Building a Movement for the Right to Health

Madison Hafitz ’16 & Hannah Lieberman ’16

Every student who takes “Introduction to Community Health” at Tufts is asked to read Tracy Kidder’s Mountains Beyond Mountains, a novel chronicling the early work of Dr. Paul Farmer, the chief strategist and co-founder of Partners in Health. PIH, a non-profit healthcare organization, works to achieve global health equity through direct care and strengthening of health systems. Through strong partnerships with sister-organizations in Haiti, Rwanda, Lesotho, Malawi, Mexico, Russia, Peru, Navajo Nation, and most recently Sierra Leone and Liberia, PIH strives to aid poverty-stricken communities through providing high-quality healthcare. Farmer’s story, inspiring, emotional, and rooted in issues of justice and human rights, serves as a call to action for many of its readers. As undergraduate students, finding a meaningful way to become involved in this type of work can be difficult. Partners In Health Engage, the newly formed grassroots movement associated with PIH, provides students who have a passion for health equity an opportunity to apply what they are learning in an academic setting to real world public health issues.

In 2012, PIH launched their Engage Campaign, which allows individuals far from PIH’s work sites to contribute to advancing the movement for the right to health through community organizing. The PIH Engage network spans the United States with 111 university chapters and communities, consisting of over 1,500 individual members. We advocate for domestic and global policies that enable governments to build functioning health systems, educate ourselves and our peers about the health issues that marginalized populations face, and generate resources to support PIH’s work of providing high-quality healthcare for those living in poverty.

Selected by PIH as co-coordinators, we founded the Tufts chapter of PIH Engage in the Fall of 2014—amidst a multitude of other established health groups on campus. Although PIH Engage is certainly not the first, or only, health group on campus, we have a distinct mission that brings both a different and needed perspective to the Tufts community on addressing issues of global health.

Many existing health groups concentrate on direct service, usually with a focus on a specific community partner. The year’s work often culminates in a short-term service trip to the site of that community partner. PIH Engage takes another approach. As undergraduates, we believe that the most effective way to work towards global health equity is to build a movement dedicated to health as a human right. In each of its sister sites, PIH practices community based public health—helping to strengthen local health systems by building lasting health infrastructure, and training local community members as medical professionals and community health workers. Our role in these efforts is not short-term volunteer missions, but rather the long-term work of education, advocacy, and fundraising. This approach allows us to address varying relevant health issues around the globe.

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Salud Sin Limites: Community Health and Perú

Aparna Dasaraju ’16

In Perú, a country with landscapes ranging from coastal subtropical savannas to Andean highlands to the Amazon Basin and more than 51 distinct ethnic Indigenous Peoples, diversity is tightly woven into the national identity. Unfortunately, the continued racism against Indigenous Peoples further marginalizes communities who already share a history of oppression and in turn, has significant implications for their health status. The continued community advocacy and recent interest by UNICEF however, has prompted the Peruvian Government to take action on the rampant HIV/AIDS rates in one indigenous population, the Awajun-Wampis. This initiative includes Lima-based NGO, Salud Sin Limites, with whom I have had the opportunity to volunteer with on this project while I studied abroad last semester. This experience has been eye-opening to the structural disadvantages indigenous communities face when it comes to health and incredible to see applied in practice, and the theory I have learned in my Community Health classes at Tufts.

Salud Sin Limites, which translates to “Health Without Limits”, is an organization that conducts health research and programs in marginalized populations. The Ministry of Health has asked Salud Sin Limites investigate HIV/AIDs in the Awajun-Wampis population. The Awajun-Wampis are two different indigenous populations that live in the northern Amazon of Perú in the selva baja or the Amazon Basin and belong to the Jíbaro ethno-linguistic family, one of the largest in the Amazon. Poverty, lack of government support, and relative inaccessibility has rendered communities neglected and unequipped to deal with such a debilitating virus.

Salud Sin Limites aims to investigate how the Awajun-Wampis understand the causes and consequences of HIV/AIDs from a medical and cultural standpoint. They also work to determine the best methods of education with regards to prevention and treatment of the disease. The team conducting field research is an impressive interdisciplinary collection of

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Meeting the Challenges of the 21st Century: Undergraduate Education in Community Health

Over the past century, we have seen dramatic gains in health outcomes as a result of community/public health intervention and prevention programs: life expectancy has increased, there has been a worldwide reduction in infant and maternal mortality, and the threat of many infectious diseases has been eliminated or ameliorated. Still, new community/public health challenges continue to arise. New and reemerging communicable diseases must be confronted, the prevalence of chronic disease is increasing, environmental hazards and degradation pose new health threats, and there is an increased need to prepare for human-made and natural disasters. In the era of globalization, community/public health faces new and increasingly complex issues that are central to the human condition, well being and social justice.

