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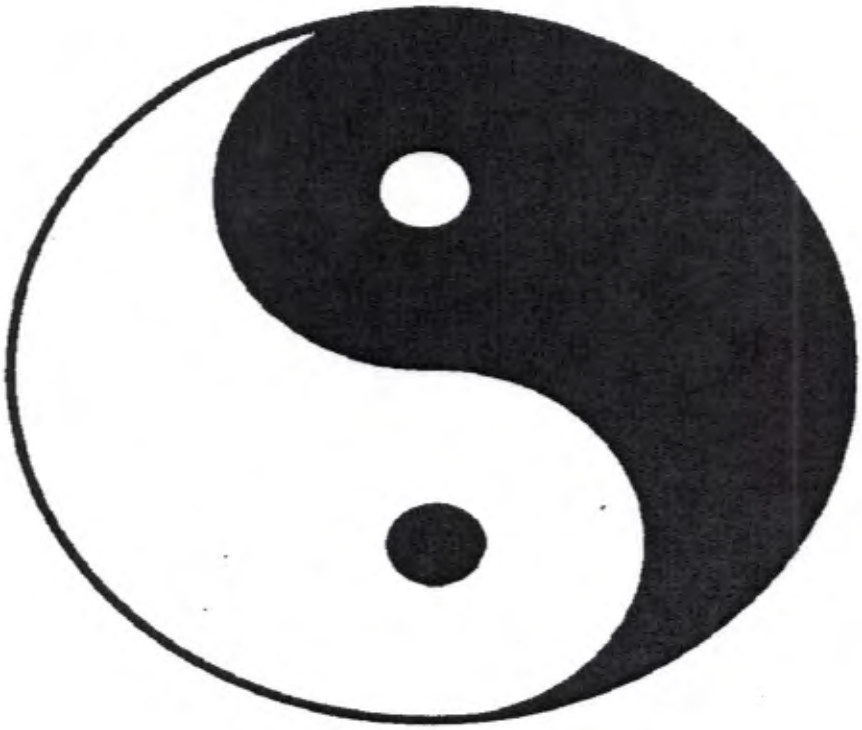
# Traditional Chinese Medicine and Infectious Disease



A Clendening Fellowship Proposal

Charles Coffey

SOM 2011

February 19, 2008

**Introduction**

When one hears the phrase "Traditional Chinese Medicine," the immediate thoughts that come to mind are acupuncture, herbal medicine, and massages. Growing up in Kansas, I was exposed almost exclusively to allopathic medicine and never gave alternative medicines, like Traditional Chinese Medicine (TCM), much thought. The closest my family came to using alternative medicine in my house was a "hot toddy" given to me by my grandmother when I had a cold. I knew about blood tests, X-rays and surgery, and I really believed that these were the sole tenets of medicine upon which the whole world built its healing practices. It was not until I had some personal experiences with alternative medicine that I even began to consider its merits.

In the summer of 2007, I traveled to China to visit a friend and have some fun before entering medical school. Before I left, I had all of my immunizations and obtained all of the necessary prescriptions to prevent any kind of impending illness, from Japanese Encephalitis to altitude sickness. Soon after my arrival in China, I noticed shops that carried an extensive array of strange roots and leaves. When I inquired about these peculiar stores, I was told they were pharmacies for TCM. I thought this was interesting but did not take it very seriously. I continued on with my vacation and decided to travel by train from Shanghai, China to Lhasa, Tibet. On the train, I was offered a root that supposedly took care of altitude sickness. My friend and I decided to buy some but not take it unless we felt ill. Twelve hours later, my friend started getting light-headed and nauseous. She took the medicine and somewhat to our surprise, two hours after taking the mystery root, she felt fine. After two similar experiences with herbal medicine while in Vietnam, I began to develop a keen interest in alternative medicine and began to consider it a legitimate way to heal.

**Background**

With a two to five thousand year history, Traditional Chinese Medicine (TCM) approaches illness from a very different point of view than Western Medicine. To understand the fundamentals of TCM, one must appreciate three main concepts. First, all beings are interconnected with nature and are affected by the changes that occur in the natural world. Second, in order to be in harmony with the world around you and with yourself, one must strive to maintain balance. This is illustrated by the theory of the Yin and Yang; there are two sides to every force and harmony between these two forces is what one attempts to achieve. Finally, the interconnectedness with nature and struggle for balance is manifested in the human body and illustrated most specifically by the Zang-Fu Theory of the organ networks of the body. The Zang-Fu Theory is based on the notion that the traditional organs of the Western World are actually manifested throughout various points within the body instead of one specific location (1).

Chinese Medicine includes the concepts of medicine, spirituality, and philosophy. Humans are part of and intimately connected with nature. Just as the seasons change throughout the year, so too does the health and well-being of human beings. Tradition holds that there are five main elements in nature, and each of these elements' existence is dependent upon the others. The elements of Wood, Fire, Earth, Metal, and Water are the primordial powers that shaped the world, and are intrinsically linked to each organ system in the body. To understand TCM, one must understand the connection between each of these elements. The relationships are established in a natural order, and each element is dependent on all of the other elements, such that a complete interdependence is achieved. Wood is required to make Fire; when the Fire goes out, Earth remains. After sufficient time, Earth will transform into Metal. Then, under the right conditions, Metal will liquefy (Water). Finally, you must have Water in order to get the Wood to grow, which restarts the cycle. Furthermore, each of the five elements has an

energetic association with an organ system. For example, Water is energetically associated with the "Will" and is said to reside in the Kidneys. Thus, the entire universe strives to keep these different elements in balance with one another, and, in turn, maintains harmony within the body (2).

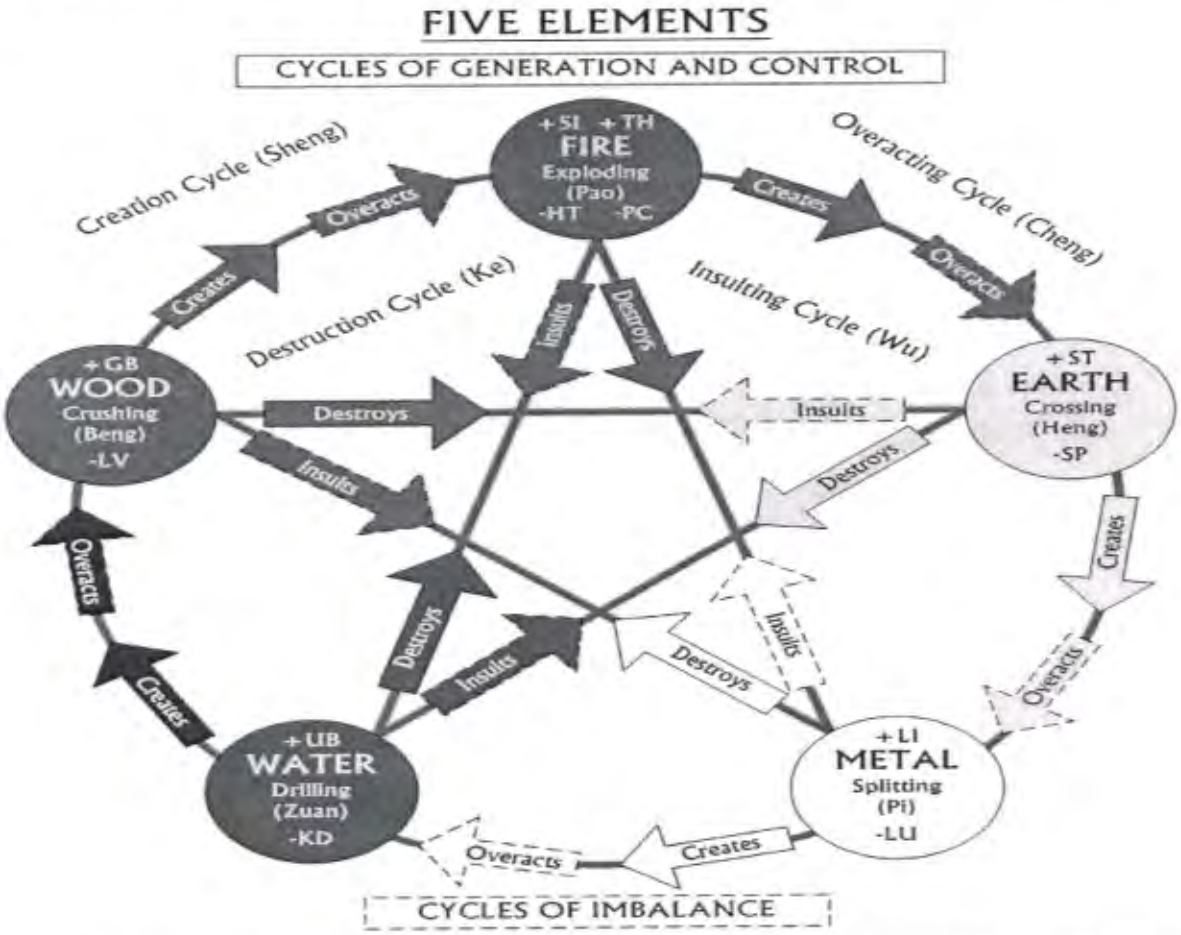
Long before Sir Isaac Newton's Law of Reciprocal Actions, that for every action there is an equal and opposite reaction, the theory of the Yin and the Yang were well ingrained in Chinese culture. The dual concept of yin-yang describes the opposing but complimentary forces said to exist in all non-static objects and represent all opposite principles one finds in the universe. The yin, which is feminine and corresponds to the night, is the dark element and represents weakness, cold, and negativity. The yang, which is masculine and corresponds to daylight, is the light element and represents strength, heat, and positivity. The goal is not to posses all of the characteristic yin or all of yang, but rather to balance these complimentary forces. The familiar black and white yin-yang symbol shows that complete balance is never possible due to the curved line running through the symbol. Hence, there is no way to cut the symbol as to have equal amounts of yin and yang, dark and light, or strength and weakness. As one side grows larger, the other grows smaller. Furthermore, the yin-yang theory applies not only to the health and well being of each person, but also to the specific organ systems of the body. For example, the heat emanating from one yang organ must be counterbalanced with the cooling properties of a yin organ. When this equilibrium is skewed, illness manifests (3).

