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Global Health Task Force: Contributions of U.S. Volunteers Towards the Improvement of Global Health and U.S. Diplomacy

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U.S. SUMMIT & INITIATIVE FOR GLOBAL CITIZEN DIPLOMACY

NOVEMBER 16-19, 2010 | WASHINGTON, DC

GLOBAL HEALTH

TASK FORCE

**Contributions of U.S. Volunteers
Towards the Improvement of Global Health
and U.S. Diplomacy**



EVERY CITIZEN A DIPLOMAT

Published in conjunction with the
U.S. Center for Citizen Diplomacy's U.S. Summit & Initiative for Global Citizen Diplomacy
November 16–19, 2010, Washington DC.

Materials included in this document are the views of the submitting organization and are meant
to serve as a tool for discussion.

Some proposals may be edited for length. Summary content is from original submissions by the
organization, and was compiled but the U.S. Center for Citizen Diplomacy.

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On the cover: Dr. Angelo Tomedi, President of Global Health Partnerships, provides nutrition education
for community health workers in Kenya. Photo: Global Health Partnerships

TASK FORCE PROCESS

The work of the nine Task Forces began in the fall of 2009, each one representing a specific area of international activity and citizen diplomacy. Each Task Force is led by two co-chairs and made up of members selected by the chairs themselves.

These nine groups met periodically throughout the year to determine guidelines for selecting proposals from organizations vying for a top ten best practices slot, the format and content of their presentation at the Summit, and drafting three measurable outcomes that will allow the U.S. Center for Citizen Diplomacy to monitor each Task Force's progress during the ten-year Initiative for Global Citizen Diplomacy — which aims to double the number of American citizens engaging in international activity and address the global challenges of the 21st Century.

The co-chairs were given complete control over the Task Force, including decisions that needed to be made regarding the process to solicit, accept and select the top ten proposals from organizations in their field. (*Note: If a Task Force member's organization submitted a proposal, that member was removed from the selection process to avoid conflict of interest.) The U.S. Center for Citizen Diplomacy has not and will not receive any compensation, monetary or in-kind, from the organizations or individuals on the Task Forces or organizations or individuals whose proposals were selected for the top ten. The selection of these top ten proposals was solely on merit and is the result of work completed by the individual Task Forces, not the U.S. Center for Citizen Diplomacy.

The top ten list for each Task Force was selected from a pool of applicants that submitted a two-page proposal with the intention of being considered in the top ten. If an organization did not submit a proposal, they were not under consideration for the top ten.

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GLOBAL HEALTH TASK FORCE

Over last few years, public support for global health initiatives has increased as philanthropists, students, scientists, private industry leaders, and citizens commit time and resources to respond to worldwide health challenges. Despite recent increases in global health funding, however, the U.S. commitment to development assistance for health abroad still remains below that needed to meet the United Nations Millennium Development Goals, a list of eight goals aimed at reducing poverty, hunger, and disease worldwide by 2015 that were adopted by U.N. members, including the United States, in 2000. Increased research devoted to health problems specific to poor populations could provide new tools for use in global health programs: from population based systems to improve primary care and public health services to the development of a vaccine for malaria. Improving deployment of existing technologies, however, even those as simple as insecticide-treated bed nets, could also have a large impact.

American citizens have opportunity to advance the welfare and prosperity of people within and beyond the borders of the United States through intensified and sustained attention to better health. Over the last decade, American government and citizens have spent record amounts on global health. By building on these commitments and deploying the full complement of U.S. assets to achieve global health, the United States can improve the lives of millions around the world, while reflecting America's values and protecting and promoting the nation's interests. We are proud to share examples of the accomplishments that the dedicated members of our field are pursuing, and the opportunity through proposals for you to become involved in supporting the efforts to improve our world. We thank all of the members of our field for their commitment to pursuing our shared goals, as well as the specific members who have worked to prepare proposals to you today.

We look forward to achieving our shared goal of global citizenship and addressing global issues alongside you.

In partnership,

Jeffery E. Heck, M.D.

Executive Director, Shoulder to Shoulder
Professor, University of North Carolina, Asheville, North Carolina

Yogesh Shah, M.D.

Associate Dean, Global Health
Des Moines University, Des Moines, Iowa

Co-Chairs
Global Health Task Force

GLOBAL HEALTH TASK FORCE MEMBERS

CO-CHAIRS

Jeffrey Heck, M.D.	Executive Director, Shoulder to Shoulder Professor, University of North Carolina
Yogesh Shah, M.D.	Associate Dean, Global Health, Des Moines University

MEMBERS

W. Dwight Armstrong, Ph.D.	Chief Operating Officer, National FFA Organization
Theresa Bernardo, M.D.	Knowledge Management and Communication (KMC), Pan American Health Organization
Daniel Fantozzi	Former Director, Office of International Health and Biodefense, US Department of State
John Howe, M.D.	President & CEO, Project Hope
Nancy Kelly	Executive Director, Health Volunteers Overseas
Andrea Lindell	Dean and Professor of the College of Nursing at the University of Cincinnati
Michael McDonald M.D.	President, Global Health Initiatives, Inc.
Dr. Ed O'Neil	Executive Director, Omni Med
Suzanne Petroni	Vice President for Global Health, Public Health Institute
Dr. Greg Reinhardt	Vice President of Research and Nutrition, Mathile Institute for the Advancement of Human Nutrition
Richard Roberts, M.D.	President Elect, Wonca
Brigadier General Ron Sconyers (USAF, Ret.)	President & CEO, Physicians for Peace
Professor Chris van Weel	Past President of Wonca
Dr. Anvar Velji	Co-founder, Global Health Education Consortium; Chief Infectious Disease, Kaiser Permanente, South Sacramento; Clinical Professor of Medicine, University of California at Davis
Dr. Marijke Velzeboer-Salcedo	Gender, Ethnicity and Health (GEH), Pan American Health Organization
Wayne Waite	Board President, Shoulder to Shoulder
Edwin Brown	Department of State Liaison Deputy Director, Office of International Health & Biodefense, U.S. Department of State

GUEST SPEAKER

Mary Flake Flores	Former First Lady of Honduras
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GLOBAL HEALTH BEST PRACTICES

The Global Health Task Force's measurable outcomes support the Initiative for Global Citizen Diplomacy's goal of doubling the number of American citizen diplomats in the next 10 years.

OUTCOMES

Increase impact and improve monitoring and evaluation of US health volunteers worldwide

Strengthen and leverage contributions of US citizens to meet the goals of the Global Health Initiative

Build sustainability through health system strengthening and increased country ownership

Cape CARES (Central American Relief Efforts)

Ridgefield, CT | www.capecares.org

GLOBAL CHALLENGE(S) THAT INITIATIVE ADDRESSES

Reducing Poverty and Disease & Encouraging Cultural Understanding

Quality Health Care Delivery

Cape CARES was founded over twenty years ago as a group of volunteers dedicated to improving the health of people in the rural areas of Honduras, where there is no electricity, no running water, and no physicians or dentists. Originally most of the volunteers came from Cape Cod, Massachusetts, but today our volunteers come from all over the United States, as well as from several foreign countries. Our members include physicians, dentists, nurses, chiropractors, pharmacists, physical therapists, opticians, social workers, dental hygienists, translators, as well as many support personnel and general helpers. Many of our volunteers work stateside, “behind the scenes”, ordering and packing medicines and supplies for the teams of volunteers to take to Honduras. We always need volunteers—all one needs is a desire to help others. The Cape CARES volunteers donate their time and expertise and pay all their own travel expenses

Each year Cape CARES sends eight to ten teams of volunteers to three separate sites in southern Honduras where there is little access to health care. Cape CARES sets up a temporary clinic on site, providing medical and dental care to several villages in the area. Many people walk for up to five hours to receive the free care provided by these compassionate volunteers.

Our primary purpose was and still is the delivery of quality health care. Over the years, we have expanded our efforts and emphasis on community health care education. We visit the local schools and provide lessons on basic personal hygiene as well as proper tooth brushing and good dental health. We have been able to continue this community outreach through the help of students—both from the United States, and from Honduras. For the past eight years, students from the Discovery School in Tegucigalpa, Honduras, have joined us as team members. These students have served as translators, and dental and medical assistants. In addition they have produced educational materials for use in patient education, both in the clinic and in the schools we visit. The students from privileged backgrounds in Tegucigalpa are impressionable and enthusiastic, and have the opportunity to see a different side of their country and the people that live there. These future leaders of Honduras see, firsthand, the problems of daily life in these rural areas. Because they understand the Honduran culture, social mores and lifestyle, they are able to creatively explore ways to improve daily living conditions

Students in the United State also participate in improving the health of the people in rural Honduras. For the past nine years, students in Ridgefield, CT, have collected new toothbrushes for the children of Honduras. In student assemblies, the Ridgefield students have learned that the daily living conditions in Honduras are very difficult, and the people are so poor as to not even have their own toothbrush. The students are amazed to learn that the children in Honduras have large cavities in their teeth so severe that they cannot be repaired and the teeth must be extracted. The compassionate and generous Ridgefield students want to help, and this year collected over nine thousand new toothbrushes for the children on Honduras. The students studying Spanish made cards and letters in Spanish, explaining the importance of, and the need for good oral health. High school students developed and produced brochures on a variety of diseases and health issues, and these brochures are used in the medical and dental clinics on site, and in the health education program in the Honduran schools. The compassionate and altruistic spirit flourished in these students and in addition to toothbrushes and cards and letters, the Ridgefield students also collected vitamins and over the counter pain relieving medicines as well as soccer balls, pencils, markers, and stickers for the schools in Honduras.

Cape CARES has developed a linked website (www.capecares.org) that is used for recruitment, fund raising, and to enhance our visibility. Working with Caring for the World Films we have two videos that are used in presentations to schools and civic and community groups. These videos may also be viewed on the website. The Internet has been an effective tool to help tell the Cape CARES story and to generate interest and enthusiasm, resulting in additional contributions as well as new volunteers. Cape CARES volunteers pay their own expenses, but medical and dental supplies, and medicines must be purchased with cash donations from generous individuals and groups. For the past two years, the Unilever Corporation has helped Cape CARES by donating cases of toothpaste and bar soap for use and distribution in our clinics.

