

Preventing Sexual Assault at Tufts

by Karen Swietek

An estimated 1 in 5 women in the United States will experience sexual assault during her lifetime,¹ and college women are 4 times more likely to be assaulted than their non-college-bound peers.² As a college woman, I find these statistics to be disconcerting. As a Community Health student, it seems to me that this issue requires a concerted community health response with a heavy emphasis on prevention and health education, especially on the part of universities. Unfortunately, a search of the Health Services and Women's Center websites reveals that although Tufts provides a comprehensive set of resources to students who have already experienced sexual assault, there is not currently a strong program aimed at violence prevention.

If a student is sexually assaulted at Tufts, there are a number of on and off-campus resources available to him or her. On-campus resources include the Sexual Assault Clinician, Sexual Violence Resource Coordinator, Tufts University Police Department, and the Counselor-on-call.³ While these services

are crucial for survivors of violence and an important element of the university's response to sexual assault, they are part of a downstream approach that addresses the symptoms and not the root causes of the issue. In an effort to help students defend themselves against attacks, TUPD offers a class in Rape Aggression Defense in conjunction with the Ex-College. However, this class does not raise campus-wide awareness about the issue. These individual and post-assault interventions should be combined with education and awareness campaigns in order to reduce the incidence of sexual violence on campus.

This semester I am enrolled in Rape Crisis and Recovery, a class that explores the issues surrounding rape and domestic violence in the United States from a multi-disciplinary perspective. Offered through the Women's Studies Program, the course addresses the legal, social, and health consequences of sexual violence and offers students a chance to obtain a certificate for Rape Crisis Counseling in the state of Massachusetts.

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Traffic Accidents and the work of BLBC

by Adnan Alam

Traffic accidents cause more than a million deaths and 50 million injuries across the globe every year.¹ To put these numbers into context, the number of lives lost in traffic accidents is equivalent to ten survivorless jumbo jet crashes daily. With the number still rising, road accidents have already become the fourth largest killer among 15-59 year olds in low and middle income countries.²

Bangladesh is not immune to the burden of road accidents; thousands of people are affected every year. Even if one is fortunate enough to survive an accident on the streets of Bangladesh, the chances of undergoing amputation remain quite high. Getting to the root of the problem will require infrastructure development, adequate law enforcement and a change in driving practices. Although the responsibility of ensuring safe roads falls on the government of the country, a lack of political will has left the public quite vulnerable. In the absence of acceptable preventive measures, a local non-governmental organization called Building Resources Across Communities (BRAC) established the BRAC Limb and Brace Center (BLBC) in 2000 to provide support to the physically disabled. The majority of BLBC's clients are victims of traffic accidents.

Since its inception, BLBC has focused on making its

services available to the poor. The artificial limbs that are made at the center are very affordable. The limbs are manufactured at the center by local staff who have received training from partner institutes in India and Vietnam. Although each prosthetic is custom-made, local assembly of the raw materials makes the limbs highly cost-effective. The International Committee of the Red Cross Special Fund for the Disabled (ICRC-SFD) supplies the raw materials and provides technical support to BLBC staff.² In addition to creating user-friendly limbs, the center trains beneficiaries on how to use their new prosthetics. This holistic approach ensures that those who visit BLBC leave with new tools and skills for increasing their mobility.

In spite of the low cost of these services, there are still many individuals for whom these expenses are too costly. Fortunately, a "poor fund" that pools together public and private donations has been created at BLBC to act as a safety net for clients who are too poor to pay for the products and services at BLBC. I met such an individual last summer: a rickshaw-puller by the name of Mr. Hashem Ali. Lack of employment opportunities led Mr. Ali to this unusual and highly challenging job choice; think about how difficult it is to ride a bicycle with just one knee, let alone transport two additional people. BLBC's poor fund allowed

