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HEALTH INNOVATION
READER

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NOTE FROM THE EDITOR

By Shana Montrose, MPH
Global Health Editor and Contributor

Structure of the Reader

Public health is not a well-known field, nor is it easy to define. But public health continues to be one of the most important fields of our day. It is a field of study and action that aims to keep people from falling ill, sustaining injuries, or dying prematurely.

The first section of this reader is all about defining public health. Global health is a subset of public health. Traditionally, it has been understood to mean public health in an international and under-resourced setting, but today the definition has been expanded to mean health for all, which includes under-served populations everywhere.

You may also wonder, what's the difference between public health and medicine (or healthcare)? The fields of public health and medicine work closely together, but they are not the same. In the pre-trip section you will read about public health from the perspective of a young doctor. There are additional articles and activities that will help you to clarify important similarities and differences.

Public health is nothing less than controversial. There is an ongoing and unresolvable tension between health in the public's interest and the preservation of individual liberty. Public health policy involves the allocation of scarce resources, including tax dollars and private donations. Spending money requires clarifying priorities, which

are based on values. And no two people have the exact same set of values because people have different knowledge, experience and beliefs.

Later in the reader you will gain access to the tools of public health. It is important to understand these tools because you will be asked to apply them in the section on global health. An introduction to these tools will also give you a sense of whether you might be interested in pursuing further studies in public health and where to focus your efforts. Because public health is so interdisciplinary, it is useful to understand the entire set of tools. Knowing what tools are at your disposal is key to forming a team of the best minds to holistically confront a public health problem.

The final section is on global health issues. This section starts with communicable disease and goes on to address non-communicable diseases. Think about how the public health approach is similar and how it is different depending on which type of affliction you aim to reduce or prevent.

Different countries and communities are confronted with different threats to public health; try to figure out which threats are most significant in your community. Also try to find out which health threats have most successfully been quelled in your community. The ThinkImpact approach is to build off of strengths and successes, so try to keep this in mind as you read each article.

How to read the Reader

You will likely recall a teacher or parent telling you that math builds on itself and that missing class can really set you back. This is not so true for public health. Because public health is so interdisciplinary it tends to be quite non-linear. We think it makes sense to first learn what public health is, why it's controversial and then how to do it. But arguments for other sequences could be made. We encourage you to skip around and to read in a way that makes the most sense for you.

While we encourage you to skip around we do not encourage you to skip too many articles. We understand how much you are being asked to do in the ThinkImpact Institute, so we suggest reading as much as you can before you go and on the plane. Articles with titles that do not initially grab your attention may open up a new fields of interest for you. In fact, that happened to us as we prepared this reader. This is yet another reason to read as much as you can.

We encourage you to read the case studies regardless of location. Many issues overlap and comparing and contrasting is an excellent way to assimilate new knowledge.

One of the criteria for selecting articles was that each article represented both a topical issue and a public health approach. Even if a particular topic does not interest you as much as other topics, we still encourage

you to read the article because it may have been selected because it demonstrates a certain approach. The more you read, the more you will be able to connect the dots.

We have varied the text so you will be reading excerpts from textbooks, but also news articles and online reports. We've broken up the text with reflections, actions, and case studies. We hope this helps to make the story of public health come alive and to help make global health your story. Reading is a great start, but where you will really learn is when you are on the ground and when you are challenged. So go make this your story!

About the ThinkImpact Institute

The Global Health Reader is a supplement to the Innovator, an experiential guide to social innovation in global settings. Together, these books comprise the curriculum for the ThinkImpact Institute. ThinkImpact Institutes are summer and winter programs for students to live in rural communities to experience social innovation. In collaboration with locals, students identify opportunities and co-create products and services with a social impact. ThinkImpact facilitates community immersion and long-term local partnerships that advance sustainable and meaningful impact.

Program participants, called Scholars, embark on a journey to put into practice leadership skills, intercultural communication, and creative problem solving.

About the Founder and CEO

Saul is the founder and CEO of ThinkImpact, a certified Benefit Corporation, which offers design thinking-based experiential education programs in Africa and Latin America. In addition to building his company, he serves the board of More Than Me Foundation. He has been featured in The New York Times, Inc., Fast Company, and The Washington Post. He has contributed to Innovations Journal and blogs for The Huffington Post.

Saul has been recognized in Inc. Magazine's 30 Under 30, Diplomatic Courier's top 9 Young Foreign Policy Leader under 33, and CoBiz Magazine top 25 young professionals in Colorado. He is a Truman Scholar and a regular speaker with the US Department of State. In 2004 his work for educational advancement in South Africa was endorsed by President Nelson Mandela. Saul received his BA with honors from Johns Hopkins University and his MA from Johns Hopkins School of Advanced International Studies (SAIS). A runner, skier and devoted Broncos fan, Saul lives in Denver, Colorado with his wife Emily.

About the Editor

Shana Montrose earned her Master's in Public Health with a focus on policy from the Harvard School of Public Health after receiving a Master's in Latin American Studies with a concentration in political economy from the Georgetown School of Foreign Service. She has served in the Office of Global Affairs for the U.S. Department of Health and Human Services as well as the Adolescent Division in the Ministry of Public Health of Uruguay. In Uruguay she participated in programs to prevent oral caries, parasites and the flu. She is the lead author on a Harvard published case study on health reform in Mexico that was used at Harvard's forum for health ministers from developing countries. She has lived, studied, and worked in Mexico, Costa Rica, Brazil, and Uruguay. In the U.S. she has worked at the federal level as well as the state level including the Colorado Department of Health Care Policy and Financing and the Colorado Department of Public Health and Environment.

CROSS-CULTURAL IMMERSION

By Ronnie L Leavitt, PT, PhD, MPH

DEVELOPING CULTURAL COMPETENCE IN A MULTI-CULTURAL WORLD

Objectives

Upon completion of this two-part continuing education (CE) article, you should be able to:

- Define cultural competence.
- Describe the role of culture in a person's health status and during interactions with health care providers.
- Identify specific knowledge regarding different population groups and cultures including, but not limited to, terminology and demographics, degree of acculturation, socioeconomic status, incidence and prevalence of disease and disability, access to health care, comparative value orientations, verbal and nonverbal communication styles, learning styles, and health beliefs and behaviors.
- Recognize how sociocultural knowledge can be applied to influence the patient-provider interaction positively.
- Apply the concept of cultural competence to your own professional behavior and in the therapeutic environment.

