Health Horizons International: Addressing Health Disparities in the Dominican Republic

by Kristin Finigan and Caitlin Payne

On the north coast of the Dominican Republic, thousands of Haitian and Dominican families face an unjust burden of poverty and poor health. The lack of economic opportunity and the presence of social inequality heighten the challenges already experienced by the overburdened health care system in the DR. Health Horizons International (HHI) operates in four communities in the inland region near Puerto Plata with a unique, comprehensive model that aims to break the cycle of illness. In order to address the underlying determinants of health, HHI pairs regular medical service trips and a community health workers program with public health initiatives, patient care management, and community development. HHI’s mission is to provide quality primary health care to underserved patients of the Dominican Republic and to build local capacity for achieving improved community health. Through partnering international medical service trips with community-based health initiatives, HHI works to promote well-being and access to health care.

This January, a group of nine Tufts University students traveled to the Dominican Republic with HHI to carry out a community health mapping project and needs assessment of Pancho Mateo, one of the organization’s partner communities. The students were accompanied by a team of doctors and Physician Assistant students from Quinnipiac University. The doctors and Physician Assistant students operated medical clinics, while the Tufts students spoke with community members and gathered survey responses. The Tufts students’ project aimed to improve patient follow-up care by utilizing GPS mapping technology to locate chronic care patients as well as to gather survey information to inform future community-driven health

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Urban Agriculture: A New Spring Reading Group

by Laura Van Tassel

If you peer into the Hodgdon Hall lounge on a Tuesday morning, you’ll find Professor Balbach and two Community Health seniors, Emily Balk and me, sitting on the scratchy red couches in the corner. For seventy-five minutes we knit and drink coffee, but mostly we talk about food. This is not an academic class or an extracurricular meeting, but rather a reading group — a half-credit pass/fail option for second semester seniors who want to explore a topic more casually. Professor Balbach traditionally leads a reading group each spring on a different community health issue, reading the six or seven books for the first time along with her students. This reading group, however, where we share stories about public school lunches and discuss the merits of terms like “food justice,” is the result of a search for a creative way to do an independent study.

Although my other major is International Relations and I’ve spent considerable time studying or volunteering abroad, my passion for food issues frequently brings my focus back to the U.S., the battleground for critical food politics and the testing ground for many food interventions. After taking the senior seminar “The Politics of Food and Fat,” doing some independent research on food security, and writing a critique of food banks last semester, my interests were once again U.S.-centered. I approached Professor Balbach with the idea of doing an independent study on the alternative food movement, broadly defined as those activities in opposition to or offering another choice besides centralized factory farming and large-scale distribution — maybe some sort of directed reading. “Well, do you want people to read with you?” she asked me, and an additional spring reading group was born. I was charged with picking out six books that looked at urban agriculture. Starting with my own “to-read” list and clicking

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through scores of Amazon reviews, I took a risk with my best educated guesses and picked out six books:

- *Remaking the North American Food System*, edited by C. Claire Hinrichs and Thomas A. Lyson
- *Food Justice* by Robert Gottlieb and Anupama Joshi
- *Food Rebels, Guerilla Gardeners, and Smart-Cookin’ Mamas* by Mark Winne
- *Public Produce: The New Urban Agriculture* by Darrin Nordahl
- *The Town that Food Saved* by Ben Hewitt
- *The Vertical Farm: Feeding the World in the 21st Century* by Dr. Dickson Despommier

So far we have read selections from the first book and finished the next two. While we haven’t solved the problem of world hunger or fixed the dilemmas posed by agricultural subsidies, the books have given us a lot to mull over. The reading group’s theme, urban agriculture, is part of what many see as the alternative food movement that confronts, or at least tries to sidestep, the well-documented ills of the industrial food system. With the global food crisis of 2008 and another one currently underway, the popularity of Michael Pollan books, and the growing sales of farmers’ markets and community supported agriculture (CSAs), many people are becoming curious about our food system. Some write off all of the food talk as elitist and question the ability of alternative options, especially small-scale urban agriculture, to feed the hungry. Even those who see the potential benefit of food initiatives can be quick to throw up their hands when they think about the chance of any policy change happening at the federal level. But there’s a lot of noise around food and agriculture right now, and an exploratory reading group seemed like a good way to see what’s going on with the movement.

