA AND WORLD IN TOTO? This is just one circumstance and there are many, there are many other LALI's who are in wish for aid to get out of the trap they are entangled in. I just wait for a day when all the girls in the world will have their status taken under consideration and give them all the freedom they deserve.

I spent nearly 3 years in Sheragada, taking in more such circumstances that left my moral compass spinning. All the while, my silent acceptance of such ridicule made me feel like an accomplice to social injustice as I couldn't bring about change, making me deeply depraved. So, I quit the job to pursue public health course, which will empower me to make my surroundings a better place.

Dr. Parimala Mohanty encountered this incident when she was working as an AYUSH Medical officer in a rural block named Sheragada of Odisha, India. This scene had a deep impact on her and she decided to pursue a master of public health, during this phase of her training she composed this essay. Currently, she is pursuing her doctoral studies and will soon graduate with her Ph.D. in public health from the Department of Community Medicine, from the Institute of Medical Sciences e³ SUM Hospital, Siksha 'O' Anusandhan Deemed to be University, Odisha. Her background, experience, and interest in research activities provide her with a broad set of skills that are extremely applicable to the development of society.



Screening of Child Health and Early Intervention Services under RBSK.

Photo Credit: Parimala Mohanty

Finding Meaningful Connection Through Problems

By: Lusayo Mwakatika

On the 6th of August 2017, I arrived in the US with only hopes and dreams. I had the hope of acquiring knowledge in agriculture and health that would steer the development of my country. I had read multiple stories of Africans who had “made it” abroad and returned home with fortunes and changed the fate of their families for the better. But for me, I wanted something different. I was looking to find a purpose and direction for my young 18-year-old self. I had a feeling this was the place I was going to discover my purpose, or at least it would send me in the right direction.

I had no friends or family in the US since I had never traveled here before. I was, however, eager to make friends and create a community. In my 18 years in Malawi, I had made a lot of friends. But I knew this would be different because I felt like I had just turned my life upside down. However, I was very eager for a challenge. In all the movies I had watched, people met their best friends in college, and I desperately needed one. As a result, I became more social, attended all of the first-year events: played soccer with strangers, went to free concerts, and more. I met a lot of people and thought I had a good connection with them. I had the impression that everything was going swimmingly. Little did I know, I was in for the biggest surprise of my life.

When I first arrived in the United States, I realized something: I was a black man in America. Until I moved to the United States, I had no idea what it meant to be black. Because everyone in Malawi has the same skin tone, you can barely tell you are different. I had no idea that being black meant people looked at me through certain stereotypes - stereotypes that I had never heard of before. The US taught me I was black, before my ethnicity, Christian beliefs, or my jokes. Sometimes I would sit in class, and if I did not know anyone, the seats to my left or right would be the last ones filled, and there were a couple of times where I was the last person to be chosen for a group project. This experience made me more aware of how I interacted with others. When I was in a group, I became more self-aware of how I dressed, talked, and acted. I tried not to raise any red flags by appearing to be a threat. I began to see myself coiling up all of a sudden. I was

no longer excited to attend the events that I had previously enjoyed. I started closing up - seeing as how - the only thing going through my mind was not to offend any more strangers in this foreign country. I started avoiding social situations; I began to spend more time in my room than I had previously, making me wonder if I would ever make real friends.

It was hard to deal with the situation, and it was even depressing at times. But I also learned something along the way. I started to question my identity; I wanted to find out who I was as a person. During this quest, I started learning more about the struggle of African Americans in the US. I took lessons that taught me about the many racial histories in the United States and how black people have been affected. I also learned of the strong men and women who have fought for racial injustice over the years. This new insight prompted me to join groups on campus that focused on fighting for more equality and racial justice. And all of a sudden, I was no longer lonely.

As a result, I learned the importance of confiding in friends and others about my struggles. I noticed that the more I shared my story, the more I learned about others' similar experiences. I started feeling seen and understood. Sharing my problems connected me to different people. As a result, I grew more comfortable and began sharing more about my culture and country with the people around me. I was once again proud of what I am and my home origin. I embraced my uniqueness and understood that I had a story to tell. And through this, I realized I had a purpose. I found there was much to learn and benefit from if I connected my two communities- Malawi and US. I saw an opportunity to engage a local organization I was involved with to the various funding entities in the US and to my university. In exchange, students from my US university would intern in my country at the local organization. This connection turned out to be beneficial for both communities. It showed me why I had gone through some of the difficulties. I decided to pursue this opportunity as a career. As a result, after I graduated, I returned to Malawi to use my experiences and connections to assist a local organization in making a greater impact on Malawian youths' health through agriculture. I would like to keep telling the story of my people to a larger audience. And I believe that being in close proximity to the people whose stories I want to share is the best way to do so.

Lusayo Mwakatika, Agribusiness Management, University of Wisconsin Madison, works on a project empowering youths in rural areas in Malawi through agriculture and this later translates to improving their nutrition and health wellbeing. Mwakatika currently lives in Lilongwe Malawi and our work extends to 5 districts of Malawi.

When Stories Are All We Have

By: Pooja Parameshwar

I first saw Caimile standing in the hospital hallway. She was so thin, no older than 20. Her delicate, bony fingers were wrapped around a tall, brown, wooden staff. Only later would I realize what that was for. I was working with an organization that provides surgery for women with obstetric fistula, a condition that can occur after a prolonged obstructed labor, resulting in incontinence to urine and/or stool. From my work interviewing women with fistula, I came to know that many of these women experience tremendous suffering. I wanted to ask Caimile about her life, to try to understand who she was and what she had gone through, and ultimately to give her, and these women, a voice.

I learned that Caimile had undergone a severely prolonged obstructed labor. It was her first labor, and her town's health center told her to wait, to keep trying for a normal delivery. A second health center would not have any electricity for a C-section, and finally, when she arrived at the third health center, ours, her uterus had ruptured, resulting in sepsis. "We thought we were going to lose her," said the on-call physician who saw Caimile that fateful night. As a result of the obstructed labor, Caimile developed a fistula. To make matters worse, the compression of the baby's head against her sacral nerve plexus resulted in foot drop, or nerve damage that causes an inability to walk. But most devastating of all: Caimile had lost the baby.

I will never forget Caimile's tears as she said her lifelong dream was to have her own baby. My heart sank as I wondered if she knew that she could not. She did. I struggled to find words, so I held her hand. I still remember that silence, more profound than anything words could fill, because it held a moment shared, a heartbreak felt, one young woman in a space of sheer vulnerability, another in a space of deep empathy. Not only were Caimile's baby and fertility taken away, but also, her identity and role in society were forever altered. In Caimile's community and many traditional cultures, the role of women is understood to be at the center of the household, with the responsibilities of being a wife and mother, of having and raising children. Caimile was just imagining the start

of her adult life as such. This was a deeply personal, socioeconomic, and cultural loss. I felt crushed by the immense weight of limits: the unforgiving socioeconomic barriers and the social determinants of health that had rendered this young woman's dreams into nightmares. So far in my life, I never ceased to look for answers. So much of what drew me to medicine and research was the ability to provide answers to people in their moments of greatest vulnerability, uncertainty, or fear. Instantly, my train of thought raced down this track: Caimile could adopt a baby; there is a world of options out there if we can help make them available to her. Nurse Rachel, my translator and cultural broker, saw this. She smiled sympathetically at me, but she shook her head. She knew the reality. Caimile was not the first woman she had seen to have lost so much so young. Nor would she be the last. "There are very many sad stories here," she would say.

The reality of limits set in again when I saw the dark stains on Caimile's bed after her surgery. She was still leaking; the fistula was not fully repaired due to excessive scar tissue. Caimile's doctors discussed with her the options: re-operate and possibly make things worse, or try again later, after she had time to heal. Caimile chose the latter, meaning that she would go home leaking, and come back for surgery. I saw a deep sadness in her face when she realized that she would not yet go home dry, but a weak smile suggested hope.

When Caimile and I talked, she said she enjoys going to quiet places to draw pictures. She beamed proudly when she showed me a drawing she made while she was in the hospital. I thought about all that she endured and in the face of it all, how she continued to find joy. I asked her what she would say to other women in her shoes, and she tells them there is hope, hope of being better. This word: "hope". A perfect opposite to the word "limit". Hope is what I learned from Caimile. Although I had realized the magnitude of what Caimile had lost, she also made me see what she may be able to gain. She forced me to consider the small joys, like the drawings she made, and the staunch hope for recovery that she maintained. I learned that it is about perspective. You could look at the resource limitations and immense need for care and not know where to start. But if you instead look at Caimile, or the women who left the hospital with newfound hope, you begin to understand that you can do something, and things can get better. Still, I am not sure if it will ever become easier for me to see how a lack of resources can impact lives so deeply, how countless barriers, injustices, and basic inequality can create needless and immense suffering, and how at times, it can feel like your hands are tied. But it is the stories that will keep me going. It is the faces behind each statistic and diagnosis. It is the tangible lives, like Caimile's, for which we must advocate. As James Orbinski, former president of Médecins Sans Frontières writes, "and when there are no easy answers, stories are all we

have.” Each of these women, each of these human beings, deserves every bit of a chance at a life of health and happiness, and to provide them with that... well, there is no other thing I would rather strive for. Caimile, thank you for telling me your story.

Pooja Parameshwar was an undergraduate student at the University of California, Los Angeles when she spent time documenting the stories of women living with obstetric fistula and other childbirth injuries. She is currently a fourth-year medical student at the Stanford University School of Medicine.

Lessons Learned from a Car Stuck in the Mud

By: Hannah Peifer

“Hey, I can get out and walk now, this area is usually mudd – (*insert the sound a car makes when it is sinking into the earth*) – y...”

I cautiously glance at my friend in the driver’s seat. His calm demeanor and nonchalant tone as he shrugs it off, “this happens all the time,” allows me to release a breath I hadn’t realized I had been holding. He gets out to assess the situation.

It was after 10pm on a Sunday. Phillip* was a resident physician and I, a medical student assisting with the expansion of cervical cancer screening program in western Kenya. This was my third summer in Kenya. My most recent visit had been three years prior. The area where I was presently working was a five-hour drive north of Migori, the place where I had stayed previously. Over the years I had kept in touch with some friends from my first two visits. Phillip heard me asking about the best way to get to my friends’ location and generously offered a ride as he was heading that way to visit his family. We were on our way back from that weekend trip.

