



Partnerships

IN

Prevention

*Putting Public Health into Practice*

**Boston University School of Public Health**

**Dean's Report 2002–2003**

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# Partnerships

## IN Prevention

### *Putting Public Health into Practice*

I AM PLEASED TO PRESENT the third annual Dean's Report of the Boston University School of Public Health. Founded in 1976, BUSPH has evolved a great deal in the past 27 years, dedicating itself to building a comprehensive, well-qualified faculty; undertaking a broad array of research projects; and educating a diverse and dedicated student body.



Ours is not an ivory-tower institution. We recognize that public health is by definition the science and practice of protecting and improving the health of the community, be that community local, regional, national, or international. To that end, BUSPH partners with governments, nonprofit organizations, other schools and universities, and local groups that can help us reach out to a wide range of populations in need. This year's Dean's Report describes and celebrates some of those partnerships, although it can highlight only a few of the very significant alliances that exist between the School and other institutions and community groups across the globe.

BUSPH stresses the practical aspects of public health, preparing students and encouraging faculty to go out and apply their skills in real-world institutions and organizations that make a difference in people's lives. One way we do this is by developing collaborations outside academia that seek alternatives to current practices in such fields as HIV prevention, emergency preparedness, and asthma control by applying the kind of scientific, objective approach learned only in the classroom.

Each of the partnerships highlighted here — from the Zambian government's malaria program to the bake sales of Rotaract — is also working toward one of the primary goals of public health: empowering people. The axiom “teach a man to fish and you'll feed him for life” is never more true than it is in public health. BUSPH seeks to reach out because it's what we do and who we are, not because it is required of us.

Recent world events have reminded us more than ever of the importance of interconnectedness — of nations and communities, between public health practitioners and their constituents, and across disciplines. One of the most exciting aspects of our partnerships is that through them we learn from others. We build our skills and knowledge with input from a variety of colleagues, including primary care physicians, mental health specialists, lawyers, dentists, social workers, English as a Second Language teachers, and even hotel managers. Such partnerships strengthen not only the collaboration itself, but each of the groups involved.

To enhance our efforts toward improving the public's health, BUSPH will continue to connect with partners — in Boston, across the nation, and around the world.

Robert F. Meenan, MD, MPH, MBA, Dean

# Boston Housing Authority, Boston Public Health Commission

The Boston Housing Authority (BHA) is the largest landlord in Boston, housing approximately 10 percent of the city's residents, and is the largest public housing authority in New England. The Boston Public Health Commission was the nation's first health department and traces its roots back to 1799, when Paul Revere was named the city's first health officer.



Debra Brown, Marilyn Mills, and Perfecta Laboy (shown with Arrow Ravenel, left) reach out to help maintain and improve the health of residents in their housing developments. Arrow's aunt, Geneva, is one of a group of friends at Franklin Field that Marilyn calls her "sisters." Together they look out for the kids in their neighborhood, and have spruced up the common areas between their units, creating gardens and play areas.

**Though they're supposed** to put in only six or seven hours a week at their new jobs as Resident Health Advocates, Marilyn Mills, Perfecta Laboy, and Debra Brown are finding themselves instead on virtually 24-hour call.

"I get phone calls at home, in the middle of the night," says Mills, the RHA at the Boston Housing Authority's Franklin Field development in Dorchester. "Calls from the friend of a friend of a friend. Or they see you on the street walking and say, 'Can I talk to you for a minute?' Then they cry on your shoulder."

Brown, of East Boston's Maverick Gardens, smiles with recognition. Being indispensable can be a trial. But despite the near-constant demand for their services from members of their communities and beyond, the women's pride in their accomplishments is evident. "I said to myself, Well, if I never did anything in the past," says Laboy, of the Charlestown Development, "I want to do something now. At least I am helping people."

The Resident Health Advocates program is part of a broadly focused effort funded by the Centers for Disease Control and known as the Partners in Health and Housing Prevention Research Center (PHH-PRC) — a collaboration among BUSPH, the BHA, and the Boston Public Health Commission — to improve the health of public housing residents. Other aspects of the project include the GirlStars after-school program (see sidebar); Waging Peace, a pilot project that is testing the feasibility of training residents to identify and prevent domestic violence; and Reach 2010, a breast- and cervical-cancer screening program that aims to help eliminate racial and ethnic health disparities by disseminating information among public housing residents in a culturally sensitive way.

The Boston Housing Authority oversees 64 developments citywide and hopes to have RHAs in nearly a dozen by the end of 2003. Together, Mills, Laboy, and Brown assist the residents of nearly 2,000 housing units, pointing them in the right direction for such diverse concerns as drug use, arthritis, lack of health insurance, smoking, mental health, diet, and exercise. They also, at times, act as



informal counselors, as illustrated by a discussion Mills recalls having had with a teenage girl at Franklin Field.

“She was 14,” Mills says. “I said, ‘Don’t let no one force you. You’re too young to be doing drugs, having sex.’” Mills pauses, smiling. “She was, like, ‘Can I come live with you?’”

The sense that they are understood is what bonds residents to the RHAs. People feel they can trust those who live among them more than they might an outside “expert.”

“We wanted residents to see the RHA as the go-to person,” says Rachel Goodman, director of the BHA’s Community Services Department, “someone who brings resources to the development. The RHAs are already well known in the community, and they’re outgoing. And if they don’t know who to contact about a particular question, they know how to find out who to contact.” RHAs attend skill-building sessions on topics that include leadership, cultural competence, and navigating the health care system, as well as educational seminars on health issues. Their training makes a difference to the residents of their development and to the RHAs themselves.

“They receive a certificate from Boston University School of Public Health and they complete a course of study that could lead to a career path,” says Gail Douglas, associate dean of students at BUSPH. “It’s a significant accomplishment.”

Debra Brown concurs. “I’ve looked into a lot of training courses and you always have to pay to get the skills,” she says. “Here, they pay you. Plus, once I started doing the work I realized that I need to know people in management in my community. Now I know how to get the information to help myself, too.”

The PHH-PRC is not the only aspect of the partnership among BUSPH, the BHA, and the Boston Public Health Commission.

An equally important initiative, called Healthy Public Housing, teams the same key players with Harvard, Tufts, and others to examine the relationship between housing conditions and respiratory health, particularly childhood asthma. This, too, is a community-centered project; it engages public-housing residents in improving building conditions in a similar way to the RHA program — but in this case residents are taking the lead in improving sanitation, pest control, and indoor air quality rather than overall health.

The partnership among the universities, city agencies, and public housing residents is unusual in several ways. “In a traditional research project,” says Kate Bennett, director of planning at the BHA, “an academic institution would come in to research our population as part of a larger low-income group. But this project focuses exclusively on public-housing residents, which is exciting and unique. Also, this research is practical and applied, as opposed to purely theoretical. This will actually improve the quality of life of our residents.”

According to Bennett, the collaboration is one of the few in the country to rely on the community to gather health data, assist with making improvements, and collect environmental samples for lab analysis. “Our residents help the Prevention Research Center,” she says, “and the PRC helps us deliver better services to our residents. We’re in the affordable housing business; we don’t have the resources to do this kind of work on our own. But the PRC brings programs, resources, technical expertise, and evaluation to the table.”

“When I first started, I was so afraid,” says Debra Brown, who was unemployed before becoming an RHA and is now training to be a patient-care assistant at Boston Medical Center. “Now I have more confidence. I know I can do whatever I set my mind to.”

## girlstars

Eleven-year-old Marjourie Jiminez (left) and “best friend” Katherine Colon, 12, at GirlStars, an after-school program for girls 9 to 13 years old who live in Boston public housing developments. Sponsored by the Partners in Health and Housing Prevention Research Center — a collaboration among BUSPH, the BHA, and the Boston Public Health Commission — GirlStars focuses on physical activity and health education, with female BUSPH students leading discussions on such topics as nutrition, body-image, alcohol, smoking, drugs, violence prevention, and career development. “We always do something fun at GirlStars,” Katherine says. “We do exercise, we eat healthy snacks, and we always learn something new.”