I should say “movement” in quotes because it reflects one of our reading group’s main impressions so far: the food movement lacks a governing metaphor. The activists who care about food are often divided into issue silos such as local food, organics, hunger, nutrition, genetic engineering, and the environment. While groups organizing to get more farm-fresh produce into school lunches in their district, for example, may see some success, the systemic overhaul that many desire remains distant. Getting all of the “foodies” to gather around a central framing of the problem and agree on potential solutions will require compromises, but could strengthen the movement.

The group itself involves reading and talking, but it’s about finding solutions. This is what I love about Community Health – it stresses the many ways to understand a problem, the many ways different groups are affected by the problem, and the many ways we can try to mitigate or prevent the problem. Food and agriculture are complicated issues. Because food is about sustenance, pleasure, and culture, it is a positive cause for people to rally around. In the next books we’re going to learn about planting food along city streets, how food system change affected a rural Vermont town, and how urban vertical farms might provide a substantial source of food. We’re not going to save the food system with our reading group in the Hodgdon lounge, but we’re doing a lot of thinking on those couches, and we can enjoy the intellectual community at Tufts and some coffee while we do it.
Traditional and Biomedical Views of Pregnancy and Birth in Ladakh, India

by Sophie Lyons

In April 2010, I spent a month in the region of Ladakh, India researching traditional and biomedical conceptions of pregnancy and birth among Tibetan and Ladakhi women. In a place like Ladakh, where western biomedicine and traditional Tibetan medicine collide, concepts of pregnancy and birth take on different meanings than in western countries.

Ladakh is nothing like the rest of India. Situated in the very northern-most part of the Jammu-Kashmir region of India, right in the middle of the western Himalayas, Ladakh is geographically similar to the Tibetan Autonomous Region, northern Nepal, and other such places located in the Himalayan mountain range. The majority of Ladakh consists of rural villages that rely on subsistence farming and seasonal tourism. Ladakh also has a total of three Tibetan refugee settlements in Choglamsar and the Changthang region. Ladakhi culture appears to be much more akin to Tibetan culture than to other Indian cultures. Both are Buddhist in religion (as compared to the Muslim presence in Kashmir and the Hindu prevalence in much of the rest of India) and have parallel traditional lifestyles. Traditional beliefs, food, language and general way of life in Ladakh and Tibet are similar. Reports about how pregnancy and birth are perceived and dealt with by Tibetan and Ladakhi women also tend to be very similar.

The two most prevalent health systems in Ladakh are the western biomedical system put in place by the Indian government and the traditional Tibetan medical system. Here, the term biomedical refers to the style of medicine that focuses more on biological processes and scientific research and was developed predominately in western countries. In Leh, the capital of Ladakh, there is a biomedical, government funded hospital that many women use for prenatal care and to give birth. In more rural villages and all of the Tibetan settlements, there are primary health care clinics that the government has set up. These clinics are staffed by medical assistants, nurses, and sometimes auxiliary nurse midwives (ANMs) who are trained to assist in birth. In addition to the government-funded, biomedical system in place, Tibetan medicine is also fairly prevalent, although less so with the influx of biomedicine over the past twenty or thirty years.

With both pregnancy and birth, traditional Tibetan medicine does not play much of an active role. Women will occasionally go see an amchi, or traditional Tibetan doctor, when pregnant, but only if there is a problem. The vast wealth of knowledge about pregnancy and birth in Tibetan medicine is rarely utilized. But at the same time, Tibetan medicine is increasingly promoted by organizations such as the Ladakh Society for Traditional Medicine (LSTM), an NGO currently working to teach women and amchis about maternal and child health in rural villages. In extremely rural areas without medical facilities or affordable transportation to Leh, women must use traditional Tibetan medicine. Here lies the juxtaposition of biomedical and traditional medicine. Not everyone in Ladakh has access to a government village clinic, let alone the hospital in Leh. Therefore, organizations such as LSTM see a place for traditional Tibetan medicine in the absence of biomedical care. They are working to reincorporate and train people in traditional birthing methods in communities which rely on Tibetan medicine.

Indian health policy surrounding pregnancy and birth is largely biomedical and promotes family planning and hospital birth, two concepts not traditionally used by either Ladakhis or Tibetans. Prenatal care is also a growing phenomenon in Ladakh. It has become fairly common for women to go to the hospital for checkups during their pregnancy. Women in more rural areas and poorer women often cannot travel to or afford to go to Leh for prenatal care. I also found that regular prenatal care does not really exist in traditional Tibetan medicine. Women may only go to an amchi if they feel something is wrong.