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Michael Pollan Visits to Tufts

by Andrea Schpok

This spring, award-winning author Michael Pollan arrived at Tufts University's Medford campus to speak to students about the complexity behind food policy and food issues in the United States today. Pollan's work addresses food policy, agriculture, drugs, and architecture. He is known for his recent books *In Defense of Food: An Eater's Manifesto* and *The Omnivore's Dilemma: A Natural History of Four Meals*, and contributing articles to *New York Times Magazine* among others. Through his writing, his role as Knight Professor of Science and Environmental Journalism at UC Berkeley, and his guest lectures at universities and conferences, Pollan shares his innovative look at how the natural and man-made worlds intersect and strongly influence each other. In *The Omnivore's Dilemma*, for example, Pollan analyzes the changes and dependencies people have developed in relationship to agriculture and diet. People, however, are not alone in implementing adaptations in response to their food. Pollan explains that corn has in some instances evolved to rely on growers to ensure the proliferation of its species.

Pollan's lecture, *In Defense of Food: The Omnivore's Solution*, took place at Tufts on March 24th from 4:30-6pm in Cohen Auditorium. In his lecture, Pollan discussed the industrialization of food and agriculture, its intentions, and its unintended consequences. Many students from related classes, including Human Nutrition, and Health Care in America, were invited to the lecture but the talk also attracted students and faculty from a variety of concentrations. We will feature a more detailed article about his talk in the next CHP issue.

CHP Internship Placements Spring 2009

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Children's Hospital -

Clinical Research Program

Two Points on the Same Circle

Eleanor Rally Gonzales, CH Senior and Linda Cragin, CH alum

The Community Health Program forges a path for each of us to follow. We begin in the classrooms where we broaden our knowledge of theory, research results, and principles that guide the practice of public health. The praxis piece follows, with our internships: an opportunity to step into the field and make the abstract concrete. We are able to engage with the communities that we study and discuss in class, while creating a symbiosis with a community health organization. As we gain experience and insight, our placement sites receive the benefit of a fresh perspective, the latest information being disseminated in Tufts classrooms, a potentially lasting relationship with a nearby university, and a willing worker. Perhaps most importantly, our internships are an opportunity to observe impact, and witness what is being achieved in the field we will soon join. Finally, we enter the career field, as many of us will this May.

I am currently at the service learning stage of the full circle from class to internship to career, and am finishing up classes during my last semester here at Tufts. My internship is in the Primary Care Office at the Massachusetts Department of Public Health. The mission of the Primary Care Office (PCO) coincides with one of my firmly-held beliefs: it is necessary to ensure access to primary care for all residents of Massachusetts, guided by the concept that primary care is the foundation of a functioning public health system. Primary care physicians provide vital screening, one-on-one interaction, advice, and expertise to the communities they serve, which enable community members to take advantage of broader, population-based public health interventions. To reach this goal, PCO focuses largely on recruiting and retaining primary care workforce (family doctors, pediatricians, psychiatrists, dentists, nurse practitioners, and general internists) in designated Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs).

The Primary Care Office executes several programs to further this goal, such as the Conrad 30/J-1 Visa Waiver Program, which allows foreign doctors who have completed their medical educations in the United States to waive the requirement that they return to their countries of origin for a minimum of two years after completing their studies. This program stipulates that they must serve for at least three years in a HPSA or MUA in order to qualify for a J-1 visa waiver. The Primary Care Office also operates the Massachusetts State Loan Re-Payment Program (MSLRP) for primary care practitioners who have graduated with debt and are willing to work in a HPSA or MUA. Lastly, PCO works in conjunction with the National Health Service Corps by matching up potential applicants with community health centers across the country. I work on all of these projects, processing visa waiver applications and tracking inquiries regarding NHSC and MSLRP, as well as designing and implementing a survey directed toward past participants of MSLRP in order to gauge how effective loan

re-payment is in recruiting and retaining healthcare workforce to underserved areas and populations.

It's exciting to see the ways in which the work of the Primary Care Office echoes what I have learned in class. PCO prizes cultural competency and works to ensure that doctors have skills (both linguistic and cultural) that are concurrent with the communities they serve, to provide better doctor-patient relationships and less medical miscommunication. PCO understands and exemplifies another tenet of healthcare policy: without access, cost and quality are moot points. Care must be effective and cost-contained, but first it must be delivered. Health insurance only functions in conjunction with providers who can actually deliver preventative medical care. Benefiting from this care requires that health professionals practice in one's local area. We know that the rising cost of medical education leaves many graduates with few options for eschewing high-paying careers (generally not in underserved communities), and loan re-payment aims to ameliorate this burden of the health professionals in Massachusetts who choose to dedicate themselves to practicing among the disadvantaged.