Likewise, the Zang-Fu theory relates back to the interconnectedness with nature and the balance of the yin and yang. Each organ system corresponds to one of the primary elements and is further divided into Zang organs, which represent the yin, and Fu organs, which represent the yang. The table below divides the organs into their respective groups with associated energies (4).

| Element | Associated Energy | Zang Organs (yin) | Fu Organs (yang) |
|---|---|---|---|
| Wood | Ethereal Soul | Liver | Gall Bladder |
| Fire | Aggregate Soul | Heart | Small Intestine |
| Earth | Intellect | Spleen | Stomach |
| Metal | Corporeal Soul | Lungs | Large Intestine |
| Water | Will | Kidneys | Bladder |

The organ names listed are not necessarily the anatomical organ with which we are familiar, but rather concepts of those organs. For example, Kidneys (capitalized to differentiate between the organ and the concept) store the Will or Essence of a person and are the root of everything. They govern water balance, reproduction, metabolism, some brain function, and are responsible for growth and development. The Kidneys are in charge of the bones and bone marrow and also manufacture blood. Moreover, the health of the Kidneys is revealed by the hair on the head (4). At first glance, this representation of the Kidney may seem like a rudimentary or even inaccurate understanding of the renal system. Upon closer inspection, however, one can see that many of these concepts are indeed accurate. Erythropoietin is a hormone produced by the kidneys that stimulates red blood cell production in the bone marrow. When blood calcium levels are low, the brain releases parathyroid hormone, which causes the kidneys to absorb more calcium which is critical for bone maintenance. This shows the amazing insights that have been developed over the years without the luxuries of modern technology. All of these theories were established well before blood tests or microscopes were ever developed.

In order to treat any type of imbalance within or between organ systems, practitioners of Chinese Medicine must diagnose the patient correctly and be aware of how each organ affects another. In Western Medicine, if an organ is functioning properly, it is said to be working at 100%, and below that mark there may be some sort of dysfunction. In Chinese Medicine, dysfunctions are diagnosed by an imbalance in that organ system (too much Yin or too much Yang) or the organ systems that are directly related to the system in question. Staying with the previous example of the Kidneys, if there is a Kidney dysfunction, one must look at the Kidneys (Water), but also the Lungs (Metal), Heart (Fire) and Spleen (Earth). If the Heart and Spleen are too strong, then the Kidneys will suffer. Treatment can be improving the function of the Kidneys and/or Lungs, or it can be through suppressing the Heart or Spleen. This TCM physiology is a complex discipline that takes years to fully appreciate and understand. Included is a diagram provided by Dr. XiaoMing Zhang that attempts to put this physiology into a simple scheme showing the interdependence of all of the organ systems.




Where Western Medicine may view an illness as single organ dysfunction, TCM would view that illness as an imbalance between the different systems. The use of herbal medicine, acupuncture, massage, and meditation are incorporated into treatment plans and target not only the organ system that is out of balance and associated systems, but also the patient's relationship with his or her surroundings. This emphasis on the interdependence of organs systems which recognizes the needs of the whole (patient), makes Traditional Chinese Medicine unique among the healing arts of the world.

As a medical student, I have seen first-hand that Western medicine is sometimes too focused on the specific illness at hand and physicians can lose sight of the person they are treating. I have also begun to appreciate the interconnectedness of the human body, where pathology of one organ system can have a profound effect on a patient's overall health. The World Health Organization (WHO) defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity." Physicians must take every facet of a patient's well-being into account and not just attempt to eradicate the pathology of the day. Combining Western medicine's use of scientific data and pathology specific therapy with TCM's holistic and individualistic approach to a patient's overall health status will have synergistic results. The FDA recently approved a phase II clinical trial to test the efficacy of a Kanglaite, which was isolated from a Chinese herbal remedy, as an anti-cancer drug (5).

**Plan**

I have devised a three part plan to approach such a complex field as Traditional Chinese Medicine (TCM). First, Dr. XiaoMing Zhang, a professor from the Department of Anatomy and Cell Biology at KUMC has offered to be my advisor for this project. Dr. Zhang earned an MD from Capital University of Medicine in Beijing, a PhD from the University of Kansas School of Medicine, and has extensive knowledge related to the theory and practice of both TCM and Western Medicine. I will draw from this wealth of knowledge to build a foundation of understanding for TCM. Second, I have arranged to take courses at the ZheJiang College of Traditional Chinese Medicine (ZJCTCM) in Hangzhou, China. These courses are designed to teach students basic theory of TCM, "herbology", diagnostic techniques, and treatment courses. Finally, I have been in contact with Dr. Greg Livingston, a Chinese Medicine physician who lives and practices in Hangzhou, China. I plan to observe Dr. Livingston in his clinical setting in order to gain first-hand experience in the practice of TCM.

While I have already researched the fundamentals of Traditional Chinese Medicine, much more research will be done prior to my departure. I plan on reading and studying about TCM and other forms of alternative medicine as to be better prepared when my classes begin. I have also arranged to work with Dr. XiaoMing Zhang, a professor at KUMC. Dr. Zhang has extensive knowledge about the practices of TCM and has agreed to not only let me interview him, but also agreed tutor me on some of the tenets of TCM. I hope to use his expertise to better understand the fundamental practices and medical procedures utilized in TCM.

Working in a foreign country can be a daunting task, especially when one considers the language barriers, the difficulty of establishing contacts, and actually carrying out the work one hopes to accomplish. I believe that my project will be a success and that I am in a unique position to do well, as I am familiar with the language and customs of China and the city where I will do my work. I plan on traveling to Hangzhou, China and doing the bulk of my work throughout the city in universities, hospitals, and private clinics. Hangzhou is in southern China and is two hours west of Shanghai. I lived in Hangzhou for almost two months last year and became familiar with the city and also have a basic knowledge of the Mandarin language that will offer a substantial amount of freedom getting around Hangzhou.

My professional contacts in Hangzhou are Allan Jiang and Dr. Greg Livingston. Allan Jiang is the Foreign Affairs Officer in the International Education College at the Zhejiang College of Traditional Chinese Medicine (ZJCTCM). ZJCTCM is one of the leading institutions that teaches in TCM. It was established in 1959, has 9 affiliated hospitals, 5 affiliated outpatient clinics and 20 teaching/practicing hospitals (6). I will be taking 5-6 weeks of class in herbal medicine including: herbal medicine and the immune system, general internal medicine, and common disease of the ear nose and throat. These

courses are designed to be an intensive introduction into specialized herbal medicine. Dr. Livingston is licensed to practice Chinese Medicine Physician in both the USA and China, was born in San Francisco and now lives in Hangzhou with his wife and kids. I met Dr. Livingston through a mutual friend and since then I have been discussing with him how I can most efficiently study TCM in the amount of time that I have in Hangzhou. Time and schedules permitting, I will observe Dr. Livingston working in his clinic. Spending time with a practicing Chinese Medicine physician will provide real world experience that one cannot obtain from classroom work alone. The fact that Dr. Livingston speaks English and Mandarin will make my research more efficient as I will not need a translator. The specific days I will be in the clinic or at the university are not set but below is my tentative plan.

- Taking class at the university: 5 days per week (May 26-July 14)
  - Three hours of class/lecture every morning
  - Three hours of clinic every afternoon
    - Week 1: Basic Theory of Chinese Medicine
    - Week 2: Pulse and Tongue Diagnosis
    - Week 3: Chinese Herbal Medicine
    - Week 4: Herbal Medicine for Internal Medicine
    - Week 5: Herbal Medicine for Infectious Disease
    - Week 6: Herbal Medicine for Disease of the Ear, Nose and Throat
- Studying and researching independently: evenings (May 26-July 14)
- Interviewing friends and acquaintances: as available (May 26-July 14)
- Working with Dr. Livingston at his clinics: TBD (May 26-July 14)

Having watched some of the Clendening presentations, I realize that plans can take a turn for the worse. I have dozens of personal contacts in Hangzhou and Shanghai that I can call upon if any part of my plan falls through. While I am not anticipating any problems, I know that it is always best to be prepared.

**Goals/Methods**

While the main goal of this project is to better understand the basic tenets of TCM, I am fully aware that two months of research is not a sufficient amount of time to fully grasp the breadth and depth of the practices of TCM. Instead, I have three main ideas I would like to explore and gain some first-hand experience with.

As a first year medical student I am just beginning to determine what kind of physician I would like to become. I do understand that I have plenty of time to make that decision but the specialty of infectious disease has recently piqued my interest. TCM treats the body as a whole, but I want learn more about the manner in which infectious pathogens are addressed. Influenza, Rhinovirus and a host of other common illnesses are as prevalent in China as they are in the USA (7). The courses I am taking at ZJCTCM will introduce me to the basic herbs and roots used to treat common illnesses and will prepare me for spending time in the clinic with Dr. Livingston. I will then observe Dr. Livingston treat these types of illnesses to understand how infectious diseases are handled by TCM. While shadowing Dr. Livingston, I hope to gain a better appreciation of the diagnostic methods of TCM and specific treatments of common illness caused by infectious agents (i.e. the common cold or strep throat).