Introduction to Part 1

Today, diversity in the workplace is the norm rather than the exception. Patients and clients are likely to look different from—and think and act differently than—the clinician. They have a wide range of ethnic identifications, religions, “material realities” (a term that encompasses socioeconomic status), beliefs, and behaviors that lead to rich diversity and cultural complexity. Each patient, and each physical therapist, is unique. The purpose of this two-part continuing education (CE) article is to help the physical therapist to become culturally competent when working with patients and clients.

Cultural competence is a set of behaviors, attitudes, and policies that come together in a continuum to enable a health care system, agency, or individual practitioner to function effectively in transcultural interactions. In practice, cultural competence acknowledges and incorporates—at all levels—the importance of culture, the assessment of cross-cultural relations, the need to be aware of the dynamics resulting from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs.¹

For physical therapy practitioners, cultural competence is essential to all five elements of patient/client management: examination, evaluation, diagnosis, prognosis, and intervention. Developing rapport, collecting and synthesizing patient data, recognizing personal concerns about function, and developing the plan of care for a particular patient requires cultural competence. The physical therapist, who sees a wide range of impairments, functional limitations, and disabilities, is expected to meet the needs of a patient within the context of that patient, the patient's family and community, and the broader cultural setting. By reviewing information on some of the unique characteristics associated with several cultural groups, physical therapists may gain insight and adapt the patient-therapist interaction and the rehabilitation services they provide to create the best plan of care possible.

Understanding the concept of culture is the key to understanding cultural competence. Lynch and Hanson² describe culture as the framework that guides and bounds life practices. People do not biologically inherit a culture, they learn it. People may share cultural tendencies and pass these tendencies to the next generations; however, cultural frameworks are never rigid, and they are constantly evolving.

Many factors—such as ethnic identification, socioeconomic status, migration history, gender, age, religion, and physical capabilities—have a profound impact on a person's way of life. Based on these variables, people may be members of several subcultures (smaller, but in some ways distinct, units within a larger culture³). A person's culture is closely interrelated to value systems, health beliefs and behaviors, and communication styles. Cultural pluralism is an underlying philosophy of this CE article; that is, cultures are different but one is not inherently better or worse than any other. Culturally competent practitioners^{1,4}:

1. Acknowledge the immense influence of culture. It is essential to understand that all people are immersed in their own culture—with its associated beliefs, attitudes, and behaviors—which guides their personal and professional interactions. However, human nature is such that everyone tends to be ethnocentric (ie, believing that their own cultural way of life is the norm and the standard by which all others are judged). What we forget is that the next person, who may be from another culture, also may be ethnocentric. This self-awareness (or lack of it) is especially critical when physical therapists work with patients who come from different cultures.

2. Assess cross-cultural relations and are vigilant concerning the dynamics that result from cultural differences.

With cross-cultural interaction comes the possibility that the other person's intentions and actions may be misjudged. Each party brings a specific set of experiences and personal and communication styles to an interaction. Physical therapists must be vigilant to minimize misperception, misinterpretation, and misjudgment. With more insight into the patient's or client's perspective—and less stereotyping—the ability to develop a mutually advantageous relationship is bound to be enhanced.

3. Expand their cultural knowledge and incorporate this knowledge into their everyday practice. If the assumption is that health care professionals can work effectively with people from other backgrounds, increased knowledge about the patient's or client's sociocultural context can only improve the relationship. Physical therapists must seek out sociocultural information about the patient or client that will then help them appropriately modify an interview or history—what questions to ask and how to ask them—and modify interventions based on the person's cultural reality. Physical therapists should ask patients questions about their culture and lifestyle and indicate a willingness to learn about that culture. In that way, each party in the interaction can presume the desire to both give and receive

information. It is impossible, and unnecessary, to learn everything about all subcultures, but clinicians must be aware of the ethnographic makeup of the local community and the relevant beliefs and behaviors of their patients and the patients' families.

4. Adapt to diversity. Physical therapists need to develop culturally sensitive examination and intervention techniques that allow a patient to be comfortable during the visit. The physical therapy department or health care environment should be adapted to create a better fit between the needs of the people requiring services and the needs of the clinicians and staff. It is important to remember what cultural competence is not. It is not abandoning your own culture and "becoming" a member of another culture by taking on all of the attitudes, values, and behaviors of that culture.

Stages of Cultural Competence

The field of cross-cultural health has begun to flourish in this new millenium, and the idea that cultural competence is desirable has become more widely accepted. It is critical that all therapists be culturally competent, regardless of their own ethnic background. In the Thirty-First Mary McMillan Lecture, Ruth Purtilo called for cultural competence to be a non-negotiable skill, tested as rigorously as competence in pathokinesiology or any other field of study.⁵

Cross et al¹ described six stages along a continuum of cultural competence ranging from cultural destructiveness to cultural proficiency.

In cultural blindness (stage 3), clinicians and health care institutions assume that they are unbiased; however, this assumption is based on an incorrect belief that all people are the same. In this stage, facility policies and practices do not recognize the need for culturally specific approaches to solve problems. Cultural pre-competence (stage 4) moves toward the more positive end of the continuum. In this stage, therapists recognize weaknesses in the health care delivery system or in their personal cultural knowledge base, and they explore alternatives. They also are committed to responding appropriately to cultural differences. Cultural competence is stage 5, and the last stage is cultural proficiency, in which physical therapists recognize the need to conduct research, disseminate the results, and develop new approaches that might increase culturally competent practice.

In my opinion, which is based on my 30 years of experience in this area, many physical therapists—and health care institutions—today are progressing from cultural blindness to cultural pre-competence.

Campinha-Bacote⁶ has suggested four factors that contribute to a culturally competent model of care:

1. Having cultural awareness (“cultural sensitivity” is often the term used), including awareness and minimization of cultural biases.
2. Increasing cultural knowledge (ie, understanding the theoretical and conceptual frameworks for the worldviews of other people).
3. Developing cultural skills (ie, how people of different cultures can be examined and their condition managed appropriately).
4. Having a cultural encounter (ie, exposure to people from different cultures, with an opportunity to help them achieve shared goals).

This article will primarily address the second factor—increasing cultural knowledge—in order to enhance cultural awareness and skill development. Examples will come from a variety of cultures and patient populations and will emphasize those cultures with which physical therapists in the United States are more likely to come into contact because of national demographic trends or their practice setting. Cultural competence in working with patients from any one of these groups could be the sole focus of a CE article.