PCO's programs also work towards eliminating health disparities, be they racial, ethnic, linguistic, or economic. Patient-centered medical homes and culturally competent primary care lay the foundation for a functioning public health system. The Primary Care Office maintains that this is a right deserved by all. In my opinion, the public health and the biomedical model of medicine are inextricably linked, and one cannot function fully and effectively without the other. Every day at MDPH, I see that community-wide policy interventions can better connect a community to doctors; physicians, in turn, can direct their patients to community health resources.

The other day, as I prepared to leave my internship to go to class, I was introduced to Linda Cragin. Linda went to Tufts before Community Health was a major. Linda speaks fondly of her time with the Community Health Program and commented to me that it is the reason she works where she does. Linda and I are two points along the full circle. It is inspiring to look at a point ahead on the circle, see her there, and know we are coming from the same place: Community Health at Tufts. And now, Linda Cragin, CH alumna, gives us her perspective:

In the late 1970's (I realize this is before current CHP students were born), CHP was a new program. I remember a meeting of all the students involved (probably 12), in a very small room to meet our new director Rosemary Taylor. For me, while my declared major was social psychology, my true major was Community Health. I took every CHP course offered except ethics (it conflicted with epidemiology) and I had to get special approval from the dean to take 6-8 courses each semester. I loved the CHP courses and they made my first year at the Harvard School of Public Health a breeze.



Eleanor at work in the Primary Care Office at MA Dept. of Public Health

Smiles around the World

by Neha Wadekar

For the past six years I have been involved with the Global Smile Foundation, an organization that provides free surgical and dental care to underprivileged patients around the world. The Global Smile Foundation aims to alleviate the suffering of underserved patients born with facial congenital deformities with special emphasis on cleft lips and palates.

Annually, GSF sends volunteers on five trips, traveling to Bamako, Mali, Trujillo, Peru, San Salvador, El Salvador, Guayaquil, Ecuador, and Manta, Ecuador. Certain geographical regions tend to have higher instances of cleft deformities than others. In the United States, approximately 1 in 700 newborns has a cleft deformity, and it is usually corrected immediately. However, in regions in the Andean Mountains, such as Peru and Ecuador, 1 in 350 newborns has a cleft deformity. This discrepancy can be attributed to a small gene pool and little genetic mixing. Often, these children do not have their deformities corrected at birth, and are forced to grow up with a cleft palate or cleft lip.

In my six years with the organization, I have traveled on trips with GSF to Quito and Guayaquil, Ecuador and Rajasthan, India. I became involved in the Global Smile Foundation when a close family friend, Dr. Usama Hamdan, founded the organization. He needed volunteers to help keep things running smoothly and assist in Spanish translations. My mother and I both speak Spanish, so we flew down to Quito with the team in August before I started my freshman year in high school. As I went on more trips with the organization, I took on more responsibilities. I was in charge of the peri-operative room, preparing the patients for surgery before the nurses took them into the operating room. In addition, I was responsible for taking both social and intra-operative medical pictures. Finally, I helped in translations and fundraising with the organization, and aided in administrative work when it was needed.

The Global Smile Foundation (GSF) was officially accepted as a Massachusetts-based, nonprofit organization in 2008. GSF emerged as a branch of a similar nonprofit called Medical Missions for Children (MMFC). In order to raise funding for the trips, GSF holds numerous fundraisers throughout the year. In addition, private donations, grant proposals, and gifts in kind all help GSF accomplish its mission. Donors such as The Smile Train, American Airlines, Americares, The Rotary Club, and Boston Volvo donate money, pharmaceuticals, and discounted rates on airfare and hotels.