Phillip began gathering rocks to place under his tires attempting to gain traction. He revved the engine several times to no avail. I went to ask the guard at my apartment complex for help. He came with a flashlight and a gardening hoe. After half an hour, we realized we needed more people to help lift the car. The guard asked two men walking by to help us, but four men were not enough. Feeling helpless and responsible as I watched them struggle, I was overcome with the desire to DO SOMETHING. I began walking the path and looking for help. This time, the unsolicited attention I received as a white female in rural Kenya worked to my advantage. With the light of my iPhone – how ironic that this phone I am so dependent on in the US could merely serve as a flashlight in this situation – I walked down the path and caught several people watching from behind their gates. A white person was enough to draw attention, but a white person speaking Swahili would certainly do the trick, “Hamjambo, mnaweza kutusaidia? Gari yetu imo – mud – uhhh... matope.” (“Hi, can you help us? Our car is in the mud.”)

All nine men were able to carry the car out of the mud in less than five minutes. At the risk of sounding dramatic, that was truly one of the happiest moments of my life. The men cheered and we thanked them. They lingered around and we realized they were waiting for us to show our gratitude monetarily, which I then did.

This experience highlights some lessons I have learned about global health:

1. Murphy's Law has unchecked influence in low-resource settings. What should have been a relaxing ride was full of twists, turns, and bumps (literally). This was no less true with our screening program: After we had drafted a proposal, met with all of the stakeholders, and solidified our plan, I found out that the nurse we were relying on would be on leave for the first full month of the planned screening program.
2. You must attack each problem from multiple angles to accomplish a goal—rocks for traction, hoes for digging, and people for lifting. Our screening program had to address client transportation (or lack thereof), stigma/misinformation, and competing staff responsibilities in order to provide screening to the women who requested it.
3. The role of an outsider, especially a Westerner, in global health should be to use their privilege to facilitate work on the ground – not to be in command. I was in the passenger's seat for a reason – Phillip knew the roads, I didn't. My colleagues know their community and its needs in a way that I don't. I will always, however, try to learn.
4. If you are an outsider doing global health work, you should make every effort to learn the local language, especially a noncolonial language. When I went to ask for help, I asked in *their* language. Speaking Swahili – even though I make mistakes and am not fluent – allows me to connect with my colleagues and the community in a way that would not be possible otherwise. It shows them that I respect their culture and am willing to learn.
5. Money matters. I had experienced frustrations in the past working with NGOs where organizational agendas were determined by the interests of the donor. I naively thought that this would be less of an issue in the academic model of global health. The reality is that the money is just controlled by researchers and their grants rather than wealthy benefactors. Both scenarios run the risk of money being allocated inefficiently because the people making financial decisions have their own agendas and impressions of the community they are “helping.” The ultimate solution would be for former colonizers to make reparations for colonialism to the countries that were colonized as wealthy countries became wealthy from colonialism

and continue to benefit from exploiting others. An intermediate solution is that global health work must involve listening to and learning from the community and local experts regarding community needs and resource allocation, acknowledging power imbalances between Kenyan (or those from other low- and middle-income countries) and American (or those from other high-income countries) colleagues, and intentionally working to rectify and reverse those imbalances.

6. The final and most important lesson is “Mtu ni watu” (literally “a person is people”). This Swahili Proverb expresses the widespread African sentiment that people need one other and can accomplish more together than alone. We needed nine Kenyan men (plus one American) to get the car out of the mud. We needed nurses, social workers, doctors, research assistants, pharmacists, students, community health workers, community members, and the local chief to get the screening project off the ground.

I have learned a lot from my time in Kenya, but above all, I learned that mud can be a lot deeper than it first appears.

*Name changed for anonymity

Hannah Peifer is currently a student in the MPH-45 Global Health Program at the Harvard T.H. Chan School of Public Health. Hannah wrote this essay after working on the expansion of a cervical cancer screening program in Kenya while she was a student at the Warren Alpert Medical School of Brown University. After completing her MPH degree, Hannah will return to medical school to finish her fourth and final year as she prepares to specialize in obstetrics and gynecology.

Preoperative Preparation

By: Joseph Peterson

“Listen to your patient, [s]he is telling you the diagnosis” - William Osler

In the cacophony of the busy operating room, it might have been easy to miss the quiet susurrations emanating from the young, gentle Filipina with the slight frame, lying on the table. The clanging of instruments into the Mayo stand, the stereotypically loud Americans calling for a desired and vital component of surgery, the conversations bandied between surgeons operating on a thyroid at an adjacent table all could easily have masked the pleas expressed in her halting English grammar. The focus on the next steps of leveling the spinal anesthesia or prepping her belly or maintaining a sterile field almost resulted in a lost opportunity for many whose stated purpose was to meet exactly the needs this patient was plaintively expressing.

“This is my punishment. This is what I deserve. This is how I pay for my sins,” she murmured a bit louder from beneath the blue surgical drape pulled to her face. My wife, standing near, turned the patient’s hair around her ears as she grasped the sides of her face and asked her for clarification of what she had just said. And at that moment, the world stopped. Instruments stilled, footfalls ceased. The total count no longer mattered. No rattle of tools or crinkling of cloth interrupted what followed.

My wife, a physical therapist and newly-christened *de facto* circulator in this third-world operating room, took Joanna’s head in her hands and asked, “Would you like to pray?”

Though we lacked knowledge of the fine detail of the tapestry of her life, we had been made aware of the broad strokes that painted her as prostitute, destitute, desiring fertility, in chronic pain, wishing for definitive management. With or without the substandard preoperative imaging she had brought with her, we couldn’t guarantee her any particular outcome. We did know she had a very large mass and her pelvis appeared to be fixed on exam. Combined with her profession, chronic pelvic inflammatory disease would not be unexpected. Perhaps it was endometriosis. Maybe, though unlikely due to her age, we would unfortunately find a cancer that would be beyond our scope of practice to

deal with that day. Would her completed surgery find her barren, lacking a uterus and therefore the will to continue living her life fully, absent her fertility? Would she suffer one of the many complications that had been included, directly and via a translator, in her informed consent? We didn’t know.

Worse yet, Joanna didn’t know. That, combined with her spiritual beliefs, and despite her repeated preoperative statements of nervousness, had culminated in us nearly failing to recognize the depth of the need of this weeping, quivering being - lying with body and soul bared, filled overflowing with abject humility, fully expecting retribution for her past deeds, delivered via the hands of those who had come professing interest only in helping and healing - while we went eagerly about our routine.

So, while every person in that previously clamorous room then stood stone-still, as if anchored to the cracked and stained tile floor, my wife’s prayer with Joanna competed only with the quiet hum of an underperforming window unit. Forgiveness was requested with a fervent passion. Strength, solace, peace, and assurance were solicited. Recognition of the God-given talents of her care team was offered and a blessing of a guiding hand for the surgeons was given.

Back in the comfort and ease of my life in America, the spiritual needs of patients around me are no less acute than Joanna’s. They are no less hesitant to express them overtly or implicitly if we are only interested and equipped to listen.

No matter where we individually stand along the spectrum of spiritual or aspiritual belief systems, no matter which part of the elephant of the truth of experience our blind eyes and stumbling hands have marked out as our core interpretation and therefore beliefs, our patients benefit when we pay attention to what is important to them - *their* core value system. They tell us the diagnosis and they lead us to their healing - if we only listen. There are souls as well as bodies longing, crying out for the touch of our gift of healing.

It is shameful that it took a trip half a world away to bring me to the point of recognizing the nuances of a patient’s fears and anxieties before surgery. Surgeries that for me had become...not routine...but they were no longer recognized for the extraordinary opportunities they presented.

Today, I follow Osler’s advice, addressing the emotional and spiritual facets of my patient’s lives as well as the surgical. I take the time immediately before surgery to discuss fears and offer prayers with my patients. Every day, I hope and pray that I can see patients healed not only physically as Joanna was after her complex endometrioma was removed, leaving her fertility intact, but also spiritually as they are guided, navigating through the difficult emotional roadmap of what weighs on both their health and hearts.

I strive to be a physician expressing genuine concern, putting forth effort to endorse their beliefs, providing comfort and prayers before each physical treatment.

Joseph Peterson, MD, associate professor. At the time of this encounter, Dr. Peterson was a relatively new attending working with multiple resident physicians on a medical mission trip to the Philippines. Dr. Peterson is currently a full-time faculty physician for the University of Florida OB/GYN residency program in Pensacola, Florida.



Operating table (1 of 3 in the same theater), with accompanying wooden blocks for Trendelenburg.

Photo Credit: Joseph Peterson, MD

Dignity in Death

By: Aparna Ramanathan

I stand beside Mr. O's bedside in the emergency department of our small private hospital in rural Western Kenya as he struggles to breathe. This morning, we chatted about the prospects of Gor Mahia, the local soccer team, and now, he is barely lucid. The cause for his sudden decompensation is unknown to us, and un-diagnosable with our limited laboratory capabilities. And so Death and I have reached our first crossroads, pistols drawn, each eyeing the other with suspicion.

I am all too familiar with this battleground. In medicine generally, and in global health specifically, Death is Common Enemy #1. We talk about him daily and try to measure him in mortality statistics. Our war is constant, and our outcome measures are binary: Life – we win, Death – we lose.

After discussing the situation with Mr. O's family, we decide to intubate him and transport him to the nearest referral hospital with ICU capabilities, which is about an hour away. The clinical officer on duty with me, J, calls the referral hospital to let them know we are coming. I place the endotracheal tube and begin manual ventilation with a bag. The man's critical condition stabilizes and we begin to make arrangements for transport. Death retreats to his camp, but continues to watch us, knowing that the situation is critical. We load everyone up into the "ambulance" – which is essentially a repurposed van with the back seats removed and replaced with a metal bench to act as a patient bed of sorts. The family crowds into the front seat with the driver and I support the man's head and neck while continuing ventilation with the hospital's one oxygen tank. I manually ventilate the patient until we reach the referral center. The nurse then takes over while we seek out the clinician in charge.

The emergency triage ward at the referral hospital is bustling, and the clinician in charge appears weary and haggard. "I'm sorry, but we had another emergency come in and we had to give away your bed," he says. Death has taken his first shot, and it has knocked the wind out of my chest. "The next referral hospital is about two hours from here." I look at J, who is slowly shaking his head. "We don't even have enough oxygen

to make it back home,” he says. “We didn’t plan for a return journey.” Panic rising, I ask the clinician if we can borrow a tank from them and bring it back full the following day, but he tells me they don’t have one to spare. Besides, what guarantee did he have from me that I would bring it back? As we both know, “borrowed” items in our setting are seldom returned. I grip the side of a cot for support as I see Death sneering at me, triumphant. The barrel of his pistol is inches away from my face, and I know that I have lost. But before I fall, there is still something I can do.

I find the family and let them know what I’ve been told. I tell them that we will run out of oxygen on the way back, meaning that Mr. O will likely die in transit. As an alternative, I offer to remove the breathing tube now and focus on making him comfortable, to which they agree. We get back into the ambulance; I stabilize Mr. O’s head on my lap and remove the tube. His breathing gradually becomes more labored until after several minutes, Death throws Mr. O over his shoulder and takes him from this world. Exhausted and covered in sweat and bile and blood, I struggle with the shame of failure.