A strong word of caution is in order. Physical therapists manage individual patients or clients and not a population. Broad categories are practical for descriptive purposes, but they also can be used to perpetuate racial or ethnic stereotyping and prejudices.

This article is intended to provide examples of the extensive and diverse cultural landscape in which our patients live.

Remember that not only is there interethnic diversity, there is also intraethnic diversity. Clinicians should not make general assumptions about an entire ethnic group any more than they would make assumptions about patients with stroke, Parkinson disease, or joint degeneration.

Terminology & Demographics

Terminology for identifying people and groups of people is often controversial. (See “Note on Racial/Ethnic Designations.”) From a sociocultural perspective, “ethnicity” is a better label than “race.” Ethnic identification is classified by common traits or customs. It is based on a person’s self-identification as belonging to a distinct behavioral group or ideational group (ie, a group with common ideas, values, and opinions) that has a presumed shared cultural heritage. Ethnicity may be based on a person’s color, religion, place of origin or place of ancestry, language, or territory. Race, a concept historically used to divide the world’s population into three biological types (ie, Mongoloid, Caucasian, Negroid), is an increasingly meaningless concept.

According to the US Bureau of the Census,⁷ in 2000, approximately 75% of the United States population was white; 12.5% was

black or African American; 12.5% was Hispanic or Latino; 1% was American Indian and Alaska Native; 3.7% was Asian, Native Hawaiian, and other Pacific Islander; 2.4% identified themselves as part of two or more ethnic groups; and 5.5% identified themselves as “Other.” Understanding the 2000 US Census is somewhat complicated by the fact that it used 63 ethnic categories, instead of the five categories used previously, and by the fact that respondents could select more than one category. This more complex scheme was created to accommodate people who identify themselves in ways that are different from the five typical classifications or who consider themselves “multiracial.”

Broad categories are often a necessary expedient, but they fail to represent subgroups and the presence of intracultural diversity and individuality. For example, the category “Asian” encompasses at least 18 subcultures, and the category “Hispanic” (a term more common on the East Coast of the United States) or “Latino” (a term more common on the West Coast) encompasses more than 20 subcultures. There are more than 500 Native American tribal groups in the United States. “Black” may refer to a person who is African American, Jamaican, Nigerian, and so on. There is enormous individuality among white cultures as well. The term “white” encompasses people whose ancestors come from many

European nations. In real-life circumstances, if someone prefers a particular label, that label should be used with that person. Today, the phrase “people of color” is often the preferred term used in the United States for people who are “non-white.”

The future can be imagined by reviewing the recent past. Between 1980 and 1990, the total population of the United States increased by 9.8%; however, the rate of growth varied widely among ethnic groups. The rate of growth of the Asian/Pacific Islander population was 108%, whereas the white population grew by 6%.⁸ Between 1990 and 2000, the historical course that was sharply defined during the previous decade continued. During the past two decades, there has been a tremendous influx of immigrants from South and Central America and Asia. Birth rates also are generally higher for the Hispanic/Latino group, especially Puerto Ricans. These trends are expected to continue. Currently, the largest number of immigrants to the United States by far come from Mexico.^{7,8}

Based on immigration patterns and fertility rates, the US Bureau of the Census projects that white non-Hispanic Americans will represent approximately 53% of the total population by the year 2050, demonstrating a continuous downward trend from

the 2000 Census figures. Hispanic Americans will account for 24% of the population, African Americans 15%, and Asian/Pacific Island Americans 9%.⁹ The great increase in the population over 65 years of age expected during the next decades is also relevant. The relative increase in the population over 65 years of age will be greatest for people of color. The changing demographics within the United States, therefore, provide a pragmatic reason why rehabilitation professionals need to pay more attention to the concept of culture.

An additional observation when examining these population statistics is the substantial disparity between the number of students from particular ethnic groups who are enrolled in health care education programs and their representation in society as a whole. APTA estimates that approximately 10% of its membership are people of color.¹⁰ Although it is ideal for all ethnic groups to be proportionately represented by professional staff within the treatment setting, it is equally (if not more) important for all physical therapists, no matter what their own ethnic background, to be culturally competent. In addition, the didactic and clinical educational materials used in physical therapist professional education have historically used a “Western biomedical model” and a Eurocentric point of view concerning disability, health, and illness with limited regard

for sociocultural variables (eg, visiting a traditional healer or using alternative medicine). This ethnocentrism contributes to a less-than-ideal delivery of care and can result in a cultural clash and conflicting expectations between the patient and the physical therapist.

Special Considerations for Managing A Diverse Patient Population

In an effort to learn about the material realities and beliefs and behaviors of patients and clients and to facilitate the process of becoming culturally competent in the practice of physical therapy, clinicians must, in essence, do a health care ethnography. An ethnography is a description of a culture. It is an attempt to understand another way of life, from the point of view of the people of that culture. The health care ethnographer seeks to learn from people, to observe and be taught by them, and to discover the insider's (rather than the outsider's) point of view.¹¹ This field of study is closely linked to medical anthropology, in which illness and disability—which can be viewed as the culturally mediated responses to impairments and disease—are compared across cultures.

Arthur Kleinman,¹² a psychiatrist and medical anthropologist, has developed one process of medical ethnography that analyzes local health care systems. He

developed the “explanatory model” to explain patterns of belief about the causes of illness, the response to specific episodes of sickness, and actions taken to bring about a change in a person's health status or condition. Explanatory models “are the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process. The study of patient and family [explanatory models] tell us how they make sense of given episodes of illness, and how they choose and evaluate particular treatments.”^{12(p105)}

Open-ended questions should be used to allow patients to discuss their health, based on their perceptions of a particular illness or condition. The physical therapist can ask the patient questions such as:

- What do you call your problem?
- What do you think caused your problem?
- What are the greatest problems your illness has caused for you?
- What do you fear most about the consequences of this illness?
- What are the most important results you hope to get from your treatment?