GSF's founding members are a group of dedicated volunteers and medical professionals who have been actively involved with global outreach programs for the last 21 years. A typical team consists of surgeons, anesthesiologists, pediatricians, OR Nurses, PACU Nurses, nutritionists, speech therapists, biomedical engineers, administrative staff, volunteers, dentists, dental assistants, dental hygienists, orthodontists, an on-site coordinator, a lecture coordinator, and the local host organizations. GSF has no paid employees, and everyone involved in the organization donates their time for free. Doctors and nurses give their services pro-bono, often performing over one million dollars

worth of medical procedures in the one-week trip.

Select residents and fellows from U.S. based medical institutions including Brigham & Women Hospital (Harvard Medical School), Tufts University Medical Center, and Stanford University Medical Center join The Global Smile Foundation teams. These residents and fellows gain further training in management of congenital facial deformities as well as outreach programs that are provided for local patient communities.

The Global Smile Foundation does not only provide corrective surgery for children and adults. It also focuses on empowering local communities through educational outreach programs. GSF's ultimate goal is for the local medical communities to independently provide necessary care to poor patient communities. Through medical lectures, hands-on training in the latest, cutting-edge surgical techniques, and donations of the latest medical technology, GSF successfully transfers important medical knowledge to the local medical communities.

On a typical, weeklong mission, GSF screens approximately 400 patients with congenital facial deformities. On the first day of the mission, the physicians, anesthesiologists, and nurses examine each patient and select the highest-priority patients for surgery that week. Over the next five days, the GSF physicians perform as many as 80 corrective facial procedures and 200 dental procedures.

On my first trip to Quito, Ecuador, I was shocked to discover that only 80 of the 400 hopeful children in the waiting room would receive the surgery they needed. Timing and funding constraints force GSF to turn away the remaining 320 children, some of whom traveled days from the Andes to reach the hospital. This injustice motivated me to help with GSF's fundraising. I wrote a grant proposal to the Arthur K. Watson Charitable Trust; I was awarded \$80,000, and obtained an additional \$30,000 in private donations for the Global Smile Foundation.

Through my work with GSF, I learned that surgical care alone does not address all the needs of the communities we serve. On each trip, I worked with GSF doctors to help raise awareness about public health problems such as the importance of drinking fluorinated water to combat potential dental problems. In some communities in the Andes, cleft deformities are believed to mark a newborn as a Devil child. These boys and girls are shunned by society, even unable to attend school. I worked with GSF and the local Andean communities to dispel these myths and instead inform affected communities about the scientific causes and surgical cures for their deformities. GSF's ultimate goal is to eliminate the need for our visits by educating the local medical communities so they can help their populations without aid.

If you are interested in learning more about the Global Smile Foundation, and how you can help us help patients in need around the world, please visit our website at www.gsmile.org.

Sources:

www.gsmile.org

www.mmfc.org

International Issues in Community Health

TASA and Love for Humanity

by Gayathry Sooriyakumar

The Tufts Association of South Asians (TASA) kicked off the Presidents Day Long Weekend in Cohen Auditorium with its annual culture show, “Dhamaal”. Dhamaal, which means “fun” in Hindi, turned out to be an appropriate name for the show, which featured an entertaining medley of South Asian songs, dance, music, and comedy acts. The dance performances, ranging in style from classical Bharatanatyam to modern Bollywood, captivated the audience full of students, friends, and family all night long.

The annual TASA show is instrumental in showcasing the diverse cultures of South Asia and serves to increase awareness of the many humanitarian problems that the Indian subcontinent faces. Every year, proceeds from the show are donated to a South Asian charity of choice. This year, the directors chose the Manitha Neyam Trust, a non-profit organization in Sri Lanka.