# The Zambian Government

*The Center for International Health (CIH) at the Boston University School of Public Health works with scientists in developing countries to carry out applied research relevant to local needs. For several years, it has been working with the Zambian government on such issues as breast-feeding, malaria, respiratory infections, technical support, and training.*

**Though malaria control is an important part of improving public health in Zambia, it is not the only problem BUSPH has helped tackle. The Zambia Exclusive Breast-Feeding Study is an initiative funded by the U.S. National Institutes of Health and undertaken in conjunction with the Lusaka District Health Management Team. It seeks to maximize the benefits of breast-feeding to newborns — primarily better cognitive development and increased immunity — while minimizing the incidence of HIV transmission from mother to child.**

**It happened four years** ago, but Angela Mumba remembers every fevered moment. It wasn't the first time the 37-year-old Lusaka, Zambia, widow had come down with malaria, but it was probably the worst. "I was really afraid," she says. "The body gets too hot, and you can't eat. You have pain, you shiver, you sweat. Me, when I have malaria, I vomit. When you sleep you dream of bad things. You think maybe someone has bewitched you."

The drug she was given took its time rooting out the parasite that causes the disease. "You are in a bad state," Mumba says. "You just pray."

When her 9-year-old son, Stan, fell ill with the same disease, Mumba hated to see him suffer the way she had. "After that I bought a mosquito net," she says, "and I started using it. In fact I bought two nets. One for Stan, and the other one for the two girls."

A simple solution, but one that was all but impossible until just a few years ago.

Ninety percent of the world's 300 million cases of acute malaria each year — which result in a million deaths — occur in sub-Saharan Africa, according to the World Health Organization (WHO).

mid-1990s, there remains much to be done. A joint effort between BUSPH's Center for International Health and the Zambian government's National Malaria Control Programme aims to lower the country's malaria rates in several ways.

Malaria parasites — borne by infected mosquitoes — have become so resistant to chloroquine, the drug of choice for many years, that one of the first orders of business was to begin introducing a new medication, Fansidar. "Right drug, right dose, right time," says Jon Simon, director of the CIH and an associate professor in the School's Department of International Health. "People's life's work has been based on these three components." A major success for the collaboration came when the government officially adopted the new drug policy.

A second, and perhaps even more important, effort aims to make insecticide-treated mosquito nets more available and affordable, particularly for mothers and children, since malaria can cause low birth weight and maternal anemia.

"Last time I had malaria," says Mumba, "nets were hard to find. Now nets are easy to find and easy to afford."

Zambia, with an infection rate of 35 percent, is second only to Malawi in the number of cases a year. The disease is the leading killer of children under 5, and, according to WHO, it "presents a major obstacle to social and economic development," costing an average of U.S. \$12 billion a year in lost GDP, continent-wide — "even though it could be controlled by a fraction of that sum."

Though Zambia has had a Roll Back Malaria campaign under way since the

Previously, imported nets were taxed at 45 percent; since the Malaria Control Programme lobbied to remove the tax, nets can now be purchased through retailers and at district health centers for 10,000 to 15,000 kwacha, or about \$2, with proceeds going into a revolving fund for the purchase of new nets. "A few years ago when we started," says John Chimumbwa, coordinator for the National Malaria Control Center, "the household coverage with mosquito nets was less than

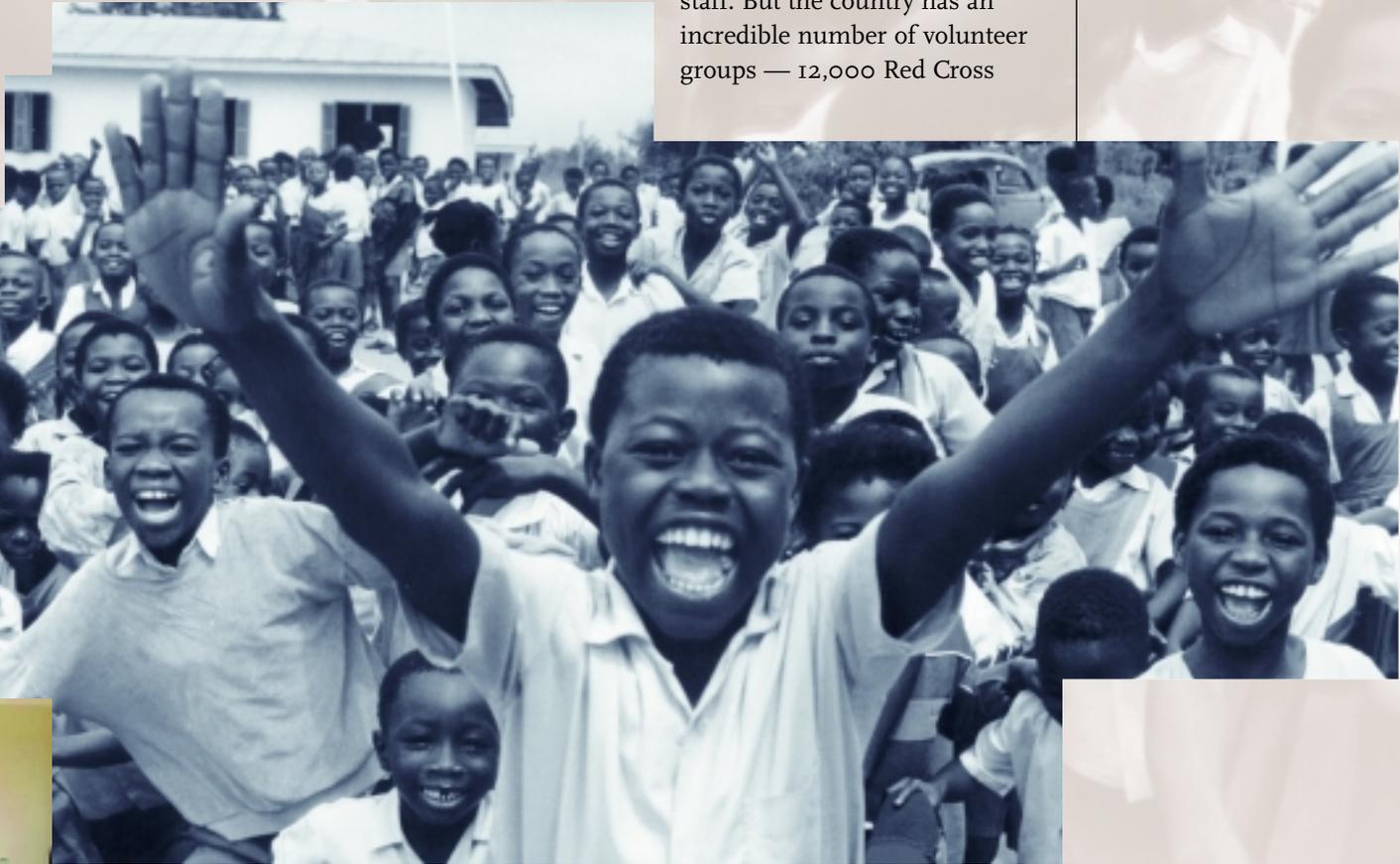




5 percent of the population. But a recent survey showed that, nationally, we have gone up to 27 percent.”

Part of the reason for the success is that those working in the field have learned that supplying nets and the latest drugs doesn't work without education. “At the district center I was given some

church groups, and even the Zambia Scouts Association. “The issue for us is the scale of the problem,” says Mike Macdonald, an advisor to the National Malaria Control Center who is employed by the Center for International Health. “We have 72 districts with 15 or 20 health centers in each. It's a very decentralized system, with an extremely small staff. But the country has an incredible number of volunteer groups — 12,000 Red Cross



posters that say what we should do,” says Mumba. “Clear the surroundings, not have bins where there's stagnant water. They taught us everything about how to prevent malaria. Everywhere you go now, people know what is going on. Even the child will tell you, Do this to prevent.”