Although physical therapists need to focus on the patient's explanatory model, it is essential to understand that clinicians also have an explanatory model and operate within their own distinct culture. The patient and his or her family cannot be expected to always and completely comply with the

practitioner's explanatory model, and the health care professional cannot be expected to "buy into" the patient's explanatory model. Several variables—including degree of acculturation, socioeconomic status, the effects of racism, incidence and prevalence of disease and disability, comparative value orientations, methods of communication, learning styles, and health beliefs and behaviors—must be considered during the process of ethnography. Each of these variables must be assessed so that the examination and the interventions may be appropriately modified based on a person's culture. The variables explored below (and in part II of this CE article) never exist alone. Each is intertwined with the other variables. Furthermore, greater emphasis needs to be placed on the difficult task of sorting out the relative influence of these variables (eg, separating biological/genetic factors from socioeconomic factors from cultural lifestyle habits). In other words, what is the relative influence of family structure, diet, exercise, alcohol consumption, income, community, and other variables?

Once again, multiculturalism encompasses cultures that differ based on age, color, ethnicity, gender, national origin, political ideology, race, religion, and sexual orientation—and includes

the presence and participation of people with disabilities and those from different socioeconomic backgrounds. Thus, we need to sense patterns and variations without overgeneralizing.

Degree of Acculturation

Acculturation is the process by which people from another culture adopt the traits of the mainstream culture. Many of the variables discussed below are more or less significant, depending on the level of acculturation. A person might be:

- highly assimilated (the person has largely adopted the new culture),
- bicultural (the person functions comfortably in two cultures), or
- highly traditional (the person's values and behaviors are similar to those found in the country of origin).

In the United States, the degree to which people acculturate to the mainstream culture (what has been referred to as the "white, Anglo-Saxon, Protestant" culture) is influenced by factors such as age, level of education, number of years in this country, and socioeconomic status. Acculturation may affect people's health status, their perspective on health, and their interaction with the health care system and the clinician.

Migration history is one means to assess the degree of acculturation. Physical therapists should be aware of when, why, and how migration occurred. Immigration often does not occur under ideal

conditions; therefore, many patients and clients are not seen under ideal circumstances. For example, Mexicans came to the United States in large numbers in 1848 and 1910 during postwar periods; their decision to emigrate was influenced both by the need for a labor force in the United States to build railroads and by the extreme poverty and the religious persecution of Christians in their home country. Since the 1940s, large numbers of Mexicans have come to perform agricultural labor, and this immigrant group remains relatively poor and politically powerless.¹³

Unlike Mexican immigrants, other immigrant groups show more distinct intraethnic differences depending on the time of immigration. Vietnamese who arrived in the United States during the mid-1970s were primarily well-educated, upper class, and Christian and were escaping a repressive political regime. In contrast, Vietnamese immigrants during the 1980s were more likely to be escaping economic as well as political deprivation, and they arrived with fewer economic resources, different and more considerable health problems, and a more marginalized social support system. A look at the migration history for the Cuban American population will reveal a similar distinction between the first and second wave of

immigrants.¹⁴

A number of factors predict the presence of more traditional beliefs and behaviors, including emigration from a rural area, frequent returns to the country of origin, limited formal education, little or no ability to speak or read English, low socioeconomic status, recent immigration to the United States, immigration at an older age, and housing segregation. Typical ways to measure the degree of acculturation are based on the language used within the home, the language of preferred media sources, and the people who are part of the individual's primary support system.¹⁴ Although physical therapists might not formally measure their patients' level of acculturation, they can ask questions about these subjects that will help them better understand their patients.

Socioeconomic Status

Socioeconomic status, which includes level of income, level of education, and occupation, is arguably the most relevant variable affecting a person's worldview and health status. There is a direct linear correlation between class (which is primarily evaluated through socioeconomic status) and health. The relationship of education to health status is especially important—even more than income. Education is associated with the acquisition of beliefs and knowledge about health and with a person's ability to integrate healthy behaviors into

his or her lifestyle.¹⁵ For example, people with higher education levels are less likely to engage in unhealthy behaviors such as smoking.¹⁶ Higher educational attainment is also associated with a lower risk of obesity.¹⁵

The clinician should be aware that only about 50% of Hispanics have finished high school (46% of Mexican Americans, 60% of Puerto Rican Americans, and 62% of Cuban Americans, compared with 84% of whites).¹⁴ Clinicians should also consider that people with lower educational levels may use “traditional medicine” to a greater extent than people with higher levels of education.

Poverty is not randomly distributed; rather, it is strongly related to race or ethnicity, gender, and age. Although socioeconomic advancement continues for most families, 13% of families in the United States, according to conservative estimates, are below the poverty line, and this figure climbs considerably for some groups. In the United States, about 22% of African American families and 21% of Hispanic families live in poverty, compared with 10.8% of Asian and Pacific Islander families and 7.5% of white families.¹⁷

Intracultural diversity is again apparent. For instance, some of the small but growing subcultures in the Hispanic/Latino population are especially poor. For example, Dominicans in the United States have mean annual earnings below

\$8,000, and more than one third live in poverty.¹⁸ Female-headed households are associated with poverty, and over 40% of Puerto Rican households are headed by a woman.^{14,19}

These data have tremendous implications. There is a direct correlation between poverty and access to comprehensive, effective, and efficient medical care.^{20–24}

The effects of socioeconomic status tend to be stronger for the poorest populations. Poor housing (or even homelessness) and unsafe environmental conditions, inadequate food sources and nutrition, harmful lifestyle habits, and lack of access to transportation are all prevalent. Being poor is also associated with stress and a sense of alienation, hopelessness, powerlessness, and isolation. All of these feelings can lead to further estrangement from (with a concomitant loss of social support systems) and marginal participation in society, including the health care system. Poverty at a young age has multiple effects on health as a person ages, notwithstanding the availability of Medicare.

Poverty among people who are expected to care for their older family members adds to their personal economic challenge and limits the amount of assistance they can provide to their older relatives.²⁵

Moreover, poverty is known to influence the availability of health insurance. Being among the working poor or having no documentation

often leads to lack of health insurance. Almost 90% of the people who are uninsured are working, but their employer does not offer health care benefits. More than one third of the Hispanic/Latino population does not have health insurance, and the Hispanic/Latino group is the largest segment of the approximately 43 million people in the United States who do not have insurance. Recent immigrants, including the great majority who are legal residents, also are less likely to be insured.^{20,26} Furthermore, the changing economic and political landscape of the early 21st century (eg, welfare reform, tighter eligibility requirements and reduced benefits for Medicare/Medicaid and private insurance, and a weakening economy) may significantly affect patients with low income (because of their considerable reliance on Medicare and Medicaid) or those patients who are less acculturated (because they may be uninsured). Sensitivity to these socioeconomic and cultural issues can be tricky. How can you inquire about these issues without being insulting or without damaging the patient's pride? This is one area where skill development in cultural competency can be especially important.