Traditionally, many women give birth at home with the help of an older female family member. Most women, though, will travel to Leh, sometimes for long distances, to give birth in the hospital. Women are encouraged by medical staff to give birth in the hospital when they go in for prenatal checkups. In addition to the trained medical staff, the Indian government appoints other health workers called ASHA (aggregated social health activist) who act as social workers and try to get women to go to the hospital for prenatal visits and birth. From what I found, the reasons for giving birth in the hospital are widely agreed upon. Many women see the hospital as cleaner and safer than their homes for giving birth. Fear of complications during birth also drives many to deliver at the hospital.

For the few women that do choose (i.e. have the choice) to give birth at home, many do so because they simply feel more comfortable at home. They often do not feel comfortable with the rules that the hospital forces on them, especially the rule that they must lay down in a bed to give birth. This western style of giving birth seems unnatural and uncomfortable for many women who cite the traditional way of squatting or kneeling as the easiest way to give birth. For these home births, sometimes an auxiliary nurse midwife will assist, but more often than not, a family member will be the primary assistant.

Some people in Ladakh expressed the fear of forgetting Tibetan medicine. With the majority of women, especially in Leh, going for prenatal care and birth in the hospital, traditional practices surrounding pregnancy and birth are fading away. Some people, however, are promoting traditional Tibetan medicine. Though these people do not necessarily view western biomedicine as bad, they tend to take the stance that amchi medicine should be utilized more regularly and work in conjunction with the western biomedical system. All of the amchi I spoke with agree that when there are complications in pregnancy or birth, the hospital is the best place to be to make sure the mother and/or baby survive. They tend to be in favor of prenatal care. However, when it comes to birth, they support a traditional home birth. On the surface, pregnancy and birth can be viewed as mundane aspects of life, but in Ladakh they raise complicated questions. With traditional and western medical cultures clashing, traditional ideas can take on new meaning or they can be lost as western ideas are promoted as the norm. It is not for me to say whether the influence of western medicine in this field is good or bad, but it has dramatically changed the culture surrounding pregnancy and birth in Ladakh.

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The United States was ranked by the World Health Organization (WHO) in 2010 to have only the 37th best healthcare system in the world. Additionally, healthcare expenditures in the United States constituted 17.3% of our GDP in 2009, a large amount of spending relative to other Organization for Economic Cooperation and Development (OECD) countries. Key to addressing this issue is the creation of policies which would simultaneously improve the quality of healthcare and reduce expenditures. How is the healthcare market significantly different from the car production market, which similarly needs to reduce costs and improve safety ratings? The healthcare market must adopt a business AND patient-centered model in order to confront the healthcare challenges of the future.

We have heard about how political factions and economic constraints impede the delivery of care in CH2: Health Care in America, a mandatory course for Community Health majors. To promote these discussions and explore a career in this direction, I decided to explore these topics further. As an Economics and Community Health major, I have found it particularly difficult to find my niche in public health careers while combining my academic interests. Healthcare consulting is one area that receives far less attention by most undergraduate Community Health students.

Healthcare consultants advise hospitals, pharmaceutical firms, biotechnology companies, HMOs, and public health policy makers on how to conduct business. Healthcare consultants can assist these healthcare organizations with business challenges including internal operations, marketing, financial planning, strategy development, government regulation, information technology, human resources, and operations management. The work of consulting requires a detail-oriented eye and team-oriented nature to research a problem through qualitative (surveys and interviews) and quantitative (statistical analysis and financial modeling) measures, strategically analyze trends, and create recommendations with a team. Due to concerns about the nation’s rising healthcare costs, there is a growing need for healthcare consulting.

I have had two different internship experiences in hospital and pharmaceutical consulting. They differ in terms of the setting, nature of the work, strategic goals, and amount of client interaction. These two experiences illustrate the importance of management and strategic thinking to solve pressing health issues.

In 2009, I had my first experience in healthcare consulting with the Greater New York Hospital Association, a trade association for non-profit hospitals which offers summer internships for undergraduate students and graduate public health students in hospitals. That summer, I was assigned to work at a state hospital in a neighborhood of Caribbean immigrants. This hospital had faced an increased number of patients in the Emergency Room due to the closure of two local hospitals. To help address this, I worked on a project to analyze the hospital’s patient flow. I subsequently recommended solutions on how to reduce the average length of stay (ALOS) by half a day which would generate $72M for the hospital. This was a top priority for the management team because the hospital frequently had to inform the Emergency Medical Services (EMS) that they no longer had the bed capacity to take patients, and those seated in the ER waited several hours for services.