When I reflect on that day in Kenya, I feel the most sorrow and regret about the manner in which we met Death at the end. It fills me with remorse that Mr. O’s last visions and sensations involved a cold metal bench in an ambulance on a bumpy road, rather than the warm embrace of family. In global health, we are often challenged to “do everything,” and many small hospitals and clinics feel shame and blame when people die on their premises rather than in a last-ditch transfer effort. However, this mentality poses huge emotional and financial burdens to families. Why not take a lesson from our palliative care colleagues in the cancer world, and look at death not as a battle foe, but as an old traveler who we all must meet eventually? With that mentality, we might have enabled Mr. O and his family to prepare themselves for Death’s arrival by celebrating his rich, full life. We, as physicians, do ourselves a disservice by treating mortality outcomes as binary. Even when death is inevitable, we can make a positive impact by helping our patients and their families meet the end of life with dignity and compassion.

Dr. Aparna Ramanathan, MD MPH FACOG, is a fellow in Minimally Invasive Gynecologic Surgery (MIGS) at MedStar Washington Hospital Center/Georgetown University. During the period described in her essay, she was a fellow in Global Health Innovations and Leadership at Harvard University; during this fellowship she worked in a hospital in Sagam, Kenya. She is passionate about developing and implementing innovative technologies to improve women’s health outcomes in low- and middle-income countries.

A Tuesday in East Africa

By: William E. Rosa

We can all remember a moment that sparked a new understanding of ourselves, others, and the surrounding world. It can occur in a fleeting second that forever changes our insides. One such moment happened on a Tuesday in January in East Africa.

I had moved to Rwanda for the year as a part of a multidisciplinary global initiative to improve the quality of healthcare through knowledge and skills transfer between local colleagues and my team. My small home in the capital city of Kigali served as my refuge but also as my rehearsal space for Rwandese drumming lessons. Every Tuesday at 5pm my teacher Josette would arrive, and for the next sixty minutes, the house would shake with the vibrations of tradition. Josette danced and self-expressed with the distinction of any enlightened artist: joyful, brilliant, spontaneous.

That particular Tuesday, we had finished the lesson and I went to the kitchen, leaving Josette to rest in a chair by the front door with a glass of water. Her bare feet rested on the carpet, enjoying blissful liberation for the toes that walked her miles a day to and from work in ill-fitting shoes. When I returned, Josette was staring outside the window; the mood in the room had shifted to a palpably thick sorrow.

I asked if she was alright and she answered, “It’s just sometimes, this time of day, the way the light is – it just is hard.”

“What do you mean?” I tried to clarify.

The gravity of her posture and weight of her pause called me to the attention expected of any loyal soldier.

“During the genocide,” she said, “It was at this time of day they came to rape me.”

I became prescient to the fact that my worldview was about to become radically and forever altered. Josette proceeded to tell me in great detail her 100-day story of survival during the 1994 Rwandan Genocide Against the Tutsi - a demonstration of government-incited mass murder that led to the brutal demise of an estimated 1 million people. Josette spoke of the day she watched murders taking place just down the road, and in her desperate agony, wanted to ask the militia men to please kill her... but she was

too tired. After weeks of running with only leaves to eat, hiding in swamps and carrying her 3-month-old son on her back, she lacked the energy required to stand, walk over, and ask to be killed.

As she opened her heart with intrepid humility, I was scared to breathe for fear I might take up too much space in the room. There was nothing to say or do except to be present and deeply listen. I was simply being asked to sit and bear witness.

In the days that followed my time with Josette, my entire relationship with my work and purpose shifted. I had come as a small part of a major international initiative, and while my employment objectives remained unchanged – to foster capacity building for the Rwandan healthcare workforce – my ethical “must” and foundational task was only just emerging. I began to realize that almost every person I cared for in the hospital or bumped shoulders with at the market was still palliating the sequelae of the 1994 genocide in some form or another. I had been missing the point.

I came to understand that it is impossible to reroute the global narrative of the future if I am not willing to listen to where it has been. So often health initiatives seek to implement “evidence-based” solutions in cultures and countries where they do not wield contextual relevance. We, as a group, need to do a better job of being with, listening to, and learning from the people we seek to help. We cannot stake the consequences of our global health endeavors on erudition alone; empirics isolated from the human beings they impact render their genius barren. We must integrate *all* ways of knowing, beyond the quantitative measures, and learn what it means to bear the privilege of witness. This will mean dethroning our ego as the expert scholar and embracing the naïve curiosity and audacious humility needed to “gently shake the world,” as Gandhi wrote.

Global health workers move into the field charged with specific tasks, whether it is building capacity or building a clinic. However, neither the capacity nor the clinic can sustain themselves without attention to the context on which they rest. That Tuesday afternoon, Josette taught me skills that have forever transformed my work - making peace with uncomfortable emotions, eliciting patience amid upset, and listening for answers instead of merely providing them. It is not sufficient for me to simply tick the boxes of my agenda; my interventions also include the dexterity to remain present and open and available so that I might be able to respond from a more compassionate place.

Months later I realized that Josette’s pain was not mine to carry; but it was mine to witness. It was mine to bear in those moments of trust and connection that made it safe for her to speak her truth. The willingness to bear witness makes us vulnerable to the depths of human suffering; but it also avails us to the ineffable merits of resilience that are birthed from the human spirit. In the quest for health and well-being, for social justice

and equity, we must not only be willing to tell our own stories but also help others to heal and express theirs. For it is another’s narrative that illuminates their context and it is in their context we find our relevance as global health workers.

The questions that confront us are varied and complex. Sometimes the answers are found in the classroom debates, research findings, or implications for practice and policy. And sometimes they are revealed in the stories that make themselves known on a Tuesday in January in East Africa.

William E. Rosa, PhD, MBE, NP, is a palliative care and psycho-oncology researcher, nurse practitioner, educator, and advocate. This essay describes events from 2015-2016 when he worked as faculty for the Human Resources for Health Program in Rwanda, East Africa. Dr. Rosa is currently an Assistant Attending Behavioral Scientist in the Department of Psychiatry and Behavioral Sciences at Memorial Sloan Kettering Cancer Center, New York, U.S.A.

A Radical Act

By: Mitra Sadigh

It was June 2020. Six months into a global pandemic. Just weeks following the murder of George Floyd. The height of the Black Lives Matter protests. Our Global Health Program was finding a new home in the virtual sphere. I had claimed two sessions of our two-week elective to discuss cultural relativity and humility. The course was carefully crafted in an attempt to recreate the global health environment; that moment when a person, through interacting with a different culture and way of life, excavates their own privileges and beliefs and perhaps for the first time, questions them.

Our nation was tearing at seams that have always existed but have never appropriately been acknowledged. That Friday morning, a student opened our class discussion with a few questions I could not have prepared myself for.

Did Christopher Columbus arrive in the New World in peace, but couldn't communicate his intentions because of the language barrier?

Were slaves in the United States unable to own land because they weren't educated in how to own land?

Did slaves not know they were being oppressed because they weren't educated?

The virtual room fell silent. I had never heard anyone ask these kinds of questions. I was not aware that anyone had these kinds of questions.

I responded the best I could in the moment.

No, the issue with Christopher Columbus was not the language barrier. Peace is offered through actions, not words.

Slaves couldn't own land because they were oppressed.

No, a person does not require an education to know that they are being oppressed. Every human being knows when they are subjected to injustice.

A few students chimed in—to help me, to help this questioning student, to help their own sense of helplessness. To help our colleagues of color in the virtual room.

The session left me reeling. At first I blamed myself for being unprepared—I should have known that our national reckoning would seep through the screen. Later, I blamed

our education system for allowing a student to make it so far without a basic understanding of history. I then blamed our medical education system for allowing a student to enter clinical care without understanding this continuing history that impacts countless peers, colleagues, and patients. The thought evolved over the weeks to follow. I harnessed the only thing in this cascade that I could control: ensuring students completed our global health elective having been exposed to this understanding. The next cycle, I taught a new course: Colonization and Global Health—a delving into the ways colonization has and continues to create inequity, and the pervasiveness of the colonial mindset in today's global health sphere.

As it turns out, this is not an easy thing to teach. One student's takeaway was that colonization was not as successful elsewhere as it was in the United States. Despite grave human rights violations, it was worth it because the nation is one of the world's greatest superpowers today. Other students have begun the course perplexed by the connection between colonization and global health, and completed it with the two concepts only slightly more reciprocal.

But the overall response has moved me. Many students feel catharsis in sharing their personal experiences with colonization. Relief in connecting with others in shared perspectives. Elucidation in naming the traumas that affect them every day more clearly than before. Awe as they start to observe their world through a new lens. Shock, even indignation for the false narratives they had been taught previously—from the media, from teachers, from textbooks, from culture. Guilt and shame in the reality they didn't see before. One student applauded my efforts in “sharing truths that were direct and arguably radical.” I am still sitting with the question of why speaking the truth is a radical act.

Do people in low-to-middle income countries (LMICs) not know they are getting the short end of the economic, resource, and life expectancy stick because they are not educated?

Do people in LMIC have lesser access to resources because they're “not educated” in how to use those resources?

Do people from high-income countries (HICs) come to LMICs with well-intentioned solutions, but are misunderstood as having a colonially-rooted savior complex?

Global health experiences on-the-ground are capable of overturning these same fallacies, but with greater harm to host communities. It is the learning of a student from a HIC at the expense of a person in a LMIC, much like the students of color that day who were teaching the white student about the awareness that intrinsically arises within the oppressed.

We cannot provide the breadth and depth of a global health experience in the virtual sphere any more than we can craft the nuanced, personalized lessons that a student on a global health elective would be faced with. But we can provide them with a platform on which to question how inequality came to be before they rush in to help fight it. We can encourage them to investigate the ways harmful legacies continue to propagate through our subconscious and the systems from which many of us benefit. We can awaken them to the abuse and mistrust from which global health emerged and currently inhabits so that they may someday truly connect with the populations they feel compelled to serve.

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Defining Poverty: From India to South America via USA

By: Vatsla Sharma

In the year 2011, I was based out of Bihar, a northeastern Indian state, as a program officer for an international non-profit affiliate of a leading American university. That year, our office hosted two students from nursing school of that university for their summer internship. They were interested to learn about our programmatic activities focused on nursing education and nurses' clinical training in Bihar.

