

S E P T E M B E R 2 0 1 4



Global Health Fellows

NORTHERN PACIFIC GLOBAL HEALTH RESEARCH
FELLOWS TRAINING CONSORTIUM

NPGH Fogarty Global Health Fellows Newsletter

The NIH Fogarty Orientation: A Good Opportunity for Encountering Global Diversity

by Year 1 alumnus Segundo Leon



The NIH headquarters in Bethesda was the venue for the 2014 cohort of Fogarty fellows' orientation meeting.

This was the first meeting of this kind I had attended. More than 130 people were united for more than a week, some of them receiving important advice and further tools before they departed to their training sites, others came from their countries just to share their experiences from previous years, and all of them, including faculty and administrative teams, were representing different cultures and ethnic backgrounds from all over the world.

One of the things I noticed and celebrated during the meeting was the youth and diversity of the attendants, men and women, juniors and seniors, fellows and faculty, all of them as a global family living together between the hotel and the NIH, apart from their families and friends and maybe resting a little bit from their regular duties at home. *Continued pg 8...*

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Nicole and Nikki packing boxes for Ghana

Upcoming Event

**September 18; Core Competency Discussion:
Cultural Differences and Ethics**

6am Seattle; 8am Lima; 1pm Ghana; 2pm Cameroon; 4pm
Kenya/Uganda; 8pm Thailand; 9pm China

Link for Adobe Connect:

<http://uwmedical.adobeconnect.com/ghfellows>

(Login with your name)

Funding Opportunities



American Fellowships support women scholars who are completing dissertations, planning research leave from accredited institutions, or preparing research for publication. Candidates are evaluated on the basis of scholarly excellence; quality and originality of project design; and active commitment to helping women and girls through service in their communities, professions, or fields of research.

3 different fellowships available.

Deadline for applications: Nov 15th, 2014.

Eligibility: Female US Citizens and Permanent Residents

<http://bit.ly/aauwscholarships>

International Fellowships are awarded for full-time study or research in the United States to women who are not U.S. citizens or permanent residents. Both graduate and postgraduate studies at accredited U.S. institutions are supported.

Deadline for applications: Dec 1st, 2014.

Eligibility: Female LMIC applicants

<http://bit.ly/aauwintlffellowship>



The HIV Research Trust is a charitable foundation that provides financial support to physicians, nurses, scientists and other health care professionals in resource-poor settings from LMICs working in the field of HIV infection. The Trust supports early/mid career researchers (from doctoral students to group leader level).

Deadline for applications: Oct 13th, 2014.

Eligibility: LIMC applicants

<http://www.hivresearchtrust.org.uk>



The National Science Foundation's Graduate Research Fellowship Program (GRFP) helps ensure the vitality of the human resource base of science and engineering in the United States and reinforces its diversity. The program recognizes and supports outstanding graduate students in NSF-supported science, technology, engineering, and mathematics disciplines who are pursuing research-based master's and doctoral degrees at accredited US institutions.

Deadline for applications: Oct 29th, 2014.

Eligibility: US Citizens and Permanent Residents

<http://www.nsfgrfp.org/>



*Traditional Peruvian dancing—
captured by Segundo Leon*



Research Spotlight: Fan Lee, Kenya

Fan Lee is currently in her 3rd year of medical school and has a background in cancer research and bioengineering. Her Fogarty project will be exploring the knowledge and attitudes of Kenyan men towards cervical cancer and their potential impact on cervical cancer screening at the University of Nairobi, Kenya.

Including Men in Women's Health

Persistent bleeding after intercourse. That is what drove Mama Ruth to the hospital three years ago. She felt strong at 42 and there was no sickness - no fever, no pain, no fatigue, so she let it go unnoticed for months. She had heard rumors of a cancer that affects a woman's parts, but thought the bleeding was AIDS. She has lived with HIV for over 13 years now, visiting the HIV clinic every first Tuesday of the month for her antiretrovirals. When the bleeding would not stop, she was sent on a three hour motorbike trip to town. "They said they could operate if I can pay. But they gave me nothing," she said, "and no hope. They told me I had another disease of which there was no cure. Why would I let them cut me?"

Cervical cancer is a death sentence for too many women in low-resource countries. Since her diagnosis, Mama Ruth took on the role as a community health worker and single handedly brought cervical cancer screening to her district. Armed with a teaching flipchart she received at a visual inspection with acetic acid (VIA) training course, she and I spoke to women. For the handful recruited for screening, Mama Ruth would conduct VIA in spare rooms of the hospital, and then send women to the national hospital in town for removal of detected lesions.