In order to understand the ambiguous source of the problem, I reviewed patient flow, and length of stay at the three nursing stations with the highest ALOS and the highest demand. I interviewed people from various departments throughout the hospital to understand the interdisciplinary communication regarding a patient’s discharge. From the interviews, I was able to gain information to map out the entire patient flow process (i.e. how all the departments work together to expedite a patient’s discharge) from the point of patient entry to patient exit. In order to substantiate the interviews, I analyzed several datasets to better streamline the work processes for discharge.

Upon analysis, I formulated twelve recommendations to improve work efficiency. For the purpose of this article, I will review the most meaningful recommendation. Since it is a teaching hospital, residents undertake discharge rounds at different times each day in order to accommodate their academic schedules. This source of the problem (scheduling) was corroborated from surveys given to nurses in the three nursing stations, a simulated resident’s schedule, and several other datasets. All of the results pointed to the incompatibility between the resident’s academic and clinical schedules. This information was useful to the hospital because with improved discharge planning, the hospital could efficiently treat and discharge more patients. This experience conveys one example of the importance of business concepts to the healthcare industry.

My other experience in healthcare consulting is with a healthcare consulting group as part of my Community Health internship. I am currently interning with Quintiles Consulting/Market Intelligence Group, a pharmaceutical consulting firm that assesses the potential market demand for a new product and the accompanying marketing strategies. For example, it is important to understand the following questions to better market a drug when working on Drug X for Health Problem Y:

- Will prescribers use this medication given the current medications on the market for Y?
- For which patients or situations would the physician use Product X versus other available products?
- What unmet need does this product provide that the other medications don’t provide?
- What are the advantages or disadvantages of this product? Does it have a low safety or efficacy rate compared to...
Wombs for Rent: The Practice of Commercial Surrogacy in India
by Neha Wadekar

The summer before my junior year I participated in the Tufts Summer Scholars program, which offers students of all majors the opportunity to conduct research or work on projects with professors and mentors. My mentor was Professor Madhumita Roy (English, Women’s Studies), my academic advisor, and she introduced me to her current research on the growing practice of commercial surrogacy in India. I knew nothing about this topic in the beginning of the summer when Professor Roy handed me a small packet of photocopied newspaper articles and instructed me to begin informing myself.

It starts with the issue of infertility. Infertility is generally defined as a heterosexual couple’s inability to become pregnant after two years of unprotected intercourse. Infertility can afflict both men and women, although in patriarchal societies, the women tend to get the blame. The age-old remedy for infertility has always been adoption. If a couple is unable to get pregnant and desperately wants a child, why not provide a home for a child in need?

Throughout the 20th century, medicine improved, technology advanced, and the drive for doctors and scientists to be able to control the reproductive cycle prevailed. Numerous techniques were invented to help both infertile men and infertile women overcome their biological obstacles to procreate and have their own, genetically related offspring. Hormone injection regimens, intracytoplasmic sperm injections (ICSI), in vitro fertilization (IVF), artificial insemination (AI), the list goes on, and when all else fails, there is surrogacy.

“Surrogacy” is a broad term applied to two very different types of procedures. Traditional surrogacy is achieved via artificial insemination, with the surrogate using her egg and another man’s sperm. In gestational surrogacy, a woman’s newly ovulated eggs are carefully removed, fertilized, and mixed with sperm in a Petri dish. The resulting embryo is transferred into the womb of another woman, who will carry the child to term and give birth on behalf of the genetic mother. Commercial surrogacy occurs when a woman, or couple, provides compensation to the surrogate who carries and delivers the child.

Gestational surrogacy has provided many mothers with a miraculous chance to have their own genetically related children. It is considered cutting-edge medical technology, and has spread rapidly to the far corners of the world. The first successful IVF baby was born in England in 1978, the second was born several months later in Kolkata, India.

In the United States, gestational surrogacy remains a practice primarily available only to the upper and upper-middle classes. The medical bills are expensive, and can cost upwards of $80,000. The gestational surrogacy process is not always successful, and many infertile couples cannot afford to risk such a large sum of money on such a risky procedure. In the US, the legality of commercial surrogacy depends upon state law. However, in most of Europe, and countries such as Australia and Japan, the practice is entirely banned. In response, more and more infertile couples around the world have been turning to India for the procedure.