The Knights of Malta in Tegucigalpa assist Cape CARES in submitting the professional credentials and documents to the Honduran Ministry of Health in advance of our arrival in Honduras, and serve as our liaison. In addition, the Knights of Malta provide the Honduran Ministry of Health with information regarding the number of people who receive medical and dental care in our clinics, and the specific villages we serve.

Over the past twenty years or so, over 100,000 people in Honduras have received care at the Cape CARES clinics. In addition to direct delivery of medical and dental care, Cape CARES strives to provide education and information to prevent many of the diseases and chronic medical conditions prevalent in this area. Our success is measured by the number of people who return to our sites to manage acute as well as chronic conditions like diabetes and hypertension. In addition, the numbers of people seeking preventive care rather than tooth extraction reflects our success in dental health education. Cape CARES hopes to expand our efforts, recruit more volunteers, and increase the number of sites and number of trips each year. Cape CARES relies on financial donations for its operating expenses and to purchase supplies and medicine for the trips. Those who cannot join us on a trip to Honduras can help by making a financial contribution, which will enable us to provide care to a greater number of our Honduran friends.

We continue to increase our volunteer recruitment and fund raising activities so that we can continue our work in Honduras for at least another twenty years.

For more information please contact:

Randall G. Baldwin DMD | President | cabady@sbcglobal.net

Care for Life

Mesa, AZ | www.careforlife.org

GLOBAL CHALLENGE(S) THAT INITIATIVE ADDRESSES

Reducing Poverty and Disease

Family Preservation Program (FPP)

Care for Life's mission is to relieve suffering, promote self-reliance, and instill hope. As the orphan crisis continues to grow and the AIDS pandemic marches on, hope fades. Our goal is to teach families to take responsibility for their futures. We do not advocate handouts, which lead to dependency. Instead, we focus on providing education with an emphasis on behavioral change. Using a holistic approach to teach the principles of self-reliance and individual responsibility, families are guided and trained to be healthy, self-reliant, and hopeful. We are fighting the orphan crisis—by preventing it.

PROGRAM DESCRIPTION:

Care For Life is addressing the Global Challenge of “Reducing Poverty and Disease”. Over the past five years Care for Life has been quietly developing the Family Preservation Program (FPP) that is making a tremendous impact on the lives of families in Mozambique, Africa. Specifically, our program has cut the infant mortality rate in half and has slashed the maternal mortality rate to an actual rate of zero in the communities we have worked in (14,000 to date).

Care for Life is a 501(c)(3) charitable organization based in Mesa, Arizona. We are in our tenth year of operations in Mozambique, working in one of the most difficult places on earth. We currently have over 10,000 Mozambicans participating in our program in the Sofala Province.

The Family Preservation Program is a family-based development program, implemented at the community level. It is not gender-biased, and all family members are expected to participate in the program. The only requirement is that they are among the poorest of the poor, and live within a community that is seeking for a better life for its members.

FPP is a holistic approach that focuses on eight areas of development simultaneously:

- Education (Literacy)
- Sanitation
- Food Security & Nutrition
- Home Improvement
- Health & Hygiene
- Income Generation
- Psycho-social & Spiritual
- Community Participation

While many organizations specialize in one specific field, we have found that each of the eight areas depends on the others for sustainable success (e.g. clean water without proper sanitation is insufficient). In reality, the best clean water program in Sofala Province is not a “clean water” program only. It is one of the components of the Family Preservation Program.

The program targets the poorest of communities, with a manageable size of 160-200 families. CFL meets with local leaders and community members who commit to participate. Care for Life personnel oversee the program with the help of community volunteers. Together, they work with each individual family, and as a community, to improve their lives by setting, and following up, on goals specific to each family's needs.

FPP works because individual families are challenged to make changes, and each family in the community is working together to meet their goals. All program participants are evaluated and tracked on a regular basis to determine their progress and to refine the program. Data is collected on all aspects of their lives and compiled to provide us with results and information to best meet the needs of each family. We know how each family is progressing in real time, helping us maximize our efficacy and track our resources carefully. Technology is assisting in the expansion and effectiveness of FPP in the areas of communication and data collection. All participant data is entered into a web-based system, giving us real-time access for analysis.

Our program has been audited, evaluated and endorsed by experienced professionals in this field of work.

Care For Life administrative costs are borne by the Board of Directors, enabling 100% of all donations to flow directly to the programs aiding the poverty-stricken people in Mozambique. We are very carefully managed and are pleased to report that over the past five years administrative costs have not exceeded 10% of total expenditures. Program costs are currently \$50 per person, per year, with an average cost per family of \$250. An entire community of 1,000 people can change their lives for an average cost of \$50,000 per year. Attached documentation will demonstrate the sources of funding. Please note that the vast majority of funding comes from private donors. Partnership participation is not required for existing implementation, but would be beneficial to program expansion.

The program is sustainable for two important reasons. 1) It is cost effective. 2) It is designed with an exit program. At the end of 2-3 years, the CFL leaves a functioning community and moves to another to begin the program. We have statistical proof that the changes that take place are maintained after the program has left the village.

FPP has now been documented and is ready to be shared with other organizations that wish to extend a productive program to the people they serve. It is scalable, and with resources and partnerships, FPP could move forward in a major way, not limited to Sub-Saharan Africa.

For more information please contact:

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Children's Hospital, Los Angeles

Los Angeles, CA | www.chla.org

GLOBAL CHALLENGE(S) THAT INITIATIVE ADDRESSES

Reducing Poverty and Disease & Encouraging Cultural Understanding

Adolescent Medical And Human Rights: The Health And Healing Conversation In Their Own Voice

This project seeks to provide physicians with adolescent perspectives, specifically female youth perspectives, of their own health care needs and experiences. Adolescent medicine specialists are trained in issues specific to adolescents and young adults such as reproductive health, drug use, and mental health. They gain experience through apprenticing in Adolescent Medicine environments often working with high need populations. A large part of the training experience for Adolescent Medicine physicians is learning to advocate for patients with a large variety of needs. This project will bring a portion of these experiences to a global setting in order to apply the principles of adolescent health and advocacy in India.

PHASE 1: Comprehensive interviews and discussions with Indian adolescents; adolescent stories in the words of the teens themselves will describe personal experiences, both good and difficult, within the health arena.

PHASE 2: An educational video of the teen narratives will be created for physicians in India highlighting female youth health needs and health care expectations. Specifically, female youth will be speaking about their own experiences of health care and access to health care in India. Narratives have been shown to be an effective tool for affecting behavioral change amongst healthcare providers. In instances where youth are unable or unwilling to appear on camera other youth will relate their stories.

PHASE 3: The video will be shown to physicians, particularly those in training - medical students and residents. Select students will be invited to participate on a panel to speak to physicians at their medical institutions or in a community setting, immediately following viewing of the educational video. Students will be given skills on effective methods of public speaking and presentation.

PHASE 4: Periodic evaluations will be conducted to assess the value of Project Health and Healing (PHH) on: a) Helping the student volunteers to become effective educators b) The development of new understandings on the part of local physicians, and c) Potential changes in their clinical practice and approach to teens.

It is expected that through the provision of information to physicians via widening their scope of the adolescent health experience that there will be a direct and positive effect on understanding the needs of female youth. This improved understanding and empathy will better position these physicians to act as advocates for young females, hence improving the access and utilization of health care for young women within their communities.

Project Health and Healing (PHH) will interview female students between the ages of 12 to 21 years of age at local schools and colleges in New Delhi, India. Each student will be given the opportunity to offer accounts of their direct and indirect experience with the health care system in India. This information will then be reviewed for common themes highlighted by experts in adolescent health care in both India and the United States.

The long-term goal is to influence the quality of adolescent health care and encourage collaborative care amongst physician healers and female youth.

PROJECT DETAILS: GOAL #1 To promote understanding of female adolescent health needs, not limited to reproductive health. Objective #1.1 - To provide physicians and physicians in training with relevant information regarding health needs as framed by youth themselves. Objective #1.2 - To assist physicians and physicians in training in learning how to effectively apply this information in helping their patients to be healthier.

GOAL #2 To effectively use youth volunteers as a major factor in helping medical professionals to learn. **Objective #2.1** - To recruit a group of adolescents (aged 12-21) from local schools and universities to become volunteers in the Project Health and Healing Program (PHH).

Objective #2.2 - To provide a 4 week training program for the volunteers that covers a) basic information on public speaking and b) information on teaching methods. A centralized location will be determined and participant will be asked to commit a certain number of hours each week in order to prepare for their panel discussion.

FOCUS POPULATION:

There are two different focus populations for this project. The first groups are physicians and physicians in training, who live and work in New Delhi, India or the major and credited medical universities in that area. This focus population is represented in the project objectives for Goal #1. The second focus population is female youth in New Delhi, India who will participate in the Project as video participants and then student volunteers. This group is represented in the project objectives for Goal #2. Both groups are essential components of this project. It is expected that significant learning will take place for both populations.

Methods: The primary methods for achieving the goals and objectives of the Project will be:

- The identification of major college and universities that are medical teaching facilities and faculty or physicians associated with these institutions the identification of high school and colleges within Delhi that will allow the participation of female youth/students in the educational video
- Creation of an educational video that will become a focal point for providing information on youth health needs as delineated by them in their own voice the development of a recruitment/training program and supervised practicum for youth volunteers

In addition, a plan will be developed by staff to guarantee the systematic collection of information about the operation of PHH.

EVALUATION PLAN:

- A survey questionnaire will assess physician actions, attitudes, and beliefs about adolescent health care and female youth specific issues at baseline and one-year post intervention. Physicians will be asked about their type and volume of exposure to adolescent female youth, emphasizing non-reproductive health care. This information may be used to create a research study detailing the effect of the intervention and to either support or refute its continued use. A control group, trainees and physicians not participating in the educational intervention may will be used examine statistically significant changes in attitudes or beliefs, and practice.
- Qualitative data will be captured through open-ended questions with physician participants prior to the video and panel discussion. They will be asked about basic attitudes and beliefs towards teen health, the attractiveness of the training materials, and other questions to provide feedback for the ongoing improvement of the project.
- Data will be collected from youth on their views of the video, the panel experience, their interactions with peers around speaking to physicians, and their willingness to initiate conversations with physicians in their own life experience.