Related to gaining a better understanding of the role of TCM in treatment of infectious diseases, I hope to learn more about the herbal medicines and medical procedures unique to TCM. The topics of the courses I will take at the university are designed to teach beginners the basic theory and practice of

TCM and herbal medicine. I have enrolled in an introductory course in Traditional Chinese Medicine and Chinese Herbal Medicine, as well as three specialty herbal medicine courses and a diagnosis of disease course. The introductory courses are designed as orientation courses for students that do not have previous experience with TCM. Instructors will review the fundamentals of TCM and Chinese Herbal Medicine in a classroom setting. The herbal medicine courses are clinically based and organized into different specialties. The herbal medicine courses I have chosen, General Internal Medicine, Infectious Disease, and Disease of the Ear, Nose, and Throat, will give me maximum exposure to the diagnosis and treatment of infectious diseases. Practitioners of TCM believe that it is possible to diagnosis illness based on characteristics of the patient's pulse and tongue. The last course I have enrolled in teaches students how to practice this art. I hope to incorporate the knowledge I gain into the clinical practice with Dr. Livingston. I also plan on visiting the Museum of Traditional Chinese Medicine in Hangzhou which is not only a museum but an active pharmacy/TCM clinic. My goal is to interview the practicing pharmacists and make an effort to learn more about how they treat illnesses. Finally, to better understand medical procedures used in TCM, I will call upon the expertise of Dr. Zhang. Under his guidance, I hope to gain a better understanding of medical procedures that are utilized by practitioners of TCM (8).

As China continues to modernize and the exposure to Western Medicine grows, a potential medical conflict looms. How do you incorporate more traditional aspects of Chinese medicine with the ever-evolving practice of Western Medicine? People who have access to both types of medicine are in a unique position and, as such, get to choose which they prefer. Thus, I would like to ascertain what motivates a person to choose one type of medicine over the other. Is it based on the illness a patient has, the severity, the efficacy of treatment, or just personal preference? I hope to also discover what specific demographics are more likely to utilize TCM over Western Medicine and why. Are Chinese citizens with an advanced education more likely to use TCM? How about rural versus urban populations? To achieve these goals, I intend to interview students and faculty at the college as well as interview some of my friends who live in the city.

Living in China will also afford me the opportunity to work on my language skills. While I was living in China last summer, I was able to learn the fundamentals of the language, which was fortunately enough to get by. I was able to communicate with merchants, cab drivers, and waiters/waitresses but was not proficient enough to maintain actual conversations. During this Clendening, however, I will be immersed in the language and hope to improve my proficiency in Mandarin. I am also excited to learn more about Chinese culture and hope to do some traveling in the country during my free time. Finally, I hope to use this experience to educate myself and my peers about using alternative medicine. An increasing number of people are turning to alternative medicine and as a future health care provider, it is my duty to understand the resources available to my patients (9).

**Logistics/Budget**

I plan on flying from Kansas City to Shanghai during the last week of May. Upon arrival in Shanghai, I will stay the night with a friend and take the train from Shanghai to Hangzhou. A working/living space has been provided by one of my friends in Hangzhou. She has graciously agreed to let me stay in her extra room for the summer for a minimal fee. Also, I plan to purchase a bicycle upon arrival so I have my own mode of transportation. In addition, I will take taxis or ride my bike to the university and clinics each day.

Roundtrip airfare from MCI to SHA (Air Canada).....$1500.00

Roundtrip train fare from SHA to HZ.....$30.00

Tuition ($160/class x 6 classes).....$960.00

Room and Board.....$250.00

Visa Service and Chinese Visa.....$200.00

Incidentals and Leisure Travel.....$500.00

Bicycle.....$25.00

**TOTAL.....$3465.00**

I am aware that the Clendening Fellowship is not enough to cover all of my expenses. Therefore, I will take full responsibility in raising the necessary extra funds, and my family has offered to help cover the difference.

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Hangzhou International School

**Timothy O'Shaughnessy (personal contact)**
Sentry International
Director of Asia Operations, Shanghai

# Health Care Access for Hispanic Immigrant Residents of Cameron Park, TX

A Clendening Summer Fellowship Proposal

By

Stephen Hinkin
KUMC School of Medicine
Class of 2011

February 18, 2008

## BACKGROUND

I pull up to the house of a local resident with Sister Phylis Peters, a member of the Daughters of Charity order of Catholicism. Sister Phylis has been serving in healthcare as a nurse for over 30 years, and for six in the neighborhood (known locally as a "*colonia*") of Cameron Park. She makes house calls regularly to see the residents and today we are visiting a man who fell from a ladder during work and no longer has use of his legs. Sister Phylis provides him with basic physical therapy (stretching, strengthening, etc.) and checks up on his general health. During this visit, she also inspects the wheelchair he uses, which, while grossly inadequate, is all he can afford. Next, we visit a man who has been dealing with debilitating abdominal pain for quite some time. He has been taking medication, which will soon run out, and he also needs further medical testing for a definitive diagnosis of his condition. Like so many of their Cameron Park neighbors and peers, neither of these men speak English and neither carries health insurance. And, like so many people living in America, today, they must place their healthcare hopes in the efforts of so few, like Sister Phylis, trying to do so much.

Cameron Park is a *colonia* comprised mostly of Mexican immigrants. Located less than 15 miles from the Texas-Mexico border, it is an ideal location for families making the transition from Mexico to America, as it has been for many decades. The stories of these two men are not atypical for residents of the *colonia*. The average income in Cameron Park is $16,000, compared to $33,000 for the rest of Texas according to the US Census Bureau.[1] Furthermore, the Bureau estimates that nearly 57% of Mexican immigrants do not have health insurance, regardless of immigration status.[1] Regarding this issue, since many of the residents of the *colonia* are not citizens of the United States, they are unable to access government health programs such as Medicaid. So, what healthcare options exist for these people? Currently, two organizations are present that provide care to the uninsured of Cameron Park: Proyecto Juan Diego (PJD), located in Cameron Park, proper, and the Brownsville Community Health Center, located in the neighboring city of Brownsville.

Last summer I had the opportunity to travel to Cameron Park and lead sessions of a summer camp for primary and middle school children. The camp was held daily at the local Catholic Church, Iglesía de San Felipe de Jesus. The classes were only taught in the morning leaving my afternoons free, and I spent most of them playing soccer and cards with the boys from camp. However, one afternoon I was given the opportunity to make medical house calls to residents with Sister Phylis. Fleeting though it was, that afternoon has stayed with me and still continues to resonate. My experience

that afternoon, and in Cameron Park in general, have since become the inspiration for this project. Afterward, I realized that it was possible to provide care to those without means to pay, either through insurance or personal finances. Furthermore, I found that the practice of medicine need not be confined to clinics or hospitals, that health care personnel have a duty to provide care to all people in all settings, and it is possible to provide care to those who cannot afford the regular clinic visits to which I am so accustomed. These values are evident in the everyday work of PJD and BCHC and I would like to return to Cameron Park in order to further investigate the contributions of these organizations to the care of the immigrant residents of the *colonia.*

There is a harmony in the work that PJD & BCHC perform. BCHC that tends to patient healthcare needs, within a standard clinic setting. It is overseen by the Texas Association of Community Health Care Centers, a non-profit coalition of safety net clinics located throughout the state of Texas. BCHC has been serving the community of Brownsville since 1956 and provides a wide range of medical services such as women's health, pediatrics, adult medicine, pharmacy, laboratory and social services.[4] An astounding 82% of the patients seen at this clinic carry no insurance.[2] PJD, meanwhile, is a non-profit, faith based organization run by Sister Phylis focusing on the lives of patients, themselves, outside the clinic. PJD is an organization invested in educating the residents of the *colonia* about a variety of health care issues. Its employees and volunteers teach the residents about the benefits of preventative medicine and further educate patients about specific illnesses that may be affecting them. PJD also assists residents who are covered by Medicare with issues related to prescription drug coverage.[3] Together, these two organizations work tirelessly to help the Cameron Park community both receive the healthcare they need, currently, and learn how to better manage their personal health lives, for the future.

**PLAN**

I would like to return to Cameron Park and further investigate the work of PJD and of BCHC. I plan to spend 2 weeks with each organization during the month of June. During my service time with these organizations I want to investigate the ways in which they provide care to the residents of the *colonia* and how the social environment effects that care. I plan to accomplish this through interactions with physicians, employees, local community officals and patients along with my own observations. At PJD I will observe and participate in the preparation of health care education initiatives and make house-calls with Sr. Phylis. At BCHC I will interview physicians and other health care personnel on the front

lines of primary, indigent care. I would like to experience the challenges they face, daily, and see how they tailor their standards of care according to the native traditions and beliefs held by their patients. At both locations I will speak with financial and advocacy personnel concerning the various financial and political challenges that are intimately tied to providing care to this indigent population of both recent and more *native* residents.

Furthermore, I hope to meet with Brownsville city officials and other community leaders to discuss the ways in which local legislation provides assistance to programs such as PJD and BCHC. I also plan to discuss health care access with residents, themselves, in an informal manner. Specifically, I hope to start a dialogue with these people about their thoughts and experiences as legal or illegal immigrants trying to provide for themselves and their families. At the end of my time in Brownsville and Cameron Park I hope to have the information to answer the following questions:

1. How does citizenship affect the type of care each organization provides? Specifically, what different recommendations can be made to those who are documented as opposed to those who are not?
2. What are the issues that make providing health care to an immigrant population a struggle, i.e. funding, adequate staff, access to supplies etc?
3. In today's political climate, how are current views and current legislative efforts to change how America handles Immigration, both legal and legal, affecting these people? How is it affecting their daily lives, their families and, most importantly, their healthcare?

While at PJD, I will work under the guidance Sister Phylis. I made her acquaintance and had the honor of working with her during my visit to Brownsville last summer. Sister Phylis has been working in the health care industry for over 30 years both at home in the U.S. and abroad, in Ethiopia, as a medical surgery nurse and administrator. She has served in the Brownsville and Cameron Park communities for 6 years. While at BCHC I will work under the guidance of Dr. Marsha Griffin, a pediatrician who has also been serving in the Brownsville community for several years. I met Dr. Griffin through the priest of San Felipe Church, Fr. Michael Seifert. While I have yet to work with her as I have with Sister Phylis, Dr. Griffin and I have been in contact via email concerning this project and she is very enthusiastic about my possible visit.