Since I was leading the implementation of quality improvement, national standards at public hospitals and their affiliated nursing schools, they shadowed me in my routine visits to various districts of the state. On one such visit, as we walked through the hospital corridors, we noticed a commotion between a nurse and a man with a feeble boy of about 3 years clinging to his waist. As it turned out, the boy was malnourished and the man - his father, was insisting to get his son discharged, without completing the required inpatient stay of 15 days from the Malnourishment Treatment Center. The nurse was urging the man not to do so. I learned that the man was a daily wage laborer and wanted to leave because he was afraid of losing his job and becoming insolvent. A caregiver was required to be with the child, so he had to be stationed in the hospital itself. While treatment and stay at the hospital were free, there was still a huge opportunity cost. The free services weren't enough to insulate him from monetary damages incurred through loss of daily wage. I was moved beyond words to see the man having to make the proverbial Sophie's choice. He had to sacrifice his son's health to hedge against a potentially catastrophic future.

Later on our way back to the office, one of the students asked me about the incident and I explained the situation wrapping up with the pithy statement that the man had to compromise on quality healthcare for his son to prevent severe long term economic consequences. The following conversation ensued:

Student : "but he did not *seem* to be *that* poor"

I : What makes you say that?

Student : “Well, he had a cell phone. I also heard him say words such as “time”, “late”. I was under the impression that most poor people are illiterate and don’t know English.”

I was taken aback but quickly processed that it was the students’ maiden visit to a developing country. They came from the first world, with limited exposure to the gamut of poverty in this part of the globe. Indeed, the picture of poverty painted by Hollywood - that of sunbaked faces, tattered clothes and mud smeared bodies is an antithesis to a cell phone wielding man. Thinking thus, I explained to them that cell phones are relatively inexpensive in India. Sometimes second-hand, Chinese manufactured ones being as cheap as \$10. Also, employers often give them so that daily laborers can be summoned to work at a moment’s notice. Call it the vestiges of colonialism but English is widely spoken throughout India. Some English words are so common that they have replaced their Hindi/regional synonyms. So even if that man did not appear to be “textbook poor”- he was, in fact, struggling to make a living.

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It was 2016, and I was based out of the US, volunteering with a non-profit that aided impoverished Latin American communities by providing health care. US doctors and nurses traveled to South America to perform medical procedures on local people who had limited or no access to them otherwise. I happened to join the organization at a time when it was rethinking its strategy for the next three years and aspired to include a program evaluation component. I was entrusted with the responsibility of generating scorecards and outcome metrics. One of my ideas was to measure the percentage of patients, who were below the international poverty line, among all those who were served. This idea immediately found favor with the Director of programs - “it would be great if we can show to our board that our services are directed towards those who are needy. You see, we often get the feedback from our doctors that the patients they treated did not *seem* to be poor”. She also mentioned the reason for this belief - “They were not dressed in indigenous clothing.”

Ah, Deja vu.

The same story, the same precipitous judgment! Was this a mere coincidence or is there a deeper pattern that dictates the inherent notion of poverty among US based global health professionals? Do the well-intentioned, starry-eyed doctors and nurses realize that they may be operating under airtight definitions of poverty?

The Director, who was of Hispanic origin, and I appreciated that just like in India, indigenous Latin Americans tended to dress up in their best clothes when visiting a hospital. Doctors and nurses are revered figures in these cultures and people endeavor to

be presentable for them. Ubiquitous availability of cheap non-traditional clothing such as jeans and shirts, that are considered more sophisticated especially by current generation, accords affordability to this gesture.

According to the Organization for Economic Co-operation and Development (OECD), the US is the world’s largest donor to global health, having spent a total of US\$9.9 billion on health official development assistance (ODA) in 2016 (accounting for 50% of all health ODA provided by OECD donor countries). Besides monetary aid, it also contributes skilled manpower by packing thousands of volunteer health professionals, each year, to developing countries for serving the locals. But does it do enough to sensitize this philanthropic army about the poverty spectrum?

Poverty is relative, multidimensional, and not always abject. A seemingly “well-to-do” person might very well be within the clutches of poverty. Only when the misconceptions and myths surrounding poverty are debunked, sustainable solutions for ensuring health equity can come up. It requires global health professionals to relate to the ground realities and refrain from judging a book by its cover.

Vatsla Sharma is currently pursuing a Master of Public Affairs with a concentration in Health Policy from O’Neill School of Public Affairs, Indiana University. At the time of writing this essay she was in an evaluation consultant role with a USA based non-profit organization.

Lungile

By Ilana R. Siegal

“What’s your Swazi name?” the Gogo (grandmother in siSwati) with soft eyes and missing teeth asked. As if my white skin, tall stature, and quintessential brown Jewish curls didn’t scream “foreign” loud enough, I wondered, “How did I deserve a Swazi name?” In response to my confused expression and silence, she emphatically proclaimed, “I am going to name you Lungile! It means ‘the righteous one, the righteous tree from above and a mother of nations.’”

Righteous? How was I righteous? What was I contributing? I had just finished my first year of medical school and was spending the summer in Eswatini (formerly Swaziland), unsure of my purpose. I immersed myself in medical information and cultural nuance but felt my contribution was limited. While Gogo may have gotten the righteous designation wrong, at least she got the tree thing right. I explained to her that in Hebrew, my real name means “tree.” She smiled knowingly, content with her chosen Swazi name for me. She thought that it fit; I was grateful it made me feel like I belonged.

“How do you know me enough to pick that name?” I inquired since Gogo was the family member of a patient I had seen only briefly in the clinic.

She revealed, “I can pick up something about you, even though I just met you. A special character.”

“I feel like you know something about me that I don’t know yet...” I questioned.

She winked playfully and said, “you do, huh?” with a crooked smile and a chuckle. I thought that she was just playing with me, until she continued... “Earlier I saw you leave, maybe you went to eat, and you came back looking energized. Then I saw you playing with the kids. You love kids and have a loving heart. You got low to be on their level, so I know you’ll serve low.”

Apparently Gogo was watching me for hours prior to our meeting while she waited for medical care with her adult daughter. I remained completely oblivious to her gaze from a distance. But as a porcelain face in a sea of ebony, I was easily spotted. Ultimately,

she witnessed my genuine and loving interactions with the kids and deemed me worthy of a Swazi name.

She taught me that names matter. I did not know I desired a Swazi name she gave me one. I had spent much of the summer feeling like an outsider and imposter, which I attempted to combat by learning the Swazi words, songs, dances, prayers, and medical system. I was gaining infinitely, while providing significantly less. However, Gogo helped me realize that one of the purposes of global health student experiences is human connection. Through a name Gogo facilitated this connection and made me feel that I belonged.

Gogo also taught me that servanthood matters: “You got low to be on their level, so I know you’ll serve low.” Being a “servant” is the fundamental role of a global health student. As much as I read and studied in preparation for my experience, I quickly learned that my main purpose was to listen, learn, ask questions, and follow the lead of and serve the people with whom I was working.

In today’s world driven by the COVID-19 pandemic, student engagement in global health efforts is logistically challenging. However, our travel is not required to build sustainable systems. Efforts in Eswatini and numerous other countries are more sustainable when they are locally driven, organized, and staffed. Money is best spent for supplies, training, equipment, and infrastructure that benefit the locals.

I often question my purpose as a global health student, desperately hoping that I have contributed positively. Gogo taught me that human connection and servanthood are the basis of future global health interactions. Students who gain these experiences hopefully are more inclined in the future to participate in sustainable global health efforts through capacity building. I will strive to live up to Gogo’s prophecy of Lungile (righteousness) and live according to these lessons as I continue my global health journey.

Ilana R. Siegal is a recent graduate of Boonshoft School of Medicine at Wright State University Medical and is on the path to becoming a plastic and reconstructive surgeon. She earned her M.A. in Bioethics from Case Western Reserve University and her B.A. in International Relations at Syracuse University. She wrote this reflective essay based on her summer experience in Eswatini between her first and second years of medical school.



A warehouse turned outpatient clinic with an open window looking toward the mountainous Swazi sunset.

Photo Credit: Ilana R. Siegal, MD, MA



A community leader, “Gogo” (grandmother in siSwati), walking home after a full day of home visits to the ill.

Photo Credit: Ilana R. Siegal, MD, MA



Swazi tree at sunset that I passed daily walking to the medical campus.

Photo Credit: Ilana R. Siegal, MD, MA

The Touch

By: Lisa Simon

The medical interviewing class I help teach recently held a group discussion. It was on the subject of touching. I don't teach the class alone – I share a small group of first year medical and dental students with two other faculty members from different specialties. It's an intimate group with insightful students, and our conversations often meander to unexpected places. Even so, I was surprised when both my colleagues took a reserved and cautionary tone when we talked about how we touch our patients.

"Think twice before you touch a patient." One exhorted, "You never know if they might respond badly, so it's a risk you might not want to take." The other nodded in agreement.

"It can land you in deep trouble." She said.

I don't want to put my students at risk, and it is important to read an intimate situation before acting. Both my co-teachers are older, more experienced. They have been in practice much longer than me, fresh out of residency. I felt worried and confused. Were they right? Was I doing something wrong?

Because I work as a dentist in a jail, and I touch my patients all the time.

When I first started my job, I confess I expected to find it a little glamorous, or at least a little exciting. But for all the video cameras and alarm bells and concrete walls 3 feet thick, the dental clinic is actually a completely normal-looking room. The dental chair is even a cheery shade of blue. Unfortunately, it's a chair it takes far too long to get into for those in need. There are about 600 men in the jail where I work, and last time I checked, the list of people in urgent need of a dentist was nearing 200.

All of my patients are in pain, and usually, they are terrified. They have waited patiently for months because they have no choice. Sometimes this is the first time in their lives that they have visited a dentist. I spend most of the day pulling teeth and cleaning infection out of gums. Sometimes I can devote some time to explaining how a patient can find a dentist to treat him when he is released. Many of my patients are eligible for free

dental care because the state, the same one that has put them in jail, still considers them, for health insurance, to be children.

My fourth patient of the day, like the others before him, needs to have a tooth extracted. The antibiotics given to him by a nurse have brought the swelling down, but his eyes are red from lack of sleep, and his hand tightly cups his chin. It is obvious that he is suffering. He is quiet when I ask to examine his mouth, and even more quiet when explain what I will do. When I ask if this is alright, he simply nods.

As I attend to his infected teeth, I hear a wordless lilt that I know is a question. "I'm sorry, what?" I remove my tools from his mouth to hear him better.

"Do you feel safe here with me?"

Everyone entering the building goes through a metal detector. The elevators don't work without a special badge. There is always a correctional officer standing at the open door leading into the dental clinic. I am far safer here than I will be on my bicycle, coming home at the end of the day. But that is not what he means.

Lots of people are afraid of dentists. I'm used to that; actually, I'm pretty good at working with patients who have dental anxiety. But when I walk down the street, no one is afraid of *me*. I exist in a body that guarantees I will always have that luxury. I can only imagine how painful that must be, like the constant dull ache of a bad tooth. And yet the man before me wants to make sure I'm comfortable. My patient, a person it is my job to care for, is caring for me.