BUSPH and the Malaria Control Programme are not the only partners in this effort: invaluable assistance has been provided by the ministry of education, the ministry of youth sports, many NGOs and

volunteers; 10,000 Boy Scouts and Girl Scouts; 23 Peace Corps volunteers in very, very rural areas. They provide insecticide treatment for the nets and communicate the changing drug policy.”

Though hard data are not yet available, anecdotal evidence indicates the program is having a positive effect. “It has made a big difference in the life of the village,” says Mumba. “I think there is not a lot of people getting sick. This time I see few people in the clinic. That is what I've noticed.”

# Veterans Health Administration

*The Center for Health Quality, Outcomes, and Economic Research (CHQOER) at the Bedford Veterans Administration Hospital is a VA Center of Excellence and a Boston University Dean's Committee Hospital. The center has linked its structure, operations, and research themes with BUSPH and the Boston University School of Medicine, focusing on improving the quality of care that veterans receive.*



This nation's largest health care system, the Veterans Health Administration is committed to expanding its clinical and research activities into areas, such as mental health disorders, that affect a large number of active and retired military personnel.

**Say the words** “Veteran’s Administration,” or “VA,” and certain images arrive unbidden in the listener’s mind. Images of men who fought in World War II, their eyes clouded by cataracts, perhaps, their hair gray, their skin lined with age. Or the image of a Vietnam vet, a little younger, wheeling himself along a parade route. Few people would conjure up a college-educated Latino woman about to give birth or a young woman with mental health issues looking for reproductive care — but that is the changing face of the VA.

Women who served in the U.S. armed forces were granted veteran status in 1946; but up until 1973, when the draft was abolished, only 3 percent of enlisted personnel on active duty at any given time could be female. Today approximately 16 percent of the services’ 1.5 million members are women. “Now, for the first time,” says Katherine Skinner, Ph.D., an associate professor of health services at BUSPH and a senior researcher at the Center for Health Quality, Outcomes, and Economic Research (CHQOER, pronounced “checker”), “women with children are leaving to fight in specific areas, and they can do virtually anything in the military. Providing health care for these women — who may experience illnesses such as Gulf War syndrome or post-traumatic

stress disorder, in addition to issues such as infertility, menopause, and sexual assault — is not something the VA has ever had to do.” The result, Skinner says, is that women often feel like an invisible minority.

A patient who had to pick up her prescription at the VA pharmacy recalls an experience: “It was at night,” she says, “and there was nobody there except me. And I’m standing there. I turned in my prescription and I’m waiting. This guy comes out, he looks in the hallway, and he goes back in. I wait another 15 minutes. He comes back, he’s looking around, he goes back in. I tap on the window. I say, ‘Are you looking for someone?’ He goes, ‘Yeah, Pat.’ I say, ‘That’s me.’ I waited half an hour because he was looking for a man.”

The Veterans Health Administration, this nation’s largest health care system, is working hard to change this perception. It recently instituted maternity care and will soon have mammography machines available at its Women Veterans Comprehensive Health Centers, which were established in 1993. Also, every VA hospital across the country now has a women’s health coordinator who helps women navigate the system and makes sure VA policies are followed regarding women’s health. “This is a unique approach,” Skinner says. “It’s certainly not seen in the private sector.”



Also unusual is that CHQOER and the VA have paired with a school of public health. “The VA works mainly through schools of medicine,” Skinner points out. “BUSPH is a little different. It enables us to seek out other resources for our work, such as statisticians, epidemiologists, organizational experts — all of which are crucial to improving the care of such a large population.”

Of course, the VA continues to have a predominantly male population, and so the CHQOER/BUSPH consortium also concerns itself with men’s health issues. For example, Jack Clark, a CHQOER researcher and an associate professor at BUSPH, is studying the impact of prostate cancer on male veterans. Though few would argue with the idea that men’s self-image is linked to their sexuality, its diminishment as a common side effect of prostate cancer treatment was rarely studied in an organized way until the Veteran’s Administration and BUSPH teamed up under the auspices of CHQOER for a large quality-of-life research project.

“The VA is interested in outcomes research,” says Clark, “in order to pursue its mission of delivering effective, patient-centered care for the complex health problems that come with aging, especially the problems that afflict its still largely male population.”

Previous studies of men with early-stage prostate cancer suggest that the physical complications of treatment — primarily urinary, bowel, and sexual dysfunction — have little substantial impact on overall quality of life. But, according to Clark, these studies were severely limited.

“The way outcomes were assessed in the past was that physicians would query their own patients in an unsystematic fashion,” Clark says. “The resulting data came from patients who felt indebted to their doctor for saving their lives, and were confounded by

men’s reluctance to talk about such issues, even to their physicians.”

Recent studies, which have included more than 700 patients in the past 5 years, use confidential, standardized, third-party surveys, focus groups, and in-depth interviews to address this shortfall, and have resulted in clear findings that prostate cancer has a complex and profound impact on men’s lives.

“It’s giving us a better picture of changes in the whole man as he goes through the process of diagnosis, choosing a treatment, getting a treatment, and living with the consequences of the treatment,” Clark maintains. “Things like the behavioral consequences of incontinence — how it keeps men from enjoying life fully, their fear of embarrassment, always having to be near a bathroom — and also things like sexual confidence, masculine self-esteem, marital affection, worries about satisfying a spouse, health worries. All these are huge quality-of-life issues that have received very little attention in the past.”

In addition, men disclosed irremediable uncertainties about their health and their treatment choices, beginning with diagnosis. For example, for older men who are told they have prostate cancer, the treatment options — radical prostatectomy, external beam radiotherapy, radioactive seed implant, and cryosurgery — are also confusing because little information exists about their relative effectiveness. In addition, many men whose blood shows elevated levels of prostate-specific antigen will never suffer from the effects of the disease. For older men with nonmetastatic cancer, in fact, no treatment has definitively proved more effective than “watchful waiting.”

Clark hopes the research will put things in perspective so patients can make informed choices for their treatment. “Our results will show what the experience might be like for them,” he concludes, “and how radically their lives could be changed.”

**“Now, for the first time, women with children are leaving to fight in specific areas, and they can do virtually anything in the military. Providing health care for these women — who may experience illnesses such as Gulf War syndrome or post-traumatic stress disorder, in addition to issues such as infertility, menopause, and sexual assault — is not something the VA has ever had to do.”**

— KATHERINE SKINNER, PH.D.

# Framingham Heart Study

The National Heart, Lung, and Blood Institute (NHLBI) provides leadership for a program of research, clinical trials, and education projects in diseases of the heart, blood vessels, lungs, and blood, as well as sleep disorders. Boston University researchers are under contract with NHLBI to conduct one of its major initiatives, the Framingham Heart Study, which began in 1948 and is the longest running epidemiological study in U.S. history.

## RESEARCH MILESTONES

- 1948 Start of the Framingham Heart Study
- 1956 Findings on progression of rheumatic heart disease
- 1959 Some heart attacks discovered to be “silent” (causing no pain)
- 1960 Cigarette smoking found to increase the risk of heart disease
- 1961 Cholesterol level, blood pressure, and electrocardiographic abnormalities found to increase the risk of heart disease
- 1967 Physical activity found to reduce the risk of heart disease; obesity increases its risk
- 1970 High blood pressure found to increase the risk of stroke
- 1976 Menopause found to increase the risk of heart disease
- 1978 Psychosocial factors found to affect heart disease; high levels of HDL cholesterol found to reduce risk of death; and “type A” behavior associated with heart disease
- 1994 Enlarged left ventricle (one of two lower chambers of the heart) shown to increase the risk of stroke; progression from hypertension to heart failure described
- 2001 Risk factor model created to assist in decision making about cholesterol treatment
- 2003 Clinical guidelines on cholesterol management released

**When the late** Herbert Haynes volunteered to participate in the Framingham Heart Study more than five decades ago, he had no idea he was starting a family tradition. “When it first started,” his daughter, 89-year-old Genevieve Read, recalls, “they picked names out of a telephone book, and his was one of the names. My mother had passed



away, so he went with his second wife, and eventually the whole family followed along. My sister and me and our four brothers.”