For more information please contact:

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Center for International Disaster Information (CIDI)

Washington, DC | www.cidi.org

GLOBAL CHALLENGE(S) THAT INITIATIVE ADDRESSES

Reducing Poverty and Disease & Encouraging Cultural Understanding

Cidi Pilot Global Citizen Diplomacy Program

For more than 22 years, CIDI has had the unique experience of communicating with millions of Americans in the US and abroad about the best ways that they can provide assistance to those affected by disasters. By understanding how programs should support the ability to earn and save, our trainees will have a better understanding of how successful poverty alleviation programs work. By understanding the importance of sustainability in health programs in ending disease, our trainees will help provide better solutions. Our aim through this pilot GCD project is to take these situations, as distressing as they are, to train cadres of citizen diplomats, both technical and non-technical, with real-life scenarios to help them formulate approaches to addressing these issues wherever they occur.

Relative to this is the introduction of a unique GCD program designed to include the voices of “New Americans” as valuable members of the citizen diplomacy corp. The Diaspora is hungry to share their perspectives on issues and is an excellent choice to speak to American ideals to those living abroad and to learn more about the ideology, culture and foundation principles of those with whom they will be dealing. Past efforts to include the Diaspora in activities have been perceived overseas as less than credible and the community often feels that they have been “used.” CIDI’s approach is to offer a realistic and believable approach that recognizes that “Yes, America isn’t perfect, but we’re learning and changing and listening and we’re offering our hands in friendship and mutual respect. Let’s talk.”

One of the more exciting components of the program starts with practical training on the ground with our first GCD program in Africa. Through our partners throughout Africa, we will provide hands-on experience to field students in terms of a prosthetics-provision project, which begins with the identification and counseling of victims of civil conflict, the process of manufacturing a custom-fitted prosthetic device, and rehabilitation of these victims by means of on-going professional physiotherapy, counseling, and a community-based agricultural program that not only provides the victims (and their dependents) with the means to become self-sufficient, but provides them with an ability to generate an income within their own communities and thereby build both self-esteem and financial independence. This program is designed to become self-sufficient and self-supporting, dramatically reducing the dependence on foreign food aid. In addition, this program is fundamentally designed with expansion in mind, in order to extend training beyond the realm of agriculture to numerous trade skills (metalwork, woodwork, sewing, weaving, and beadwork) that are designed to expand the boundaries in terms of economic self-sufficiency. There are also programs designed to provide medical training to nurses in areas where such services are virtually non-existent, improving not only the capability for communities to benefit from an improved level of general health care and regimens, but also to facilitate a reduction in child mortality rates, and to address the stigmatization suffered by HIV / AIDS sufferers by introducing an enlightenment programme that will ease the integration of those affected into general society.

An important element in respect of our approach to offer numerous opportunities for Americans to serve as citizen diplomats is education by means of the website, and practical field training, of prospective diplomats about the severity of illnesses they may not currently perceived as being life-threatening: measles, malaria, dengue fever, worm infestation, tuberculosis, and influenza being amongst the deadliest in the developing world. As an ongoing activity, CIDI will focus on one major disease per month to offer participants the opportunity to have in-depth knowledge about the disease; how it is spread; how the disease impacts people in their communities; treatment, prevention and recovery regimens; and how epidemics affect families, countries, regions and economies.

Our proposal is inherently action oriented, and not limited to theory alone: CIDI already maintains a captive, interested audience of potential participants through its web site and hotline services dedicated for international disasters. CIDI already works with many of the groups and organizations we would target as part of the citizen

diplomacy corps including service groups, cultural/Diaspora organizations, religious organizations and associations of students, working and retired professionals. Right here in Washington, the list of relevant university, diplomatic and international foreign affairs and relief and development organizations at the program's disposal is rich, abundant and limitless.

CIDI has the resources to reach hundreds of thousands of potential participants during the GCD pilot program period, which can easily be measured by online participation and documentation of local outreach activities they have performed, which will be required as part of the training program. While the measurement of the impact of global civilian diplomacy could be seen as subjective, the success of participants in changing perceptions and attitudes within a community may be measured through interviews and polling within those communities. In as much as our programs call for the direct input from citizen diplomats, the ability of a specific project to meet its stated goals is directly proportionate to the success of the advocacy and training provided to participants.

The technology available to CIDI allows the program to arrange for those with internet access overseas to video-tape messages through our partners to share their perspectives on what they hope for their countries, not as people begging for help, but peer-to-peer discussions to allow for frank dialogue and mutual respect, with the additional benefit of a reduction of reliance on traditional development aid channels by encouraging beneficiaries to actively participate in their own development programs and to encourage participants in this GCD program to understand the need for, and apply the tenets of GCD, donor impact and accountability.

With technology, CIDI can reach millions through our web site. Video blogs from experts in diplomacy, international relief, development, international economists from the World Bank and the United Nations, and ambassadors from around the world will add valuable elements to the program's course-work. CIDI is located in the National Press Building in Washington, DC, which offers the program access to a state-of-the-art broadcast operations centre, web-casting, satellite communications, video production and other audio-visual services for briefings and training. Together with the latent synergy waiting to be released by this combination of technology, experts and elements at our disposal; our active partners on the ground; and American citizen diplomacy, we can ensure an improved standard of living to those for whom this is currently nothing more than a pipe-dream.

PARTNER

CIDI has a commitment from Africa Medical Assistance (Pty) Ltd. to join in the proposal to launch the pilot program.

BUDGET

The new program described above would cost approximately \$1,800,000 for the start-up year and \$1,400,000 per year thereafter.

For more information please contact:

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GlobeMed

Evanston, IL | www.globemed.org

GLOBAL CHALLENGE(S) THAT INITIATIVE ADDRESSES

Reducing Poverty and Disease & Creating a Globally Competent Society

Overview Of GlobeMed

GlobeMed is a network of college students who partner with grassroots organizations around the world to improve the health of the impoverished. Through their involvement today, students commit to a life of leadership in global health and social justice. The GlobeMed Network currently includes 19 chapters at university campuses throughout the country and a national office in Evanston, IL. The grassroots organizations supported by GlobeMed chapters span the world from Mexico to Nepal.

University students have the passion and energy to make an impact in global health. GlobeMed engages and trains students to work with communities across the world. By organizing a yearlong global health curriculum, an Annual Summit in the spring, and volunteer trips during the summer, the GlobeMed National Office prepares U.S. university students to become the next generation of leaders advancing global health equity.

GLOBEMED'S PROGRAMS HEALTH PARTNERSHIPS

GlobeMed believes in the power of partnerships between grassroots organizations and students. Every GlobeMed chapter volunteers and fundraises for an established community-based organization. Projects supported by GlobeMed chapters are never traditional foreign aid; rather, they empower communities to serve their own health needs. Past projects initiated by GlobeMed chapters include micro financing in Liberia and clean water and electricity for hospitals in Rwanda. GlobeMed has partnered with 19 universities (see website for list) and their international partner organizations to deliver programs.

YEARLONG GLOBAL HEALTH CURRICULUM: “globalhealthu”

Guided by a comprehensive set of topical resources, each of GlobeMed's 19 chapters hosts a yearlong series of on-campus global health discussions, workshops, and lectures as part of its globalhealthU curriculum. Through these events, GlobeMed members develop a foundational understanding of issues impacting their grassroots health partners and global health more broadly.

During the 2009-2010 academic year, GlobeMed explored how the fields of politics, environment, gender, and structural violence affect the health of impoverished people around the world.

ANNUAL GLOBAL HEALTH SUMMIT

The GlobeMed Global Health Summit brings together GlobeMed members from universities across the country for several days of intensive lectures and workshops with leaders in global health. The Summit is designed to educate students with a broad understanding of relevant issues in global health and prepare them with the specific skills needed to make an impact today.

Over the past four years, the GlobeMed Summit has reached hundreds of students from over twenty universities. Stephen Lewis, the former UN Special Envoy for AIDS in Africa and Dr. Paul Farmer, the Co-Founder of Partners In Health, delivered the keynote addresses in 2009 and 2010, respectively. Every year, hundreds of GlobeMed students leave the summit excited to lead their universities' engagement in global health.

EVALUATION OF GLOBEMED'S PROGRAMS

In order to evaluate GlobeMed's wide-ranging programs, students complete an annual survey, chapters create annual reports, and partner organizations provide feedback to chapters. GlobeMed surveys its members annually to evaluate personal impact and whether students plan to pursue careers in global health after college. Additionally, each chapter creates an annual report that details the past year's fundraising and educational efforts along with the impact of its work with its health partner. Moreover, partner organizations will provide feedback to chapters on the effectiveness of the GlobeMed-sponsored projects, how many individuals were reached, and how they can improve projects in the future.

GLOBEMED'S CONSTITUENCY AND SUPPORTERS

DEMOGRAPHICS

The defining characteristic of GlobeMed's demographics is the overwhelming percentage of females. Young women have seized leadership in the student movement for global health equity. Over 75% of GlobeMed's members are young women, and 18 out of 19 chapters have a female president. Concerning ethnicity, 62% consider themselves Caucasian, 33% Asian, 4% African American, 3% Hispanic, and 1% Native American. At this time, GlobeMed does not have any data on the social class or sexual orientation of its members. GlobeMed encourages a broad range of perspectives to come together to make an impact in global health.

FINANCIAL SUPPORTERS AND SUSTAINABILITY

GlobeMed has critically examined its model of student engagement and ensured sustainability before expanding. Every project GlobeMed initiates involves empowering a pre-existing community based organization. The organizations with which GlobeMed chapters partner have other sources of funding that cover operating costs. Therefore, 100% of the funds raised by GlobeMed chapters directly support tangible health projects.