Racism

Although a detailed discussion of the effects of racism is outside the scope of this article, physical therapists should be cognizant of

the continuing marked effect of racism on health status and health care interactions.^{20,21} (See Smey²⁷ for further information.)

In a recent article in the *Journal of the American Medical Association*, after adjustment for potential confounding factors, Schneider et al²⁸ reported disparities in the quality of health care for blacks who were Medicare beneficiaries and enrolled in managed care plans. These enrollees were less likely than whites to receive eye examinations, beta blocker medication after myocardial infarction, and follow-up after hospitalization for mental illness.²⁸ Moreover, the collective historical health care experience of African Americans, including the Tuskegee syphilis study (in which the US Public Health Service deliberately withheld treatment from poor black sharecroppers in order to study the natural history of the disease), sterilization initiatives, and sickle cell screening abuses, have led many African Americans to distrust the medical profession.²⁹

Incidence and Prevalence of Disease And Disability

Disease and disability are not randomly distributed. Many factors, including race, ethnicity, age distribution, socioeconomic status, geography, and migration history, play a role in determining the incidence and prevalence of disease and disability. Discovering the determinants of disease (ie, those risk factors related to the development and cause of the

condition) is a major aspect of epidemiological work. Sometimes a single variable is associated with a pathology (such as with vector-borne diseases), but, often, several risk factors are associated with a disease. Broadly speaking, risk factors can be related to inherited characteristics, environmental factors, or personal behavior and lifestyle.^{27,30–32}

In the United States, people of color have many more health problems than the white population.^{16,20–22,29,33} They are also more likely to report poor health and more restricted activity.^{34,35} Latinos are reported as having significantly more “functional impairments” than blacks or whites, which may result from lower income and education levels and from their residential environment.³⁴ Puerto Ricans have more health problems than any other group.³⁵ Women from all ethnic groups are especially disadvantaged with regard to health status and report greater limitation in activities of daily living.³⁶ People of color have a lower life expectancy, higher infant mortality rates, and higher morbidity and mortality rates for a wide range of diseases. The elimination of health care disparities between people of color and whites is one of the three major goals of Healthy People 2010, a guiding document for the US Public Health Service.¹⁶

Some surprises do exist. For example, although cardiovascular disease is the number one cause

of death for older people overall in the United States, Hispanic/Latino people have the same or lower level of heart disease mortality than whites despite high rates of diabetes and obesity and high blood lipid levels. Intraethnic diversity is once again a factor, because this advantage is present for Mexican American men, but not women. Paradoxically, Mexican American men have twice the rate of angina pectoris compared with white men. It is believed that their genetic makeup leaves them vulnerable to some diseases (such as angina and diabetes) but less prone to having a fatal outcome.^{14,36,37}

Another paradox is that Hispanic/Latino people historically have lower rates of some of the most common kinds of cancer (eg, lung, breast, colorectal, and prostate cancers), yet have higher rates for other cancers (eg, stomach, gall bladder, liver, and cervical cancers).^{14,35} Once cancer is diagnosed, however, the higher-than-expected death rates from cancer among the Hispanic/Latino population are thought to be related to culturally motivated resistance to screening tests and early treatment because of language and communication barriers and the cultural belief in fatalism.^{29,38–42}

Non–insulin-dependent diabetes mellitus (type II) is the most significant medical concern for Hispanic/Latino and Native American people (and a disease common among African Americans as well).^{14,43,44}

It deserves special attention because of its prevalence and the severity of its complications and consequences. Family history, genetics, obesity, and age are key risk factors. The so-called "thrifty" gene theory related to Mexican Americans and Native Americans with diabetes is an example of the interaction of both genetic and lifestyle variables. When particular tribes were semi-nomadic, they frequently subsisted on a feast-or-famine diet. The tribes developed a genetic ability to metabolize their food efficiently. Today, when people exercise less and food is more abundant (and likely to be high in fats and calories), there is a higher rate of obesity and diabetes. People with more Native American genetic heritage are more resistant to insulin and unable to break down glucose in the blood. On the positive side, some Native Americans have the benefit of a gene that causes their blood sugar levels to respond to moderate exercise more quickly than other groups.^{14,45,46}

African Americans and blacks are disproportionately affected by cardiovascular disease, hypertension, and strokes.⁴³ AIDS is increasingly a disease affecting African Americans and Hispanics.⁴⁷ Obesity, a health problem unto itself and a risk factor highly associated with disease and disability, is increasingly a problem in the United States, especially so for people of color. African American women have the highest rates of obesity, followed by Mexican

American women.^{14,48} Several factors contribute to obesity, such as genetic admixture, limited ability to metabolize carbohydrates, low socioeconomic status, decreased exercise, and cultural attitudes toward food and weight. Greater degree of acculturation is associated with decreased rates of obesity.¹⁴

No matter what the impairment, functional limitation, or disability, the intervention should not necessarily be the same for all people. In an interview for the article "Cultural Competency: Reaching Out to All Populations,"⁴⁹ Woodruff cited several examples of why physical therapists might need to modify examination procedures and interventions when treating people with darker skin color, such as:

- It is more difficult to see redness on black skin; therefore, the effects of infection are more difficult to assess.
- The presence of keloid tissue scarring after a burn, which occurs in some African American and Arab American patients, and the use of cocoa butter as a treatment of choice for burns may decrease the durability of pressure bandages.
- A child with sickle cell anemia may benefit from exercise in a pool because the buoyancy of water can support the weight of the limbs and help reduce the pain caused by movement.

Reimbursement policies do not necessarily take this kind of information into account.

Medicare, however, has updated its classification system for the evaluation of darker skin for decubitus ulcers, which should help decrease the number of associated amputations.⁴⁹

Access to Health Care

Regarding access to the health care system, people of color, once ill, are more likely to receive episodic, crisis-oriented care that occurs later and less frequently than for white people. Recent immigrants are typically unfamiliar with how the American health care system works. They, along with many African Americans and Hispanics, will commonly use the emergency department for primary care, which wastes resources and is not conducive to comprehensive care.²⁰ Tran et al¹⁹ report community-based social and health services are underutilized by Hispanics.