**GOALS**

I would like the opportunity to complete this project for several reasons. First, in our current political climate the issue of health care for illegal & legal immigrants remains a hot button topic for many Americans and is likely to remain so for quite some time. Traveling to Cameron Park will give me first-hand knowledge of the struggles the immigrants themselves face, as well as those of the entities providing care. This experience will be incredibly valuable in my future practice as it would allow me the requisite knowledge to, in at least a small way, better understand and aid in the plight of patients who are not just struggling immigrants in a new country, but struggling, in any context, to receive adequate healthcare and provide the same for their loved ones. Through this experience, I would also aim to educate others on this important issue. Though we do not live in a border town like Cameron Park, Kansas City still faces the same challenges of providing healthcare to those in need. We need look no further than our very own JayDoc Clinic as evidence of this. Second, I believe the contributions of organizations such as these two often go unrecognized outside of the communities which they serve. Bringing their stories to KUMC would provide them with exposure and potentially provide the basis for an ongoing relationship between these organizations and students of KUMC. Third, the project affords an opportunity to sharpen my Spanish skills in a health care environment. In my future practice, I hope to provide services to both English & Spanish-speaking patients. To that end, I began taking Spanish last year while completing prerequisite courses for medical school and I am currently enrolled in the Intermediate Medical Spanish class at KUMC provided by Aura Morgan.

**BUDGET**

| | |
|---|---|
| Airfare (Roundtrip) | $ 300.00 |
| Car rental (1 month) | $ 900.00 |
| Food | $ 250.00 |
| Misc. | $ 250.00 |

- Gas for rental car ($100)
- Gift to Father Mike for lodging ($50)
- Gifts for Sister Phylis and Dr. Griffin ($100)

| | |
|---|---|
| **Total Expenses** | **$ 1,700.00** |

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Dr. Marsha Griffin, MD
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2137 E. 22nd St.
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Father Michael Seifert, SM –Lodging provider
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Simon Patton

# HEALTH CARE ISSUES IN THE HOMELESS POPULATION

## A STUDY ON THE FRONT LINES AND BEHIND THE SCENES

**SUBMITTED TO:**
**Dr. Martha Montello, PhD.**
**19 February 2008**

**INTRODUCTION and MOTIVATION**

I had the opportunity to spend last year working in San Juan, Puerto Rico, where the weather is always sunny and the temperature hovers around eighty three degrees every day. It sounds like an ideal life (especially in Kansas city during February), and for me it was. I was working with a population, however, that, despite the sunshine and warm weather, lived an extremely hard life because they were homeless. I worked in a shower facility that offered the very basics to the participants; a shower, a change of clothes, a small snack, and, most importantly, a place where they felt welcomed and respected. One service that was greatly lacking, however, was tending to their medical necessities. Although we had a doctor come every Friday, we were hardly able to fill the immense need in our small and under stocked "clinic".

This experience not only showed me the very real health disparities that the homeless experience, but also cemented in me a desire to do my best to help them as a doctor. I believe that as a member of the medical community I will have an opportunity and a duty to help in a unique way. As is written in the American Medical Association code of ethics, "Each physician has an obligation to share in providing care for the indigent."[1]

Doctors do play an integral role in lessening the health care gap, but they are only part of a large network of outreaches and community members working to improve the condition of the homeless. I was able to witness this first hand last year as I attended meetings of the *Coalición Apoyo Continuo a Personas Sin Hogar* (the Coalition of Continued Support for the Homeless) in San Juan. The members of this coalition organized various health fairs, conducted screening tests , and collected statistical data; work that also had a very real impact on the health of the participants.

Motivated by both my time working in direct service to the homeless and my experience with the coalition, I am proposing to use a Clendening Summer Fellowship to explore more fully the health disparities faced by the poor and homeless in Washington DC. By working in the So Others Might Eat (SOME) outreach, I will have the opportunity to see firsthand the illnesses and the barriers to health care that they experience, and by working with the National Coalition for the Homeless (NCH) I can witness the efforts that are being made to help them through advocacy and policy change.

**BACKGROUND**

Homelessness is a problem throughout the country, estimated to affect around 842,000 adults and children in any given week.[2] In Washington DC, more than 16,000 people are homeless during the course of a year, one of the highest rates in the country.[3] These individuals face a wide array of problems that both cause and stem from their condition of being homeless. In researching this project, all of the evidence I found corroborated what experience showed me regarding these problems: that addiction, mental health troubles, lack of insurance, and the effects of the hard life on the street are the main causes of health related issues in the homeless community.

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[1] American Medical Association: Medical Ethics. http://www.ama-assn.org/ama/pub/category/8538.html Accessed February 2008.

[2] Substance Abuse and Mental Health Services Administration. http://mentalhealth.samhsa.gov/publications/allpubs/homelessness/ Accessed February 2008.

[3] The Washington Legal Clinic For the Homeless. http://www.legalclinic.org/about/facts.html Accessed February 2008.

Addiction was probably the most devastating to witness, as it had complete control over the addict, causing them to disregard every aspect of their lives except their next high. A 2006 study by the United States Conference of Mayors estimated that more than 26% of the homeless population was struggling with a substance abuse problem.[4] Smoking is a particularly bad problem, as more that 75% of the homeless smoke, are more likely to start smoking earlier, smoke more frequently, and are less likely to quit.[5] The problem with various addictions is often a stumbling block for many of the people trying to end the cycle of chronic homelessness.

Along with addiction problems, many of the homeless also have mental health issues. In fact, an estimated 39% suffer from some form of mental illness. As one researcher pointed out, "[the] inferior mental health status among the chronically homeless reflects the combined impact of multiple factors we often overlook, such as chronic or acute medical problems as well as inferior social support from family and friends."[6] His comments underscore the truth about all problems the homeless face; that they are not isolated, but instead involve the interplay of many factors.

One of these factors is access to health insurance, which many of the homeless do not have. This problem is compounded by the fact that the rates for both acute and chronic diseases are much higher in the homeless population.[7] As one can imagine, any disease that requires extended treatment or regular, continued care, such as diabetes, tuberculosis, HIV/AIDS, or cardiovascular disease, is extremely difficult to treat in this population. Lack of insurance can also be the *cause* of homelessness, as an estimated 15% of the total population is uninsured, and one severe illness can cause "a downward spiral into homelessness, beginning with a lost job, depletion of savings to pay for care, and eventual eviction."[8]

Just a brief glimpse into the facts and statistics behind the health care issues reveals a glaring disparity between the homeless population and those with adequate access to treatment. The prevalence of addiction, mental health issues, and lack of insurance is exacerbated by the hard life of living without a roof.

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[4] National Coalition for the Homeless. http://www.nationalhomeless.org/publications/facts/addiction.pdf. Fact Sheet on Addiction. Accessed February 2008

[5] "Smoking Cessation Delivered by Medical Students is Helpful to Homeless Population" http://ap.psychiatryonline.org/cgi/reprint/31/5/402.pdf Accessed on February 2008.

[6] "Poor Mental Health Among Homeless People Reflects Multiple Factors Beyond Addiction". http://main.uab.edu/show.asp?durki=80168 Accessed February 2008.

[7] National Alliance to End Homelessness http://www.endhomelessness.org/section/policy/focusareas/health. Accessed February 2008.

[8] National Coalition for the Homeless. http://www.nationalhomeless.org/publications/facts/Health.pdf Fact Sheet on Health Care. Accessed February 2008.

**PROJECT DESCRIPTION and GOALS**

My goal if I were to receive a Clendening Scholarship is to examine the health care issues that the homeless face by working with two organizations, the National Coalition for the Homeless (NCH) and the So Others Might Eat (SOME) outreach clinic. I propose working on Tuesdays and Thursdays at the NCH as a Health Care Intern, where my main duties will include researching the causes and numbers of homeless deaths throughout the country as well as researching and promoting smoking cessation programs in local shelters. My job will be to prepare a fact sheet about the research, conduct surveys about smoking cessation in the shelters, write legislative announcements for the NCH website about health care issues that affect the homeless or impoverished, and work with others to write sample legislature to be distributed to homeless advocates around the United States. I think this internship would be a wonderful way to learn the facts about the hardships that are faced by the homeless population, as well as an opportunity to experience the work that goes on "behind the scenes" for them to advocate changes in the health care arena.

I would spend the remaining days (Monday, Wednesday, and Friday) working at the SOME clinic, where my main duty would be helping the patients with the referral process as they seek help in programs or specialty care. I would also have a chance to do some work with taking vitals, as well as shadowing Dr. Maurice Wright, an internist who works at the clinic. SOME is a primary care clinic that provides service to the homeless and indigent in the Washington DC area. They see a wide variety of illnesses, including hypertension, diabetes, Hepatitis A and B, mental illnesses, and addiction. I think that work in the clinic will be a perfect opportunity to see firsthand the very real health issues that the homeless face. Washington, DC will provide a unique study in regards to the health insurance problem, as it is one of the only places in the country that has a program in place for people who do not have access to insurance, known as the Chartered Health Plan.[9] I think that working with the referral process will show me what resources are available to the participants through this program, as well as the barriers that they might face.

I know that logistics are important for this proposal, and I would like to say a few words about my planning for this project. I have spoken personally with both Mr. Michael Stoops, the Acting Director for NCH and Ms. Chloe Gross RN, Clinic Coordinator of SOME. In those phone calls we discussed my duties (which were then repeated in subsequent emails, included below) as well as transportation and lodging. Each organization is located right off the Metro system that runs through Washington, DC; the NCH is four blocks from the DuPont Circle stop on the red line, and SOME is a half mile from the New York Avenue stop. As far as housing is concerned, they both recommended using Craig's List, as interns in the past have had good results finding housing for the summertime.