GlobeMed's National Office has received generous support from multiple funders, which allow all chapters to fundraise only for their health partner. Individual donations comprise approximately 25% (about \$50,000) of GlobeMed's operating budget. For the past three years, the Abbott Fund, the Bristol-Myers Squibb Foundation, Northwestern University, and The Buffett Center have given generously to GlobeMed, totaling over \$100,000 each year.

GLOBEMED'S FUTURE

Within the next 2 years GlobeMed is expanding from 19 to 60 universities. By tripling its network over the next three years, GlobeMed will recruit and train an estimated 2,000 college students each year to effectively partner and work alongside grassroots health organizations around the world. Not only will students raise thousands of dollars every year for capacity-building projects at community health organizations, but these experiences will inspire students to become lifelong advocates for global health equity and social justice.

For more information please contact:

Jon Shaffer | Executive Director | jon@globemed.org

Indiana University, School of Nursing

Indianapolis, IN | <http://nursing.iupui.edu/>

GLOBAL CHALLENGE(S) THAT INITIATIVE ADDRESSES

Reducing Poverty and Disease & Creating a Globally Competent Society

Educating Globally-Minded Nurses

The Global Health Initiative at Indiana University School of Nursing (IUSON) began in 1998 as a citizen diplomacy program in partnership with the Bloomington, Indiana - Posoltega, Nicaragua, Sister City Program. An undergraduate student recruited fellow students and a faculty member to provide prenatal education for lay midwives in a rural community in Nicaragua. Since then, 47 IUSON undergraduate and graduate students have participated in cultural immersion nursing programs in Nicaragua, Mexico, and Costa Rica and 30 students in local cultural competence programs.

The overarching aim of the Initiative is to engage nursing students in collaborative global health efforts that link the work of nursing with the excitement of experiential learning for both professional and personal growth. The Initiative's objectives include:

- Engaging students in developing personal relationships with people from other countries and effectively representing the United States while traveling abroad, improving students' Spanish fluency in order to offer linguistically sensitive nursing care to the rapidly increasing Spanish-speaking population in Central Indiana,
- Involving students in international health care experiences, increasing students' understanding and appreciation of life ways of people living in other countries and of people from other countries that are living in Central Indiana.

The Initiative engages nursing students in health experiences in Latin American countries through various arrangements. For example, in 2000 we were invited by a US-based community organization with a long-standing relationship with the Mexican community to provide health care to a rural community in Mexico. Over the next ten years, nursing students and other health professions students and faculty developed relationships with community residents while providing health service to this community. In 2004, members of the Indiana University (IU) health professions faculties approached officials at the state university, Universidad Autonoma de Estado de Hidalgo (UAEH), to partner in training health professions students collaboratively while providing service to this rural community. Since then US nursing students have developed meaningful relationships with Mexican nursing student peers while working side-by-side to provide health care in Mexico, have learned about health care and educational systems, and have learned about Mexico through visiting important cultural sites and participating in social events.

Nursing students comprise the largest group of undergraduates in a month-long, summer campus-wide language/cultural immersion program in another Mexican or Costa Rican community. The program includes five hours of daily language study and twice-weekly service-learning experiences. Students develop personal relationships with Mexican families through home stays.

The pre-departure preparation for both of these programs orients students to service-learning and international study, evolution of the program and host country partnerships, common health and dental problems in Latinos in the United States and in Mexico, and the history and politics of Mexico. In addition, students are connected through videoconference technology for an initial getting-to-know-each-other session and later for a session that contrasts the health care systems and health professions education of the two countries.

Publications and presentations about the Initiative have included students and colleagues from Mexico as co-authors. The Initiative is under continual evaluation, and each year the specific activities are determined by an assessment of outcomes of previous experiences. A comprehensive program director's report evaluates logistics, academic learning, finances, and other program features.

Action Research is used as a strategy for continuous quality improvement and research training. A family health needs assessment was conducted in 2005 by nursing faculty and students from UAEH and Indiana University Purdue University Indianapolis (IUPUI) in order to elicit data from Calnali residents about their main perceived health problems, what they believed caused the problems, and what they thought could be done to improve the problems. Diabetes was a major concern, not surprising considering the extremely high obesity and diabetes rates in Mexicans and Mexican Americans. To address this problem, the UAEH-IUPUI nursing team developed and provided a Healthy Eating Program to elementary school children designed to be offered in both countries by joint teams of nursing students. In 2010 a pilot study was conducted in Pachuca with four fourth grade classes. Pre-post evaluation of the children's knowledge and attitude changes after the weeklong program was positive. A focus group involving students and faculty from both schools was conducted at the end of the program to discuss strengths of the joint experience and to elicit suggestions for improving the program. Plans are underway to host Mexican nursing students in Indianapolis and offer the program at a local elementary school.

Citizen diplomacy development occurs in our home community of Indianapolis as well. Although learning to effectively function abroad is important, it is vital for nurses to be skilled in integrating migrants from abroad into all aspects of community life locally. In our community health nursing courses, students learn about new migrant populations, their ethnic customs, and specific health needs and practices. They engage with immigrant students and parents in school health settings, learn about health care services for new arrivals, and meet with social service agency staff to learn about resettlement issues. The students create bulletin board displays for the stairwells of the nursing building that provide information about specific ethnic populations, their country of origin, and common health needs.

The Globally-minded Nursing Education Model was developed to design local and global nursing education experiences at IUSON. The Transformative Theory of Learning undergirds the model and is the basis for designing reflective activities for students to focus on their personal growth and transformation from participating in globally oriented nursing experiences. The model incorporates the IUPUI International Learning Guidelines, the IUPUI Service Learning Principles, and the IUPUI Principles of Undergraduate Learning, as well as course objectives and program outcomes for baccalaureate nursing education. This model is being used by an interdisciplinary team of health faculty to develop a qualitative research program for investigating what and how students learn from global health experiences.

We believe that by offering a range of global experiences both abroad and locally, the IUSON is preparing graduates as citizen diplomats. We believe these efforts further graduates' acceptance and appreciation of the multiple interests of the global community and promote engagement in addressing global health problems.

For more information please contact:

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Malaria No More

New York, NY | www.MariaNoMore.org

GLOBAL CHALLENGE(S) THAT INITIATIVE ADDRESSES

Reducing Poverty and Disease

Malaria Griots Program

Worldwide, malaria takes over 860,000 lives each year and kills more African children than any other single disease. 89% of all deaths occur in sub-Saharan Africa, resulting in an estimated \$12 billion yearly loss in economic output due to decreased productivity and increased health expenditures. This disease, however, is not just treatable; it is also preventable, and we have the tools to fight it.

Malaria No More (MNM) is determined to leverage these tools to end malaria deaths in Africa by 2015 — a goal endorsed by the global community. With our network of committed partners around the world — including organizations like the Bill & Melinda Gates Foundation, USAID and UNICEF — we help empower African families to protect themselves from malaria. With high-visibility partners like American Idol's "Idol Gives Back" and FC Barcelona, the world's biggest soccer team, MNM has outlets to communicate both the urgency and the reality of ending malaria deaths to enormous audiences worldwide.

By pairing the mass distribution of anti-malaria tools—such as mosquito nets, medicine and spraying—with wide-scale education and awareness efforts focused on the importance of properly using these interventions, we have seen tremendous return on investment. This multi-pronged approach has helped reduce malaria deaths and illnesses by more than 50% in 10 African countries since 2000 – including Rwanda, Eritrea, Zambia, Botswana and the Islands of Zanzibar.

A surge in commitment to ending malaria deaths has paralleled these African successes and nowhere has this effect been more palpable than in the United States. American commitment to ending malaria deaths has swelled as MNM continues to engage students, adults, sports stars, celebrities and faith groups alike through its dynamic network. From youth soccer programs participating in "Kick it to Malaria" events to high school students hosting "Stayin' Alive" dance fundraisers, Americans have proven to be exceptionally responsive to malaria messaging.

In particular, MNM has seen great success in utilizing new technologies, such as Twitter and Facebook, to create a grassroots movement of Americans who support our goal to end malaria deaths. Leveraging this social networking media in new and innovative ways, MNM has conducted tremendously successful awareness campaigns and blazed a new trail in global communications. In April 2009, MNM teamed up with Ashton Kutcher to unleash the power of Twitter to benefit the malaria fight. After Ashton announced that he would donate 10,000 mosquito nets to MNM if he beat CNN's Breaking News account to one million followers, hundreds of thousands of users signed on worldwide to support the cause. Once Ashton won the race, countless others, including Oprah Winfrey and Ryan Seacrest, were inspired to publicly commit donations using this breakthrough technology, raising over \$600,000 for life-saving mosquito nets. Distribution of the "Twitter Nets" began in January 2010 in Senegal, and will provide over 89,000 nets to help the village of Velingara become the first in Senegal where every person has access to a mosquito net. This project, in turn, has prompted the government of Senegal to set the goal of achieving nationwide universal mosquito net coverage by the end of 2010.

MNM again leveraged the power of new technology to activate global support for malaria using Facebook's Causes application in December 2009 when Sean Parker, the creator of the Causes application, donated his 30th birthday to MNM. Demonstrating the remarkable potential of online social networking to activate and engage American citizen diplomats, this simple action motivated thousands of supporters to spread the word about malaria and raise over \$27,000 for MNM.

To capture this surge in interest, MNM has developed the Malaria Griots program in partnership with the ONE Campaign, a grassroots and advocacy organization committed to fighting poverty and disease. Malaria Griots is a distance-learning program that enables instructors, who are experts in malaria and global health advocacy, to reach a committed team of individuals using online technology that is faster, more interactive and more flexible than traditional learning media. The goal of the Griots program is to equip individuals with the tools to be local advocates in their communities, spokespersons for the media, engaging presenters at neighborhood church basement meetings and educators to everyone they meet. The program is open to anyone with a willingness to learn and access to a computer, from college students to business professionals, across the country.