“Manitha Neyam,” which means Love for Humanity, was formed in 1999 to provide charitable and social services to the needy and disabled, in the north and east regions of Sri Lanka. Based in Colombo, Sri Lanka, it is now an international organization with trustees from the USA, Canada, England, and Australia.¹ With worldwide support, MNT has been able to foster harmony and opportunity for over 875 individuals between 2004-2008. Whether it is the construction of new hostels and bathroom facilities, or the provision of transportation, ambulatory services, medical aid, school equipment, and computer training, MNT works in numerous ways to improve the standard of living for those in need.²

This year, the donation from the TASA culture show will bring smiles to the 30 girls and 80 boys at the Hostel for Needy Children in Ratmalana, an orphanage 8,579 miles away from Medford. A majority of the proceeds will be used to build a computer lab for the students. Rather than providing temporary aid, MNT tries to establish sustained relief by empowering people to improve their standard of living through education and vocational training. Building a computer lab will facilitate these goals for the Ratmalana children in the context of a modern, high-

tech world.

In the summer of 2005, I spent over three weeks volunteering at the Ratmalana Hostel. I took the children on field trips, organized educational activities, and donated books, clothing, and shoes for their use. These children have suffered from abandonment, abject poverty, violence stemming from a civil war, and the disaster of a tsunami. It was refreshing to see that they still somehow maintained the courage and enthusiasm to live and learn. Even at the tender age of 6, these children understood the immeasurable value of education, and dreamed

big despite their difficult circumstances. In retrospect, I can attest to the fact that even a little bit of thought can go a long way in improving the lives of these unfortunate children. After almost four years, I am still in contact with many of the children I had the pleasure of getting to know. They write me stories about soccer games, school, and books they have to read. Despite having so little, all they ever innocently ask for is more candy or funny stories from college. I encourage anyone who is interested in volunteer work to work at an orphanage. It is truly an eye-opening and fulfilling experience.

Manitha Neyam has made many accomplishments to date. Yet, thousands of people in Sri Lanka are still struggling to survive amidst tiny living spaces and unhygienic conditions. With continued support from donors and volunteers, MNT is committed to expanding their services so children such as the ones from Ratmalana can dream big and achieve big things.

For more information regarding the Manitha Neyam Trust or to make a donation please visit

www.manithaneyam.org/what.html

Footnotes

¹ ACStec. “Manitha Neyam Trust: Love for Humanity.” 2009. 16 Feb. 2009. www.manithaneyam.org.

² Personal communication, Mr.K.Aravinthan, February 21, 2009.



Young girls displaying a sand art project at the orphanage in Ratmalana where Gayathry volunteered

Attention Alumnae!

Please get in touch with us and let us know what you are doing.

chp@tufts.edu

All Milk is Not the Same

by Mary Cheng

"I tried but he only takes 2%", a mother with rollers pinned around her head said with a resigned smile. Nutritionist Joanna Pan had just explained the new WIC policy encouraging children to drink only 1% milk and skim milk. The new policy change is one of the few nutritional adjustments that WIC has made in twenty years. Since 2005, The American Institute of Medicine has been working on this initiative with doctors and dieticians to develop a more sensitive nutritional package to best reflect the demographic change.

Women Infants and Children (WIC) is a federal organization that provides nutritional supplements and healthcare referrals to pregnant, breastfeeding, and postpartum women and their young children. WIC offers food stamps toward cereal, juice, cheese, milk and other items. In 2009, WIC will implement different policies for milk and breast milk to reduce childhood obesity and to help babies grow stronger.

As a WIC volunteer in Cambridge, I created a project titled All Milk is Not the Same to help mothers better understand the organization's reasons for this adjustment. According to a WIC report, 1% milk and skim milk have the same amount of Vitamin D, protein, and calcium as whole milk. The only difference lies in a reduction of 70 calories and 8g fat in skim milk.

In response to many moms' complaints about skim milk's watery taste, Woanyih Lin, the director of Cambridge-Somerville WIC, suggested a step by step process to acclimate into a fat drinking habit. She recommended that children first try a mixture of 1/4 skim milk and 3/4 whole milk and then move towards drinking pure skim milk.

In addition to addressing the fat content in milk, WIC also looks at breastfeeding. WIC awards postpartum mothers with food packages according to how often they breastfeed. An exclusively

"Preventing Sexual Assault" cont'd from page 1

Through this class, I have been studying area community health organizations that seek to put an end to the problem of sexual assault in America. Since its founding in 1973,⁴ The Boston Area Rape Crisis Center (BARCC) uses a combination of upstream and downstream approaches to bring an end to sexual assault.