Through this experience after my first year of medical school, I caught a glimpse of the day-to-day struggles women face and how these struggles impact women's access to care. I heard about poverty and lack of transportation, poor facilities and limited trained personnel. But there was another discussion that emerged over and over again, one of stigma, society norms and gender disparities that affect the healthcare seeking behavior of women. Though it is

important to be aware of resource limitations for successfully implementing women's health services, we must also take into consideration the complex social dynamics that play a large role in a woman's ability to make health decisions for herself. That is what I hope to explore in Kenya through a qualitative research study; to investigate the attitudes of male partners and their role in successful cervical cancer screening and treatment. I am fascinated by the nature of cervical cancer as a disease, and my experience working with women of East Africa has impassioned me to improve the health of women worldwide.

Gender power relations play a crucial role in sexual and reproductive health around the world. In patriarchal societies like Kenya, where male partners hold significant power over the health seeking behavior of family members, involvement of men is critical for the success of cervical cancer prevention programs. Our novel effort to engage and explore male partners' awareness and attitudes towards cervical cancer screening will provide a critical perspective that will inform the development of interventions to engage partners not only in the screening process, but all aspects of female reproductive care. Potential interventions could be to incorporate partner counseling during screening, educational programs for men who accompany their female partners to follow-ups, peer education programs among men, or large-scale media campaigns to encourage male partner support. We believe that the more men are able to understand the implications of reproductive

Fan Lee's article, continued...

health and preventative care for their female partners, the more they will be able to provide encouragement and support. This study hopes to explore perspectives of not only women, but men, on the barriers to partner support as well as the actual and potential role as supportive partners in cervical cancer screening. This information will be helpful in developing strategies to implement sustainable interventions to include male partners in the cervical cancer screening process.

As a medical student, I cannot imagine a more exiting career than one that allows me to work closely with women at an individual and community level. It is a privilege for me to be a part of important intimate conversations with women and advocate for women's health worldwide. I plan on pursuing an OBGYN residency after returning from this Fogarty year in Kenya and envision working with local health professionals to improve women's access to health, develop effective treatment strategies and work with policy makers to implement culturally sensitive prevention and disease control programs. Ultimately, I hope to have the ability to think critically about the biomedical, behavioral and community aspects of healthcare and disease so that I can better serve my patients at home and abroad.

In case you missed it...

Delivery Room Screening

If you work with mothers, you may find this policy briefing useful to learn three quick screening questions for detecting post-partum depression now being used in South Africa:



maternal mental
health short screenin

Mental Health Resources

Did you know suicide kills more young women every year than maternal causes? Check out [this article](#) on a hearing in the UK addressing global mental health, or explore the [Mental Health Innovation Network](#) for more resources for collaborating and contributing to global mental health research.

HIV/AIDS Comorbidity

Several former Fogarty Fellows and mentors contributed to this month's issue of the Journal of Acquired Immune Deficiency Syndromes. Read the preface by Dr. Roger Glass, director of the Fogarty International Center, or [browse through the other articles](#).

Have something to share?

Email your submissions to Mallory Erickson
emallory@uw.edu



Mentor Spotlight: Alison Roxby, UW

Finding the Next Question



Alison Roxby MD, MSc received her MD degree from UNC-Chapel Hill and a Master's in Public Health from the London School of Hygiene and Tropical Medicine. She has worked in 5 different African countries to improve access to HIV care and prevent HIV transmission. After completing a residency in internal medicine at Stanford, she came to UW in 2007 for the Infectious Disease fellowship and then moved to Nairobi in 2009, where she was a Fogarty Fellow. Dr. Roxby's research goals are to improve maternal health, promote family planning, and reduce perinatal transmission of HIV.

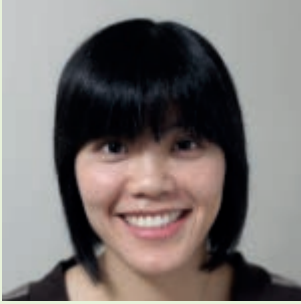
I was a Fogarty Fellow in Nairobi, Kenya from 2009-2010, working on a randomized controlled trial of valacyclovir among pregnant and breastfeeding women with HIV. With my research mentors, Carey Farquhar from the University of Washington and James Kiarie from the University of Nairobi, I studied whether or not valacyclovir could reduce HIV in breast milk. I had a great experience and developed strong relationships among the clinic staff in Nairobi where our study was conducted.

As our research team followed women through late pregnancy and one year postpartum, we got to know the women and their babies very well. However, even with the rapport we developed, it was difficult to get women in this cohort to use family planning in the postpartum period. We even had a few repeat pregnancies and abortions among women participants within the first year postpartum.

I spent so much time that year working with women, family planning nurses, and clinic staff to try to improve our postpartum contraceptive uptake – but it didn't seem to be working. At the end of the study, only half of the women were using any kind of contraception, although most of them said they weren't ready for another child. Ultimately, I realized that this frustration was actually a research question. Why was family planning uptake limited in this group? What were the barriers and facilitators of family planning use? How could we promote postpartum family planning use among women with HIV? Could newer family planning methods, like implants, be more popular with this group?