I have included below a timeline and budget, as well as copies of the emails regarding my duties at the two organizations. Thank you very much for the opportunity to apply for this scholarship, it is my hope I can use it this summer to further my knowledge of the health care issues faced by the homeless population.

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[9] DC Health Care Alliance, Chartered Health Plan website http://www.chartered-health.com/dcha/1Alliance.htm Accessed February 2008.

**TIMELINE**

3/10-3/14 (Spring Break): Meet with Chloe Gross, RN (SOME) and Michael Stoops (NCH) to familiarize myself with the clinic, the office, and the metro system (I am planning on going to Washington, DC for the break anyway)
4/1-4/30: Continue checking Craig's list and finalize housing plans
5/28: Fly to Washington, DC from Kansas City
6/2: Begin work at SOME clinic
6/2-7/23: Work M,W,F at SOME, and T,H at NCH
7/23-7/25: Begin write-up of summer project
Return to Kansas City in time to begin second year

**BUDGET**

Flight.....~$201 (roundtrip leaving May 28th and returning July 28th according to Travelocity.com)
Meals ($70/week buying groceries).....$560
Metro Pass ($26/week x8wks).....$208 http://www.wmata.com/riding/passes.cfm
Rent (according to Craig's List) ~$500/month.....$1,000

Total: $1,969

(I realize the estimations for flight and rent might go up, any expense not covered by the scholarship will come out of my pocket)

**CONTACTS**

Michael Stoops
Acting Executive Director
National Coalition for the Homeless
2201 P St NW
Washington, DC 20037
NCH website: http://nationalhomeless.org/

Chloe Gross, RN
Clinical Coordinator
So Others Might Eat
71 "O" Street, NW
Washington, DC 20001
Web: www.some.org

Novell WebAccess

## Mail Message

N

Reply Read Later

Mail Properties

**From:** "Michael Stoops" Tuesday - February 12, 2008 4:56 PM

**Subject:** summer '08 internship with the National Coalition for the Homeless
**Attachments:** Mime.822 (11738 bytes) [View] [Save As]

Dear Simon Patton:
I am writing regarding our recent phone conversation about what a Health Care Internship would entail at the National Coalition for the Homeless this summer in Washington, DC. You will be working on two main issues, legislation requiring medical examiners to report both numbers and causes of homeless deaths, and reduction of tobacco use in the homeless population. Your specific duties will include researching the issue of homeless deaths, writing sample legislation that can be distributed to our grassroots advocates, conducting surveys of local shelters regarding smoking cessation programs and interest in said programs, and writing legislative alerts for our website and newsletter regarding health care policies that affect either the homeless or the impoverished.
I understand you will be working with us two days out of the week from early June through July, and as we discussed, Mondays and Fridays are usually slower, but any days you choose to come in will be fine. I look forward to working with you this summer, please let me know if I can be of any assistance.
Sincerely,
Michael Stoops
Acting Executive Director
National Coalition for the Homeless

----------Forwarded message ----------
From: Chloe Ann Gross
Date: Wed, Feb 13, 2008 at 6:21 AM
Subject RE: Summer Project

Simon,

Please forward this to the doctor in charge of the program. Please let her know that she can contact me or Dr Maurice Wright and we can give her more details (Dr. Wright is cc'd in this email). My phone number is 202-797-8806 X1065 We really hope that this works out. We would be very happy to have you here this summer.

SOME Medical Clinic is an urban clinic in Washington DC serving the homeless and indigent in the area. We have one full time MD, 3 part time psychiatrists, 4 full time nurses and 2 part time nurses. We are a primary care clinic serving the medically vulnerable population We see patients with hypertension, diabetes, HIV hepatitis B and C, drug addiciton (a treatment program is also available through SOME), mental illness and a variety of other ailments. Washington DC is one of the few states that has an insurance program for people who would otherwise be uninsured so we are lucky that many of our patients are able to get the specialty care that they need. However, the referral process is quite labor intense and we would like to have Simon Patton help us with that over the summer. In order for our patients to get the treatment that they need, a lot of advocacy is required Mr Patton would also help us with vital signs and EKG's. Mr. Patton would also be able to spend some time shadowing the internist, Dr. Wright. We very much hope that Mr. Patton is able to work with us this summer

Sincerely,

Chloe Gross, RN
Nurse Manager (Clinic Coordinator) SOME Medical Clinic

**From:** Simon Patton
**Sent:** Tuesday, February 12, 2008 12:36 PM
**To:** Chloe Ann Gross
**Subject:** Summer Project

Hello Ms Gross.
I hope this email finds you well. I know that right now we're experiencing quite a cold snap here in Kansas City, really looking forward to a change in weather.

I recently emailed a draft of my proposal to the doctor in charge of selecting who receives the stipend, and she told me that it would be a more viable proposal if I were to include a detailed description of what I would be doing at the clinic, as well as some proof that I have actually contacted the people involved in my project. I am wondering if you would have a chance to write me a brief email outlining what I will be doing with you this summer, including a brief description of the SOME medical outreach, as that would really help in getting the stipend I realize that we talked about this over the phone, but I think a tangible email would be a little more official.

I wrote the proposal concentrating on examining both the health problems that the homeless face and the resources they have to address these problems. I think that working with the referrals and any time spent

around the participants themselves will be a perfect way to accomplish this.

I am really looking forward to working with you this summer. I hope it all works out. Thank you very much for any help you can give.

Sincerely,
Simon

**OTHER EMAILS WITH THE CONTACTS:**

Novell WebAccess

**Mail Message**

Reply Read Later

Mail Properties

**From:** "Simon Patton" Wednesday - February 13, 2008 4:05 PM

**Subject:** Fwd: [NEWSENDER] - This Summer - Message is from an unknown sender
**Attachments:** Mime.822 (6748 bytes) [View] [Save As]

---------- Forwarded message ----------
From: Chloe Ann Gross
Date: Wed, Jan 30, 2008 at 6:30 AM
Subject: RE: [NEWSENDER] - This Summer - Message is from an unknown sender
To: Simon Patton

Simon,

Feel free to contact me if need be. I'm still looking into the housing situation and will let you know when I find out more information. Thanks and take care, Chloe

**From:** Simon Patton
**Sent:** Monday, January 28, 2008 5:54 PM
**To:** Chloe Ann Gross
**Subject:** [NEWSENDER] - This Summer - Message is from an unknown sender

Novell Web Access

## Mail Message

Reply Read Later

Mail Properties

**From:** "Simon Patton" Wednesday - February 13, 2008 4:06 PM

**Subject:** Fwd: Contact information
**Attachments:** Mime.822 (5155 bytes) [View] [Save As]

----------Forwarded message ----------
From: Chloe Ann Gross
Date: Wed, Feb 6, 2008 at 6:14 AM
Subject: RE Contact information
To: Simon Patton

Simon,

I'm still waiting to hear back about the housing situation. The person I need to talk to is out until Feb.14. My official title is clinic coordinator. I am an RN so you can put that after my name as well. We hope the proposal is approved as well. We would be very happy to have you here. Let me know if there is anything else you need. Thanks and take care, Chloe

----------Forwarded message ----------
From Michael Stoops
Date: Tue, Jan 8, 2008 at 4:59 PM
Subject RE Summer Project
To Simon Patton

Dear Simon Patton:

Thanks for contacting the National Coalition for the Homeless

I have done a lot of work with KU students over the years.

Glad you also got to know Glorin Ruiz Pasiush and her husband, Richard

A couple of different possibilities:

You could do some direct service medical work at some of our health clinic that serve homeless people.

1. S.O.M.E Health Services—

   71 O St., NW

   Washington, DC 20001

   202-797-8806

   Michelle Green

2. Unity Health Care

   Vince Koane

   3020 14th St . NW

   DC 20009

   202-745-4300

www unityhealthcare .org .

3. Christ House

1717 Columbia Rd.

DC 20009

202-462-4788

www.christhouse.org

Or if you wanted to do some research/advocacy/policy work on health care issues, you could do a health care policy internship at NCH.

If I can be of any further help to you, let me know.

Michael

# Health Disparities of Ethnic Minorities in Vietnam

Hang D. Pham

University of Kansas School of Medicine

Clendening Fellowship

February 18, 2008

## Introduction

"Người dan tộc thiểu số?" A common question asked in Vietnamese and translated to: "Ethnic Minorities?" Little do the populations outside of Vietnam fathom the idea of Ethnic Minorities existing in Vietnam. There are fifty-four ethnic groups in Vietnam, ranging in population from more than one million to a few hundred in each tribe, which comprises about 15% of the total *Kinh* (Vietnamese) population (1). Ethnic Minorities are found throughout Vietnam and are categorized according to the region they reside in. About 68% of the minority population reside in the Northern region of Vietnam, while the remaining twenty-two groups, comprising 32% of the minority population, live in the Southern region of Vietnam (2). In the Central Mountainous Regions, the Ethnic Minorities are termed the Montegnards. This term was used by the French because of their distinct skin color and means "Mountainous People" in English.

Little is known about the origins of Vietnam's Ethnic Minorities. However, it is theorized that the Ethnic Minorities of Northern Vietnam are descended from ancient migrants of Southern China; meanwhile, the Ethnic Minorities of Southern Vietnam are the descendants of the lowland natives of Malay (2). Today, many of the Ethnic Minorities have assimilated in to Kinh culture, language, and customs. However, many Ethnic Minorities, especially those living near the northern Chinese border, the Red River Delta, the Northwestern border of China and Cambodia, and the Central Highlands of Vietnam, are still distinguished by their unique and diverse cultural characteristics including their architecture, language, colors, clothing, religious practices, and government infrastructure (2). Yet, Ethnic Minorities are discriminated and are considered unequal to the majority of the Kinh population. This prejudice against the Ethnic Minorities further isolates them from the general population.