Sharon Imperato, a BARCC clinician and guest-lecturer in Rape Crisis and Recovery, explains BARCC's approach to ending sexual violence as "change through healing," a process of combining individual healing and education with community awareness campaigns to change widespread attitudes and stereotypes about rape and violence survivors.⁵ Topics that BARCC counselors and educators focus on include consent and respect for boundaries, survivor empowerment, gender equality, and the myth that survivors of violence are partially responsible for their attacks.⁶ According to Imperato, blaming the victim is one of the most powerful reasons that rape is still a major problem

breastfeeding mom receives the most food for the entire twelve month postpartum period; a mostly breastfeeding mom receives a little less food, and a mostly formula feeding mom receives food until 6 months of postpartum. The food package includes milk, eggs, juice, breakfast cereal, whole grain bread, dry beans or peanut butter, canned fish, and fruit and vegetable vouchers.

Nutritionist Pan explained, mothers who breastfeed burn more calories, so they need more food. The idea is to [make breast feeding] serve as an incentive [for receiving more food stamps]. Currently, a partially breastfeeding mom receives a food package that contains the food supplements until her infant turns one year old. However, in October of this year, WIC will not offer the mom any food package, if she receives more than three cans of formula for her baby.

In order to encourage moms to produce more milk, WIC does not provide infant formula to breast feeding moms. Because breasts make milk according to the needs of the infant, the greater the demand, the more milk is produced. WIC hopes that

such a promotion will help moms achieve greater success at breast feeding.

As the obesity epidemic worsens, WIC encourages skim milk and breast milk, which have lower calories and higher nutritional values, to meet children's dietary needs. Though the staff at WIC-Alewife embraced skim milk and breast milk projects with enthusiasm, some doubts still hung in the air. Woanyih said, because these health packages are so new, we won't know their effects until they are in progress.

Sources:

All info. gathered from WIC pamphlets and handouts including "Milk: Make the Switch", Lindsey Diane Toth, 2008



Mary Cheng and members of WIC

in our society. Placing some of the blame on survivors rather than entirely on the perpetrator sanctions the crime and allows it to continue practically unpunished.⁷ In fact, stigmatizing and blaming survivors contributes to lenient sentencing of perpetrators, which in turn leads to underreporting of sexual assaults and the "culture of silence" that isolates victims. BARCC hopes that providing accurate information to both survivors and community members on the reality of rape will help survivors on the path to healing as well as dispelling the social myths and stereotypes about sexual assault that allow the cycle of sexual violence to continue unchecked.⁸

How should Tufts approach this issue? At present, there is a lack of programs that address the social risk factors that precede sexual assaults such as sexism, binge drinking, and stigmatization of assault survivors. Currently, the only program at Tufts that touches upon these issues is In the SACK, a workshop

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To the left, Mr. Hashem Ali before getting fitted for an artificial limb.



To the right, Mr. Ali being helped with his new leg.

Mr. Ali to obtain a prosthetic limb; now he has the opportunity to explore other job options.

Having worked with Mr. Ali to make sure that he would be able to walk without crutches once again, I was able to get a glimpse of how vital it is that the BLBC’s poor funds are sustained. Before I left Bangladesh to return to Tufts, I promised Dr. Shahinul Hoque, BLBC’s Senior Medical Officer, that I would spread the word about their work. To learn more about BLBC and for an opportunity to get involved with the organization’s efforts, please

visit <http://www.ddpweb.org/brac.html> or <http://www.jolkona.org/projects/4>.

Footnotes

- 1 [http://www.ddpweb.org/brac.html](http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,contentMDK:22032705~pagePK:64257043~piPK:437376~theSitePK:4607,00.html) or <http://www.jolkona.org/projects/4>.
<http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,contentMDK:22032705~pagePK:64257043~piPK:437376~theSitePK:4607,00.html> [Accessed February 17, 2009]
- 2 Personal communication, Dr. Shahinul Hoque, June 2, 2009

“Preventing Sexual Assault” cont’d from previous page

for incoming freshmen on issues of consent and safety in college relationships. While the workshop is necessary, it is not sufficient to change the social trends on campus that permit sexual assault and harassment to continue. Recent changes in the structure of Tufts’ violence prevention programs have created an opportunity to adopt a two-sided approach similar to that of BARCC.