"Do you feel safe here, with me?"

I think of the concerns my colleagues voiced, and I think of the times my patient has been touched. There is the jostling of the correctional officers who escorted him to the clinic. There is my own rough, clinical manipulations in his mouth. Perhaps, if he is lucky, he has felt a furtive pat on the arm from a visiting family member. My hand goes immediately to his shoulder and gives a warm squeeze. I leave it there for a while before I resume my work.

My day at the jail is also visiting day. At 7 pm, I grab my backpack and bicycle helmet and slip past the lines of people here to see their incarcerated loved ones. Some are gray-haired; some look like they have come here straight from their high school classroom. Some hold newborns. I do not know how long they have been waiting. Before being granted entrance, they are heavily scrutinized, yield their driver's licenses, and deposit all their belongings in lockers. They wait in small groups to pass through the jail's hulking doors, holding laminated visitors' passes up to the officer, who frowns at them behind a thick pane of bullet-proof glass. I don't have to do any of that. For me, the doors just open.

Biking through the crisp fall air, I reflect on the day, on what went well, on what I can do better. My mind snags on my patient's words and they echo back to me. "Do you feel safe here?" There are so many things I wanted to say in response. *I'm sorry you're in pain. I am sad things are so unfair. I am so touched you are concerned about me. I want you to have the dignity and respect you deserve.*

A touch, I know, can't say all that. But what I hope it manages to say is simply *I'm here.*

Lisa Simon MD DMD was an Instructor in Oral Health Policy and Epidemiology at the Harvard School of Dental Medicine when she wrote this essay. She is now an incoming faculty member in the Department of General Internal Medicine and Primary Care at Brigham and Women's Hospital.

"Why Are You Doing Global Health?"

By: Jonathan Steer-Massaro

"Why are you doing global health?" "Why medicine?" "Why OBGYN?" I thought after applying to medical school, residency, and then fellowship, these incredibly common, yet deceptively difficult questions would end. I've always struggled answering them. The answers sound trite, disingenuous, or pompous. Nobody wants to talk with someone who proclaims they are saving the world. As I've transitioned from OBGYN resident to global health fellow, I've been asked this question often. And the questioner is frequently me.

I'm nearing the end of my first trip to western Kenya as an OBGYN consultant. "Why are you doing global health?" I think I know. It's *a lot of fun*. Not greasy street food and less paperwork fun; instead, nerdy, academic fun. I can problem solve. Medicine is fun again. For the past eight weeks, I've been working without studies or guidelines applicable to this patient population. The antibiotics we have one day are not the antibiotics we'll have the following day. The only feasible imaging is what we personally do with portable ultrasound.

In medical school, when you learn for the first time, you're asked to problem solve. Each class gives you a small piece of the puzzle and you get to assemble it on your own. You are allowed and encouraged to make mistakes; you piece knowledge together as you choose. But as you progress in residency and memorize hospital protocols and societal guidelines, you rely more on those rules and less on what you learned in school.

This is how I feel practicing obstetrics in a resource-rich, urban, academic center. Sometimes working on Labor and Delivery in Boston feels as if you simply need to be good at reciting protocols and reading literature. Some prestige even goes to those able to cite the most recent ACOG Practice Bulletin or last month's practice-changing NEJM article during rounds. I am not disparaging these skills. There are benefits: it's largely evidence based, standardization of care reduces variation and errors, and it provides legal protection.

How does the above style of medicine translate to resource-poor, global settings? Initially, not well. An example: a woman presented, stable, with a fetal demise around 25

weeks. On admission, portable ultrasound showed what appeared to be an extra-uterine pregnancy. Or did she have a bicornuate uterus? Without knowing exactly where the pregnancy was, we couldn't know what would be the safest way of delivery. If I were back in Boston, I'd have resources. I would have obtained a confirmatory transvaginal ultrasound, then an MRI, and then discussed the findings with my senior colleagues to make a surgical plan.

But we're not in Boston; we're in western Kenya. Here, I have a fellow OBGYN consultant and a senior clinical officer. No radiologist. No specialists. So we sat and talked it through. We considered what was most likely, what could be the worst case scenario, the best case scenario, and everything in between. It was one of the most invigorating medical discussions I've had. It echoed the excitement I felt shadowing in the wards as a first year medical student. We had to make decisions with certain details missing, details we'd never have at that time. The next day we took our patient to the operating room for an ultrasound guided exam under sedation where we realized there was no connection between the fetus and her cervix. This was not coming out vaginally; she needed an exploratory laparotomy the following day.

Details were still scarce. I've never been so anxious for surgery. I would have given anything for those radiology reports, published studies, and expert opinions I once took for granted. Lying in bed the night before, I saw the grainy ultrasound scroll past my eyes as I recited the anticipated anatomy. I second-guessed each decision we had made and considered hundreds of "what-if" scenarios. But come the morning when we called "skin incision!," I was ready. I knew I was a good surgeon, standing across from another good surgeon, and that together we had done everything in our power to prepare for the worst while hoping for the best. The patient ended up having an extrauterine pregnancy. We removed it without complication. She went home three days later. Problem solved.

I tell you this not to make myself feel good. I tell you this not to make you pity the patients and providers at this resource-limited hospital. Instead I tell you this to illustrate my point. I'm not advocating being cavalier and making things up as you go. I wish I had protocols to tell me exactly what to do with that *exact* patient given those *exact* resources. I wish I had scholarly articles telling me the incidence of extra-uterine pregnancies in rural western Kenya. I wish I had an MRI machine. My Boston training had appropriately instructed me to ask for these. But there are times when one doesn't - and I didn't - have those luxuries.

So what am I trying to say? Just this. Yes, it is challenging to learn what feels like two types of medicine as you move between America and resource-limited settings. Yes, the way I was trained and how I practice medicine in Boston does not always serve me well in

Kenya. No, I didn't receive poor training. In fact I received fantastic training. And this is precisely why I am doing a global health fellowship. It's to bridge a gap. I am rediscovering how to use my physiology, pharmacology, anatomy and entire medical foundation to problem solve when resources are limited. It's not just necessary, it's exciting! But these skills don't stay behind in Kenya. These skills: critical thinking, flexibility, creativity, and problem solving will come back with me to make me a better physician back in Boston. This is why I am spending two years on a global health fellowship. And this is why I am doing global health.

The Sixth Sick Child

By: Paula Tavrow

Some days we public health specialists are hell-bent on improving quality of care and reducing medical errors. Other days we wring our hands about the lack of access to health services, turning our focus to affordability and outreach. In reality, quality and access are two sides of the same medical care coin. But this presumes that the coin is within our grasp, not rolling down an embankment and into a muddy river.

On this particular day, my team's goal was quality improvement. In rural Kenya, doctors are scarcer than sunscreen, so nurses have to act as frontline health providers. Our task was to observe and rate nurses as they diagnosed and treated sick children at two government health facilities about two hours from Vihiga town and three hours from the nearest city. The protocol was for us to assess a nurse's management of six sick children--enough to observe a range of ailments.

The team I was leading consisted of eight Kenyan clinical supervisors and assessors from several cities. A supervisor would first document how the nurse handled each young patient. Then, in a separate room, an assessor would perform a "gold star" re-examination to determine if the nurse had made any errors. It was a painstaking process. The nurses, understandably nervous in the face of such close scrutiny, took 20-30 minutes with each child, rather than the usual five to seven.

The day had dawned grey with a chill wind. As we bobbed along rutted roads, the team cautioned me about afternoon downpours, which could mire our vehicle if we were not careful. At the first health facility, half of the team disembarked. Thirty minutes later, the rest of the team and I reached the second facility. For nearly six hours, the supervisors and assessors worked to observe, assess, and record the nurses' performance. I handled logistics and instruments. By the time we finished and drove back to the first facility, it was already late afternoon.

My group remained in the vehicle as I ran inside to retrieve the rest of the team. The sky was now ominous and I felt a few droplets of rain. A long queue of mothers with feverish children were sitting on narrow wooden benches along the outer wall of the

health center, still waiting to be seen. The facility was dilapidated, with peeling paint, pocked bulletin boards, and no running water. It had only four light bulbs to illuminate the interior. In one office, I found our supervisor gazing intently as a thin, tired-looking nurse assessed a two-year-old boy. The supervisor assured me it was his last observation of the day—the sixth child for this nurse. All that remained was the assessor's re-examination.

At that moment, a bolt of lightning crackled across the sky and the droplets became a deluge. I urged them to hurry. Another lightning flash. Suddenly the lights went out and we were in semi-darkness. While the assessor rapidly conducted her re-examination, the other team members packed up and sprinted for our vehicle. I turned to leave, but the assessor, accompanied by the father and two-year-old boy, stopped me. "We have a problem," she declared. I was focused on the rain and barely heard her over the din on the corrugated roof. "Yes?," I offered. "The nurse had diagnosed this child with malaria, but his symptoms are far worse. He is gravely ill. He must go to hospital, or he may die tonight."

I peered at the child. I am not a physician, but I could see that the boy was exceedingly pale and breathing poorly. The father, barefoot and in a lacerated shirt, was grim-faced. The nurse seemed utterly deflated. I later learned that she had been up all night with a difficult delivery. I said to the assessor, "OK, fine. Let's take the father and child to Vihiga hospital. It will be a squeeze, but we can do it." The assessor turned to the father and translated what I had said into Kiswahili. The father responded quietly, "Hapana" (no).

I felt sure that he had misunderstood. "Please explain to him that the child is deathly sick. He needs to go to hospital." The assessor spoke again to the father. He told her that he knew that the illness was severe, because they had buried the child's older brother just two weeks earlier. "So, what is going on?," I asked, growing more anxious as I watched the rain plummeting. The assessor replied, "His wife just gave birth yesterday. That is why he is here with the boy. He cannot leave his wife at home, not knowing his whereabouts. She will panic."

I thought quickly. "OK, let's drive to his home, inform the wife, and then head to the hospital." The nurse intervened, "That's impossible, because he came here on a footpath. There is no road near his home." I eyed the queue of mothers in the waning light. "Is there anyone here who knows where this man lives?" The father scanned them and recognized a woman. "Excellent. Tell her that you are going to Vihiga hospital," I said, relieved that we had overcome this hurdle. But the man repeated softly, "Hapana."

Now I was confused. "Why not?," I asked. The father pulled out his pants' pockets to show that they were empty. No money for a hospital stay, or for the two-hour drive back to Vihiga. The recent funeral and birth had sapped his limited finances. I dug into my

purse and found a 1000-shilling note (about \$15), which I thrust on him. Problem solved, right? “Let’s go!,” I begged. But the man shook his head, with sad fatalism, “Hapana.”