And those siblings’ children, and their children’s children. And now, there is a fifth generation waiting in the wings. Debra Dubovsky, 37, Henry Haynes’s great-granddaughter, says of her son, Tyler, 9, and daughter, Rebecca, 6, “I can definitely see them going into the study someday. I’d like them to follow in their great-grandfather’s footsteps.”

When the study began in 1948, no one could have imagined it would become the longest running epidemiological study in U.S. history. Initially undertaken as a 20-year project by the National Heart Institute — now known as the National Heart, Lung, and Blood Institute (NHLBI), and part of the National Institutes of Health — the study came to Boston University when its medical director, Roy Dawber, M.D., accepted a teaching position in the late 1960s. Today, faculty from the School of Medicine and BUSPH are under contract with NHLBI as primary investigators for the study.

“We didn’t envision that this would become the pioneer and premier cardiovascular and epidemiological investigation and the pattern for numerous other studies that have been done,” says William B. Kannel, M.D., M.P.H., director of the Visiting Scientist Program and a professor of medicine and public health at Boston University. Kannel has been with the

Framingham study since 1949, and was its director from 1966 to 1979. “It was a novel idea when we started. We had to basically invent multivariate statistical techniques, tests for some of the biochemical parameters, and standardization of certain clinical procedures.”

Though heart disease remains the number-one killer it was in 1948, according to Kannel

“it has taken a dramatic downturn.” Today, the lifetime risk — determined because “we are the first study to follow an original cohort of 5,209 people throughout their lives” — for men is 50 percent and for women, 30 percent, or three times the risk of breast cancer. Over the years, the study has made huge advances in identifying the major “risk factors” (a phrase coined by the study) and lifestyle choices that contribute to the ailment. These risk factors include smoking, being overweight, high cholesterol levels, high blood pressure, diabetes, and lack of exercise.

The study’s latest innovation is the 10-year risk calculator derived from the 2001 risk factor model created to assist in decision making about cholesterol treatment. “It’s a simple mathematical equation that allows clinicians and patients to estimate their future coronary heart disease risk based on their risk factors today,” says Lisa Sullivan, an associate professor of biostatistics at BUSPH. “You plug in your blood pressure, cholesterol, age, whether you smoke or not, and other factors, and this model gives you a number that represents your chance of developing heart disease over the next 10 years.” The model has become a tool with which a physician can, in a clinical setting, design an individualized heart disease prevention plan.

“Heart disease death rates,” Kannel says, “have steadily decreased over the past three decades. We’ve been gratified to find that people have always taken our Framingham



*Through the generations (clockwise from upper left): Paul Lupien, Wendy Lupien Dunham, Debra Lupien Dubovsky, Shirley Read Lupien, Stanyan Lupien, Genevieve E. Read, and Deborah Read Copithrone.*

findings seriously, and acted upon them. In fact our findings stimulated the national campaign against smoking in the 1960s, against high blood pressure in the 1970s, and against high cholesterol in the 1990s. We corrected a lot of misconceptions physicians had about heart disease.”

But heart disease isn’t the only ailment being studied at Framingham. Using the existing cohort, scientists have begun to analyze new data regarding stroke, dementia, osteoporosis, arthritis, diabetes, eye disease, cancer, lung function, and pulmonary disease, among other things.

“The multigenerational structure of the Framingham Heart Study allows us to look at patterns of disease in families,” says Daniel Levy, M.D., the director of the study and an associate professor at the Boston University School of Medicine, “and from that structure we have the opportunity to begin looking for the genes that cause disease. In a sense this was anticipated in 1971, with the recruitment of the second generation.”

The 5,209 residents between the ages of 30 and 60 that began the study at the time made up two-thirds of the population of Framingham, a medium-sized suburb of Boston. The “Offspring Study” added another 5,124 people to the cohort, and the third —

or, in Herbert Haynes’s family’s case, fourth — generation of participants is currently being recruited. Framingham was the first major cardiovascular study to enroll female participants, and has recently begun the Omni Study, which recruits minority participants to determine whether their risk factors are the same as those in the original cohort.

“With our commitment to a third generation,” says Levy, “we’re poised to contribute in important ways to the understanding of the genetic basis for many common conditions and risk factors. And we can look at many diseases because it’s very inexpensive to introduce ancillary objectives when you already have the study sample in place. There’s remarkable town support for what we’re doing.”

And no wonder. “They give you a good examination,” says Genevieve Read. “It’s good to know they’re finding out things that the doctor ordinarily wouldn’t be concerned with, and that you would never think of yourself.”

Her daughter, 69-year-old Shirley Lupien, an Offspring Study participant, agrees. “I feel fortunate to be included in something like this,” she says. It’s an important study. You feel as though you’re helping to discover something.”



*A healthy legacy: Herbert and Angelina Haynes, 1948*

# Boston Medical Center

*The Center for Refugee Health and Human Rights, created in 1998, serves survivors of torture and related trauma by providing care of the body, mind, and soul. It is located at Boston Medical Center and staffed by BUSPH professors and BMC physicians, as well as faculty from Boston University's law, medical, and dental schools.*

"We have taken the strengths of the support that clients get at Center for Refugee Health and Human Rights and combined it with the strengths of the bilingual, bicultural case managers who work in our office and know the clients very well. There's an important aspect of cultural expertise, language ability, and sharing that can make a huge difference in the lives of these people who really need to connect with someone."

— RITA KANTEROWSKI,  
INTERNATIONAL RESCUE  
COMMITTEE

A **Tibetan monk** who believes his problems are rooted in a previous life; a young Sudanese with hepatitis who wants to see a liver shaman; a Muslim who worries that taking medications will break his Ramadan fast: All in a day's work at the Center for Refugee Health and Human Rights, a collaboration among BUSPH, Boston Medical Center, and the Boston University Schools of Medicine, Law, and Dentistry.

"Cross-cultural medicine is very challenging," says Michael Grodin, M.D., a professor of health law at BUSPH and a founding codirector of the center. "Our patients come from all over the world, and

homeless; most have endured sexual abuse; and the vast majority are depressed or suffering from post-traumatic stress disorder. All, according to Grodin, have "enormous" psychosocial needs. "Torture and sexual trauma worldwide are grossly under-reported," he says. "They're where child abuse and spousal abuse were 25 years ago. It isn't new — just newly recognized."

Recognition, however, is just the beginning of the hard work. "A major issue is getting victims of extreme torture to tell their stories," says Susan Akram, J.D., director of the center's Asylum and Refugee Program and an associate professor at the Boston University School of Law. "When we

present a medical professional to our clients as someone who will work with them over the long term, as part of a team, it helps tremendously to break down the initial barriers, and helps them realize we're interested in them as human beings. The collaboration gives the clients ongoing holistic care."

Such care may include not only physical and mental health services and pro bono asylum cases, but also social work, employment services, housing aid, medical insurance, and even transitional cash assistance. All of which is set against the larger pic-

ture of several ongoing research projects.

"Ours is the only one of about 30 refugee programs in the United States that is contributing not only in terms of advocacy but also in terms of scholarship," says Lin Piwowarczyk, M.D., M.P.H., an assistant professor of psychiatry at the Boston University School of Medicine and a founding codirector of the center. "Our academic work is extremely important, because it is helping to improve the quality of care by clarifying some of the issues this population faces."

they have very different ideas about what makes them sick and what makes them well. A big issue is mental health, which is not identified as such in many cultures. They see health as primarily a physical phenomenon or a spiritual malaise."

These attitudes can be particularly troubling because nearly all of the center's clients are asylees or survivors of torture. Many have physical injuries; some are



Last year, the Boston Center for Refugee Health and Human Rights provided direct care to more than 200 people from 30 countries

Rotaract is a group for BUSPH students, run by BUSPH students. It is part of an international network of service clubs for young adults, and is sponsored by Rotary International and the Rotary Club of Boston.