In West Africa, a Griot is a storyteller, a singer, a history keeper and an agent of cultural change. Echoing this tradition, the Griots program is designed to transform passionate volunteers into powerful spokespersons in the fight against malaria by transmitting malaria knowledge to committed community members. The program kicks off with an online course exclusively designed with Elliott Masie, an early pioneer in distance learning and e Learning and the chair of the Learning CONSORTIUM, a network of over 240 'learning leaders' from some of the largest companies in the world. The Griots program is a five-month, in-depth course, and includes live discussion with leading malaria experts, access to cutting-edge resources and the opportunity to participate in current malaria campaigns.

Malaria Griots will finish the program with a 12-month outreach and activity plan, designed to reach the public, media and political leaders with malaria messaging towards the ultimate goal of recruiting volunteers and other advocates for the malaria cause. This built-in advocacy component of the Griots' outreach provides an information platform for future Griots to learn about this opportunity, providing front-line exposure to malaria experts and energizing a limitless citizen base of engaged Americans. Subsequent Malaria Griots classes will also incorporate lessons learned from past participants, informing the expansion of this innovative program. This citizen-expert training course represents an advocacy framework that can be adjusted to achieve high-impact awareness and messaging for any global health issue.

Support for the Malaria Griots program is an extraordinary chance to transform ordinary Americans into malaria advocates, experts and leaders. Malaria Griots will play a key role in MNM's efforts to end malaria deaths in Africa by 2015 by spreading the word and encouraging other Americans to join in the malaria fight.

For more information please contact:

Kate Carr | Managing Director & Chief Development Officer | info@malarianomore.org

Mano a Mano International Partners

Mendota Heights, MN | www.ManoaMano.org

GLOBAL CHALLENGE(S) THAT INITIATIVE ADDRESSES

Reducing Poverty and Disease

Overview

Mano a Mano's mission is to create partnerships with poor Bolivian communities that improve health and increase economic wellbeing. We have been guided by the simple premise that groups of committed individuals can reach across national boundaries to make a dramatic difference in the lives of others. The power of this premise has been demonstrated by the extent to which the organization's scope and accomplishments have expanded to exceed even our most ambitious dreams. Mano a Mano has grown from a small, all-volunteer organization that re-distributed 500 pounds of medical supplies from the U.S. to Bolivia in 1994, to one which now builds infrastructure for health care and economic development in Bolivia that is constructed, supported, and run by Bolivians.

AMPLIFYING HOST COUNTRY EFFORTS

To fulfill our mission, we helped create three Bolivian NGOs that complete projects in partnership with us. The accomplishments of our partnerships include: 1) collecting donations of over 2.9 million pounds of usable medical surplus from health care providers in the U.S., transporting them to Bolivia, and distributing them to health care programs that serve the poor; 2) building 106 rural community clinics, establishing their health care and education programs, and teaching local residents to co-manage them with us; 3) building public showers, bathrooms, laundry tub facilities, and water access sites near the public school in 37 of these communities, making it possible for residents to apply good hygiene practices learned through their clinic's health education program; 4) building three agricultural water reservoirs that help rural communities manage their limited water supply. Farm family income has doubled in these communities as a result of increases in crop and livestock production.

Mano a Mano seeks to address the concurrent problems of extreme material poverty and premature death in rural Bolivia. Disparities between urban and rural populations are striking. Access to attended deliveries provides one example: 77% of urban Bolivian births, but only 38% of rural births are attended by a trained health care provider. Rural maternal and infant mortality rates are nearly twice that of Bolivia's urban areas. Mano a Mano clinics have achieved stunning results in reducing these disparities and mortality rates. While Bolivia's level of rural infant mortality reaches 80 per 1,000 and maternal mortality is approximately 5 per 1,000 rural births, there have been no maternal deaths in the more than 11,000 deliveries attended by Mano a Mano's medical personnel, and all but 50 infants have survived. Mano a Mano medical personnel attribute these results to their strong focus on outreach and health education within clinic communities and to our superb continuing medical education program.

Community residents participate in all aspects of planning, construction, and operation of these facilities. Mano a Mano personnel in Bolivia organize residents to partner with them. Extensive discussions lay the groundwork for developing formal agreements among the elected community leaders, local government officials, the Bolivian Health Ministry, and Mano a Mano and define, prior to construction, the contributions and responsibilities of each participating entity. All clinic staff members are Bolivian. In addition to the physicians, nurses, and dentists employed in these clinics, up to ten local volunteers are trained as health promoters who administer first aid and assist with outreach and health education. Local residents devoted 50,000 volunteer hours to building clinics last year, making an indispensable contribution to the common good.

SUSTAINABILITY

All Mano a Mano programs focus on long-term sustainability. With 106 Mano a Mano clinics now in operation, 99 no longer require funding from us. Bolivian sources cover all but 2% of salary costs, and fund pre and post natal care and deliveries, care of children to age five, and case management of chronic diseases such as malaria and tuberculosis. The clinics have had over 2,250,000 patient visits since 2001. All of the clinics continue to receive donated supplies, medical supervision, and continuing education from Mano a Mano to ensure high quality service. The focus on sustainability has made it possible for Mano a Mano to continue to expand the network of community clinics throughout the country, a result we could not have attained while continuing to financially support each clinic.

ENGAGING U.S. CITIZENS AS GLOBAL DIPLOMATS

Joan Velasquez, a former Peace Corps volunteer, and her Bolivian husband, Segundo, founded Mano a Mano. In 2008, she received the Peace Corps' prestigious Sargent Shriver Award for Humanitarian Service for her fifteen years of creating, managing, and volunteering with Mano a Mano. For its first seven years, Mano a Mano was staffed entirely by volunteers in Minnesota and Bolivia. We continue to function with only two paid employees in the U.S. and over 200 U.S. volunteers. Nearly 100 of our volunteers have traveled to Bolivia to engage in conversations and participate in Mano a Mano volunteer activities there. They return home telling us that the cultural interchange that occurs as they interact with Mano a Mano's Bolivian volunteers has literally transformed their lives. Several of our young adult travelers have chosen to enter graduate-level programs in international health and development as result of their participation in our travel opportunities. Mano a Mano intends to expand this program beyond its current two trips yearly for 5 – 10 participants when additional funding becomes available.

In 2009, Mano a Mano entered into a new collaborative relationship with St. Paul's Regions Hospital. Regions staff traveled to Bolivia twice last year to deliver weeklong practica to Mano a Mano staff and other Bolivian health professionals. Another practicum is planned for this year.

EVALUATION

Clinic staff tracks the numbers of patients who use its services, the purpose of their visits, the extent to which its service-related goals are met, records of deliveries, and maternal and infant mortality for the Bolivian Health Ministry and Mano a Mano. Spanish-speaking volunteers interview community residents and clinic staff on their views of the care provided and the ease of using clinic services. Medical staff and community volunteer health promoters complete evaluations of each continuing education workshop.

For more information please contact:

Daniel Narr | Executive Director, US | dan@manoamano.org

University of Pittsburgh, Supercourse

Pittsburgh, PA | www.pitt.edu/~super1/

GLOBAL CHALLENGE(S) THAT INITIATIVE ADDRESSES

Reducing Poverty & Disease

Supercourse Overview

Citizen Diplomacy is defined as the concept that the individual has the right, even the responsibility, to help shape the U.S. foreign relations “one handshake at a time.”

We believe that our Supercourse programs are a very important example of Global Citizen Health Diplomacy as we have over 56,000 volunteer collaborators from 172 countries. This includes large numbers of people from the Organization of Islamic Conference countries, Chinese, Russians, Cubans, Iranians and Israelis.

Question: What is the best way to improve global health and science training?

Answer: Improve lectures.

Question: How do we improve global health and science lectures?

Answer: Faculty worldwide share their best PowerPoint lectures:

Question: Will faculty share lectures?

Answer: Yes, the Supercourse has 56,000 faculty members from 172 countries who created an open source Library with 4400 lectures. In the last 12 months we taught over 1 million students worldwide. 40,000,000 saw our H1N1 lecture.

We were originally funded three times by NASA, and the National Library of Medicine. We built a “Library of Lectures” which is like the Carnegie Free library, but instead of sharing books we share out best slides and lectures. We have the highest global health page ranks for any educational institution. We are the highest-ranking global health educational project on the web. Our program consists of:

OPEN SOURCE:

Our Global faculty shares their best, slides/lectures on prevention. The experienced faculty member can beef up their lectures. New instructors reduce preparation time with better lectures. Faculties in developing countries have access to current prevention information.

“EMPOWER” EDUCATORS

Teachers worldwide create their own lectures. We aid them providing top quality slides and lectures.

FACULTY

Twenty Nobel Prize winners, 60 IOM members and other top people contributed lectures by Sept. 1. Gil Omenn, AAAS, Vint Cerf, the father of the Internet, Elias Zerhouni, head of NIH, etc. contributed lectures.

MIRRORED SERVERS AND CDS

We have 45-mirrored servers in Egypt, Sudan, China, Mongolia and others. We have distributed 20,000 Supercourse CDs

JIT LECTURES

We created scholarly disaster lectures within days after the Bam Earthquake, Rita, Pakistan Earthquake, Haiti and H1N1 and reached >200,000. Over 40,000,000 people saw our H1A1 lecture. These are the highest rated disaster lectures. We have had Arabs, Israelis, Chinese, Russians, Iranians and many others working together. Our H1N1 lecture was translated into 11 languages, including Arabic, Farsi and Hebrew. 40 million Chinese individuals have viewed it.

LEGACY LECTURES

We are collecting the best of the best lectures from Nobel Prize winners, members of the IOM, NAS, and American Epidemiologic Society.

LIBRARY OF ALEXANDRIA SUPERCOURSE OF SCIENCE

We are ramping up to collect the best lectures of science.

ISLAMIC SUPERCOURSE

We have been capturing lectures from Islamic scholars on prevention and Islam. The goal is to develop educational systems within Islam to better provide prevention education.

HEALTHY CITIZEN'S DIPLOMACY

We are directly collaborating with 3000 Arab scientists, 200 Cuban and 100 Iranian colleagues.

PRODUCTIVITY

We have published over 150 papers in leading medical journals including Science, Nature, Lancet, BMJ, Nature Medicine, and PNAS among others. PC Magazine has identified our web pages as in the top 100. We receive 75-100 million hits a year. We rank #1 and 2 out of 60 million sites for Global Health Lectures.