The biggest problem that Ethnic Minorities of Vietnam face is poverty. They comprise 30% of the impoverished population of Vietnam and about 75% of Ethnic Minorities fall below the international poverty line. The figure shows the Population [Ethnic Minorities by tribes] Living Below the Income Poverty Line (% 1999)(3):

However, there is a strong commitment to the Ethnic Minorities from the Vietnamese Government, which guarantees the rights of Ethnic Minorities:

> The State of the Socialist Republic of Vietnam is the unified State of all nationalities living together in the land of Vietnam. The State implements the policy of equality, unity and mutual assistance among the nationalities and strictly prohibits all national discrimination and division behaviours. The nationalities have the right to use the spoken and written languages, preserve the national identity and promote the customs, habits, fine traditions and cultures of their own (2).

The Vietnamese Government also has a strong commitment to enhance health care among Ethnic Minorities including better access, quality, and treatment. However, according to a report published by the World Health Organization:

> Constraints to ethnic minority development and well-being include factors such as isolation, remoteness, low access to credit and productive assets and limited access to quality social services. The overall education level among ethnic minority groups is lower and most ethnic minority groups live in geographical and climatic conditions that are harder than those of the majority ethnic group. In addition, the quality of health facilities are poorer. These factors combined result in different health problems, limited access to health care and poor health status of ethnic minority groups (3).

The report states that the Vietnamese Government may have a strong commitment to the Ethnic Minorities, but, the advancement of health care has increased very little. Many other factors that may play a role in the health disparities of the Ethnic Minorities which are not listed in the World Health Organization are traditional beliefs of medicine, beliefs in healing and death, and their cultural and religious beliefs of health care. There are many factors that can explain the disparity of health care among ethnic minorities and thus data through direct interviews can provide a clear understanding of the problem facing Ethnic Minorities.

## Background

Mountain ranges painted in different hues of green that extend beyond the horizon; mountain tops that reach beyond the clouds and remain unseen; misty fog rolling along the sides of the mountains as a driver turns and curves along a treacherous mountain road. This was my first experience in the Central Mountainous Regions of Vietnam. It was my first trip to Vietnam when I was eleven years old. I can remember the stories my father told me about hearing tigers' roars, leopards sulking among the trees, and in rare occasions, elephants. When I reached my destination, my family and I unloaded boxes of clothing and gifts for my immediate family in Vietnam. After the distribution of gifts, my uncle loaded some of our gifts into an empty box including warm blankets and clothing and announced that he was

going to donate the box to an Ethnic Minority tribe he knew. I was stunned and surprised, from my expression, my father replied, "Người dan tộc thiểu số" which translates, "Ethnic Minorities." I felt very naïve because in school I only learned about minorities in South America and Africa. But yet I felt empowered because it allowed me to embrace a newfound part of my culture and heritage. My uncle explained how they are very isolated and very few people are granted access to their tribes. He also explained how poor they were and how little they knew about the modern world. His explanation sparked my interest and curiosity about the Ethnic Minorities and I wanted to learn more.

Not only did my first experience in Vietnam involve learning about the existence of minorities but also the terrible conditions of the impoverished. Walking along side my aunt, people rushed over and held out their hands, begging for food or money. As we walked, I asked my aunt, "Is there any help for the homeless?" My aunt replied, "If you have money, you live. If you don't have money, you die and no one cares." For the first time, I saw the distinct differences in poverty in America and Vietnam. During my stay in Vietnam, I experienced the distinct socio-economic gaps that allowed citizens with stable income to survive and citizens with little to no income to perish. It fueled my ambition to enter medicine because no life should have a price tag. After experiencing firsthand the distinct socio-economic gap among the general population of Vietnam and listening to my uncle's explanations about the 'Người dan tộc thiểu số', I could only imagine the impoverished conditions of the Ethnic Minorities.

During my senior year of college at Wichita State University, I decided to take an advance psychology course, the course was entitled: Problems of Society. The course was enlightening because it allowed me to gain some insight into the socio-economic gaps that society faced and the government policies that have been implemented which have either succeeded or failed. And one of the major topics was health care. I became immersed in disparities in health care and it further fueled my passion for medicine. As I entered my first year of medical school, the lectures that captivated me were on the disparities of health care from access to quality. I had so many questions to ask but yet very little answers were provided.

## Objectives/Goals

- To evaluate the practice of medicine of Ethnic Minorities of each tribe.
- To gain insight into the views of health care of Ethnic Minorities.
- To determine health care disparities among the different Ethnic tribes.
- To compare and contrast the health care of the different tribes of Ethnic Minorities.
- To access traditional beliefs and religious practice and its impact on medicine of each Ethnic Minority tribe.
- To compare and contrast health care disparities among the ethnic tribe.

## Method

I have contacted my aunt, Ms. Hoang Thi Dan, who works for a non-profit organization in Vietnam that works alongside the minorities of Vietnam. She holds a very close relationship with the tribal leaders and have asked them for permission for access and interviews into their tribe and territory. I have been granted access and interviews to four tribal communities in different regions and different provinces that range-from the Central Mountainous Regions to South Vietnam. I will be participating and interviewing each tribe per week. I will be conducting interviews with the tribal doctors, leaders, and citizens. I speak fluent Vietnamese and my aunt, Ms. Hoang Thi Dan has provided me with minorities who are able to translate from Vietnamese to their native language. Such questions that will be conducted:

1. What are your views on medicine?
2. For the tribal doctor, how were you appointed as healer for your tribe?
3. What certain treatments do you use to treat illnesses?
4. What is your belief on illnesses and death?
5. Do you use the government implemented health care for minorities?
6. What are your views on the government implemented health care for minorities?
7. If answer yes to questions 5 and 6, how would you describe the quality of health care? Do you still prefer your traditional medicines?
8. What hardships and difficulties have you faced with the government and the general Kinh (Vietnamese) population?
9. Describe the access to health care through the government?
10. What is the cost for health care implemented by the government? If there is payment, are there any hardships to provide payment?

## Schedule

May 29th Departure to Ho Chi Minh City, Vietnam
May 30th Arrival to Ho Chi Minh City, Vietnam
June 2nd – 6th Province: Dong Nai
City: Dinh Quan
Tribe: Chu Du
June 9th – 14th Province: Lam Dong
City: Don Duong
Tribe: Bea Kan
June 16th – 20th Tribe #3 – Information Pending
June 23rd – 27th Tribe #4 – Information Pending
July 8th – Departure from Ho Chi Minh City, Vietnam
July 9th – Arrive to Kansas City, Kansas

## Budget List

| | |
|---|---|
| $1,488 | Flight Ticket @ Travelocity |
| $500 | Transportation to the 4 tribes |
| $400 | Thank You gifts to the 4 tribes |
| $0 | Housing and Food will be provided through my immediate family |

Total: $2, 388

Note: Any extra costs will be from personal account

## Conclusion

After many months of my first year of medical school, The Clendening Fellowship was presented and I was thrilled with the prospect of writing a research proposal. I have always been involved in the scientific aspects of medicine but with this opportunity it will provide for me a chance to venture 'out of my own skin' and 'grow a new skin' in the social discipline of medicine. Many do not know about the Ethnic Minorities of Vietnam, and with this opportunity, I can help provide a voice for them to be heard.

## Contacts

Tribe # 1: Bea Kan
Name: Mrs. Ma Hiep

Tribe #2: Chu Du
Name: Ms. Tran Thi Trinh

Tribe #3 and #4 have confirmed but information is pending.

## Bibliography


1. Aboriginal Planet. "Vietnam". 01 February 2008. < http://www.dfait-maeci.gc.ca/aboriginalplanet/around/asia/arvietnam-en.asp?prn=1>.
2. Ronald J. Cima, ed. *Vietnam: A Country Study*. Washington: GPO for the Library of Congress, 1987.
3. "Health and Ethnic Minorities In Vietnam." World Health Organization: Technical Series No. 1 Jun. 2003: 31.

# HIV and Spirituality: Exploring the role of spirituality and religion in HIV+ individuals

Submitted to
Dr. Martha Montello
The Department of History and Philosophy of Medicine
February 19, 2008

By
Kevin Wood
University of Kansas Medical Center

**Introduction**

The Human Immunodeficiency Virus (HIV) has been estimated to have killed over 25 million people since it was first recognized on December 1, 1981 (Joint United Nations Programme on HIV/AIDS). The retrovirus is the cause of acquired immunodeficiency syndrome (AIDS), which creates a drastic weakening of the immune system leading to a plethora of opportunistic infections, eventually causing the death of the patient. In the 1980s, when the virus was still an enigma to scientists and the medical community, a patient being diagnosed with an HIV+ status was equivalent to a death sentence. The patient would be inevitably dead in a matter of months to years, while the doctors and nurses stood hopelessly aside. With the introduction of antiretroviral drugs in the 1990s, HIV+ individuals have been given hope. While there is still no cure for the illness, the advancement of drug cocktails and increasing knowledge of the virus has enabled patients to lead healthy, active lives.

With the status of HIV being altered from an acute to more of a chronic disease, the patient's psychological and mental health has now become a key issue. Not only must the individual learn to accept that the illness and the overwhelming number of medications will be a part of their daily routine for the rest of their lives, but the individual is also forced to deal with the enormous social stigma that is so closely linked with the virus. HIV was first noticed in the homosexual community, and for many years was branded as a "gay disease". While we now understand that anyone is capable of contracting the illness, because of its history and its route of transmission through sexual contact, the disease is still seen as taboo. This has caused many to mistakenly stereotype HIV+ patients as dirty, irresponsible, and promiscuous.