This was maddening. The rain was torrential. We would never get out of here. “Why not?,” I nearly yelled. The father pointed to the boy. In his misery, he had vomited all over himself. The father could not imagine traveling with the child in this state. The nurse spoke up, “Wait here.” She ran to her cottage near the health center, and returned with a pink baby’s blanket from her own daughter’s bed. She gently wrapped the ill boy in it. Finally, we could leave.

Yet the rain by now had rendered the road treacherous. We slid and slipped. At one point, the vehicle sank heavily into an immense pothole that consumed both front tires. One supervisor muttered that the child would die before we reached the hospital. A group of us pushed and pushed, until the vehicle kicked out, splattering us with mud.

At 9 PM, exhausted and hungry, we reached the hospital. It loomed dark and still, like an abandoned warehouse. One supervisor and I ran inside, with the father and child close behind. “Is there anyone here?,” we shouted, with rising urgency. Eventually, a male nurse came and led the father to the pediatric ward. There the nurse started the child, whose name was John, on an IV.

When I visited the next day, I found that John was on the mend, with his aunt sitting at his bedside. His father was already on a bus heading home to his wife and newborn. By remarkable luck and his own resilience, our sixth sick child had survived. But how many other children perish in these macabre, human-made obstacle courses? Clearly, even if medical errors were minimized, sick children and their families would still face abysmal hurdles.

For the next two weeks, we soldiered on with our nurse performance assessments in Vihiga county, as we were being paid to do. We knew it was important. More nervous nurses, worried mothers, and exacting assessments. Yet, contrary to protocol, we also continued to assist some small souls who could not otherwise endure the impenetrable river. Was this our way of saving the world, as the Talmud teaches? Or just assuaging our consciences as we carried out our work?

All we knew for certain was that a correct diagnosis, an offer of transportation, a helpful neighbor, some necessary cash, a soft blanket, a vanquished pothole, or a decently-equipped hospital were not sufficient to keep a sick boy like John alive. Instead, it required all of these—quality, access, teamwork, family and community. Helping children thrive takes more than a village, more than a health system. It takes all of us learning together, not faltering, eyes on the prize, building bridges over the murky waters. Maybe someday John will join the effort.

Paula Tavrow is the Director of UCLA’s Bixby Program in Population and Reproductive Health and Adjunct Professor in the Community Health Sciences Department at the UCLA Fielding School of Public Health. She was the founding Co-Director of the Center of Expertise in Women’s Health and Empowerment at the University of California Global Health Institute. Dr. Tavrow’s research interests center on adolescent sexual and reproductive health, coerced sex, intimate partner violence screening, early marriage, crisis pregnancy centers, and the quality of healthcare services in sub-Saharan Africa. She has worked on public health issues in East and Southern Africa for three decades.

Going Gently: A Case for Palliative Care in India

By: Ilika Tripathi

It had been raining all night. I sat in a corner of the room and watched as my grandfather slowly drew the sheet over my paternal grandmother's face. I heard crying, almost synchronized, from my entire family, as I tried to absorb the first death I had ever seen.

Her death was not out of the blue. My family had been vigilant for the six months since she broke her hip. At the time, I was in 8th grade, young enough that I had no say when she decided not to stay in the hospital and my family decided to honor her wishes. But I was old enough to privately express to my mother how thoughtless I thought her decision to not stay in the hospital was - how I thought that she didn't want to get better, that it was like she almost wanted to live in pain.

Her body slowly wasted away- bed-ridden, she became dependent on other people for the most basic demands of her body. Additionally, she was schizophrenic, and the constant physical misery led to her having several breaks in reality. Young and immature as I was, I believed her misery proved that her decision to not go to the hospital was what I initially thought it was- giving up before even trying.

I was old enough to know that "trying" at that point wouldn't magically cure my grandmother. I only wanted her to be comfortable, so she could spend her last days on Earth in the company of the people she loved most, remembering the memories that were dearest to her.

But her last day in this world was painful. And on that day of swirling grief over so many things present and past, during my first experience of someone close to me passing away, these beliefs about pain and death embedded themselves into my mind.

It was only after she died that my mother told me about my maternal grandmother, who passed away before I was born. When she was diagnosed with cancer, she chose to undergo no formal medical treatment and decided to stay at home. And as I kept growing up, I kept getting to know of more terminally ill people who refused to seek the comfort a hospital could give them- both inside and outside my family, I recognized a trend in terminally or chronically ill Indians.

In India, many people believe that if they are terminally ill- being hospitalized is "useless." Not only will it drain the family of financial resources, but also put the entire family under immense emotional strain. Wouldn't it be better, my maternal grandmother used to tell my mother, to spend the last few months of life surrounded by family and good memories instead of the cruelty and sterility of medical facilities?

The cruelty of medical facilities in India is more mental than physical. While medicines are constantly administered as a part of a treatment regimen, the emotional agony a patient goes through is unimaginable. I cannot imagine the emotional agony my family would have gone through if my maternal grandmother spent her last year in hospitals, wasting away even as medicine tried to make her hold on. I cannot imagine how exhausted my paternal grandmother would have been, hoping that something in her body would be cured. Indeed, I don't want to imagine the utter discomfort terminally ill people go through in the last days of their lives.

Curative care is defined as the care given for medical conditions that are considered curable. And while it has a noble medical philosophy of not giving up, I can now see all the ways this would have exhausted my chronically ill grandmother. I can finally see my grandmother's decision to not to go to the hospital for what it truly was - not giving up before trying, but prioritizing herself and her family over aimless trying.

All this convinced me further that it was unfair that my grandmother had to make an arbitrary choice for the sole aim of comfort in the last days of her life, and that there had to be another way.

It was not very long ago that I got to know about palliative care. Palliative care is generally defined as specialized medical care for people living with a serious illness. But the characteristic of palliative care is that the type of care administered is focused on providing both relief from the physical symptoms and mental stress of the illness. A multidisciplinary team of practitioners work with the patient and the family to provide medical, social, emotional and practical support for terminally or chronically ill patients.

This concept stood out to me strikingly in the case of my grandmother. Palliative care is holistic, and I believe could have not only helped my grandmother achieve relative physical peace, but also mental tranquility. It could also have helped her know her end-of-life options better, rather than let her feel stuck between simply staying home and going to a hospital.

It is thus astonishing that palliative care is so inaccessible - not only in my hometown which doesn't have very advanced healthcare systems, but also in the major cities of India. Only two states in India even have palliative care policies and the majority of Indian nurses and medical professionals are not trained for palliative care.

I could tell so many cultural stories about stigma about terminal illnesses, but the fact that doesn't change is that in a country of a billion people, pain and illness is disregarded in the face of death. Just because an illness is chronically debilitating or terminal doesn't mean that Indian health structures cannot do anything to alleviate the patient's short-term mental and physical agony.

Indian medicine needs to take a more patient-focused view to terminal illness. It needs to understand that impending death does not mean that life is over, and providing end-of-life care is just as important as trying to treat more conventionally curable diseases.

Ilika Tripathi is an undergraduate student at Mount Holyoke College majoring in Economics and minoring in Computer Science. She composed this essay in her sophomore year, reflecting on familial experiences with death in the early days of the COVID pandemic. Today, she is a graduating senior hoping to work in the financial industry, but even more cognizant of the importance of palliative care in post-COVID society.

Beyond the Burden of Disease

By: Jessy Uchindami Gondwe

“Of all the forms of inequality, injustice in health care is the most shocking and inhuman,” said Martin Luther King, Jr. in 1966.

These words were said when I, like the other twenty-two global health care providers, advocates and researchers in my class were not born. But, the words surfaced our common, long-standing inequality narrative in health care that transcended from the socially defined privilege of gender, social economic class, race, and geographical position. As I deeply immersed myself in the first assigned readings from the introduction of Global Health, I vividly remembered the wretched year of 2004. My closest friend, Ndaona (not their real name) and, I were merely 10 years old girls and oblivious to the evil of uncertainty lurking on Ndaona's family that morning. Her mother, Mrs. Phiri (not their real name) who had been recurrently unwell then, had collapsed suddenly. A clamour of bang caught our attention. A shudder ran through our spines. We ran in the direction of the sound, our adrenaline so high, and without looking back. We rushed to get Mrs. Phiri up while crying for help. The horrid scene had Mrs. Phiri fallen listless on the floor, with blood trickling down from her legs.

Ndaona's father and some neighbours immediately reached out and took Mrs. Phiri on a bicycle to the health centre. The nearest health centre was 40 kilometres away from our village, which meant navigating through the bumpy and slippery roads of the rainy season in northern Malawi. The following day, she came back as there were no skilled personnel or adequate resources to diagnose and manage her condition. What disease was she suffering from? Do you mean there were no remedies to stop the bleeding that made her pale every day? Or the strange smell that forced her into isolation from the community gatherings? We all wondered. Mrs. Phiri was referred to the central hospital in the city, approximately 200 kilometres away, on the basis of arranging her own transport as the health center had no ambulance. This meant taking all the family income and going into debts for one person to access health. How fair was this for a poor mother in a rural area? The questions were aplenty.

We saw Mrs. Phiri shedding tears when she left the village for the city, probably asking herself, how the family will pay back the debts for health care? She stayed for approximately three months in the city. Ndaona's father told us that she was diagnosed with cervical cancer and had been scheduled for surgery. Unfortunately, her surgery kept being postponed almost every week either due to a long waiting list or unavailability of surgical instruments, when the same services were accessible to other privileged population in global north countries. Ironically, countries like Malawi in sub-Saharan Africa bear the highest burden of cervical cancer and associated 90% preventable deaths of women due to poor access to prevention, early screening, and treatment. Is it because the disease affected women and had less priority in health care? Or because it affected more the black women and from the global south? Surely beyond the burden of cervical cancer were numerous inequalities that Ndaona's family and others experienced.

The experience stayed with me ever since. I pushed myself to work hard in school and studied Nursing and Midwifery to help those who are underserved. I started working in a public hospital and this was my dream coming true! I finally had a chance to deliver skilled health services and bridge the gap between health care and vulnerable people in poor rural communities like Mrs. Phiri. To my surprise, this wasn't the reality of health care delivery in Malawi. Just in 2015, the government of Malawi introduced bypass fee charges of MWK1500 (2.05 US dollars) for walk-in patients in public hospitals. The government's intention was to use the revenue from fees collected to address a funding gap in the health sector. Was this an equitable plan for a country that has over half of its 19 million population living below the national poverty line and surviving on less than 1.2 US dollars per day? Of course not. There it was, another instance of many inequity dimensions in health care that continued to marginalize the poor and increase the financial debts from out-of-pocket expenditure for health care. I realised that nursing never gave me an in-depth view of the underlying causes of disease, its occurrence in specific population groups or an understanding of the differentiated burden among women and men, the poor and the rich, or those from global north and global south.