The Need for and Growth in Community/Public Health Education and Research

Community/Public Health (C/PH) is an established, rigorous, interdisciplinary field of study whose goal is the preparation of engaged citizens to tackle the unparalleled health challenges that face our society today, both locally and globally. Nationally, the number of C/PH degrees awarded at the undergraduate level in the U.S. has increased 750% over the last two decades, growing from 759 degrees conferred in 1992 to 6,464 in 2012. The number of universities and colleges offering undergraduate degrees in public health soared from 45 in 1992 to 270 in 2013. In 2012, C/PH ranked among the top 10 fastest growing majors.1

The American Association of Schools of Public Health and Institute of Medicine project a need for approximately 250,000 additional C/PH workers in the next six years.2 The Bureau of Labor Statistics projects a 21% increase in demand for C/PH workers in the next five years. The CH program at Tufts is well poised to train student who can meet this demand. Our alums are working in many different types of environments and positions, including jobs in local, state and federal governmental agencies; hospitals and community health centers; community-based organizations and advocacy groups; private consulting firms; and voluntary organizations. Furthermore, many of our alums remain actively involved with CH at Tufts, sharing job announcements, offering to do informational interviews with current students, and assisting students current with networking for jobs. This is a tremendous resource and we plan future events to increase opportunities for students to connect with alumni.

There is a strong and growing track record of scholarly work in CH. For example, in the 2013-2014 academic year, our faculty secured $1 million in extramural and more than $50,000 in intramural grants for research. In total, our faculty published 15 articles in peer-reviewed journals during that same period. We are actively seeking ways to increase opportunities for students to be involved in faculty-led research and to become involved in community-engaged learning. We have also instituted new supports and seminars for students seeking to conduct a thesis in CH and look forward to supporting more students in attaining this goal.

Assessing Financial Feasibility of Improved Sanitation Interventions in Rural Communities

Rachel Salzberg ’16

Introduction: Rural Sanitation Interventions and Individual Demand

Many sanitation projects have been implemented in low-income countries since the identification of improved sanitation as a 2015 Millennium Development Goal (MDG) priority. Yet community utilization of newly constructed ventilated improved pit (VIP) latrines and simple sewerage systems is notably low (1,2,3). Even when the installed technology is well-suited to the community’s surrounding environment, uptake of improved sanitation is not ubiquitous (4).

Studies to identify why interventions fail to motivate widespread behavior change have taken various approaches. The assessment of sanitation knowledge, attitudes and practices of community members is a crucial stage in project planning (2,5). Such studies are essential, but their scope is limited; they address only some of the barriers to behavior change and sanitation adoption. Other literature applies behavioral economics to explain the limited success of sanitation interventions, citing over-simplified assumptions and financial characteristics as key flaws in many project plans (1,4). Specifically, it is crucial to consider willingness-to-pay (WTP), ability to pay and demand for the specific technology to effectively promote behavior change. Financial constraints, such as income and affordability, are barriers in many rural, low-income communities (3,4). Implementing projects that have incorporated individual demand is therefore essential in rural communities. This review of the literature covers methods of assessing WTP, factors that influence individual demand, strategies for financing sanitation projects, and demand creation.

Methods of Assessing WTP

WTP, an essential component of individual demand, is the dollar amount at which an individual values the perceived benefits of an intervention (6). It is difficult to measure consistently, as WTP is subjective, and it asks individuals to respond to a hypothetical situation. The prevailing method of assessing WTP is contingent valuation (CV), which involves directly asking the individual what (s)he is willing to pay for a particular service (7,8,9).

There are two components to CV (7). The first involves describing the proposed service to the individual, which presents challenges in communities unfamiliar with improved sanitation technology. Researchers addressed this in Burkina Faso by describing instead the beneficial characteristics, such as privacy, associated with the specific intervention (7). The second component of CV is the process of determining the individual’s WTP for the specific service or technology. CV literature consists of primarily four methods for eliciting WTP: take-it-or-leave-it, open-ended, payment scale and iterative bidding game. The iterative bidding game is the prominent method of CV in the literature (Table 1) (6,8). To conduct a bidding game, individuals are given a starting point, and depending on whether they would pay for the service at that price, are asked higher or lower numbers until their answer changes. Conducted in person, bidding provides opportunities to address questions, clarify answers, and to assess factors important to community members. There is also some discussion in the literature regarding iterative bidding’s resemblance of market interactions, making it a strong choice for work in rural communities (8,9).