Prevention Awareness and Community at Tufts (PACT) is a student group led by Elaine Theodore, Health Services’ Sexual Violence Resource Coordinator (SVRC) attempting to incorporate an element of community health education into violence prevention at Tufts. Previously, violence prevention fell to the Women’s Center under the Violence Prevention Program. Funding for the program recently ended, the Women’s Center changed leadership, and violence prevention services were transferred to the Health Education Department at Health Services. Sexual violence prevention at Tufts now falls to the Health Education Department and PACT, but education programs have been slow to appear. This period of transition is an excellent opportunity to reform prevention services on campus. Rather than beginning and ending education about consent, violence, and safety during Freshman Orientation and focusing only on reactive services like counseling, the dialogue about safety on campus needs to be ongoing. Making Tufts and other universities safer should start with preventative education, not with reactive counseling services. Campus-wide awareness and education programs, such as education campaigns, student dialogues, or workshops are the

only way to fully understand this issue and begin work toward eliminating the problem of sexual assault in college populations.

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Footnotes

- 1 National Institute of Justice, p. 2
- 2 National Institute of Justice, p.ii
- 3 <http://ase.tufts.edu/counseling/sexual.htm>, 1/29/09
- 4 <http://barcc.org/join/about>, 2/2/2009
- 5 Imperato, 1/22/09
- 6 Ibid
- 7 Ibid
- 8 Ibid

Since then, I have had many different jobs and I often reflect back on my CHP education. I served as the director of geriatrics for several hospital systems – HMOs were a new health care delivery model in Minnesota discussed in our classes – and here I was contracting with them. For a period of time I was Assistant Secretary for the Massachusetts Executive Office of Elder Affairs – talk about getting a first-hand look at health policy. I took a civil engineering course on public health – we had a lot of discussion about vermin control (e.g. rats in Chicago!), and lo-and-behold, I had to respond to an elder’s home that was completely infested. A lesson to all CHP students – nothing learned is ever wasted!

Currently I am the director of a federally funded workforce training and development program, the MassAHEC Network, at the University of Massachusetts Medical School (UMMS). Area Health Education Centers are funded by the Health Resources and Services Administration, part of the US Dept. of Health and Human Services (the same agency that funds HCOP). Our focus is developing a culturally diverse, primary care workforce to serve vulnerable populations. Here – the connections to CHP continue.¹ My CHP internship was in the summer with the Frontier Nursing Service in the Appalachian hills in Kentucky (it was very unique to go away, I think I was the first student to do so). Now I work with the UMMS Rural Health Scholars program for medical and nursing students interested in rural health care. One

of my projects is with the Department of Public Health’s Primary Care Office (PCO) focusing on statewide workforce planning efforts. When Julia Dyck, the director of the PCO, talked about an intern from Tufts CHP – I said absolutely! Eleanor, Julia, and my MassAHEC colleague Joan Bohlke are now implementing new legislation to create a Health Care Workforce Center at DPH. As I look at your course listing (nice website!) and read what Eleanor has written – CHP classes are absolutely relevant to what I do today (perhaps I need to go back to CHP) – cultural competency training for clinicians, classes for medical interpreters and community health workers, concerns about health disparities, etc.



Eleanor and colleagues view a county map to research shortages of health care providers across the state

The cycle of class work to service learning to a career - and back - is important. Service learning provides an important opportunity to apply the information learned in academic courses in the “real world”; while a test or paper may show what you learned, service learning shows you how to use that knowledge. Service learning gives you a preview of a possible career. And service learning continues as your career unfolds– through committee work, volunteer efforts, etc. I got my current position through service learning – I volunteered on a committee, ended up as a consultant, and then got hired! And now the cycle continues through Eleanor...

Footnotes

¹ By the way, I think I once lived at 112 Packard Ave.

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