Strong social networks predict more regular use of the health care system to address medical needs.⁵⁰ Some of the barriers to formal assistance include lack of knowledge about availability, accessibility, and eligibility for services and discomfort with bureaucracy.⁵¹ In addition, there are few health promotion and disease and disability prevention programs. Hispanics and Asian Americans receive fewer preventive screening tests (eg, cholesterol screening) than African Americans and whites.²⁰ Under these conditions, greater complications and higher morbidity rates are inevitable.

Physical therapists need to be knowledgeable about the variables affecting the incidence and prevalence of medical conditions so that they can be better prepared to manage the impairments, functional limitations, and disabilities associated with these conditions; answer patient and family questions concerning the conditions; and develop special preventive and educational programs targeted to people in need.

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REFLECTIONS ON THE CATALYTIC ROLE OF AN OUTSIDER IN 'ASSET-BASED COMMUNITY DEVELOPMENT'

By Terry Bergdall

This paper was originally written for faculty members of the ABCD Institute at Northwestern University. No effort was therefore made to explain 'Asset Based Community Development.' With its distribution to a wider audience, a brief introduction is now in order.

ABCD focuses on the strengths and capacities of local communities. It rests on the conviction that sustainable development emerges from within a community, not from outside, by mobilizing and building upon local resources. In contrast, most conventional development work can be characterized as needs-based, i.e., interventions typically focus on problems and deficiencies. This has the unfortunate effect of encouraging communities to denigrate themselves as victims and to put their worst face forward in an effort to attract external assistance. It also leads concerned outsiders into becoming charitable 'fixers.' These are not the most effective relationships for enabling long lasting change. This paper examines ways that outsiders, especially in international settings, can play a more creative catalytic role within an asset based approach.

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For more information about ABCD, see <http://www.sesp.northwestern.edu/abcd/>.

It was good to be a part of the ABCD international planning meeting at the end of January. As was obvious to everyone present, a preoccupation of mine was to draw together insights about outsiders playing an effective role as catalysts in asset-based development. What works, what doesn't, what are outstanding issues and questions? Here are some of my thoughts. They are organised around a number of lessons learned, propositions, examples, and concerns. Though rough and personal, I hope they will prompt others to share insights from their own experience. At some future time, it is my desire to be part of a small group who might eventually produce a more formal piece on the subject.

Insiders and outsiders

Most local communities are composed of residents, associations, businesses, and institutions. The African and Asian villages where I've worked have similar aspects as these, though in a simpler form and on a smaller scale than those found in urban areas. The distinction between an insider and outsider in the countryside is more or less obvious: villages consist of local residents with everyone else being an outsider. In para-urban areas that ring major cities, it becomes a little more complex but residency still remains the primary qualifier. Asset-based

development means mobilising the skills, resources, and commitment of these residents, along with others grounded in the area, to strengthen the economic and social well-being of the entire community.

Though we would like to have community building 'from the inside out' occur spontaneously, some form of an external stimulus is usually involved. This can often be very minimal. In the Ethiopian highlands, it was exciting to see kires (informal funeral associations) initiate small-scale development work on their own after observing the accomplishments of nearby kires (see Box 1). But even in such cases, it could be said that the demonstration of successful mobilisation of local assets in one village helped stimulate 'spontaneous' activities in the other. For those interested in maximising this effect, major attention is focused on structuring and systematising the minimal external stimulus that can effectively occasion significant change across a large number of locations.

Box 1: Stimulants & Spontaneity

An interesting example of the 'dynamics of spontaneity' occurred at the Yilamo kire in the Debre Sina District of the Amahara Region. Yilamo residents made plans to improve their main spring during a community planning meeting. The kire organised a number of work days and succeeded, as they were proud

to report, in “protecting their spring from pollution better than it had ever been done before.” The practical result was cleaner water and fewer health problems. This spring was located on the border with another nearby kire. When facilitators returned to conduct a follow-up session to the first planning event, some women from the neighbouring kire came and asked the Yilamo leaders if they could attend the meeting. They explained that they wanted to use the Yilamo spring because it was much cleaner than the springs in their kire; they also said they would like to join in the work to take care of the Yilamo spring. The Yilamo kire leaders, however, refused. They told the women to go back to their kire and get people to work on cleaning their own spring. The women said that people in their kire were not interested in working together like people in Yilamo, so they would not be able to clean their spring in the same way. Still, the kire leaders said “this is our spring and should be used only by members of our kire.” After this dramatic exchange, the women returned home and were eventually successful in cleaning their own spring in a similar manner as at Yilamo.

The form of such an external stimulus is multifaceted with a number of differing dimensions. Beyond individuals from outside

of the community who play a ‘face-to-face’ role there are often various support structures, intermediate organisations, and funding mechanisms. Attention below begins by focusing on the catalytic activities of individuals before considering implications for organisations and structures.

The purpose of a catalyst is to stimulate change.

Put simply, the desired change of ABCD is to see more ‘building of communities from the inside out.’ If one is interested in stimulating change, it is helpful to have a self-conscious framework for understanding how change happens. Since it is foundational to my views about the role of a catalyst, I’ll briefly share a theory about change that guides my work.

Behaviour, the way people act individually or within a group, is based on the way they see themselves in the world. It’s a matter of self-perception, self-story, self-image – which are all ways of saying the same thing. For example, it could be said that the unilateral tendencies and actions of the current US government are consistent with an image of rugged American individualism. Images are created through the reception of ‘messages.’ People continually incorporate, or discard, new messages into their accumulated understanding of themselves in the world. Messages come in many forms: verbal, visual, and experiential. Education is an elaborate process of conveying

various 'messages' about particular subjects. Messages come in varying degrees of strength: one reads all the time about the negative health effects of fatty foods. Yet these often only mildly alter one's prevailing self-understanding and behavioural choices about diet. A heart attack, however, is a much stronger message – as are most experiential messages.

Images go through a continual process of change. Most involve minor adjustments as new pieces of information (messages) are aligned to an existing image. Inconsistent messages that challenge a strong image are usually ignored. Sometimes, especially if received several times from differing sources, or if the message is strongly experiential, 'doubt' begins to emerge as the contradictory messages gain prominence. Radical change occurs when an established image is replaced by a totally new self-understanding. When images change, behaviour changes. This understanding about change can be summarised in five points: 1) people live out of images, 2) images control behaviour, 3) images are created by messages, 4) images can change, and 5) when images change, behaviour changes.