WTP and CV assessments have serious weaknesses. Data collected through CV is inconsistent and variable, as both ability and willingness-to-pay can change at any point (2). Starting points used in bidding games can affect responses, introducing a form of bias (6). It is difficult, if not impossible, to determine what costs and benefits individuals are accounting for in their answers (2). Yet, CV studies can also identify factors that affect an individual’s demand for sanitation. WTP, while not sufficient as a stand-alone community assessment, provides crucial information for project planning about individual demand.

Factors Contributing to Individual Demand

There is no consensus regarding an average WTP for improved sanitation. The World Bank recommends that expenditure on water and sanitation not exceed 5% of a household’s income, but this is often not feasible in low-income communities where connection fees are high and subsidies are not available (10). WTP is often expressed as a percentage of disposable income, although it is sometimes given in the local currency. Problems comparing such averages arise with dynamic exchange rates and inflation.

Determining from the literature an average WTP for sanitation is difficult, as most studies assess individual demand for slightly different services or technologies, in varying communities with different characteristics. This was the case for each study included in Table 1. It is also partially a function of WTP being restricted by an individual’s ability to pay (8,9).

Factors that contribute to an individual’s WTP vary depending on the type of proposed sanitation technology. For example, age, education and socio-economic status significantly influence individuals’ WTP for solid waste management (11), but other studies found that the age of respondents was not correlated with WTP (7). Age, current sanitation facilities, satisfaction with those facilities, and socio-economic status were all significantly related to WTP for the flush toilet bathrooms (9). Multiple studies found that education of the risks associated with poor sanitation increased WTP for improved sanitation (9,11). High income households in Botswana indicated higher WTP for off-site sanitation, while low-income households preferred on-site sanitation, such as VIP latrines (4). This was also the case in Burkina Faso, where economic status and whether private sanitation facilities were already installed at home contributed to higher individual WTP for on-site sanitation (7).

Financing Rural Sanitation Projects

The World Bank suggests that countries spend 1.5% of GNP on sanitation (12). For low-income countries, designating only 1.5% of GNP would unreasonably extend the timeline of any sanitation project to the point of making it infeasible to complete. Improved sanitation is unaffordable
Community Health in the Private Sector: Interning in Healthcare Consulting

Harrison Kim’15

INTERNSHIP SPOTLIGHTS

After declaring my Economics and Community Health majors at the end of my sophomore year, I was anxious and eager to find a way to apply these two passions of mine into a fulfilling professional experience. The summer before my senior year, I was fortunate enough to complete my CH internship at Boston Healthcare Associates (BHA). BHA is a medium-sized consulting firm with a focus on the healthcare industry.

I’m sure a lot of you have heard the term “consulting” but have no idea what it means (to be fair, I had very little understanding of what I would be doing when I initially applied for the position). To put it simply, the average project consists of a pharmaceutical, biotechnology, or medical device company coming to us needing help with a new product. This can mean a few different things: a pharmaceutical company may be confused on the market potential for their new drug; medical device companies are likely interested in how physicians will respond to new surgical tools. I was able to work on projects like these, as well as many others. My personal favorite was working with a Malaysian life sciences venture capital firm looking to invest in a new catheter technology. Something to note: these projects get very in-depth. By the time we first meet with the client, the team members are experts regarding everything about the product, from something as basic as the potential market size to the most nuanced things like which CPT modifier physicians generally use to maximize their reimbursement (and no, I don’t think you’ll ever be tested on which CPT codes to use, or even what CPT codes are, in any CH class).

Interning with BHA was especially rewarding because they didn’t treat me like a clueless intern. They recognized my background, gave me a surprising amount of responsibility, and expected the highest quality of work. This made for an exceptionally fulfilling experience, because I knew that my work was having a real impact. Near the end of the summer, I even put together final presentations that would be given to our clients and modified health economic models without overbearing supervision.