India is a geographically vast and diverse country with a population of over 1 billion inhabitants. Despite its resources, India suffered at the hands of Mughal invaders and British colonialists, and is now a country suffering from great wealth disparities. It is not uncommon, for example, to see beggars lined up against the marble and gold walls of lavish temples. Poverty and wealth exist side by side, and India feels like both a first and third world country at the same time.

Traveling to foreign countries to undergo medical procedures has been termed “medical tourism.” Why not have a necessary medical procedure taken care of for a vastly cheaper sum without all of the legal hassles that arise in the US? India has cutting-edge, high-quality medical care at a cheap cost, and almost no legal restrictions on the surrogacy practice, making it the ideal destination for infertile couples. Medical tourism agencies consist of “brokers” who link the infertile couples with a surrogacy clinic in India. The broker is the go-between, who arranges all of the details throughout the process, and takes a large percentage of the couple’s payment at the end. All someone has to do is type “surrogacy in India” into Google, and pages of advertisements and agency websites pop up.

The majority of commercial surrogacy clinics in India are located in the state of Gujarat, where the first clinic originated. With no government interference and no laws to adhere to, the industry is able to run as it pleases, naturally attempting to maximize profits and minimize inefficiency. Businessmen and businesswomen run the clinics, and surrogate mothers are recruited from the surrounding villages. These women are desperately poor, illiterate, and uneducated. They are told that they may have the opportunity to do very little work and make a vast sum of money, more than they could ever make washing clothes or farming. All they have to do is get a few injections, undergo a quick medical procedure, and become pregnant for nine months. After they deliver the baby, they are all done, and can go home with their money.

For women living in poverty in a patriarchal society, this opportunity can seem too good to pass up. The issues of informed consent and psychological counseling are of no consequence to the clinics. Once the women have agreed to become surrogates (some signing their names with their thumbprints), they have surrendered entirely into the hands of the clinic. For nine months the surrogates live at the clinic, away from their families, and they are not allowed to leave. At the clinic, everything is monitored: their diet, their sleep patterns, etc. The women all sleep in one room, with rows of small beds, one television, and a bathroom. The surrogates are often not permitted to even walk downstairs for fear of damaging the precious child growing in their wombs. They are not allowed to have intercourse, even with their husbands. Many of the surrogates face social stigma and must lie to their families and communities in order to conceal the pregnancy.

Advocates argue that commercial surrogacy gives women the freedom to make their own choices about what to do with their bodies. And yes, these women do receive more careful medical care, better nutrition, and more rest during their pregnancy. However, all the precautions taken are not for the benefit of the surrogate, but for the protection of the child. The health and welfare of the surrogate is entirely disregarded. Often, as is the case in gestational surrogacy, three fetuses must be reduced to two, and the abortion is performed without presenting the surrogate with a choice. After the birth, no matter how the surrogate feels about the child, she must hand him

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As an undergraduate I knew that my professors were engaged in research, but I never gave it much thought. This semester however, I am interning with Professor Martinez’s Nuestro Futuro Saludable project, and consequently have a completely different perspective and appreciation for the research our professors are doing. Nuestro Futuro Saludable is a community based participatory research project funded by the National Institute of Health (NIH). While most projects that receive funding from the NIH seek to implement a program around an issue already well understood by the scientific community, Nuestro Futuro Saludable is unique in that the intervention is based upon issues raised by the Jamaica Plain community. Nuestro Futuro Saludable relied on a Community Advisory Board made up of community members to identify issues in the community and then brought those findings to the Steering Committee made up of people from Tufts and Northeastern to inform the design of an intervention.

The community identified institutionalized racism, and the ways in which it affects health and stress as key issues. Extensive literature reviews revealed that racism and a subsequent lack of access to resources increase stress, and that poor nutrition and a lack of physical activity contribute to the stress. The community intervention seeks to address these themes by presenting physical activity and nutrition as tools to mitigate stress and improve health outcomes among Caribbean Latino youth in Jamaica Plain. A ten-week long curriculum was developed to provide the youth with information and skills to help them understand and navigate the relationship between institutional racism and physical activity and nutrition. In addition to this emphasis on healthy lifestyle choices, there is an important civic engagement component to connect students with their community, as well as an integral empowerment component. The intervention is currently in its third week and there are approximately 70 students from The Curley School enrolled in the after school program.