For more information please contact:

Ronald E. LaPorte, PhD | WHO Collaborating Centre Director and Professor of Epidemiology |
rlaporte@pitt.edu

World Partners for Development

Heymarket, VA | www.wpdprojects.org

GLOBAL CHALLENGE(S) THAT INITIATIVE ADDRESSES

Reducing Poverty & Disease & Encouraging Cultural Understanding

Global Interconnection And Exchange Program (GIEP)

Not everyone has the opportunity to travel or participate in cultural engagement programs around the world. World Partners for Development is a U.S. based 501(c) 3 nonprofit organization and a registered non-governmental organization (NGO) in Ghana, West Africa that utilizes video conferencing technology to promote public health, cross-cultural engagement programs that helps create global awareness, understanding between cultures and providing the platform for global cooperation. America's security, competitiveness and need for global competency depend on a citizenry that understand and can interact effectively with the world and our group is helping to do that through our Global Interconnection and Exchange Program (GIEP).

Our Global Interconnection and Exchange Program (GIEP) creates an American presence in other parts of the world and also introduce other countries culture into the lives of Americans in order to establish a basis for better mutual understanding. Through videoconferencing and web chats, youth from other parts of the world participate in dialogue with their American peers about public health, their lives, communities, education, and culture. This program also enables participants to discuss issues relevant to both U.S. and overseas participants. Videoconferencing create real-time interactions between citizens in different countries in which they can experience, express, and observe emotions. Citizens that participate in the videoconference program will not only gain a first-hand experience in cross-cultural engagement experience, but also could build on this experience to gain knowledge by reflecting on their observations and emotions. Just imagine the possibilities for face-to-face real issues discussions with a native of a country, instead of just reading or hearing about it. It creates an effective networking for global awareness and global education. Research has confirmed that, intercultural learning would be more effective if it leads to practical competency in cross-cultural interactions, which requires both a more comprehensive understanding of the other cultures and a critical reflection on one's own culture.

World Partners for Development will use the following four components in fulfilling our cultural engagement program:

- **SELECTION OF COUNTRIES AND CULTURES:** As the program is to ensure multiplication of the connections between American citizens and their counterparts overseas, participants from all countries, irrespective of their race, religion, gender, or political affiliation will be invited to join the program. Various programs will be conducted for women, men and minority populations for cross-cultural exchange empowerment.
- **ORIENTATION:** An introduction of the culture(s) of participating countries through storyboards, films, web links, or other materials.
- **DIRECT ENGAGEMENT EXPERIENCE:** A minimum of 2-hour sessions of face-to-face personal engagement with U.S. and their foreign counterpart through videoconferencing or web chats. Personal engagement is more than just observation, or learning about the other culture, although those are important components, as well but the needs to be face-to-face human interaction with people from the other culture. It also fosters active involvement and discussion with people from the other culture. Schools or other participants will use their videoconference facility or will be transported to a central location with a videoconference facility for the program.

- **EVALUATION:** Program participants will be evaluated on participation and evaluation forms completed by participants. There will be a follow up monitoring report on how the program has caused social change among groups and communities. We will also find out from participants on network programs formed between U.S. and foreign participants after the program.

The program outcomes will be the utilization of videoconference and web chat technology tools to communicate information, and the following results will be achieved:

- Skills gaining in cross-cultural communication
- Understanding how the world might look from the standpoint of another community of interpretation and experience.
- Learning how to discern and, where appropriate, adapt to the cultural expectations of the other
- Learning how to distinguish between the enduring principles of human morality and their situation-specific adaptations
- Witnessing other cultural embodiments of faith, and thus to reflect on the substance and definition of one's own faith by comparison
- Youth and other participants being empowered to affect positive change

We will maintain a very strong, sustainable program through:

- The development of original, culturally relevant materials and programs that encourage cross-cultural engagement for citizens through participatory approach
- Solicitation of strong partnership with schools, government, faith communities, agencies, and local and international organizations for strong program support
- Determining follow-up steps to re-contact participants, and also participants to network among themselves through international volunteering, study abroad programs, emailing, and many more
- Assigning program coordinators to coordinate programs at all levels
- Invitation of press to cover sessions, highlight participants and outcomes
- Constant availability of effective videoconference equipment and facilities in global program locations

We believe that by leveraging resources and other partnerships in this project will help multiply the connections between American citizens and their counterparts overseas in many folds by the year 2015.

The total cost of implementation of our Cross-cultural Engagement program is \$43,000. Of this amount, \$23,000 has already been committed from fundraising and other funders.

For more information please contact:

Philip Darko | President | Philip@wpdprojects.org

NON-SELECTED PROPOSALS

The following organizations submitted a proposal to the Global Health Task Force, but were not selected.

AMERICASRELIEF TEAM

PROGRAM: Jamaica Water Treatment Project
CONTACT: Dr. Teo Babun, Jr., Executive Director
EMAIL: teob@americasrelief.org
LOCATION: Miami, FL

CAUSES FOR CHANGE INTERNATIONAL

PROGRAM: The Exploration Institute
CONTACT: Zully JF Alvarado
EMAIL: zully@causesforchange.org
LOCATION: Chicago, IL

CENTER FOR GLOBAL HEALTH & DEVELOPMENT, BOSTON UNIVERSITY

PROGRAM: Kenya Program
CONTACT: Jonathon Simon, ScD, Director, Center for Global Health & Development, BU School of Public Health
EMAIL: jonsimon@bu.edu
LOCATION: Boston, MA

CHILD FAMILY HEALTH INTERNATIONAL

PROGRAM: Cultivating Nurses as Global Health Citizens: Expanding Global Health Diplomacy Education
CONTACT: Jessica Evert, MD, Medical Director
EMAIL: jevert@cfhi.org
LOCATION: San Francisco, CA

INTERNATIONAL FEDERATION OF DENTAL EDUCATORS & ASSOCIATIONS

PROGRAM: Global Network for Dental Education
CONTACT: Patrick J. Ferrillo, DDS, President
EMAIL: pferrillo@pacific.edu
LOCATION: San Francisco, CA

INTERNATIONAL ACTION

PROGRAM: Water Purification in Haiti
CONTACT: Lindsay Mattison, Executive Director
EMAIL: info@haitiwater.org
LOCATION: Washington, DC

THE METHUSELAH FOUNDATION

PROGRAM: Advancing Medical Research and Practice Overseas
CONTACT: David Gobel, CEO & Founder
EMAIL: david.gobel@gmail.com
LOCATION: Springfield, VA

MOMBASA RELIEF INITIATIVE

PROGRAM: Food First: Connecting Schools, Farmers and Local Communities
CONTACT: Donald Harris, Vice President
EMAIL: don.harris3@comcast.net
LOCATION: Berkeley, IL

SAMUEL MERRITT UNIVERSITY

PROGRAM: Collaborative Global Health Immersion Experiences for Physician Assistant Students
CONTACT: Michael De Rosa MPH, PhD, PA-C, Chair, Physician Assistant Department
EMAIL: mderosa@samuelmerritt.edu
LOCATION: Oakland, CA

TOSTAN

PROGRAM: American Volunteers and the Community Empowerment Program (CEP)
CONTACT: Gannon Gillespie, Director of US Operations
EMAIL: gannongillespie@tostan.org
LOCATION: Washington, DC

UH MACDONALD WOMEN'S HOSPITAL

PROGRAM: Global Health Scholars Program in Reproductive Health
CONTACT: Margaret Larkins-Pettigrew, MD, MEd, MPPM, Assistant Professor, Director of Global Health
EMAIL: Margaret.Larkins-Pettigrew@uhhospitals.org
LOCATION: Cleveland, OH

Task Force Member Program Summaries

Global Health Education Consortium (GHEC)

San Francisco, CA | <http://globalhealtheeducation.org>

GLOBAL CHALLENGE THE INITIATIVE WILL ADDRESS

Reducing Poverty & Disease

The Global Health Education Consortium Capacity Project For Physicians Shortage Areas

PROPOSAL: Create a pool of skilled and experienced health professionals willing to serve in health systems of resources poor countries to enhance the training capacity of health professional schools.

BACKGROUND

The shortage of health workers in underserved regions of the world is a major impediment to address the global health crisis. The high cost of training medical professionals and the need to immediately implement large-scale public health measures has understandably moved the focus of health workforce development on low skill health workers. Yet, physicians are the most highly skilled and arguably the most influential professional group in health. According to the JLI, a crucial component of workforce development is the production of medical graduates who have the skills necessary to meet the needs of underserved communities, and equally important, the desire to remain in and serve these communities.

The low annual output of medical school graduates in many poor countries, compounded with internal and external migration of doctors requires immediate and concerted efforts to increase the capacity of health professional education institutions. For instance, in many African nations the local production of doctors and other health professionals will never satisfy national needs in the short and median terms. Given the population growth and the likely increase in demand as poor economies improve, the shortage of physicians and other health workers can only be expected to worsen, unless significant efforts are made to increase annual graduation output.

At the same time, there are a growing number of health professionals in developed countries willing and able to respond to the training needs abroad and to increase the learning opportunities for students attending schools suffering from a shortage of faculty. Yet, opportunities to participate in service and education program in developing countries are fragmented and for the most part poorly organized. Frequently, individual faculty members arrive for short period of time teaching a specific component that may not always be aligned with the rest of the curriculum or the local context. Many under-resourced schools then struggle to cope with the logistics and disruptiveness of frequent arrivals and departures of external faculty often from different institutions with different approaches and procedures. As a result there is a lack of continuum in the education programs.

A multi-institutional seamlessly managed program that tailors preparation and deployment to each institution's need would significantly reduce fragmentation of efforts and increase the institutional development impact of twinning and faculty exchange program. This mechanism would match available health professionals with existing opportunities at health professional schools in need of faculty support.

OVERALL GOAL

To increase the capacity of medical education institutions in under resourced areas to produce graduates, research and services needed by the local health system by mobilizing committed and skilled health professionals in North America to support, teach, mentor and collaborate with faculty and students of the health professions in low income countries.