While a lot of students choose to intern with non-profits, government, or big studies, I wanted to see what my options were in the private sector. I feel that healthcare consulting is a great platform to apply the skills learned through our CH program at Tufts, and is an excellent way to learn more about the more granular pieces of healthcare in America and beyond. As a little plug for working hard and doing your homework, I was offered and accepted a full-time position with BHA after graduation. I can easily say that the skills and critical thinking process learned through my time as a Community Health student were integral to my success at my internship.

Fair warning, interning with a consultancy will very likely be extremely research-heavy. If you hate reading medical and economic research papers, you will probably not have the best time. However, if you can synthesize information quickly and apply it in a real-world context, consulting may be a great internship and career option.

(“Rural Sanitation” continued from page 3)

for many low-income countries, regardless of the population’s need (9). Additionally, NGOs tend not to focus on rural communities for donations and aid, since community demand for improved sanitation is relatively low compared to urban areas (12). A notable example is the European Union’s Official Development Assistance in sub-Saharan Africa, where a substantial portion of the aid is designated specifically for sanitation projects, but up to eleven times the aid is distributed in urban areas compared with rural areas (13). Sanitation projects in rural, low-income areas cannot count on large subsidies provided by the government or from international aid. Interventions must instead be funded mostly through household contributions, further enforcing the need to understand individual demand, WTP and ability to pay (9).

Project costs can be managed throughout the intervention, starting with the choice of sanitation technology. Implementing new technologies, such as off-site sanitation systems, with high initial costs and operation and maintenance costs, will require substantial subsidies. Governments that cannot afford to provide substantial subsidies for water, sanitation and hygiene interventions should not invest in off-site sanitation services, but instead in on-site services, which have lower initial costs and require less government support (7, 12, 14).

Choosing cost-effective sanitation options not only reduces the project costs, but also addresses one of the largest barriers to community participation. Community members are less willing to pay for services with high initial costs if they do not perceive large upfront benefits (1,2). In Tanzania, where access to credit structures is limited, individuals had few options for financing latrine projects if they had little savings (3). Even when the sanitation infrastructure is already in place, initial connection fees serve as substantial barriers for community members (4).

Financing supply-driven programs, which do not take into account the financial concerns and perceptions of community members, will be much more difficult than financing programs that have a comprehensive understanding of the financial resources available from the government, as well as the individual WTP and ability to pay of community members (13).

Demand Creation and Future Sanitation Interventions

It is possible to implement successful sanitation projects, even if the results of a CV study indicate low demand. Cost-effective methods of demand creation are prevalent in the literature, including social marketing and community health clubs. Demand creation projects must address the social, behavioral or financial barriers preventing individuals from being willing to pay for improved sanitation.

Regardless of the method used to target individual demand, community involvement is crucial for the success of sanitation interventions (4). Drawing on knowledge from the existing literature, researchers and public health workers can incorporate assessments of individual demand and perceptions of sanitation technology in their future project designs to implement financially feasible, culturally appropriate improved sanitation interventions.

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If you had asked me 6 months ago what I was thinking of doing after college, politics wouldn’t have made the list. As a Community Health and Economics major, I wanted to work in health care consulting, or health insurance, or health care entrepreneurship, or health care provision. Politics, and its negative stigma, just wasn’t for me. But through a series of trials and tribulations, I find myself interning at the Massachusetts State House, so every Tuesday and Thursday, I commute down the Red Line to Park Street and walk my way into office 473B to help out Representative Denise Provost of the 27th Middlesex District and her legislative Aide, Jordan Neerhof.

My responsibilities at the State House vary wildly. Some days, I spend hours responding to constituents who reach out to the Representative with requests, concerns, or questions. I sit in on meetings and attend budget roll-outs with Senators, House Representatives, and stakeholders representing various interest groups. I take notes and report back. I organize her files, by both topic and time. I send requests for specific documents, and print and fax others. I am a cog in the wheel of the government and hopefully I allow the whole system to run just a little bit smoother.

But what is the essence of the State House? It’s politicking, of course! Politicking, as they call it in the State House, isn’t for everyone. It involves a lot of mingling with Representatives and their aides, attending meetings, and figuring out what to do with the vast periods of empty time between scheduled events. The government, a body responsible for the welfare of, well, everyone, should function like a well-oiled machine. Unfortunately, this isn’t always the case. It can be painfully slow sometimes, hours of monotonous limbo, where I would have nothing to do if not for my personal endeavors.