The intervention however is much more extensive than a mere ten-week curriculum. The research aims to understand and measure stress using a variety of scales and research methods. In-person survey interviews were conducted with a guardian present for each student, and students will be surveyed and interviewed throughout the ten-weeks. The parental survey is very extensive and aims to understand how parental behaviors, attitudes and stress influence the health and stress of the child. Questions address a wide range of topics including racism, perception of the built environment, proximate stressors like violence, police and financial security, as well as questions about health behaviors, health outcomes and life events. In addition to this data, the intervention also measures salivary cortisol, a physiological stress indicator found in saliva. Cortisol is a physiologic indicator of stress. Most of the participants provide saliva samples which offers the team additional information about stress levels at various points throughout the study.

This has been a very exciting time to be involved with the program. We are currently in the third week of the ten-week intervention program. As an intern, I am compiling and entering data, conducting student interviews, preparing for future lesson plans, and providing daily administrative support for the program coordinator. I spend one day a week at the intervention site in Jamaica Plain working with the facilitators and engaging with the youth in the program. The opportunity to actually participate in the intervention and get to know the participants enriches my understanding of the data we are collecting and the research methods used by the team.

While I have only been interning since January, this internship has already furthered my understanding of community based participatory research, improved my data analysis and entry skills, and has allowed me to see what it takes to develop and implement an intervention. The Nuestro Futuro Saludable team’s passion is contagious, and I look forward to discovering what the data will reveal about the community, and the effectiveness of the intervention.

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over to the parents immediately. There are no legal protections for surrogates if they are paid insufficiently or if they suffer physical or psychological trauma during the surrogacy process.

Although I do comprehend the benefits of surrogacy, I strongly believe that commercial surrogacy introduces an element of coercion and pressure into the process. Taking advantage of vulnerable, desperate women in order to conduct commercial surrogacy and make profits is unethical. The Indian government must consider passing laws that would regulate the commercial surrogacy industry and protect the rights of the infertile couple, the potential child, and most importantly, the surrogate mother.

(Footnotes)

1 World Health Organization (http://www.who.int/topics/infertility/en/)

2 Mundy, Liza, Everything Conceiveable (First Anchor Books, NYC) 2008
3 Mundy, Liza, Everything Conceiveable (First Anchor Books, NYC) 2008
4 Zegers-Hochschild, F., et Al. “International Committee for Monitoring Assisted Reproductive Technology (ICMART) and the World Health Organization (WHO) revised glossary of ART terminology, 2009.”
5 Mundy, Liza, Everything Conceiveable (First Anchor Books, NYC) 2008
7 Gentleman, Amelia. “India Nurtures Business of Surrogate Motherhood.” (NYTimes, March 10, 2008).
8 Mundy, Liza, Everything Conceiveable (First Anchor Books, NYC) 2008
Since the closing of the sugarcane refinery in the neighboring town of Montellano, the people of Pancho Mateo have been afflicted with unemployment and increasingly extreme poverty. Pancho Mateo is overcrowded and lacks the necessary public health infrastructure to support an effective waste management system and access to clean drinking water. Aware of Pancho Mateo’s public health status, Tufts students administered a survey to further assess the needs of the community. The survey asked questions regarding the different sources for residents’ cooking, bathing and drinking water; the location people use to wash their clothes; whether anyone in the family is sick and where they receive care; and the employment status of family members. The survey also asked qualitative questions such as how people would describe the health of their community and what type of project could be conducted to improve the health challenges they face. By conducting these surveys, the Tufts students hope to better understand the dynamics of Pancho Mateo and provide valuable suggestions for how HHI can develop future initiatives that best address the needs of the community.

Pancho Mateo is very dense and lacks a discernible street system or house address classification system. This makes it difficult for HHI’s community health workers to locate patients for follow-up care. For this reason, one aspect of the Tufts project was to create a map of the community. While in Pancho Mateo, the Tufts students took GPS points at the houses of the patients in HHI’s chronic care management program, which provides patients diagnosed with hypertension, diabetes, and other chronic illnesses with free medication, regular follow-up, and individualized medication adherence and lifestyle support. Additionally, GPS points were taken along the streets of the community, at the local corner stores, and other significant public landmarks in order to better document the assets of the community. Once the map is completed, the community health workers will be able to perform frequent follow-up care and health education because it will be easier to locate patients. The community health workers, also known as cooperadores de salud, promote prevention, health education, and access to health care in their communities. The cooperadores are a critical piece of HHI’s approach to comprehensive health care by providing continuity and support for patients between medical service trips. The cooperadores manage the caseloads of the patients in the community with chronic illnesses and acute conditions and follow up with patient referrals to local specialists.