Because of the drastic biopsychosocial effects of HIV, current research is commonly focusing on the individual learning to overcome these psychological obstacles. Religion and spirituality, with the possibility of offering mental support and an accepting community, is often seen by the patients as an enticing aid during this arduous journey of discovering how to live a happy life as a chronically ill individual. Research that focuses on how spirituality relates to the psychology of the illness has shown that most patients with HIV/AIDS belong to some form of organized religion, with 75% of the individuals claiming that learning how to deal with their HIV+ status had a positive impact on their level of spiritual faith (Cotton, Puchalski, Shermna, Mrus, Peterman, Feinberg, Pargament, Justice, Lenoard, Tsevat). Interestingly, it has been shown that religion can have both positive effects on the individual, such as providing social support and increasing the patient's quality of life, as well as negative effects in analyzing religion's relation to the individual's perceived stress. The large amount of research that has already been done in the area suggests that spirituality is often a vital element in the patient's process of learning how to cope with an incurable HIV+ status.

**Background**

During the first two years of filling my pre-medical requirements at Grinnell College in Iowa, I took my first class with the Religious Studies Department and was instantly fascinated. While I recognized the importance and need for a sound scientific background to become a medical doctor, I also realized the need for empathy and understanding to more accurately and wholly treat my patients. I felt the religious studies department, through teaching me different sociological insights and a wide range of perspectives, offered me a chance to begin advancing this deeper way of understanding and treating my future patients.

After my third year of undergraduate, I created an 8-week summer internship through Grinnell College's Rosenfield Program. I worked with two HIV/AIDS clinics, Body Positive and the McDowell Clinic, both in Phoenix, AZ. Through counseling newly diagnosed patients, teaching educational classes, and working with the nurses on keeping patients' treatment programs up to date, I realized that spirituality and religion were inevitably an issue that patients faced when grasping that they had a chronic disease and acknowledging their own possible death from it. What was interesting was the

many different ways in which the patients used religion in dealing with their status. While some patients I counseled damned God for cursing them with this horrible illness, others embraced their religion, accepting its support, and thanking God for giving them this new insight on life and forcing them to realize its importance

With the Clendening Fellowship I wish to advance these introductory observations I first noticed during my summer at Body Positive and the McDowell Clinic. Through studying how individuals utilize spirituality to deal with HIV, I hope to offer suggestions on how patients psychologically deal with other chronic diseases. Not only will this offer the medical community a better understanding of how to treat the patient when interacting with them, it will also remind the doctor that the patient's psychological struggle is life-long and continues long after they leave the doctor's office.

**Project Description**

With the Clendening Fellowship I hope to continue to explore the complex interaction between spirituality and the psychological health of a chronically ill patient. I have chosen to focus on HIV+ patients, not only because of my past clinical experience in the HIV field, but because of the added psychological obstacles due to social stigmas and unfair stereotypes. The patient is forced to deal with the physical and biological aspects of the disease, but also with the many social obstacles.

I plan to split my project between two locations. I will spend the first four weeks of the summer in Kansas City, KS working under the guidance of Dr. Stephen Waller, a doctor of Infectious Diseases at the University of Kansas Hospital. During the second month of the summer, I will be working in Washington, DC with the help of Dr. Christina Puchalski, the director of the George Washington Institute of Spirituality and Health (GWISH). Dr. Puchalski has written and helped with multiple papers in the past which have focused on HIV+ patients and their interaction with religion, so I will be constantly interacting with her during both months of my project for guidance and for possible answers or counseling if any unforeseen obstacles or emergencies should occur.

The goal of my research is to gain a better understanding and appreciation of how HIV+ individuals have used and continue to use religion and spirituality as they initially learned of their HIV+ status and finally discovered how to accept and live with the illness. My initial plan is to interview 50 HIV+ patients over a 2 month period. I will find these individuals through the help of Dr. Sharon Lee at the Family Health Care Clinic, Dr. Waller at the Infectious Diseases Department at University of Kansas Hospital, posters placed at the Kansas City Free Health Clinic and the Good Samaritan Project, and through Dr. Puchalski and the help of George Washington University's Infectious Disease Department.

Through an hour long semi-structured interview, I will ask a variety of questions pertaining to the subject's spirituality and religion. More specifically, the interview will allow me to contrast the subject's spirituality both before and after learning of their HIV+ status and how strong of a link exists between their religion and their ability to psychologically cope with a chronic illness. Finally, because there is a broad spectrum of religious ideologies and practices, I will look closely at the diversity and types of spiritual methods these individuals have used in order to help them accept their HIV+ status and continue to live their life.

The product of this research will not only benefit the medical community in gaining a better understanding and appreciation for the chronically ill patient, but will hopefully benefit the interviewed subject as well. Through asking the individual to analyze such an emotional and difficult process, the interview process will provide a comfortable, confidential environment for a period of self-introspection that will allow the patient to better understand their personal battle in accepting and learning to live with their HIV+ status.

**Tentative Timeline**

| Date | City, State | Locations |
|---|---|---|
| June 2 - June 27 | Kansas City, Ks | Family Health Care Clinic, University of Kansas Infectious Disease Department, Kansas City Free Health Clinic, Good Samaritan Project |
| June 28 - 29 | Flight to Washington, DC | |
| June 30 - July 25 | Washington, D.C. | George Washington Institute of Spirituality and Health (GWISH) |

**Budget**

| Expense | Cost |
|---|---|
| Flight (Two-way) | 250 |
| Food, etc. | 550 |
| Housing (Kansas City) | 540 |
| Housing (Washington, D.C.) | 600 |
| | **1940** |

**Conclusion**

Due to the advancement of antiretroviral drugs and large decrease in the number of AIDS-related deaths in the United States since their introduction, many live with the misconception that HIV is beginning to disappear from society. Unfortunately, this is not the case. From 1992 to 1996, the number of AIDS cases in the United States increased by over 185,000, and has continued to increase at a steady rate since then (Centers for Disease Control and Prevention). HIV/AIDS is the largest global pandemic in modern history, and it will persist as an issue until a cure is found.

Until then, the medical community can better aid their patients by better understanding them. Through acknowledging the many obstacles HIV+ individuals face and learning how they have discovered to cope with their status, doctors will not only be more sympathetic and accepting of their future diagnosed patients, but will also better be able to treat and advise their patients on how to continue to live.

Contacts

1. Kevin Wood

2. Dr. Stephen Waller
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3. Dr. Christina Puchalski, Director
   George Washington Institute of Sprituality and Health
   2300 K St NW Suite 313
   Washington, DC 20037

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# Clendening Summer Fellowship Proposal

## To Dr. Martha Montello

Department of History and Philosophy of Medicine

**Peniel Zelalem**

**University of Kansas School of Medicine**

**Class of 2011**

**Role of Transmigrational sexual practices in spreading HIV among US resident Ethiopians**

**Introduction**

Despite the tremendous effort to control HIV infection, it continues to be a great threat to public health. Currently, there are close to half a million people living with HIV in the United States. According to the CDC, fifty percent of them are African Americans. African Americans also constitute 50% of new infections every year[1]. One fact that is very often overlooked is the subgroups included in the "African American" category. Due to lack of place to indicate a country of origin in many government forms as well as statistical databases, many African immigrants are grouped with African Americans. However, very limited data that exists on specific populations show high variation in prevalence, incidence, and risk factors among these subgroups. In order to adequately address this issue in culturally diverse populations, it is important to look at factors that specifically affect these subgroups.

According to the 2000 census, of the 31 million foreign born immigrants, 3% of them are of African origin[2]. Because the census does not ask immigration status, this includes persons that are here for various reasons. The number of African immigrants may be relatively small, however, HIV incidence among this group is considerably high. For example, only16% of African immigrants are of Ethiopian origin in the DC metropolitan area. However, according to the virginia department of health, 21% of all new clinical cases of HIV are among Ethiopian residents[3]. Similarly, the public health department for Seattle and King County reports 51% of HIV cases in African immigrants were of Ethiopian origin[4]. This number continues to increase across the states, especially in big cities with high Ethiopian populations such as New York, and Texas.

Even though most Ethiopians are screened before entering the United States, and prevalence of HIV is much lower in the States compared to Ethiopia, many US resident Ethiopians continue to contract the infection at high rate. This bewilders the Ethiopian community as well as public heath personnel. What then is the reason for this phenomenon? Are there specific risk factors unique for this culture? Or, does this group practice risky behaviors at higher rate compared to others? There are many areas that need investigation to get the full picture and work to stop the ever increasing spread before it gets out of control. One possible factor that may contribute to or even be the main route of the spread is transmigrational sexual practices. Transmigrational sexual practice is a term used to characterize sexual behaviors of international travelers in the host country.

Previous research has found a link between international travel and risk of contracting HIV as well as other STDs. This risk is increased when traveling to high HIV prevalence countries such as most countries in Africa and Asia[5]. A study by Cabeda et al (2002) investigated the risky sexual behaviors of persons that traveled to Peru. 12% of people they surveyed had new sex partner during their stay. New sex partners included locals, fellow travelers, and commercial sex workers. Some risk factors they identified include longer than 30 days of stay, single marital status, and bisexual orientation[6]. Similar studies by Memish et al (2006)[5] and Lydié et al (2004)[7] found significant number of persons traveling away from home engage in casual sex during their stay. This risky behavior is further enhanced by consumption

of alcohol and drugs. When we look a step further, the risk radiates to the wives, long term partners, as well as future sexual contacts upon their return to their country of resident.

In addition to work, school, and recreation related travels, a large number of immigrants from around the world travel back to their country of origin to visit family and friends. According to Beyene Yewobdar, Director-General of the Ethiopian Millennium National Council secretariat, close to 70 thousand Ethiopians from around the world travel back to Ethiopia every year. In the capital city of Ethiopia, one in six person is a victim of HIV/AIDS. Therefore, US resident Ethiopians traveling to Ethiopia and engaging in risky sexual behaviors have a very high probability of contracting the disease. In addition, negative stigma associated with HIV/AIDS among Ethiopians keeps sex workers or other sexual partners from sharing their status if they are infected, further increasing the probability of contracting the infection. The objective of this research to characterize transmigrational sexual practices of US resident Ethiopians while visiting Ethiopia. The study will identify the percent of travelers that participate in risky sexual behaviors during their visit. Furthermore, this study will look for possible factors that may contribute to increasing the probability of one's involvement in risky behaviors such as better economic status of travelers that allow an easy access to several social entertainments, as well as alcohol and drugs usage.