Due to the slow pace of work at the statehouse, I do have a lot of self-propelled projects. I entered my internship right at the beginning of the 189th General Court. For the next two years, Representative Provost will be trying to pass 36 bills that she filed in the beginning of the session, so I am trying to get her organized. I started with creating 36 manila folders with personalized tabs. I printed out the written text of the bills, and the lists of co-sponsors, and put each set of papers into its corresponding folder. I’ve read each of her proposed bills to become acquainted with them, and am now starting to write fact sheets for as many bills as I can. Many of the bills are tied with Community Health, such as a bill protecting school children from environmental toxins, a bill regarding the inclusion of disabled peoples on commissions, and a bill requiring monitoring of public sites in areas with potentially high air pollution. I won’t be writing fact sheets for all 36 bills, but I will do what I can in the remaining hours of my internship.

During my snow-shortened two months at my internship, I have gained great insight into the world of politics. As a Community Health and Economics major, I have spent a lot of time thinking about the government, its relationship to the people, and its responsibilities. We live in an incredibly complicated world and rely heavily on the government to support us, yet we sometimes have unrealistically high expectations for what the government can or should do. Economics teaches us that we must learn how to effectively deal with scarcity, and this is an issue that comes up in the State House far too often. At almost every meeting, a senator or house rep will say something along the line of “we all know that we have to maximize and optimize our money in the budget”. Even the government is seriously financially constrained, which raises all kinds of problems. We’re asking for a lot, and things add up.

The Community Health internship is undoubtedly a useful aspect of the major. It allows us to get into the real world before we graduate, and get a glimpse at what life can be working in at least one field. A lot of people have internships throughout college, but this internship, in my senior spring, is my first, and I already feel that I’ve benefited in ways that I could not have imagined. I have gotten the chance to sit with my Representative and help her make decisions that may fundamentally alter the way our society runs. I’ve gained experience in the professional field, and gained confidence in my abilities. While my impact here thus far has been relatively small, I’ve already done a lot, and I am seriously considering trying to get a job here after I graduate.

Politics, and policymaking, isn’t for everyone, but if you are up for it, it can be a worthwhile endeavor.

(“Peru” continued from page 1)

public health professionals, anthropologists, and specialists in education and communication. It interesting to see the fundamental interdisciplinary approach of public health in play as each professional adds a unique layer to the lens with which we view the problem, challenging me to think of the problems in new ways.

Preliminary research and surveys focused on the barriers to communication and prevention have found a few major trends in notions of health, in structural barriers and in local customs that have evolved in response to HIV/AIDS in the community. For example, the Awajun-Wampis notions of health conceptualize it as one of equilibrium in the body. This complicates the idea of a chronic disease, like HIV/AIDS, that posits that one’s body is constantly out of equilibrium and could require life-long treatment. On the other hand, the aforementioned inaccessibility and inequality the population suffers has made it difficult to bring in treatment programs. Lack of treatment options and a lack of understanding of the virus, has led many to seek treatment from what communities call bravos, or from those who practice witchcraft, instead of “Western” physicians or even trusted local curanderos, or healers.

The stigma surrounding the illness and taboo associated with a brayo has rendered making partnerships difficult.

The next step of the project is developing communication materials and methods. One challenge to this has not only been finding the words to converse about HIV/AIDS but also to do so with a community that has had a relationship with the government colored by violence and distrust. As such, I have focused on revising communication materials of other health organizations across the world with rural indigenous populations in an effort to understand what has worked and what could be adapted to the specific community we work with. I have also had the opportunity to attend meetings with various actors in the project as well as analyze interviews with community members. As I read through interviews, I have found similarities in the adversities marginalized and impoverished communities face in combating chronic illnesses around the world. I am reminded that the fight for health rights is

("Peru" continued on page 7)
In only a few months time, we have built a strong and dedicated chapter of Tufts students who share the conviction that health is a universal human right. The founding of our chapter came at a time of crisis in the global health community—the Ebola epidemic that is currently devastating West Africa. The epidemic is the result and realization of deep and extensive inequities in health and human rights. Ebola has been destructive in countries such as Sierra Leone and Liberia as a result of a lack of basic health infrastructure. The systems and resources needed to handle a disease of this magnitude were simply not in place. As a result, a patient with Ebola in Sierra Leone faces a much different fate than a patient in the United States.

PIH, unwilling to accept this reality, drew on partnerships in Sierra Leone and Liberia to establish and staff Ebola Treatment Units with the goal of providing the highest level of care to patients by overcoming immense barriers of insufficient resources and workers. At Tufts, PIH Engage made supporting these efforts our first priority.