PROGRAM'S OBJECTIVES:

- Create and maintain a registry of health professional schools and teaching organizations in low income countries with the need and capacity to host visiting faculty
- Design a mechanism to evaluate, select and process applications of North American health professionals skilled and committed to providing service, teaching and mentoring students of the health care professions and assist in under-resourced academic institutions
- Establish a pre-deployment training program for participating faculty to prepare them for their role and responsibilities
- Develop a matching system that reflects the nature of international site's needs and the specific competencies and desire of individual faculty contributor
- Set up a clearing house for processing, evaluating and matching demands with needs
- Create an administrative structure to run the program and manage the partnerships
- Monitor program's components, performance, outcome and impact on host institutional capacity to meet its educational and training objectives

PROGRAM COMPONENTS:

- **CLEARINGHOUSE:** a clearinghouse will provide a mechanism for evaluating demands, identifying, processing, and recruiting US based health professionals; matching them with needs of under-resourced partner institutions and organizations internationally.
- **IDENTIFYING A US BASED POOL OF HEALTH PROFESSIONALS:** the program will be exposed widely and disseminated through the GHEC website and through communication with partnering professional associations and organizations, schools of health sciences and medicine, other relevant academic centers (schools of management...), teaching hospitals and appropriate government agencies
- **DEVELOPMENT OF A PRE-DEPARTURE/ASSIGNMENT TRAINING PROGRAM:** Prior to deploying to selected site, US based participants will undertake a training course that emphasizes their roles and responsibilities and understanding of the program's goals
- **ADMINISTRATIVE COMPONENT:** the program's administrative structure must be developed to support and manage the project. This administrative unit will be responsible to develop partnership with other stakeholders and to interact with the donor community. Whether this structure should be an add-on to GHEC or be separate will have to be discussed by all relevant groups
- **PROGRAM'S EVALUATION UNIT:** A system of evaluation will be developed and tested to assess the success of the program in assisting host institutions to meet their educational mission

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GLOBAL CHALLENGES THE INITIATIVE WILL ADDRESS

Reducing Poverty & Disease; Increasing Respect for Human Rights; Creating a Globally Competent Society; Encouraging Cultural Understanding.

Nursing Globally, Collaborating & Learning Locally

When the topic of volunteering in global health arises, Americans are often unaware of the role played by many health professionals, including nurses. Multiple opportunities exist and activities in which nurses lead in improving global health care are growing. These nurses are contributing to improve global health care in both clinical and academic settings and providing global citizenry at a critical point of need. Additionally, many U.S. university schools of nursing have initiated efforts related to development of the professional nursing workforce in underserved nations, a significant factor in meeting health care needs. Currently, there are few efforts to coordinate these activities and learn from experience.

The World Health Organization has reported a significant global shortage of health care workers estimated at 4 million. The predominant need is a nursing professional workforce that addresses concerns related to acute, community, and public health. Often, nurses serve as the first point of contact in addressing health care needs and the workforce shortage impedes the opportunity for first level, preventive interventions that can prevent more serious and complicated evolution of illness. In many situations around the globe, available nurses are empowered to provide care and treatment and often serve as the primary and sole health care professional for communities. A shortage of these professionals has serious and devastating effects on a community's health.

The American Association of Colleges of Nursing (AACN) and Health Volunteers Overseas (HVO) propose assisting U.S. baccalaureate and graduate nursing programs in developing a mechanism that will incorporate global nursing opportunities as part of the nursing students' service learning activities. These activities would be formalized as a part of their curriculum, using technology and the resources of AACN, a national nursing organization representing 642 senior colleges and universities with degree nursing programs, and HVO, a non-governmental organization with 24 years of developing world experience.

The AACN establishes quality program standards, and works with deans, directors, faculty, researchers, and clinical partners to implement the standards. AACN is committed to fulfill the profession's responsibility to assist nursing education in improving health care. As the national voice for degree programs, their membership spans university nursing schools across the U.S.

Health Volunteers Overseas, founded in 1986, is a private, non-profit organization dedicated to improving the availability and quality of health care in developing countries through the training and education of local health care providers. HVO designs and implements clinical training and education programs in child health, primary care, trauma and rehabilitation, essential surgical care, oral health, blood disorders and cancer, infectious disease, wound management, and nursing education. Each year, approximately 500 health care volunteers serve in 80 programs around the world.

HVO, and its sponsor AACN, recognize the crucial needs in global health care and are committed to the integration of international health content in our nation's baccalaureate and graduate nursing education programs. While some programs offer a component on global nursing, many other universities have expressed an interest in developing and refining collaboration opportunities for practical service. Through the collaboration of AACN and HVO, existing programs can be strengthened, and new programs can be initiated. Most importantly, the impact overseas can be far greater through a collaborative effort. Representatives from a number of universities have expressed an interest in developing or strengthening their programs (Carlow, Drexel, Eastern Michigan, Emory, Nazareth College, Northeastern, UMDNJ, University of Wisconsin-Madison and UW- Milwaukee).

Our two organizations propose creating a Steering Committee, composed of nursing school representatives experienced with international collaboration and HVO members, to develop a core curriculum that will prepare students, faculty, or clinicians for international collaborative activities. This curriculum will be developed in an on-line, web accessible format to address clinical, cross-cultural, and global health issues. Additionally, model seminar discussions on cross-cultural issues will include content related to development of outcome expectations (both for the educator/clinician and the international partner), working in complex emergencies, facing poverty in the developing world, communicating effectively across language barriers, addressing safety and health concerns of volunteers in a foreign environment, and other issues. A strong focus on developing an educational infrastructure is an essential outcome as that is often a weak link in assuring a professional, highly competent nursing workforce in developing nations. Developing such an infrastructure will allow nurses to be educated within their own country, rather than receiving their training elsewhere, with the possibility of never returning.

The curriculum will be designed as an electronically mediated course, enabling schools across the U.S. to access the material. The course will consist of different training modules, so schools can access those segments that are the most relevant for their students. A component of the training will provide students with opportunities to volunteer their services in developing nations, in conjunction with their faculty.

Although the online course is targeted toward international nursing, much of the information is relevant to domestic nursing opportunities as the course will address issues of serving in resource-strained environments, relating to patients across cultural boundaries, and promoting the nursing profession.

The benefits are numerous:

- Set quality standards and bring consistency to education programs on global health nursing;
- Expose American nurses to global health issues, which they may later encounter domestically;
- Expose nurses to volunteering. Studies show that young people who have a volunteer opportunity are more likely to continue volunteering, in their communities and internationally;
- Nurses who volunteer are better prepared, intellectually and emotionally, for the experiences which they will encounter;
- Nurses with better preparation for global experience are likelier to be more productive, focusing on their skills, without worrying about cross-cultural issues;
- Volunteers working side-by-side in a different culture tend to develop an understanding and appreciation for that culture, serving as informal country advocates.

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Omnimed

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GLOBAL CHALLENGES THE INITIATIVE WILL ADDRESS

Reducing Poverty & Disease

Omnimed: Community Empowerment In Health, Uganda: US Volunteers Facilitating The Training Of Community Health Workers In Rural Uganda

BACKGROUND & RATIONALE

Since March 2008, Omnimed has partnered with local health officials, the US Peace Corps, Volunteers for Prosperity, and local & transnational NGOs to recruit and train US volunteers to train community health workers, (called village health teams—VHTs) in the Mukono District of Uganda. These VHTs are comprised of local volunteers from the surrounding villages, who, once trained, provide valuable primary health care to the underserved population in the area. In the program's first year, we are training 400-500 VHTs, who will provide preventive and basic therapeutic care to 100,000 to 120,000 rural Ugandans. We are also conducting a randomized, prospective trial to measure the program's impact. We know the program works because the Ugandan government ran the same program model in Mpigi District from 2004-2007, with dramatic improvements in local health. Our program improves upon that model by using our volunteers to go door-to-door with newly trained VHTs to reinforce the training.

We train the VHTs to implement preventive and curative strategies such as:

- Malaria prevention and treatment through bed net usage and prompt treatment and referral
- Prevention, screening, and referral for HIV/ AIDS
- Promotion of sexual and reproductive health, with reduced birthrates, and reduced sexually transmitted diseases
- Better prenatal care, safer deliveries, and education about danger signs of pregnancy and newborns
- Improved nutrition and recognition of those cases of malnutrition that require intervention
- Importance of immunization, and how to boost overall immunization rates
- Clean water initiatives, basic sanitation, and hand-washing, leading to decreased morbidity and mortality from diarrheal illness
- How every family can prepare oral rehydration solutions (ORS) as a life-saving intervention for diarrheal illness in children
- Early referral for respiratory illness with timely use of antibiotics for pneumonia
- Recognition of and referral for mental illness, domestic violence, and many other primary health issues

Mortality and morbidity rates in Uganda are among the world's highest, with a life expectancy of only 52.72 years—the 4th lowest in the world. Easily preventable diseases such as malaria, HIV, diarrhea, acute respiratory infections, and malnutrition ravage the population under five years old, resulting in an infant mortality rate that is the 33rd highest in the world. Across the country, only 42.7% of Ugandan parishes (townships) have access to a health facility. A large percentage of Uganda's rural population is effectively isolated from any sort of health care whatsoever.

In an ongoing attempt to remedy this situation, the Ugandan Ministry of Health (MOH), created a program in 2004 called Village Health Teams (VHTs). Using WHO and Global Fund funding, the MOH trained VHTs throughout the Mpigi district as a pilot program. This locally-based “horizontal” model was found to be very effective; during this period, the MOH reported a decreasing number of malaria cases and anemia levels among children under five years of age, increasing immunization rates, increasing antenatal care attendance, and increasing institutional deliveries across the district.

Unfortunately, funding dried up in 2007, and the program failed as VHTs slowly lost motivation and incentive. Omnimed

Med's model revives the original government-based VHT program and rests on many of the same local structures. Our program does not seek to create a VHT base anew, but rather inject the infectious enthusiasm of well-prepared international volunteers into a locally developed program.