I was able to take these observations and weave them into a Career Development Award; I have several ongoing research projects addressing both the sociobehavioral aspects of family planning in the postpartum period, as well as concerns about different family planning methods and how they might influence HIV risk. Large cohorts have shown that women who use DMPA (Depo-Provera), an injectable contraceptive that lasts 3 months, acquire HIV more often than women who don't use this method. However, we don't know why – it may be that women just aren't motivated to use condoms since they know they won't get pregnant, it may be that they have more sex and sex partners, or it may be a biological mechanism between the hormones in the contraception and the genital tract that increases vulnerability to HIV acquisition. It's been great for me to integrate my interest in HIV prevention in mothers and children with my desire to promote family planning in this population.

I am confident that addressing these questions will keep me busy generating hypotheses and studying women's health for years to come. But the most important lesson I learned was: if you spend time listening to your research subjects, good research questions that are relevant, timely and important will present themselves.



Alumni Spotlight: Daphne Ma

Keeping Secrets across Cultures

Daphne Ma just finished her year as a Fogarty Fellow in Peru, working on the diagnosis of neurosyphilis.

She earned her PhD in Immunology from the University of Washington

One of the most important aspects that is required for appropriate clinical care and laboratory diagnoses is the ability to maintain patient confidentiality. Not only does this protect patient rights and limit patient discrimination, bias and stigma, it helps to maintain anonymity that allows a laboratory diagnostician to remain objective while conducting analyses. In the US and other high-income nations, there are very strict regulations such as HIPAA and IRB standards that enforce the preservation of patient protection and anonymity. However, this is often not the case in low- and middle-income countries.

During my fellowship year, I was tasked with establishing a neurosyphilis clinical laboratory that offered free diagnostic services to local clinics and hospitals in Lima, Perú. We had a very strict agreement with the universities and local hospitals that we would not collect patient information, just as if we were offering a clinical service and *not* conducting a study. This allowed us to surpass IRB reviews and implement our services much sooner. Using both verbal and written methods, we very firmly conveyed to all clinicians that we would have no patient contact and accept and process only de-identified patient samples. We also built a website with instructions reiterating this requirement.

As I was used to the strict rules and standards of clinics in the US, I had a true culture shock when I received multiple samples with the patient's name, date of birth, age and other private information from my clinic. In Peru and other countries, there aren't as strict practices for patient privacy; I found that I was given easy access to patient medical records, and cases were discussed openly between health care professionals on buses and public transportation. One of my American colleagues observed that it was a system built much more on "doctor-based care" rather than "patient-

based care." When I contacted the doctors who had sent me the samples with information and explained that I could not process them, I was met with surprise and then a bit of pleading for me to process the samples anyway. It was difficult to turn away samples, but knowing that part of my ethical duty was to maintain (and actually now implement) these practices, I sent back the samples and asked the clinicians to remove the information before sending them back to me.

Then came the day that a woman stood in the door, with her son's cerebrospinal fluid in a loosely-sealed capped tube asking for us to process the sample. She explained in Quechua (a native Andean language that is distinct from Spanish) that her son was young, was very sick with syphilis and that she had come from the provinces outside of Lima (about 3 hours away) with him to get treatment. The tube was also labeled with patient information, including name, age, date of birth, but that obviously was the least troubling part. One of my colleagues accepted the sample, to which I had to make the final decision of whether or not we were going to process it. From the human aspect, I very much wanted to help this woman out, especially now that I knew how sick her son was. On the other hand, I felt my objectivity was now compromised and that I would be ethically violating my promise to the IRB and HIPAA standards to preserve patient anonymity and have no contact with private information. I was also afraid that if I made an exception for this case that the floodgates would be opened for every other clinician to do the same. Against my emotional tendencies, I contacted the clinician and told him that I could not accept or process that sample under those circumstances. I returned the sample to that clinic, and told him that in the future, I would hold to the same practices. *Continued...*

Daphne Ma's article, continued

This violation of patient confidentiality happened all through the year, and I found myself having to repeatedly turn samples away that compromised my objectivity or standards. As I prepared to wrap up my fellowship year, I re-emphasized these standards to the scientists who took over my position. I explained to them the importance of maintaining these standards as a way to protect our impartiality as scientists, as well as the privacy of our patients. In the end, I am not commenting or criticizing the health care system in Peru or developing nations, nor am I saying that the system in the US is superior. I believe the physicians in Lima were genuinely caring and dedicated health care providers who wanted to get the proper diagnoses for their patients. It was just a difference in standard practices, and many of the clinicians and scientists were very understanding (and even excited) after I explained to them the importance of confidentiality. Helping implement a new standard for patient privacy was not initially a goal for my project, but I am hoping that this experience will further improve the patient-doctor-laboratory relationship and enhance proper diagnoses of neurosyphilis and other diseases.