This curiosity had me enrolled at the University of Global Health Equity in Rwanda to pursue a master's degree in Global Health Delivery. As I finalised reading that introductory book to Global Health, blended with other several readings, lectures and experience-based discussions with my classmates, I understood the roots of global health inequities. From the slavery and colonization era, to the birth of human rights and global health commitments such as the Sustainable Development Goals. Applying this knowledge in a continued interactive process with the Butaro community in Rwanda, I have come to realise that to achieve health equity, the social determinants of health that

lie beyond the burden of disease must be understood and addressed first. To achieve this, I had to take a leading role to promote health equity advocacy for the underserved communities. I had to work with my classmates and other global health leaders across the world to empower vulnerable populations to seek equitable access to essential health services from governments. I had to advocate for more inclusive and benevolent health services, programs, and policies for the greater good.

I now related Mrs. Phiri's story with the plight of millions of underserved women who survived cervical cancer in the world. I redefined my approaches and strategies to use the global health knowledge and my personal experiences in Malawi and Rwanda to address health inequities, particularly from women. I want to make access to healthcare a fundamental human right and not merely a privilege for few, regardless of social identities of gender, race, social economic class, and geographical location.

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Jessy Uchindami Gondwe is from Malawi. She holds a Master of Science in Global Health Delivery and a Bachelor of Science in Nursing and Midwifery. Her essay reflects childhood memories, intrigued by global health experience during her first year of master's program at University of Global Health Equity in Rwanda, which she completed in August 2020.

Lessons from a Math Teacher

By: Cristina Viguera Altolaquirre

I was standing in a small clinic room with two physicians simultaneously conducting visits. There was just barely enough space to squeeze by between their desks and not enough chairs for the patients' family members or myself. It was the middle of March in Peru and, despite the use of two fans, the air was particularly thick. I was rotating in an Infectious Disease clinic and had just finished examining Antonio, a delightful 60-year-old man who had seen an ophthalmologist for visual complaints and, in the work-up, had resulted positive for syphilis. To our surprise, he also had sensory and gait disturbances. We had a feeling this would be a memorable case. "Tell everyone in the program to come here," said the physician I was working with.

As a fourth-year medical student in the U.S., I had sought out this elective in search of an unforgettable international learning experience. I was welcomed as another Peruvian medical student, helping evaluate patients in both inpatient and outpatient settings. During my rotation, the Infectious Disease service was hosting a course designed for "*gringos*," foreigners who came to learn from experts in the field and from the otherwise rare cases encountered in this resource-limited, tropical setting.

Five minutes went by, and a swarm of white coats came in, with their iPhones in hand, ready to take pictures of interesting findings. They circled around us, struggling to find space in the room and doorway while I held on to my spot next to Antonio. The physician presented the patient and described his symptoms. "Tabes dorsalis..." a German physician muttered behind me. Neurosyphilis was high on the differential. Antonio was then admitted to our service for further work-up, and quickly became our most popular patient. For several weeks, I often saw him getting wheeled to different teaching sessions for the *gringos*. In these sessions, Antonio shared his story, which was followed by a thorough exam and the grand finale of his unsteady, stomping gait.

With Spanish as my first language, I had sought to fit in. I quickly formed friendships with local medical students and residents. We joked about the *gringos*—the exorbitant amounts of money they paid to receive lectures in the only room with air conditioning,

followed pinballing between patient rooms for one key exam finding. In that moment, I had seen myself as another member of the Infectious Disease team and, yet, I was also completely dispensable, as I only occasionally contributed to patient care and my rotation primarily involved educational experiences. I did not appreciate the irony that I was a foreigner acting not unlike the *gringos*. I, too, was learning about interesting patients during rounds and jotting down their room number, only to circle back later to interview and examine them.

I felt a cognitive dissonance with this *gringo* course. Perhaps it's because it embodied privilege all too clearly, perhaps because it was a reminder of what I truly was—an entitled foreigner learning and benefiting from others' suffering. Like many before and after me, at the end of this trip, I would have no impact in Peru. My footsteps in the well-paved path of global health would leave no mark, but I would leave with countless memories and logbooks of cases. I struggled with this transformation of patients and their stories into findings and log entries. We shared patient cases like currency, dehumanizing them in the process. I visited the necrotizing fasciitis case, the neurocysticercosis case—not the carpenter who could no longer work, or the dancer with new balance problems. I am reminded of Osler's quote: "the good physician treats the disease; the great physician treats the patient who has the disease." And in focusing on the disease, we were losing sight of the patient.

This phenomenon is not limited to overseas work. In morning reports, noon conferences, and teaching rounds at our home institutions, we take pieces from each patient and stack them away into our memory bank, hoping to one day draw from this clinical repertoire to benefit our patients. There is something fundamentally egocentric to medical training. We must recognize the selfishness in our education and accept that, at times, we will learn from cases that we do not contribute to. Sometimes we do have to focus on the disease the patient has. But I think it's important to be present and not lose sight of the patient, and to recognize the gift patients provide by allowing us to learn from them, hoping we become better physicians as a result. In return, we must rise to their expectations and become the physicians they deserve and not forget the role all our patients played in our own education.

I once jokingly told Antonio he should charge for each showing. An extroverted mathematics teacher, he told me he loved every opportunity he had to teach, including medical students and doctors. Now as a medical resident, when I learn something new from a patient, whether it's a pathognomonic finding or a diagnostic or management pearl, I stack it away in my memory bank and logbook of cases, but I also try to take a step back and look at my patient. If I one day see someone with a stomping gait, I hope

to be able to draw from my repertoire. And most importantly, I will strive to not only think back to the case of neurosyphilis, but to the mathematics teacher who taught me medicine.

Cristina Viguera Altolaquirre completed her B.S. in Neuroscience at Johns Hopkins University and her M.D. at Johns Hopkins University School of Medicine. She completed an elective in Global Health in Peru during her MS4 year of medical school, which inspired this essay. She is currently completing her Neurology residency training at Harvard's Mass General Brigham program, and will be specializing in Neuromuscular Disorders.

Life, death, and representation: Understanding the importance of imagery in global health through the Haitian *tranblemandet *

By. Renata Wettermann Capo

The first Haitian I ever saw was dead. Glancing through the news in early January 2010, I saw headlines proclaiming that an earthquake had hit Port au Prince. I clicked, and the first image that loaded was of a young man. Rather, it was of his feet, dusty and protruding from a concrete slab and nest of rebar that concealed his body. Shocked, I read on to learn of what Haitians now refer to as the *tranblemandet  12 janvye 2010* or simply the *tranblemandet *. Once the earth had stopped quaking, the *tranblemandet * continued to send emotional aftershocks throughout the world, prompting a tremendous response from the international aid community.

Moved by the powerful images, I joined my church's relief efforts to rebuild an orphanage on the southern coast of Haiti. The week-long mission trip turned into six months of living in Haiti and a realization of my passion for global health. Yet even as I fell in love with the idea of practicing healthcare in low resource settings, the images that had initially drawn me to Haiti began to occupy an uncomfortable space in my mind. The country that I had started to know and love was nothing like the pictures that had been splashed across social media and the television screen. Unpalatable though it was, it appeared that I had been deceived. Moreover, this lie came at the expense of the dignity of people I now knew and loved.

In the face of disaster, images played a pivotal role in how the *tramblemendet * was perceived by the rest of the world. The pictures impressed upon spectators a sense of devastating loss. Some images told individual stories in an attempt to create narratives of chaos and senseless loss. Others portrayed the scale of the earthquake's effects by emphasizing the sheer number of bodies being retrieved from the rubble and disposed of. Scanning the news, the volume of these images made it difficult to understand that these

were not a neutral portrayal. Rather, the photographers' choices of subject, composition, and caption socially constructed the meanings that we took from these pictures of disaster.

Media imagery of dead bodies littered across crumbled urban centers and mass graves dominated media and my early perceptions of the quake. Whether intentionally or not, these anonymous and often grotesque pictures of mass death served to reinforce the perception that Haiti is a place that is Other- a place where Bad Things happen that could *never* happen here. An unruly and foreign place stricken with disease, poverty, and contamination that were nearly incomprehensible. These portrayals of Haiti spoke to a helplessness that required outsider intervention as ethically imperative. An endless stream of stories highlighting the heroics of foreign aid workers reinforced the crucial role of outside 'experts' in relief efforts.

But where were the Haitian heroes? Although I worked alongside many and heard stories of countless more in the years following the *tranbleman-deté*, these local supporters were largely absent from the international spotlight. My friends and coworkers could show me cell phone footage of intrepid rescues or well-coordinated response efforts unifying their whole neighborhood near Port-au-Prince- but such matters did not often make the news back home.

It seemed that many times the photographic influence of foreign media told a story that was completely removed from Haitian's' own representations of their bodies in life and death. While the post-disaster images raised awareness, they also breached privacy and limited the dignity of Haitian bodies. The victims and their families played little role in determining how their bodies were presented to the world. They became the object -and not the subject- of the image as outsiders were invited to learn from their deaths and come save Haiti. Speaking as someone who was initially so drawn to these images, photographs of the *tranbleman-deté* were framed *for me* as the outside observer and consumer of media and mass death- not for the Haitians for whom each photograph represented a complex story, an emotion, a loss.

I fear that, in consuming images of Haitian death without question, we jeopardized both the humanity of Haitian individuals and of ourselves. Hiding behind the camera lens, journalists, and aid workers conflate the means (taking pictures) with the end (raising awareness). As the consumers of media, we also became consumers of the deaths of others, placing us at the same risk of confusing the end (understanding, compassion, and help for the people we see suffering) with the means (shocking and saddening images). As the rest of the world and the media moved onto the next disaster, the lessons we have learned from Haitian bodies faded from memory, thus making a spectacle of their suffering and a mockery of our shared humanity.

Questions of representation and bodily autonomy are not easily answered, particularly in disaster situations. However, as someone with vested interest in Haiti and international service at large, I raise these questions as urgent concerns. Is it possible for foreigners to both practice humanism abroad and raise awareness at home for challenges facing low-resource settings? As someone who wants to work in global health, can I ever truly do good by the people I seek to serve? And how should I document it? In reflecting on the way that I was moved by images of the *tranbleman-deté*, I was humbled to bear witness to my own humanity and misunderstanding of others' humanity. The life and death of another are sacred moments that exist beyond social constructions and geography, and they deserve context, compassion, and curiosity.