In July 2002, Mary Drake and Lisa Covington traveled to Guatemala to volunteer in a health clinic.

**Sometimes**, it's the small things that have the greatest impact. Like the time Mary Drake, an MPH student and the vice president of the BUSPH Rotaract Club, got into a conversation about myths and legends with the women at Rosie's Place, where she and other club members volunteer once a month. "They were telling stories in Spanish," she says, "comparing the legends of the countries they were from." One recounted the tale of La Llorona, who drowned her children in a jealous rage and was doomed to wander the river banks weeping for all eternity. Another spoke of the handsome stranger who serenades dark-haired beauties, conferring mystical powers on those who see him.

"Listening to the women talk gave me a real perspective about where they come from," Drake says. "It made me realize myths are part of how they look at life. Not everything is scientific, and that's a big lesson for a person like me. If I can understand more about these aspects of Latin American cultures, then when I'm planning a program or an intervention, I can put forth my ideas in a way that can be better used by the people it will serve."

Drake had a chance to do just that in August 2003, when she and four other Rotaract members embarked on a field study to assess and begin improving the quality of water in Salcaja, Guatemala. It's one of the many projects Rotaract has undertaken with partners

throughout the world. Others include work with Rosie's Place; Community Servings, which prepares and delivers hot meals to AIDS patients in the Boston area; TESFA, a Los Angeles-based organization that provides microcredit for poor women in Ethiopia; and Catholic Relief Services in the Gambia.

Just a few years ago, most students had never even heard of Rotaract, an international service club for young adults that came to BUSPH in early 2002. Sponsored by Rotary International, an organization of business-people that provides humanitarian service and encourages peace and goodwill throughout the world, Rotaract "opens up a channel through which students can become engaged in national and international service projects," says Steve Brown, chair of the International Committee of the Rotary Club of Boston, another partner. "These young people bring a lot of good, positive, new energy to our historic mission, and they make major contributions on an international stage."

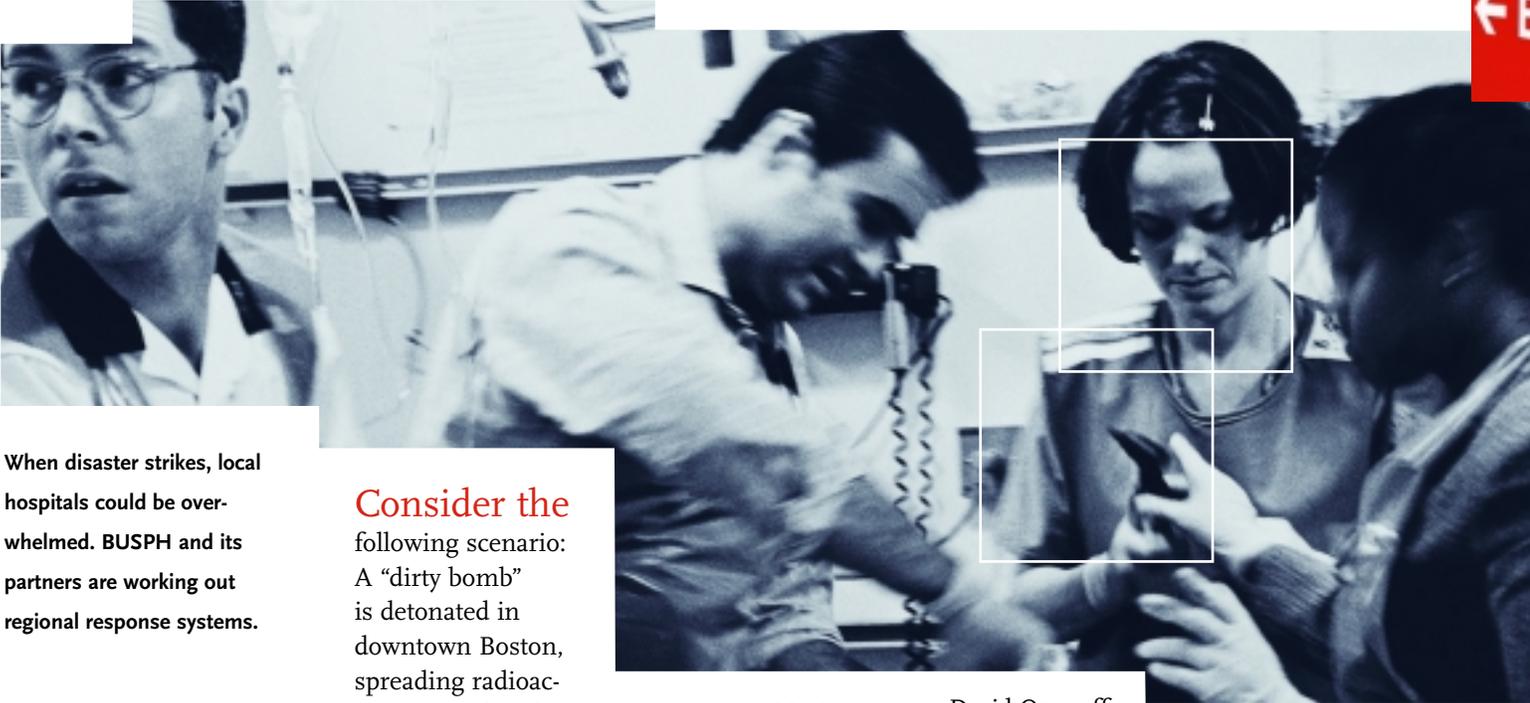
Though their impact may be large, to Mary Drake and others like her it is the small projects that add up. "Our most recent bake sale raised \$400," she says by way of example. "That will go a long way toward buying school supplies in El Salvador. Projects like this provide a venue for me to do what I really like to do: access a community and help to positively influence what's going on there."

#### ROTARACT PAST PROJECTS

- Preparing and serving dinner one night a month at Rosie's Place, a shelter for women and children near the BU Medical Campus
- Participating in the Boo to Bad Health fair at Villa Victoria, a low-income housing community for Latinos in Boston's South End
- Assisting in the preparation of food for Community Servings, a local organization dedicated to preparing and delivering hot meals to AIDS patients in the Boston area
- "Adopting" a client from Community Servings for Christmas and purchasing gifts for him from a wish list provided by the organization
- Holding a food and toiletries drive to collect items for donation to Community Servings during the holidays
- Sending the Spanish-language version of *Our Bodies, Ourselves* to health centers in Latin America for the Boston Women's Health Book Collective
- Bake-sale fund raiser to benefit TESFA, which provides micro credit for homeless and poor women in Ethiopia
- Selling metal sculpture for Tsungirirai, an AIDS-orphan care organization in Zimbabwe
- Book drive for Afghanistan and Zimbabwe
- Selling hot dogs on Boston's Marathon Monday with the Boston Rotary Club

# The New England Collaborative for Public Health Preparedness

*The New England Collaborative for Public Health Preparedness is a broadly based group of academics and others interested in formulating regional responses to emergency situations. BUSPH, Tufts University's graduate program in public health, the Harvard Center for Bioterrorism Preparedness, the Massachusetts Department of Public Health, and the Boston Park Plaza Hotel, among others, are involved in the discussions.*



When disaster strikes, local hospitals could be overwhelmed. BUSPH and its partners are working out regional response systems.

## Consider the

following scenario:

A “dirty bomb” is detonated in downtown Boston, spreading radioactive material and contaminating a 20-block section of the city. What would happen in the ensuing chaos? Where will the exposed and the worried well be taken for treatment? Would there be sufficient personnel, supplies, decontamination sites, and hospital beds? How will necessary items and personnel be moved from one area to another?

“I hope trying to answer these questions is an unnecessary exercise,” says Mindy Lubber, the executive director of the New England Collaborative for Public Health Preparedness. “I hope we never need the answers.” Just in case, though, the Collaborative is working to find them.