The desired change in my work has been to shift community self-understanding from passivity (e.g., waiting as 'clients' to receive services; self-images of being

'victims') to becoming active agents of their own development.

Catalysts play the role of a facilitator, not a direct implementer.

Effective catalysts from outside of the community don't do anything directly for people. They encourage people to do things on their own. ABCD emphasises that one leads best by stepping back. Communities drive their own development; catalysts facilitate the process. This implies a number of practical activities that are far easier to talk about than to do.

Catalysts enable a community to look realistically at itself. They hold up a mirror so residents can see themselves as they really are. Because people have been well conditioned to focus on their problems, facilitators emphasize analytic tools and exercises that help community residents to identify and recognize strengths and capacities which they may have overlooked or ignored in the past. Asset mapping tools developed by ABCD are valuable in doing this. Other methods from other sources are also helpful for identifying local strengths and capacities, e.g., those known under the name of "participatory rural appraisal" (PRA) are widespread in the 'south.' Key to them all, however, is a basic principle: Catalysts do not do the mapping, they facilitate community residents to map assets for themselves.

Catalysts connect people with each other and their existing resources. In doing so, they emphasize inclusiveness. Everyone in a community has something to contribute, be they at the centre of the community or on its margins. Facilitators, therefore, are leery of working only with small representational groups of 'leaders.' This often requires catalysts to play a role of 'provocateurs' because small cliques of leaders are typically quite content to assume responsibility themselves on behalf of the community at large. (More on a provocateur below.)

Catalysts facilitate the community to affirm its real situation without illusions or false hopes. It has been my experience that no matter how much a facilitator might focus discussions on a community's assets (i.e., the half glass that is full), sooner or later local people insist that the conversation turn to needs and problems (i.e., the glass is half empty). Though foremost attention is focused on assets, an over reluctance to discuss problems is a subtle denial of the real situation. The 'problem' with discussing problems is that they quickly cause a community to turn its attention outside of itself. Local frustrations are blamed on others or solutions are seen as being dependent upon external realities or generosities. A sense of victimisation is reinforced rather than challenged. Affirming the real situation means acknowledging the

active participation of a community in the problem. When a community recognises how it contributes to creating or perpetuating a problem, it also reveals practical ways that they themselves can self-consciously address that problem (see Box 2). Resolution may not be complete, but a way forward is always possible.

Box 2: Examining the Situation from Within

Discussions about local assets during the planning meeting were interesting to people in Endabeg, a village in the Babati District of Tanzania, but they also wanted facilitators to consider their needs.

Q: 'Okay, what do you think are some of your biggest needs?' A: 'We need for the co-op to deliver sufficient amounts of fertilizers to us on a timely basis.' Q: 'What is the problem that you hope will be solved?' A: 'Our crop production continues to go down every year.' Q: 'Besides your concerns about fertilizer, what are other possible reasons for the drop in crop production?' A: 'We are losing top soil to erosion.' Q: 'What practices are you following in Endabeg that might be perpetuating these problems?' A1: 'We are cutting trees on the high slopes above the fields; water is running too fast and flows over our fields.' A2: 'We are not careful about the direction in which we plow our fields.' A3: 'It isn't a soil erosion issue, but we are always planting the

same crop year after year so the ground is getting tired.' Q: 'What can you do differently in Endabeg to address some of these problems that are contributing to the ongoing drop in your crop production?' A: 'We could create small terraces, we could replant trees above our fields, we could rotate our crops, we could build some small dams to slow down the running water during the rains, we could ..., we could ... etc, etc. (Note: It takes patience and skill for a facilitator to ask probing questions in different ways; it also takes time to explore and consider different ideas and suggestions; small group work can be helpful here.)

Having identified its assets, catalysts facilitate people to build practical plans of action for mobilizing their resources and accomplishing realistic objectives. Local development plans thus become a symbol of consensus and a rallying point for inclusive action. They also give a practical foundation of any organizational issues that might arise within a community. My personal bias for being a catalyst is on enabling quick action rather than on long preparations periods for gathering detailed information and analysing it (whether on assets or other). In my experience, people learn best by doing and then reflecting

upon the experience. The sooner people begin acting on something of substance (even simple activities can be substantial), the better. Key, of course, is local residents being the primary implementers of their own plans. Catalysts are cautious about playing a direct and overly active role in connecting local communities with outside resources. The basic principle is this: don't do anything for people that they can do themselves.

Catalysts embody a 'presence' that helps build trust.

As a university intern living and working on the west side of Chicago in the late sixties, scathing reference to 'limousine social workers' made a strong impression on me.

More than simply describing those who drove in from the warm comforts of the suburbs to help needy people in the inner city (the 'ghetto' as we spoke back then), it symbolised an inauthentic relationship. Sophomoric abstractions about 'bad faith' suddenly became very real to me as I wrestled with my own vocation. Creating a genuine relationship with local people is essential for outsiders if they are to effectively play a catalytic role, but how is it practically done? The answer probably lies more in the way one actively struggles with the question than in prescribing a definitive formula. During the meeting in Evanston, we heard about work in Bosnia and an outsider embodying a genuine 'presence' to the local situation.

Though maybe not definitive guidelines, there are factors that might lead one in a helpful direction. Catalysts are accountable to local communities. They are there, in some form or another, only at the invitation of the community. But as outsiders, they are upfront about their role and intentions so everyone in can see their purpose and understand their motives. In doing so, a creative sense of 'obedience' to the community is established. Catalysts are consistent: they do what they say they are going to do. They are transparent: they are forth-coming about their actions and are open to being questioned about them.

Outsiders are not insiders. There may be examples where outsiders have become insiders through a lifetime of commitment (often with significant personal sacrifice), but anything short of this probably means that outsiders will always remain distinct from the community. Even in relatively short-term engagements, however, a foundation for trust can built through the integrity of one's empathetic respect and 'shared austerity.' It means standing genuinely present to the local situation. This is intimately tied to the subtle communication of visual, verbal, and experiential messages. During preparations for launching the 'Community Empowerment Programme' in Ethiopia, this issue was faced directly. Facilitators began to see how many of their

own ways of acting needed to change if they were going to be effective in working with the rural population. 'Shared austerity' in that context meant personal participation in many of the practical hardships experienced day in and day out by local community residents (see Box 3).