Faces obscured to protect anonymity of individuals.

Segundo Leon's article, continued from page 1

The walk from the hotel to the NIH was like a party on the streets and a rainbow of colors with guys wearing elegant clothes, living together between the hotel and the NIH, apart from their families and friends and maybe resting a little bit from their regular duties at home. The walk from the hotel to the NIH was like a party on the streets and a rainbow of colors with guys wearing elegant clothes, colorful ethnic dresses and of course everyone proudly wearing badges with their country names. I had the chance to share nice conversations regarding our customs, religion, dances and food with new friends from Africa, Asia and America. I think the idea of sending people from the US to southern countries and vice versa, is just a great idea; it allows us to know what the needs are on-site, how we can do research abroad and more than that, meet new cultures and places. Having all of this in one venue is quite enjoyable.

Diversity was also represented this year by the different fields of research the fellows and trainees are involved with; people working on infectious diseases (where malaria, TB and HIV drives most of it), up to surgery in rural areas or emergency medicine, passing through maternal and child health and cancer, or doing behavioral studies and also studying mental health. This wide range of research allowed us to share more than knowledge; we shared academic information, feelings and thoughts. A typical meeting day started very early in the morning, continued with a breakfast, academic sessions, lunch, more sessions and dinner, and -- let's be sincere-- beers or wine after dinner; this sounds typical but it wasn't, every piece of time of a single day was a new cultural encounter. I had the opportunity to share desks with laboratorians, psychiatrists, physicians, surgeons, epidemiologists, bachelors, masters, PhDs, professors and I also shared drinks with new friends-- some of whom have already received e-mails from me saying hello!! Of course, some of them have received requests for more information regarding their sites and work. In my inbox now, I also have yummy recipes of fruit and pancakes from the US, Feijoada from Brasil, Ugali from Kenya and Pha Ba from Vietnam.

After the meeting I realized that the Fogarty fellows' orientation was a global village.

Ask Globie



Q: Dear Globie,

Where can I find the most up to date information about the West Africa outbreak of Ebola?

I'm glad you asked! We care about the health and safety of all of our trainees, and urge you to stay informed. Check out NIH's Disaster Information Management Resource center to learn more about the virus and the US government's recommendations for citizens abroad.

http://disaster.nlm.nih.gov/dimrc/ebola_2014.html

The site has links to many US Federal and International institutions. There are also many multi-lingual resources available.

Did you know?

NPGH Fogarty Global Health Fellows is developing our social media presence to raise awareness around our program, attract great candidates, and foster community between current and former fellows and scholars. Please connect with us through the following sites, and share our information with others who may be interested in applying.



[NPGH Fogarty Global Health Fellows](#)

(Be sure to “Like” and “Share” our public page)



[NPGH Fogarty Global Health Fellows on LinkedIn](#)

(If you’ve included your Fogarty fellowship on your LinkedIn profile or CV, now you can link to our NPGH Fogarty Company Page)



[NPGH Fogarty Global Health Fellows Group](#)

(Join this private group to keep in touch with current and former trainees)



[NPGH Fogarty Global Health Official Website](#)

(We’ve recently added a “Resources” page, where you can find videos about trainees in Peru, and our monthly newsletters.)



[NPGH Fogarty Global Health Fellows on Twitter](#)

Stata Tip

Tip contributed by Frankline Onchiri (Year 1 alumnus, Kenya)

The Stata tip for this month is about two related commands: “lookfor” and “lookfor_all”. These commands are useful for finding variables, especially in a large dataset that has several variables. You only need to know 1) the full variable name, 2) part or few characters of variable name, or 3) part or few characters in the variable label. For example, suppose we have a dataset with 500 variables and we are looking for a variable that represents “socioeconomic status”. Using command “describe” will list all the variables, and you have to go through the list one variable at a time to find the variable of interest. The examples below demonstrate the use of the commands “lookfor” and “lookfor_all” to search for variables:

Find all occurrences of the word “socio” in variable names and labels

```
lookfor socio
```

Find all occurrences of the word “economic” in variable names and labels

```
lookfor economic
```

Find all occurrences of education or married in variable names and labels

```
lookfor education married
```

Typing `lookfor_all “XXXXXX”` will find for all occurrences of “XXXXX” where XXXX is a word that could be name (or part of the name) of the variable and/or a word (or part of a word) in the variable label or value.

Remember, if you don’t have any of these commands installed in your version of Stata, while connected to internet, you can always type “`findit lookfor`” or “`findit lookfor_all`” and follow on the screen instruction.