Through presentations in classes, and guest speakers like Dr. Joia Mukherjee, Chief Medical Officer of PIH, we educated ourselves and our peers about the root causes of the epidemic. Additionally, we raised over $6,000 to support PIH’s work of building Ebola Treatment Units, training health care workers at the CDC to send to West Africa, and overall strengthening of the weak health care systems in these affected countries.

While Ebola is not the sole focus of PIH Engage, it is our goal to help the Tufts community to address one of the most devastating health crises of our time in a meaningful, organized, and effective manner. Although the atrocities of this epidemic are fading from the media, patients and survivors who have lost loved ones are still living in this unimaginable reality.

PIH Engage is an opportunity to practice the ideals of active and engaged citizenship that Tufts strives to instill in each of its students. To protect and promote the right to health, a people-powered movement is essential. We look forward to continuing in the fight for health as a human right, and hope that you will join us.
**“Peru” continued from page 5**

These interviews have offered me a brief glimpse into the lives of the Awajun-Wampis and the hardships the disease has placed upon community members. My admiration for the community leaders and members has only grown as I continue to understand how individuals continue to resist and advocate for their rights in spite of their historic oppression. I am thankful to be included in the project and to have the opportunity to hear and learn from the community of Awajun-Wampis. While colonial history is easy to relegate to the past, it is important for us to confront the impact it continues to have in marginalizing communities and on health outcomes of community members. My experience with Salud Sin Limites and with the Awajun-Wampis has impressed upon me the need to continue learning about health issues and the histories that have shaped the social and environmental factors that communities face, in order to appropriately address disparities around the world.

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**“Director’s Column” continued from page 2**

**Exciting New Changes in Tufts Community Health Program**

With CH becoming a primary major, we believe that there will be a meaningful increase in the number of students attracted to the program. While the CH Program has always been proud to attract a diverse student body, we hope to build on this diversity even more and enrich the major itself as well as the future public health workforce. This is a critical goal for the CH program and for the nation as a whole, as a diverse C/PH workforce is one of the critical elements necessary for the amelioration or elimination of health inequities. 3

In other exciting news, we will be moving to the new “CLICK” building at 574 Boston Avenue in June, 2015. The completely renovated building has great open spaces, ‘smart classrooms’, spaces for students to study and do their work in the CH office suite, and wonderful areas in which to congregate and socialize, including an on-site café. We look forward to being able to host the entire CH program in one space, to having students spend more time in our building, and to offering an increasing array and number of academic, social and cultural events.

In order to attain our full potential, we believe that we must be able to amass a world-class faculty, which will require the ability to offer tenure-track positions. We have been granted approval by the Tufts Dean of Arts and Sciences, James Glaser, to initiate the search for faculty to fill tenure-track positions in the fall; currently, most positions in CH are not tenure-track. This is a tremendous demonstration of support for the CH program by the administration, and will help us to retain outstanding faculty and support increased research initiatives in CH. As the time nears, we will be assembling a group of students to participate in the process of faculty hiring.

**Leading the Future of Undergraduate Community/Public Health Through Integration of Unique University-wide Research and Learning Opportunities**

We believe that Tufts is uniquely positioned to take a lead in the field of undergraduate C/PH. The university was a pioneer in undergraduate CH study when it established the Certificate Program in 1975. The program has graduated 1,325 students since 1976 (the time period for which data are available). While all of our peer institutions now offer undergraduate studies in C/PH health, Tufts has the opportunity to distinguish itself given our unique constellation of schools (Medicine, Engineering, Nutrition, Policy, Veterinary Medicine). Moreover, we have strong and active collaborations across the School of Arts, Science and Engineering, as well vibrant and expanding bachelors-to-masters degree programs in Public Health & Community Medicine and Health Communications that are integrated with our faculty colleagues at Tufts Medical School. The newly-minted doctoral programs in Public Health and our prime location adjoining Boston’s medical mecca offer many advantages for students pursuing study in the field. The field of undergraduate C/PH will be central to many new University-wide research and educational initiatives that can provide further enrichment for our program and it’s students. One example will be opportunities integrated with the new Tufts Institute of Innovation, whose holistic mission of improving the human condition speaks directly to that of C/PH.

The future for Community Health is bright. As we plan to celebrate our 40th anniversary later in the 2015 academic year, we hope that you will all join us in celebrating the many accomplishments of students, staff, faculty, and community partners. Look for more information about these plans in the fall.

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