**Why am I interested?**

While growing up in Ethiopia, it always crushed me to see young people crippled and their dreams cut short with a simply preventable disease. Furthermore, it angers me to see HIV positive persons, who either knowingly or carelessly spread the infection to their faithful partners and their children. It now breaks my heart to see the continuation of this epidemic among Ethiopians living in the United States. Though we have come a long way in developing treatments and extending the time of AIDS development after initial infection, treatments remain expensive, too expensive for the high number of uninsured and minimum wage receiving Ethiopian community. High incidence of HIV among Ethiopians is not only a concern of the Ethiopian community but of everyone else's, as we live highly integrated in the United States, and one community's problem will not stay confined to that community for long.

I believe the best way to fight HIV among this community is to understand risk factors, use evidence based approach to increase awareness, and provide education as best as we can. Currently, due to lack of data characterizing behavior and identifying special risk factors for this community, public health personnel's as well as physicians do not have enough tools to adequately address this issue with the culturally diverse HIV patients and populations at risk.

Among friends, family, and school companions, especially those that migrated from Africa, I am often labeled "paranoid" because of my unending warnings to take precautions. Most end up ignoring my warnings assuming everyone that has made it to the US has passed HIV screenings and too often overlooking the possible threats from fellows that have gone back to visit and during their stay might have contracted the disease. Through this study, I hope to gather evidence that will highlight the important risk factors US resident Ethiopian's face and encourage public health personnel's to target those issues during their HIV prevention efforts.

**Objectives**

The research will use descriptive cross sectional studies to address transmigrational sexual practices of US resident travelers. The study will look at how many people have sexual contact with a new partner during their stay and how many did or did not use protection. Second, conditions that can increase exposure to new sex partners will be explored. Third, behaviors such as alcohol and drugs, and their contribution in enhancing risky behavior will be investigated.

**Methods**

*Procedure*

The Ethiopian Community Development Council (ECDC) is a nongovernmental organization that has been working with African immigrants since 1985. One of their main concern is the climbing incidence of HIV among Ethiopian immigrants. They are currently working on projects targeting African immigrants mainly in the DC metropolitan area. I expressed my research interest to Dr. Girum Mekonnen, a project manager for CDC funded researches regarding African immigrants at ECDC. He appreciated my interest and expressed the lack of data regarding transmigrational sexual behaviors among Ethiopians further stressing the need to conduct such research. He expressed his willingness to oversee my project and has started to do so by arranging collaborators in Ethiopia. I will be working with him and his colleagues at the University of Addis Ababa, Ethiopia for the entirety of the project. In addition, Biru Robele, chairman of HIV program at Meserete Kerestos Church, Addis Ababa Ethiopia, will assist me in my project by providing guidance as well as staff to aid in data collection process.

In order to acquire a large sample that includes residents of as many states as possible in short amount of time, it is necessary to conduct the study in Ethiopia. Therefore, I will travel to Ethiopia for four weeks. To minimize cost, I plan to stay with my aunt and use public transportation.

Upon approval of grant, proposal will be submitted to Addis Ababa University ethical committee to insure no ethical standard of the Ethiopian culture is violated with this project.

*Participant*

Mode of acquiring data will be an anonymous questionnaire addressing these factors. Survey will be done at Bole Addis Ababa International Airport at lounges and waiting areas for flights departing to the United States. This is an ideal place to find high concentrations of traveling US resident Ethiopians. In addition, it allows us to target residents of all states and even residents of other countries if time and resources allow. Surveying people during their last hours in Ethiopia also allows us to get comprehensive idea of what took place during their entire stay. Furthermore, high "hang out" areas for returning Ethiopians such as coffee shops, internet cafes, hotels, gyms, nightclubs, and resort centers at certain areas of the city will be possible places of conducting study. Since HIV affects people of all ages and gender, survey will be given to everyone willing to participate. Considering some of the survey questions inappropriate for children and the need to get parent's consent, persons under 18 years old will not be asked to participate. To increase participation in the study, incentives such as free coffee or souvenirs will be provided. Sample size of minimum 500 people is anticipated considering time, resources and 10-20% unresponsive rate.

*Measurement*

A questionnaire is prepared that will allow the assessment of characteristics of high risk behaviors in a short concise manner. The questionnaire is divided into three sections according to level of relationship to risky sexual behaviors.

The first section asks general demographic questions, purpose of visit, length of stay, and persons they traveled with. These variables are deemed important for a comparative analysis when measuring risky sexual behaviors. The second section evaluates the person's social activities through three different parameters. Places a person has visited, time spent, and the company they were with if any. These variables are also for an assessment on the correlation between the person's environment and risky sexual behaviors. The third section represents the third level of the study which inquires in depth the types of relationships developed during a person's stay in Ethiopia at different social settings. This is an extension of the measurement on the second section as it seeks to investigate the role of new or old relationships on sexually risky behaviors. This section also filters responses from pervious section. Finally the fourth section represents the fourth or highest level of this instrument as it directly asks engagements in sexually risky behavior. These items specifically ask quantitative questions to measure frequency or amount of behaviors. This is the highest level of the instrument as all answers in pervious sections will be analyzed across this section.

The survey will be available in English and Amharic (the dominate language spoken in Ethiopia). To ensure the quality of questions, the survey will be distributed to a pilot sample of Ethiopians residing in Kansas City, who have recently traveled to Ethiopia. The items on the survey will be revised according to feedback received from the Pilot study.

**Budget**

| | |
|---|---|
| Airfair | 1500 |
| Food and transportation | 300 |
| Incentive for survey participants | 300 |
| Survey printing and data collectors wedge | 500 |
| **Total** | **2600** |
| **Clendenin summer fellowship** | **2000** |
| **Out of pocket** | **600** |

Budget estimates may appear low. Please keep in mind the dollar has high value in Ethiopia and estimates are calculated according to economic standards of Ethiopia.

**Contacts**

**Girum Mekonnen, MD/MPH**

HIV/AIDS prevention and Education programs, project manager
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901 S highland St. Arlington VA 22204

**Collaborators of Dr. Girum Mekonnen**

I will provide address and phone numbers in a week.

**Beru Robele**

Meserete Kirestos Church Chair Man
Addis Ababa. Ethiopia

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**Thank you for participating in this research study. Your participation is greatly appreciated. If anytime during this process you feel uncomfortable, you may stop. Please be assured that your answers are private and no one will know as you are not required to give your name and all survey's will be stored in a closed locked box only I have access. Please respond as accurately as possible.**

## Section 1

**Age**_____, **gender**_____, State **/country of residency** _____, Zip code_____

**Marital status**: Single married divorced

**Religion:** Muslim Protestant Orthodox Catholic Others (specify) _____

**Level of Education** Cannot read and write, Grade 1-6, Grade 7-12, Above 12th grade

**Traveling with**: alone, family, Significant other, Friends,

**Place stayed during visit:** with family, with friends, rented Place, hotel

**Length of stay:** 1wk-1 month, 1-2months more than 3 months

**Purpose**: business, visit family, recreation, Seeking relationship, Other (please specify) _____

## Section 2

On the following mark social settings that you have visited and Amount of time spent

| | **Time Spent: Circle the best answer** | | | **Company: Circle the person that you were with** | | | | |
|---|---|---|---|---|---|---|---|---|
| **Place** | | | | **Alone** | **family** | **friends** | **Significant other** | **On a date** |
| **Coffee Shop** | **0-2days** | **3-5 days** | **7+ days** | | | | | |
| **Resorts** | **0-2days** | **3-5 days** | **7+ days** | | | | | |
| **Church, Mosque, Temple** | **0-2days** | **3-5 days** | **7+ days** | | | | | |
| **Social Parties** | **0-2 times** | **3-times** | **7+ times** | | | | | |
| **Night Clubs** | **0-2 days** | **3-5 days** | **7+ days** | | | | | |
| **Hotels/ Restaurants** | **0-2 days** | **3-5 days** | **7+ days** | | | | | |
| **Cinema** | **0-2 days** | **3-5 days** | **7+ days** | | | | | |

## Section 3

On the following questions mark the answers that best describes your experience during your stay.

**Coffee Shop/Restaurant/Internet Cafe**

| | Agree | Disagree | N/A |
|---|---|---|---|
| I met new people | | | |
| I met potential love interest | | | |
| I enjoyed my time | | | |
| I met a new sexual partner | | | |

**Resorts/Hotel**

| | Agree | Disagree | N/A |
|---|---|---|---|
| I met new people | | | |
| I met potential love interest | | | |
| I enjoyed my time | | | |
| I met a new sexual partner | | | |

**Parties, social gatherings (i.e. funerals, weddings, associations)**

| | Agree | Disagree | N/A |
|---|---|---|---|
| I met new people | | | |
| I met potential love interest | | | |
| I enjoyed my time | | | |
| I met a new sexual partner | | | |

**Night clubs, bars, concerts**

| | Agree | Disagree | N/A |
|---|---|---|---|
| I met new people | | | |
| I met potential love interest | | | |
| I enjoyed my time | | | |
| I met a new sexual partner | | | |

**Section 4**

**During your stay in Ethiopia how much alcohol did you consume?**

None moderate I have gotten drunk

**During your stay in Ethiopia what kind of drugs did you use?**

Inhaled drugs IV drug endogenous none

**During your stay in Ethiopia how frequently did you use drugs?**

Not at all Sometimes Almost always All the time

**During your stay in Ethiopia how many sexual partners did you have?**

0 1 2 3 4 more than 5

**During your stay in Ethiopia did you use protection during sexual intercourse?**

Not at all Sometimes Almost always All the time