It’s a nascent venture that seeks to address preparedness in the event of catastrophe — a bioterrorist attack, an infectious disease outbreak, or a natural disaster, for example — as well as surveillance of disease clusters and patterns, public awareness of and education regarding such an event, and the safeguarding of existing public health programs. Says Lubber, “We want to make sure that the government is not putting so many resources into terrorism that it decimates already fragile, underfunded public health programs such as controlling obesity, smoking cessation, and caring for the elderly.”

David Ozonoff, a BUSPH professor of environmental health, came up with the idea of a collaborative shortly after terrorists shocked the nation by striking American shores without provocation. “After 9/11 it seemed to me that a lot of people were looking for ways to contribute and there was no way to do that,” he says. “So the idea was to develop a meta-institution, or an institution without walls, to use modern means for connectedness to harvest the rich source of expertise out there and enlarge the scope of public health way beyond the traditional disciplines.”

One of the first major problems the group is tackling is “surge capacity,” or the ability of health-care workers to handle a sudden and drastic increase in demand for acute care in an emergency. “Right now most discussions are limited to how many hospital beds we have,” says Lubber. “But beyond that, there are infrastructure issues once you have the patient in the bed. How are we going to staff those beds? How do you transport personnel and stockpile pharmaceuticals? Where does the food go? Do we have back-up energy generators, and back-ups to those?”

The Collaborative, a unique notion in itself, seeks innovative ways to address poten-



tial problem areas. “Most people agree that there are not enough beds to go around,” says Ozonoff. “We’ve started planning a surge-capacity project with the hotel industry. If there were thousands of people seriously ill with influenza or SARS, for example, we could send the least sick patients in the hospital at the time, who are there for other

reasons, to stay at local hotels. Hotels could also serve as bases of operation and lodging for emergency and medical personnel.”

Transportation poses its own challenges, notes Ozonoff. “Suppose you had to move supplies or medical personnel around the city and the transportation system has been shut down. Who knows the city better than anyone else? Cab drivers do. So you enlarge the scope of preparedness to include them.”

“Government is now looking at staffing and medications and medical equipment,” Lubber adds, “but transport, food, and a whole series of next-order issues have not been part of the dialog. Government can only do so much at one time. We want to help identify and answer the questions that are not being asked.”

Surge-capacity issues don’t stop at state lines, of course, as illustrated by the fast-moving fire that killed 96 people and injured dozens in a Rhode Island nightclub in February 2003. Though Providence’s Rhode Island Hospital had the knowledge and equipment to treat serious burn victims, its critical-care resources were stretched to their limit, and patients were transported to hospitals in Massachusetts through an informal system of personal telephone calls, with the result that distribution was uneven at best. Some Commonwealth hospitals — including

Shriners in Boston, which usually does not treat adults — received several patients, while others sat ready for patients who never arrived.

“Almost any emergency public health problem we can envision is likely to cross from one city to another, one state to another,” says Anthony Robbins, former chair of the Department of Family Medicine and Community Health at Tufts New England Medical Center. “The expectation has to be one of cooperation. Governments can’t ask, When does it become someone else’s problem? They have to automatically ask instead, How can other states and jurisdictions nearby jump in here for us?”

Though this often happens, as with the Rhode Island fire, in an unofficial way, the Collaborative has proposed a less haphazard solution: the New England Public Health Compact, a formal, coordinated regional response. “The government response has been state-by-state,” says Lubber. “And since we’re not doing our planning in a regional way, we’re reinventing the wheel in every state. Most officials say they’d love to know what the other states are doing, but things are falling through the cracks because people just have too much to do.”

New England states are particularly well-positioned to help one another not only because of their proximity, but also because of the wealth of academic and health-care institutions and specialists concentrated in the region. “One of the things the BUSPH people involved in this project have demonstrated,” Lubber continues, “is how important it is to be public-spirited. They’ve shown great interest in building the public good versus building their own careers. We need to introduce that attitude to a wider circle of people in public policy.”

The New England Collaborative for Public Health Preparedness envisions having three core functions:

**Problem-solving:** Devising immediate practical solutions to key public health questions.

**Education and training:** Education of senior managers, planners, researchers, and first responders in public-health-based emergency management through academic courses and degree programs; and short-term training of first responders, health-care workers, and managers in specific technical and management skills.

**Information dissemination:** Rapid dissemination of discussion, research, and service programs for the public health community and for the public as issues are confronted and solutions proposed.

## State of New Jersey

Quitnet is the Web's original smoking-cessation site. Launched in 1995 as part of BUSPH's JoinTogether program, which targets substance abuse and gun violence, Quitnet has been adopted by many states, insurers, private employers, and other groups seeking to customize a treatment program for their constituents. It has helped people to quit in 85 percent of U.S. counties and 160 countries around the world.

### FORUMS AVAILABLE ON QUITNET.COM

- **The Quitstop:** Discuss the quitting process, ask questions of others and get feedback and support
- **Quitting Milestones:** Get motivated by celebrating one another's quit anniversaries and other accomplishments
- **Weighty Matters:** Discussion and support for quitters who are trying to keep weight off
- **Other Addictions:** For those who are addicted to alcohol and other drugs, as well as nicotine
- **Quitting and Depression:** For people struggling with both depression and withdrawal
- **Spirituality and Quitting:** Start the day with group prayers or meditations
- **This and That:** Anything unrelated to smoking that you want to talk about
- **Quitting Early:** For adults ages 18 to 24

**“Quitingsgood”** was having trouble staying on track. “My feelings are overwhelming and somewhat obsessive,” he wrote. “Then I remember why I’m here. It’s ugly! It hurts! It’s not really where I want to be! I feel so alone with the agony, and then I come here and see all of you going through the same thing. Fight back! Fight for your right to breathe and be free from this horrible addiction!”

To some, Quitingsgood, writing on the smoking-cessation Web site Quitnet, may seem to be overdramatizing. But studies have shown the addiction to nicotine to be stronger than the pull of cocaine and even heroin. Quitnet, a collaboration among BUSPH and state health departments, insurers, and private employers, directed by David Rosenbloom, professor of social and behavioral sciences, aims to help ease the pain.

Time and again, research has found that social support is a key component of any treatment plan, and the Quitnet community provides it in spades, with counselors who give expert advice in real time, a personalized quitting guide, e-mail tips that arrive at regular intervals, a buddies service, clubs, forums, and chat rooms. “What’s unique about Quitnet is that there’s this enormous community of users from all 50 states and 160 countries throughout the world,” says Kay Paine, director of partner development. “So you can get immediate responses from people who are going through the quit with you — 24/7, 365.”

The existing online community was largely what sold the State of New Jersey on Quitnet, which it has had customized as NJQuitnet.com. “We could have started a Web site on our own,” says Edward Kazimir, manager for the tobacco dependence treatment for the New Jersey Department of

Health and Senior Services, “but for the first several months, how do you build a large enough chatroom audience that there’s always people available? It’s a very powerful tool.”

Kazimir estimates the state has saved a minimum of \$3 million in health-care costs and lost productivity since joining Quitnet in 2000. More than 100,000 users have visited the site, which tracks survey respondents after six months to learn whether they have stayed on the wagon. “New Jersey has roughly 1.15 million smokers,” says Kazimir, “and 13,000 deaths from smoking a year. Quitnet is helping to lower those numbers. It’s a real step forward.”



## Faith in You

*Faith in You brings together researchers from BUSPH and Boston Medical Center, prevention specialists from the Multicultural AIDS Coalition, and members of the faith community through the Boston TenPoint Coalition. The project is a groundbreaking initiative that reaches out to people of color to provide information about HIV counseling and testing.*

### The numbers are startling:

In Massachusetts, African Americans and Latinos represent 52 percent of HIV/AIDS cases, though they make up only 13 percent of the total population. Even more disturbingly, state data reveal a lack of access to care early in the disease, when new drugs can offer the best possibility of effective management. Nearly 30 percent of the 20,000-plus people of color living with HIV or AIDS first learn they have the virus only when they receive a diagnosis of advanced disease. Why? Lack of information, fear of suffering, fear of social isolation, and, in this often intensely religious group, the feeling of having sinned and being “unworthy of God’s love,” according to Seth Welles, an associate professor of epidemiology at BUSPH and the scientific director of Faith in You, a program developed to combat the crisis.