As students participating in this project, we believe we have gained deeper knowledge of what it means to assess the health dynamics of a community, how to engage community members in conversations about health behaviors, and how to utilize technology to achieve health goals. Currently, the team of Tufts students is in the process of coding the data from the surveys. Soon, we will add the collected data onto the map. We hope that the map will visually link the areas where people live to some of their health behaviors, such as where they dispose of their waste, so we can see patterns of health behaviors. This information will be a powerful tool for HHI in taking steps to improve the health status of the Pancho Mateo community.

If you are interested in opportunities with HHI, consider applying to be part of the January 2012 trip. Applications will be available in April. You can also learn more about the organization at www.hhidr.org or by contacting HHI’s Executive Director (and CH alum), Laura McNulty, at lmcmulty@hhidr.org.

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<tr>
<th>CH Internship Placements</th>
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<tr>
<td><strong>Emily Anderson</strong></td>
<td>MA Dept of Public Health</td>
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<tr>
<td><strong>Rebecca Citron</strong></td>
<td>Southern Jamaica Plain Health Center</td>
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<tr>
<td><strong>Allison Dempsey</strong></td>
<td>Health Resources in Action</td>
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<td><strong>Jerzy Eisenberg-Guyot</strong></td>
<td>John Hancock Research Cntr</td>
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<td><strong>Ekow Essel</strong></td>
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<td><strong>Samantha Frank</strong></td>
<td>Institute for Clinical Research and Health Policy</td>
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<td><strong>Anisha Gandhi</strong></td>
<td>Rep. Alice Wolf</td>
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<td><strong>Jamie Greenberg</strong></td>
<td>LIFT and Cambridge Health Alliance</td>
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<td><strong>Stuart Henige</strong></td>
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<td><strong>Madhuri Indaram</strong></td>
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<td><strong>Vivian Mbaikuwe</strong></td>
<td>Tufts Medical Center Translational Science Institute</td>
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<td><strong>Lydia Mitts</strong></td>
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<td><strong>Caitlin Payne</strong></td>
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<td><strong>Swati Shah</strong></td>
<td>Quintiles Consulting</td>
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<td><strong>Lauren Weiner</strong></td>
<td>Somerville/Cambridge Elder Services</td>
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others? Or does it have a new design such as a user-friendly applicator?
• What are the unmet needs after reviewing the physician’s standard treatment pathways?
• Which factors drive patient and physician usage of this product?

The methodology generally includes creating and conducting interviews or surveys with physicians, patients, insurance companies, or managed care organizations. The analysis must lead to formulations of marketing strategies for the client through report-writing and presentations.

I am currently reviewing a survey for physicians about a new drug product. With this data, the consultants can provide recommendations to their client on how best to market a drug.

The inclusion of a business model in the healthcare industry facilitates efficiency and strategies to better serve the community. It may seem questionable to claim that healthcare is a market that requires this model. However, as seen in the example of my hospital-based internship, the local immigrant community utilizing the state hospital could not count on receiving timely care due to inefficiencies within the hospital. If the hospital could reduce the lengths of stay, they would be able to treat a greater number of patients and have shorter wait times in the ER. And, the additional revenue would help this state hospital remain solvent during the economic recession. Is it not a community health concern that a local hospital is solvent enough to accept and treat patients in a timely manner? Healthcare consulting is just one career path in systems-level and policy work to ensure a sounder healthcare system.

Want to Learn More about Healthcare Consulting?
• Read the book *Nudge: Improving Decisions about Health, Wealth and Happiness* by Richard Thaler
• Apply to the Summer Enrichment Program with Greater New York Hospital Association
• Seek out a summer internship with John Snow Inc (public health consulting), Putnam Associates (pharmaceutical consulting) or Quintiles Consulting, Market Intelligence (pharmaceutical consulting)
• Read the Health Section on Wall Street Journal
• Take Economics 48: Health Economics
• Reach out to me at Swati.NShah@yahoo.com!

“Ladakh, India” continued from page 3

(Endnotes)
3 Bhatia et al. 411-412.

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1. Health Horizons International
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2. Views of Pregnancy in Ladakh, India
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5. Internship Spotlight: Community Based Participatory Research
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