PROGRAM DESIGN & IMPLEMENTATION

Our program consists of the following components: a recurring week-long VHT training course (with 30+ VHTs trained per course) taught by local trainers and our volunteers, follow-up home visits by VHTs accompanied by our volunteers, and a focus on strengthening ties to local health facilities. Each Omni Med volunteer conducts one full course and completes as many home visits as possible during their stay. The home visits ensure the transfer of knowledge to those who will benefit most, and allows us to monitor the program's efficacy. As of May 14 2010, we have trained over 160 VHTs and conducted well over 700 home visits.

We feel strongly that the most effective volunteers are those that are properly screened, well prepared, and given a specific set of tasks to complete during their stay. Accordingly, before departure our volunteers are required to complete a comprehensive on-line training course that provides: an orientation to the VHT Program and Mukono; full clinical preparation to train VHTs; an overview of health and safety issues; and a broad-based understanding of global health inequality. This approach ensures well-prepared volunteers who will base their actions on principles of social justice, not charity.

We are simultaneously conducting a randomized, prospective clinical trial with Uganda Chartered HealthNet based at Makerere University in Kampala to measure the program's impact. In June 2010 we will collect data on various preventive health practices like hand-washing, use of ITNs, use of ORS, vaccinations, etc. Then we will train VHTs for the randomized half of the villages of both Ssaayi and Terere Parishes while leaving the other villages without VHTs. We will then train those VHTs for the impact villages, conduct numerous home visits, refresher days, and distribute "VHT-Guide to Healthy Homes" sheets to all involved households written in the local language. 6 months later, we will conduct the same survey, measuring the health-related behavioral changes. Using a "Lives Saved Calculator, we will be able to estimate the number of lives saved based on the behavioral changes for each specific intervention. We will then publish the results in a peer-reviewed journal. The service community has a glaring lack of data demonstrating its impact on local communities. This trial will begin to fill this void.

OVERALL GOALS AND LONG-TERM VISION

Because our program partners with a locally-based, effective initiative, we believe that our model is scalable and could cover the entire district, other districts in Uganda, and other countries in East Africa and beyond. The Edward M. Kennedy Serve America Act infused \$6 billion into the service movement within the United States. We are working with others at the Brookings Institution and the Building Bridges Coalition to develop a global corollary, in which volunteers' time and energy translates directly into measurable differences through impact-oriented programs. Volunteers in this program will have the opportunity to make a unique, measurable impact on the health of rural communities in one of the world's poorest countries.

Additionally, by prospectively measuring the impact made by volunteers, we will be able to fill a current, glaring void in the service sector.

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Physicians for Peace

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GLOBAL CHALLENGES THE INITIATIVE WILL ADDRESS

Reducing Poverty & Disease; Creating a Globally Competent Society

Physicians for Peace

According to WHO, at least 1.3 billion people worldwide have inadequate access to basic healthcare—due primarily to the lack of trained workers. There is an urgent need for more than four million additional doctors, nurses, midwives and public health workers worldwide. The hemorrhaging of healthcare workers from the developing world is taking its toll. Preventable diseases and poor healthcare are causing a dramatic increase in morbidity and mortality.

It is Physicians for Peace's commitment to reduce poverty and disease while at the same time creating a globally competent healthcare provider society. Based on more than 20 years of deploying citizen medical diplomats, Physicians for Peace mobilizes highly skilled volunteers to provide invaluable medical education and training to the healthcare providers of the world's most vulnerable populations.

With more than 500 medical education programs to 50+ countries, its goal is long-term sustainability and self-sufficiency. Its initiatives are varied in both scope and diversity, all with the singular purpose to help heal a hurting world by strengthening health systems. The emphasis is on teaching to provide sustainable long-term care for local patients by local healthcare professionals...by US citizen diplomats.

PFP programs are planned as citizen partnerships with the host organization – with all having something to teach and something to learn. Care is taken to respect local culture, especially as it relates to healthcare philosophy and delivery. There are many examples of our work:

- Childbirth remains an unnecessarily dangerous and life-threatening risk for women throughout the developing world. Almost all women who die in developing countries during childbirth would still be alive if they had pre- and post-natal care, access to a skilled midwife or doctor in childbirth. Physicians for Peace is meeting this challenge head on with a holistic and community-based approach to maternal health care. For example,
 - **PRE AND POST NATAL MENTORING:** Our Resource Mothers program pairs adolescent girls with young mothers who mentor the mothers-to-be in prenatal care, childbirth, post-partum and newborn care. Mentors assist with the practical and emotional obstacles the young mothers-to-be face in circumstances where hygiene and medical support is near to non-existent.
 - **MIDWIFERY TRAINING:** Physicians for Peace sends trained midwives to educate young women in rural areas so they can recognize signs of labor and know when it is the time to seek help. By working directly in the communities, volunteers garner credibility and respect from local traditional birth attendants by modeling hands-on patient care. Volunteers are not only qualified experts, but take an active role in establishing personal relationships and friendships.
- According to the United Nations, every year nearly 11 million young children die before their fifth birthday. Physicians for Peace is answering the call through such training programs as pediatric resuscitation and advanced life support.
 - Pediatric Advanced Life Support (PALS) is a prime example of an easily teachable and very affordable program that has a proven track record of saving the lives of critically ill and injured children. PALS teaches healthcare providers the cognitive and psychomotor skills needed to resuscitate and stabilize infants. PALS relies on careful evaluation and directed therapy, rather than on modern technology - particularly useful in austere conditions.

- Other initiatives range from countrywide healthcare education reform initiatives to community-based projects impacting more localized populations.
 - In a ground-breaking initiative, Physicians for Peace created “The Partnership for Eritrea” with The George Washington University in Washington DC and the Eritrean Ministry of Health to conduct the first ever post graduate medical education in Eritrea’s history.
 - Physicians for Peace has founded a nine-country consortium in Central America to bring innovative burn care by providing reconstructive burn surgery education, burn nursing education and the development of burn clinics.
 - Throughout much of the world, amputee victims of land mines, earthquakes, motor vehicle accidents, industrial and agricultural accidents, birth defects, disease and war receive little or no medical treatment. Physicians for Peace designed the Walking Free program to assist such victims by establishing sustainable prosthetic and rehabilitation centers in developing nations.

These are but a few of the many solutions Physicians for Peace contributes. Solutions to this global health crisis depend on our ability to empower individuals, families and healthcare professionals. The need to build bridges of cultural understanding and ease needless suffering in the world is more vital than ever. From the West Bank to West Africa and from Central America to Central Asia, Physicians for Peace seeks to answer the call of those in need, erase the artificial boundaries of race, geography, gender, politics and religion and create lasting relationships built on trust, respect and mutual understanding—using medicine as the currency for peace.

Driving Physicians for Peace’s strategic plan is its global alliances—from US and foreign NGOs to ministries of education and health. These collaborative partnerships afford Physicians for Peace the ability to develop real-time, real-world capabilities to jointly launch medical education missions. Such partnerships develop unique opportunities to distribute and transfer medical education and create a sentinel effect in jointly developing vision, purpose and mission—and citizen diplomacy.

The ability to populate the underserved areas of the world with the intellect and training from an international health care provider educator pool creates immense benefit. Our only limiting factor for scaling up even further our vast cadre of medical diplomats are available fiscal resources. Physicians for Peace is uniquely poised to expand exponentially the deployment of citizen diplomats.

Former Senate Majority Leader Bill Frist, MD, cites “medicine as currency for peace.” PFP mobilizes America’s healthcare volunteers to take teaching skills to providers of the world’s vulnerable populations, giving hope to those with few expectations of any. PFP stands shoulder to shoulder with host country practitioners, building bridges of cultural understanding by creating personal and lasting relationships built on trust and respect—regardless of race, gender, politics or religion. By training and engaging “person to person”, PFP demonstrates America’s caring, compassion and eager willingness to help others help themselves, building both capacity and opportunity—teaching, healing, enabling and empowering.

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GLOBAL CHALLENGE THE INITIATIVE WILL ADDRESS

Reducing Poverty & Disease

Primary Health Care Development Through Electronic Medical Records

This proposal focuses on the provision of an affordable, robust Electronic Medical Record (EMR) to support Family Physicians (FP) in developing and medium developed countries to strengthen Primary Health Care (PHC).

With the development of IT and medical informatics, Electronic Medical Records (EMR) has become an essential but costly technology for healthcare. For PHC, there are specific needs for (electronic) data processing and exchange of information. As PHC is the link between the population with its specific health needs, and the health care system, FPs must be able to seek and exchange information of — amongst others:

- Health status
- Socio-demographic characteristics of the population it serves
- Reasons of why people contact health care
- Health problems encountered in PHC
- Diagnostic and therapeutic interventions
- Risk factors
- Use of health care facilities

Of particular importance for PHC are (a) the possibility to store and retrieve data on an individuals' level to support continuity of care, and (b) to store data at the level of specificity, relevant for the decision making at the level of the FP. This asks for a specific granularity of data processing.

The World Organization of Family Doctors, Wonca, has developed the International Classification of Primary Care (ICPC) that provides a framework for data processing relevant for PHC. ICPC is currently in its second version and forms the basis of the EMR in many countries in Europe, and Australia. At this moment Wonca is in the process of developing ICPC-3, in which through collaboration with WHO and IHSTDO a better compatibility is sought with The International Classification of Diseases and the SNOMED classification. The revision will also serve to introduce risk factors in the database, and to make the disease category more sensitive to health problems in encountered in PHC in developing countries.

This proposal aims to develop an EMR for developing countries that can accommodate ICPC as its data framework. To function in the context of developing countries, the EMR must be (i) affordable in its acquirement and maintenance; (ii) able to link the often in isolation operating health care facilities; (iii) able to cope with unpredictable conditions of electricity and internet access. A pilot study in Sri Lanka demonstrated that it was possible to overcome these problems and that an ICPC driven EMR enhanced the functioning of FPs and PHC.

The introduction of the EMR in developing countries has to be backed-up by the teaching and education of FPs and other PHC professionals on core competencies if PHC. Wonca has the expertise to lead both developments and funding of this project will have lasting effects on the health of people and populations in the developing World.

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