“One of the best ways to reach this population,” says Paul Skolnik, M.D., director of the Center for HIV/AIDS Care and Research at Boston University Medical Center and a professor at Boston University School of Medicine, “is through church groups and community organizations. The Faith in You initiative is unusual, because it’s a partnership among two community groups and two schools at Boston University. The medical school has expertise in HIV/AIDS treatment and prevention that BUSPH doesn’t have, and BUSPH has expertise in epidemiology and social behaviors that the medical school doesn’t have.”

Even more important than the symbiotic relationship between the schools is the willing participation of the community groups — the Boston TenPoint Coalition, an alliance of 67 African-American churches, and the Multicultural AIDS Coalition, a nonprofit organization with 10 affiliate groups committed to prevention.

“People do turn to the church in the black community,” Skolnick continues. “It’s a major source of comfort and strength. That’s why we wanted to develop this partnership. Being approached about voluntary testing by people you respect and trust is critical, and church groups certainly fall into this category.”



The intervention consists of three components. First, public-service announcements made by church elders and clergy that are broadcast on minority-oriented radio stations encourage people to come in and get tested. Second, neighborhood street fairs with cookouts, music, and entertainment are devoted to health matters in general and HIV/AIDS in particular.

But the third and most important link is personal. Says Welles, “The pastor says something during a church service such as, ‘Many of us in the church have been touched or will be touched by the HIV epidemic. This is not shameful. It is *not* something that God has visited upon us; we must help each other bear the burden.’” Through such declarations, and through posters and written notices, parishioners are directed to a contact person who is part of the church community. This community member, who has undergone sensitivity training, is “the person who puts a human and spiritual face on this endeavor, who helps support people through the process,” adds Welles.

Welles insists that without collaboration, the project would have little chance of success. “Each partner brings certain perspectives and strengths to the table,” he says, “and through sharing this information we’ll do the best science. When I say best, I mean the most culturally sensitive, the most spiritual, the most comforting materials we can bring to people in parishes in the black community. And that’s the whole idea.”

**Members of the “Partner’s Group,” representing key personnel involved in the Faith in You program, left to right: Donna Bright, Multicultural AIDS Coalition; Seth Welles, BUSPH; Reba Danastorg, Boston TenPoint Coalition; Philip Braslins, BUMC; and Cynthia Harris, Multicultural AIDS Coalition.**

## Cambridge Health Alliance

*Birth Sisters™ and the Cambridge Doula Program provide culturally competent care and support to women before, during, and after childbirth. The programs are coordinated by BUSPH, Boston Medical Center, and the Cambridge Health Alliance.*



Feroza Bashar, foreground, has helped to deliver countless babies as part of her culturally sensitive training with the Cambridge Doula Program.

Sadar Banu's little girl, Sabria Uddin, is one of them — to the delight of her big brother, Wahid.

**Because Sadar Banu** never went to school in her native Bangladesh, her new life in the United States presented even more challenges than that of other immigrants — such as how to recognize numerals and dial a telephone. Luckily, when Banu became pregnant with her second child, Kabil, a savior arrived in the form of Feroza Bashar, a doula, or childbirth assistant, who speaks five languages, including Bengali, Banu's native tongue. "Having Feroza there eased so many things," Banu says, with Bashar translating. "She was an angel guiding our family."

Bashar became involved not only with Kabil's birth, but also helped translate when the four-week-old baby needed to be rushed to the hospital for emergency abdominal surgery. She also interpreted for Banu and her husband when Wahid, Kabil's then two-year-old brother, was found to have special needs, including a hearing problem that caused developmental delays. Bashar grew so close to Banu that she insisted the doula be present for the birth of her third child, Sabira, now nine months old.

"When the children were born it was such a relief to have her here," Banu says. "I felt

like my mother was beside me."

A doula is more than just a birthing coach. She provides comfort, encouragement, support, advocacy, and, often, translation during the birth, but also meets with the new mother prenatally to prepare her and spends up to 15 hours in the home during the infant's first month, helping the mother adjust to the new arrival. Basically, as doulas like to say, they "mother the mothers."

"A doula can mean so much to a woman whose family may be far away or whose husband is working two or three jobs or is just not around to give her the support to make that transition into motherhood," says Lorenza Holt, director of the Cambridge Doula Program at the Cambridge Health Alliance and a BUSPH student working toward a master's degree in public health. "When we recruit women for this job, we're not looking so much for specific skills as for a woman with a kind heart, a maternal instinct, passion, and compassion."

BUSPH provides training to both the Birth Sisters, which is affiliated with Boston Medical Center, and the Cambridge Doula Program, which partners with the Cambridge

Health Alliance. Many BUSPH nurse midwifery students choose to do their practicum with the programs.

“The BUSPH Nurse-Midwifery Program was developed in response to the high infant-mortality rates in inner-city Boston,” observes Mary Barger, director. “We are delighted to work with the Birth Sisters and the Cambridge Doula programs in continuing to find creative ways to meet the needs of vulnerable women in the community.”

Moreover, occasionally a doula from the community will go on to complete further health-care training. “A number of Birth Sisters have gone on to become nurses and midwives,” notes Suzanne Winder, program coordinator for Birth Sisters. “The nice thing about these programs, aside from the wonderful work they do with the moms and infants, is that it really empowers the Birth Sisters and doulas themselves. Many see it as a stepping stone.”

Though there are a number of similar programs throughout the nation, these two are unusual in their degree of multiculturalism. “Between the Birth Sisters and us,” Holt says, “we’re the leaders in providing multilingual doula services. There may be one in Chicago, and there may be a few in Texas, but as culturally diverse as ours? I don’t think so.”

The women trained as birthing assistants come from virtually all the communities in Boston, and speak languages including French, Spanish, Portuguese, Arabic, Bengali, Punjabi, Haitian, Chinese, Urdu, and Farsi. This is one place where collaboration has come in very handy: Birth Sisters and the Cambridge Doula Program have begun to “trade languages,” with BMC sending Spanish speakers to Cambridge, and women with Arabic language and cultural skills going to Boston. “We trust each other’s training,” says Winder. “There’s no one else I would do that with.”

Whatever language is being spoken, the intent is clear. “We’re helping women to reclaim their birthright,” Winder says, “so to speak.”

**Milton Kotelchuck** has been appointed chairman of the Department of Maternal and Child Health, after serving as acting chairman for more than a year. Prior to coming to SPH, Professor Kotelchuck served as senior advisor on child health policy for HRSA and as chairman of the Department of Maternal and Child Health at the University of North Carolina, Chapel Hill.

**Eugene Declercq**, Professor of Maternal and Child Health, has been appointed Assistant Dean for Doctoral Education; he also serves as chairman of the doctoral program committee and will oversee the implementation of the new DrPH degree program.

**Lisa Sullivan** has been named Assistant Dean for Undergraduate Education, and will coordinate the School’s educational offerings for undergraduates enrolled at Boston University. Her areas of responsibility include the public health survey course and the new BS–MPH joint degree program with Sargent College for Health and Rehabilitation Sciences.

**Roberta White**, a world-renowned expert in the field of environmental neurotoxicology, has been named chairman of the Department of Environmental Health. She is also director of the Boston Environmental Hazards Center and director of clinical neuropsychology at the Boston VA Medical Center. Professor White has been an active collaborator in research in the Department of Environmental Health for many years.

**Arthur Culbert** has accepted the new position of Associate Dean for Admissions and will be responsible for all aspects of the School’s admission functions. He will take over duties from Barbara St. Onge, who retired this year. Dr. Culbert hopes to expand outreach to a wide variety of potential student audiences.

**Gail Douglas** has been promoted from Assistant to Associate Dean for Student Services. Professor Douglas looks forward to working closely with

Student Services, the Admissions Office, the Registrar’s Office, and the Career Services Office, as a team, to offer students a superior experience at the School.