Through reflection, I seek penance for the ways that I have so often unthinkingly consumed images of Haitian bodies and Haitian death. Emotionally and ethically charged images of dead and dying bodies are what initially drew me to Haiti. These people had friends, families, and stories, but I was more interested in how they made *me* feel. At the same time, I can speak from experience and say that going to the country I had seen on the news and forming relationships with the people there changed everything. Nowadays I would never take a picture of someone dead, dying, or in abject squalor. Instead, I have learned to listen, ask questions, and when appropriate, bring stories home to share. The people in my pictures from Haiti are not anonymous; they are smiling, posing, showing off what makes them unique in a way that they see fit. They have names, and more often than not, I am in the photos beside them. These are far from perfect images, and questions of representation continue to lurk in my head. However, I've learned to hope for something beyond what post-disaster images typically have to offer. Perhaps if a sense of compassion and shared humanity are at the core of these representations, myself and others like me can hope to serve in a way that promotes human dignity.

Dr. Renata Wettermann Capo received her M.D. from Baylor College of Medicine and her B.A. in Health Sciences and Global Health Technology from Rice University. This piece was written during medical school as a reflection on formative experiences and errors made as a pre-medical student working in Haiti after the 2010 earthquake. Dr. Wettermann Capo is currently an Internal Medicine-Pediatrics resident at Baylor College of Medicine in Houston, TX.

On Power: Justice, Mental Health, and Hope in the Rohingya Refugee Camps

By: Julia Zigman

My President.

She asked me to tell her story to my President, a beacon of hope, of change. Tell him that she, Fatima*, wanted to go home.

If “the high-up people” knew about the Rohingya, she tells me through a translator, if only the right people heard how they were suffering, they would make it better. They would make their homeland safe again and bring them home. I ask her why she thought this had not happened yet.

It is July 2019, almost two years after Myanmar’s army launched a brutal clearance campaign against the Rohingya, a Muslim minority in Myanmar’s Rakhine State. Over 700,000 fled to Cox’s Bazar, Bangladesh, where they are now living in the world’s largest refugee camp. International tribunals are gearing up for potential investigations into genocide and atrocity crimes. I am in Cox’s Bazar interviewing Fatima about her mental health and perceptions of justice – what has she heard about these processes, and what outcomes does she expect? The Bangladeshi NGO I’m working with provides counseling and psychosocial support, and my team was helping them research connections between justice and mental health.

The shelter we are crouched within is smaller, warmer than the previous ones I’d visited. Maybe it is the lingering heat of small, giggling bodies, recently vacated and now peering in at the foreigner from outside. Fatima, their mother, is not much older than I am. Earlier she’d told me her mind is always turning like a coin, her stomach burning. It’s been an unimaginably difficult two years since she watched a bullet go clean into her husband’s face, nursed him back to health, if you can call it that. He’s asleep most of that day.

Fatima answers my question like it’s obvious. She’s still in the camp because the high-up people haven’t heard about the Rohingya. She would march to every king herself and

tell them their stories, she says, eyes wistful, but she must care for her kids, her blind husband. She has no idea how to support them alone. But if things were different – *if* – Fatima would tell the world leaders herself. That’s why justice was taking so long: they’re hard to contact, and Fatima, a messenger in her own right, is stuck in the camp.

That’s why she is so grateful that I, an American, came to her shelter that day: I’m going to go home and tell my president about Fatima; and she, too, will go home.

The rusted bolts holding my heart together wrench apart. I didn’t know I could feel such heartbreak for somebody I’d known for 45 minutes.

My heart breaks for Fatima because of an awful truth: The “high-up people” (my president included) know about the Rohingya, and they don’t care. Not enough for a solution, or at least enough aid, anyway. I quickly explain that no, no – I’m a researcher, a student; I don’t have that power. I don’t have *any* power. I tell her that her story will still help us improve our mental health and legal education services. She seems to understand but, as I leave, her eyes still brim with gratitude that I feel utterly undeserving of.

I cry that night for the first time since arriving in Bangladesh almost two months before. Lying on a cot in the field office, I wonder if the hole in my mosquito net is like the gaping hole in my chest. Or, maybe, it is an unbearable fullness, powerlessness and sorrow and anger at the brutality of their situation filling me whole. I still cannot fathom how humans could do to other humans what has been done to the Rohingya.

I’m angry at myself, too, for wallowing in this often-overwhelming feeling of powerlessness. How ungrateful am I, how ignorant, to feel such a way when I have a fresh university diploma, a native command of English, and a return ticket to the country I voluntarily left?

I was accustomed to bearing an identity in flux. I was a foreigner working in a local organization; a woman; a student. When I entered a humanitarian coordination meeting, my voice carried more weight than my Bangladeshi colleagues; when I went to a meeting within my organization, it sounded naïve. Regardless, I had never anticipated representing hope – or, for some, fear – in these camps when I myself felt so small and useless. Delivering mental health services in the refugee camps was a constant uphill battle. Very few people understand the Rohingya language and culture surrounding mental health, and there is such a scarcity of trained staff that many days it felt to me (again, maybe naïvely) like nothing we did was helping.

I firmly believe that more trainees should strive to understand crisis response contexts, because the planet’s refugee crises are only intensifying. As a student, I’d read about the trauma and brutality endured by the Rohingya, but nothing could’ve prepared me to hear it first-hand. And even more so, seeing the *daily* traumas of camp life – no

livelihood, no recognized identity, no idea what the future holds – grounded me every interview I conducted. Justice for this level of oppression and erasure is complex and certainly not transactional. It is sometimes the invisible wounds that cut deepest, and for the Rohingya, healing and reconciliation may take generations.

So, when I do hear hope, I pray it's not misguided. Maybe we should let others take solace in small hopes. Or maybe not – health practitioners learn quickly not to make promises. But I've become more aware of my place in the world, and what power I do have. What power we all have, and how we can use it amplify the voices that the world forgets.

I can't tell Fatima's story to my President, and I can't get her home. But I can tell it here, and hope she'd take solace in the fact that students across the world may hear it. Even when it feels like everything is too hard – I won't forget her, and at least for today, maybe that is enough.

*Name changed for privacy.

Julia Zigman has a Bachelor of Arts in International & Area Studies from Washington University in St. Louis, where she focused on global health and policy implementation. In 2019, Julia was a student researcher/trainee on a team supporting a Bangladeshi NGO working in the Rohingya refugee camps in Cox's Bazar, Bangladesh. Currently, Julia works in a U.S. public health organization supporting local health department HIV programs and is a MPH candidate and Adolescent Health Fellow at Johns Hopkins University.

Beautiful

By: Kristen Zozulin

It was a strange sort of vigil. Her mother, grandmother, Nurse Ruth, and I huddled in the front room of the small clinic, the only room with electricity. In the center, Mary lay on a thin mattress on the floor, covered by as many blankets as we could find, groaning with contractions.

Mary had come to the clinic in labor that afternoon. Her mother had chattered away happily, overjoyed that her firstborn would be giving birth that day. Mary was 19. When a boy in the city told her that she needed to seek out an illegal abortion in order to stay with him, she had informed him that she would be raising the child alone, and went home to her mother in the village. I talked with Mary's mother and eagerly waited to see my first delivery in Kenya, where I was spending my first summer as a medical student.

11 hours later, it was 4AM, and I watched my breath fog the air as Mary lay on the floor, barely 2cm dilated and in absolute agony. Her mother went into another room and closed the door. The sounds of desperate, gasping sobs emanated from the closed door as she tried to cope with her fear and helplessness in the face of her daughter's suffering.

"Nothing beautiful happens here," I thought bitterly as I attempted to curl into a tight ball in the chair, clutching the sleeves of my university hoodie.

I glanced back at Nurse Ruth, the only trained healthcare professional assigned to the clinic. She was sleeping fitfully on a gurney with a stack of patient charts as a pillow. I found a spot on the floor and just stared - cold, tired, with nothing to do but wait.

* * *

A few weeks later, I wandered back into one of the patient rooms to find a young woman, Christine, laying on the bed. Nurse Ruth stood between her legs, her hands overflowing with a mass of purple and red placenta.

"We are done!" Ruth declared, grinning when she saw me.

I had met Christine a couple times before. Nurse Ruth had been keeping a close eye on her and insisted that Christine move to a relative's house near the clinic when her

delivery date drew near. Christine had been pregnant twice before, and miscarried both times while attempting to deliver at home.

I felt a jolt of panic when I realized she had delivered. I did not hear any infant cries or see a baby. Then Ruth pointed to the woman standing by the door, who was holding a bundle of blankets. I peered in cautiously to see a small face sleeping peacefully. Ruth explained that there had been a few moments after Christine delivered when the baby wasn't breathing, but she had managed to resuscitate the newborn. Christine's tiny new daughter would be just fine.

I sighed with relief, then went to the mother, who was shivering with cold and exhaustion. By now, Nurse Ruth was intently focused on stitching a small tear from the delivery as gently as she could. I noticed the woman's inner labia and clitoris were missing, a result of the genital mutilation that is an all-too-common practice among the Kenyan Maasai.

Later that afternoon, Ruth pulled me into a car hired to take Christine and the baby home. I was unfamiliar with this type of patient-delivery service, but evidently the family had insisted Nurse Ruth come to the home, and they were happy to have me along as well. Everyone was cheerful as we piled in, with Ruth in front cooing and singing to the baby. I marveled at Christine, who was smiling and apparently unaffected by the bumps and shocks as the rundown vehicle navigated the rocky road out of the village center.

The car put us down outside of a haphazard wooden fence surrounding a small homestead, largely occupied by sheep and goats. Our party was joyfully greeted by several relatives and small children. I was given a tour of Christine's home: the kitchen where they cooked their meals and a bed behind a curtain under a low, straw-thatched roof.

When I exited the house, an old man approached Ruth and me. I followed her in greeting him in the traditional Maasai fashion – presenting the top of my head, which he briefly touched with his hand. His smile lifted every line on his face and extended past his ears, the lobes of which hung low with heavy earrings.

"This is the first child for his son," Ruth explained to me. "His son has two wives, and the first wife has also miscarried twice."

Then I realized that I was standing in the midst of a family that had endured the loss of their children over and over again. Family and children are everything to the Maasai, and that devastation had reverberated through every branch of the extended family and shaken its multigenerational roots. Now, here, today, their tree has finally fruited.

I felt a surge of gratitude at being able to share this moment with them, and for their generosity at letting a stranger from across the world witness this intimate scene. I looked out across the hills. The setting sun painted the sky deep purple and orange,

casting an ethereal glow on the family bustling to welcome the new mother home. I reflected on Nurse Ruth's role in creating this moment. How her medical expertise and her singular determination and dedication to her patient had enabled her to change the world for this family.

It was, all of it, incredibly beautiful.

Kristen Zozulin is currently a second-year resident in Family Medicine at Ventura County Medical Center Family Medicine Residency Program in Ventura, CA. The essay, "Beautiful" was inspired by experiences from her first year in medical school at Frank H. Netter MD School of Medicine in North Haven, CT, when she was working on her capstone project in rural Kenya.