**Judith Hull** has been named Assistant Dean for Student Services. In her new role she directly supervises and coordinates the day-to-day operations of the Registrar’s Office, the Office of Student Services, and the Career Office. She works collaboratively with the Associate Dean for Students to identify, coordinate, and resolve student policy issues and assists in the development of data systems to support student-related functions.

**Anita King** has been appointed Assistant Dean for Administration and Finance. She has been at the School since 1978 and has served in various capacities, including her most recent position, Director of Research Administration. In her new position she has increased responsibility for financial management and budget oversight.

**The Office of Alumni Relations** has been merged with the Office of Institutional Development, to form the new Office of Institutional Development and Alumni Relations.

**Elizabeth Ollen** serves as director; **Anne Lefavre** has joined the staff as Alumni Officer. Together, they hope to continue the work so well done by Barbara St. Onge in her many years of service. **Jane Cormuss** has joined the staff as Development Associate.

**Kate Gannon** (MPH ’99) has accepted the position of Web Master at SPH. She will use her technical skills and creativity to coordinate the redesign of the School’s Web site. Kate was previously a research data analyst at the Data Coordinating Center.

**Frances Drolette**, Associate Dean for Administration and Finance, comes to SPH from Babson College. “It is clear that she has professional presence, strong interpersonal skills, and a sharp and inquiring mind,” writes Dean Robert Meenan in his announcement of her arrival.

**Barbara St. Onge** leaves after 23 years of devoted service as the Admissions and Alumni Director at SPH; in all, she devoted a total of 25 years to the University. We will miss her immense knowledge of the School, unflagging work ethic, and marvelous sense of humor. She is planning to enjoy not working and to train her new dog, Nellie.

**David Ozonoff** has stepped down as chairman of the Department of Environmental Health but will continue his work as a professor in that department. He looks forward with pleasure to spending more time working in the area of emergency preparedness.

**Christine Ferguson**, Commissioner of the Massachusetts Department of Public Health, last May's speaker at Commencement, reminded us that "effective communication is everything. There must be a rededication to filling the gaps in access to health information and care."

The Norman A. Scotch Award for Excellence in Teaching was awarded to **Eugene Declercq**, Professor, Department of Maternal and Child Health.

**Stephanie Ettinger de Cuba**, student speaker at Commencement, received her MPH in International Health. Stephanie spent time in the Peace Corps in Bolivia before coming to BUSPH.

The John Snow, Inc., Award in International Health was presented to **Richard Mihigo** and **Jennifer Westfall**.

The Allan R. Meyers Memorial Prize for Excellence in Health Services was awarded to **Kristin Elifson** and **Joshua Rising**.

**Carrie Reed** won the Herb Kayne Prize for Excellence in Epidemiology and Biostatistics.

The Rex Fendall Award for Excellence in Public Health Writing in the Department of International Health was presented to **Shuo Zhang**.

The Dean's Award for Student Research was awarded to **Michele Jara** ("Impact of HIV-Related

Immunosuppression on Invasive Cervical Cancer Risk Among Women with Low-Grade Squamous Intraepithelial Lesions").

**Robert Meenan** has been named vice chairman of the Massachusetts Blue Cross/Blue Shield Foundation.

**Jonathan Howland** was one of six professors invested at Kalmar University in Kalmar, Sweden. His appointment is at the Kalmar Maritime Academy, where he is currently conducting a series of research studies on the effects of low doses of alcohol and other sedating agents on occupational performance.

**George Annas**, chairman of the Department of Health Law, received the 2003 Humanist of the Year Award from the Ethical Society of Boston. The citation reads, in part, ". . . we honor him for creating a system of values that provides guidance and wisdom in the health services."

**Ralph Hingson**, Associate Dean for Research, has been named president elect of the International Council on Alcohol, Drugs, and Traffic Safety. Mothers Against Drunk Driving (MADD) recently established the "Ralph W. Hingson Research in Practice" award, which will be presented annually to someone whose research is of great value to MADD's mission.

**David Ozonoff** was the Distinguished Lecturer at the National Institute of Environmental Health Sciences presentation at NIEHS headquarters in April; that same month, he was appointed to the National Academy of Sciences Committee on Homeland Security and Community Drinking Water Supplies.

**Michael Grodin** was elected a fellow of the Hastings Center. The center explores fundamental ethical questions in health care, biotechnology, and the environment.

One of this year's finalists for the L. L. Winship/PEN New England Award was **Lucy Honig**, for *Open Season*; the award honors New England authors, or books about New England.

The Aetna Susan B. Anthony award was given to **Arlene Ash**, professor of biostatistics. Aetna and APHA cosponsor the annual award to honor individuals whose research makes a significant difference in the lives of older women.

The New England Association of Drug Court Professionals has given **JoinTogether** its first Annual President's Award in appreciation for "outstanding support and contributions to helping NEADCP develop strategy and leadership."

Field Placement Practice Awards were presented at the Community Partners Breakfast on April 10; honored were: **Samantha St. Laurent** (Biostatistics), **Julie Hirsch** (Epidemiology), **Amy Donovan-Palmer** (Environmental Health), **Christine Fitzgerald** (Health Law), **Ryann Engle** (Health Services), **Aruna Setty** (International Health), **Jennifer Rogers** (Maternal and Child Health), and **Sarah George** (Social and Behavioral Sciences).

At the annual MCH Forum Day held on April 25, **Catherine Walker** and **Peggy Garland** were awarded the first annual MCH Alumni Award, given in recognition of outstanding service to improve the health of women, mothers, children, and families.

The Dzidra J. Knecht Award for Distinguished Service to the School of Public Health was given to **Anita King**, newly named Assistant Dean for Administration and Finance. This award is presented annually to a member of the staff who has made outstanding and sustained contributions to the operations of the School.

**Tara O'Toole** delivered the fourth annual William J. Bicknell Lecture. Dr. O'Toole spoke about "Bioterrorism and Public Health Preparedness."

At the 2003 Alumni Breakfast, held on October 15 at the Castle, Distinguished Alumni Awards were presented to: **Martha Werler (MPH '89)**, Sloan Epidemiology Center; **Stephen Johnson (MPH '84)**, Massachusetts Department of Environmental Protection; and **Barbara Graves (MPH '84)**, Midwifery Program at Baystate Medical Center.

The School depends on the generosity of alumni and friends to support its mission of teaching, research, and service. The School thanks all of its donors for their financial support. The following list acknowledges gifts made from July 1, 2002, through June 30, 2003.

It is important to us that we acknowledge your gift properly; please let us know of any omissions or errors in listing your name or gift, by calling 617/638-5291.

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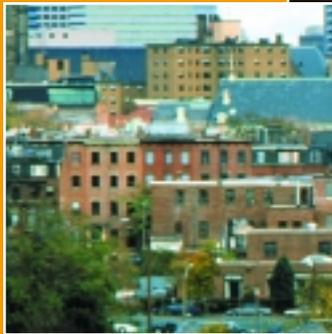
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For more information, contact Elizabeth M. Ollen at 617-638-4290.

	1993	1998	2003
<b>Applicants</b>	540	850	1,020
<b>Students</b>	669	711	742
<b>Graduates</b>	177	256	276

	1993	1998	2003
<b>Faculty Profile</b>			
<b>Full Time</b>	58	71	143
<b>Female</b>	45%	45%	53%
<b>Minority</b>	5%	4%	9%

	1993	1998	2003
<b>Education</b>			
<b>Tuition</b>	\$5,027,680	\$10,170,645	\$13,821,780
<b>Other</b>	\$483,535	\$464,625	\$1,233,315
<b>Research</b>			
<b>Direct Costs</b>	\$6,581,305	\$12,902,630	\$24,136,925
<b>Indirect Costs</b>	\$1,233,835	\$2,489,885	\$4,492,990
<b>Total Income</b>	\$13,326,355	\$26,027,785	\$43,685,010



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