Box 3: Shared Austerity

One long session during preparations in Ethiopia dealt with ways that villagers typically perceive government workers. It was generally agreed that it was one of mistrust and suspicion. Group reflections took place around the following questions: What behaviour reveals mistrust? What images are consistent with that way of acting? What experiences might have helped create those images? If trust is an important factor for working successfully with villagers, what does this tell us about how we should carry out facilitation activities?

Conversation turned to travel modes of the villagers with whom they would be working – which consisted of walking along highland paths or riding donkeys and mules. There was near rebellion when the idea was first suggested that the facilitators do the same instead of traveling by four-wheel drive vehicles. Agreement was only reached to try it on the first workshops and then to 'evaluate' its impact. The experience was a life-changing event for most of them: their interaction with villagers was at a depth they had never before

known. Henceforth, the facilitators willingly took on severe hardships in conducting kire workshops. They traveled for hours by 'public means' to the distant districts (i.e., in the back of open lorries in dust and rain), walked or rode mules for miles over harsh terrain to reach designated kires, and had slept in the flea infested homes of peasant farmers for several weeks. This was a dramatic change for both villagers and young government professionals alike. Though not complete by itself, it did help to shift the relationship dramatically in the direction of mutual respect.

Catalysts have an agenda.

Those interested in ABCD want to see community development driven by the community. Outside catalysts are interested in providing minimal stimulus to overcome inertia and build momentum. They facilitate the process and avoid becoming a direct implementer. They are not the primary actors – those roles belong to members of the community. ABCD catalysts and facilitators, however, are not neutral. They have a definite agenda based on a coherent strategy with real aims. Without one, activities like asset mapping, etc., are reduced to being a series of rudderless techniques.

Effective catalysts, I believe, are bold in declaring their agenda.

Important messages can easily be missed when conveyed in a timid manner. This, of course, doesn't mean that one should indulge oneself as an obnoxious dogmatist, but it does mean acting with clarity and consistency while remaining politely firm. Integrity, which is the raw basis for trust, comes hand in hand with the transparent declaration of one's own agenda.

Women's participation in rural Africa is a good example of an outsider's agenda. The strategic justification for involving women is the inclusive widening of the circle so that all assets within a community can be recognised and drawn upon. In African cultures, however, involving women in the planning and management of important economic and social matters is almost always an imposition from the outside. It is sometimes unwelcome and at times overtly resented. This is one mirror that many male leaders would just as soon not be held to their face. By insisting upon women's participation in strong patriarchal societies, a catalyst moves away from the congenial impressions associated with a 'neutral' facilitator and dashes headfirst in the direction of a provocateur or an agitator. The challenge is to play these roles respectfully while also remaining resolutely committed to the importance of a well considered strategy (see Box 4). The specific features of a strategy may vary depending upon differing

circumstances, but an effective catalyst conveys them clearly and acts accordingly.

Box 4: Facilitation and Transparency

During preparations for the programme in Ethiopia, the facilitators said it would be difficult to have women and youth involved in planning community development activities; 'it's not in the culture of the highlands.' As with the transportation issue, we decided to give it an initial try during the first community planning events and then reflect on the experience. These first two were held in kires near to Dessie in South Wollo. Set-up work was done by facilitators who explained that the purpose of the planning, including the importance of women's involvement.

On the appointed day, I hiked with the facilitators to the first kire where we were greeted by a large number of men waiting for the workshop to begin. Those present easily represented 90% of the kire's 60 or so households, but no women were to be seen. When asked about the women, the kire chairman said 'we speak for our women here.' All eyes of the facilitators turned to me while silently saying 'we told you so.' I repeated the standard line – women's involvement is important for engaging and drawing upon

all of the strengths and resources within the community. Once again we were told that women would not be allowed to attend. 'I understand your position' I replied, 'and I hope you understand ours. If women don't participate in the planning, we cannot stay and facilitate the process.' With that we thanked them for their time and hiked back to Dessie.

Word in rural Africa can spread like wildfire. When we arrived in the second neighbouring kire a few days later, an acceptable quorum of women was present (about 30) along with a number of young people (admittedly, they were all young boys, not girls, but a catalyst is always ready to be flexible!). Small groups of women, youth, and men met to discuss strengths of the community and to suggest ideas about things that could be done in the community through the use of their own resources.. A good substantial plan of small-scale simple 'infrastructure' projects were planned (i.e., a small check dam to control erosion, terracing on some problematic fields, and protection of the spring). In closing reflections, several men said they didn't know before that 'their' women had so many good practical ideas.

Community planning workshops with over 300 similar kires were held during the next three years in South Wollo. Never again was it necessary to cancel one because of insufficient women's participation. This probably had more to do with the facilitators'

personal commitment to the agenda of the program, and the manner in which they presented it, than with anything else.

Leveraging external resources.

Most development programmes in Africa are dominated by a 'needs' perspective. There is often an overly eager desire among outsiders, even among those who talk a good line about 'bottom-up' development and 'local capacity building,' to rush quickly into arranging financial and material support for local communities. At some point it probably is important for most local communities to leverage external resources to complement their own. An effective catalyst, however, is extremely cautious: the premature arrival of external sources can overwhelm local efforts. Special attention should be given to the word 'leveraging.' It implies the community is the driving force for finding and obtaining additional resources. 'Introducing' or 'providing' imply that the essential initiating actor is outside of the community.

Like most things in an asset-based approach, the appropriate timing for leveraging external resources depends upon particular circumstances. It is yet another important factor in the development of a coherent strategy for guiding catalytic

action. It has been my experience that it is usually more effective to delay major attention on external resources. If uncertain about timing, it is better to error on the side of later rather than sooner. The reason for this has to do with perceptions and self-images within the community. The image of being a 'needy client' is often a deeply entrenched one. It causes people to look first outside of themselves for solutions to problems. Communities experience internal power by mobilising their own resources. The more times they successfully repeat it, the stronger the experiential messages become for reinforcing a new image (i.e., we are agents of our own development) to replace an old dominant one (i.e., we are needy clients). Forming a new image – which is the foundation for change – is a delicate process. Emerging new images are easily overpowered by old familiar messages (see Box 5 below).

Box 5: Unintended Results

The "Cooperative Members Participation Programme" (CMPP) in east Africa was a strategic effort (via funding from the Swedish Cooperative Centre, Utan Gräsner), to transform local co-ops from being service providers to becoming organisational vehicles for local initiative and action based upon local resources. A small team of two or three facilitators would work with a village co-op to enable the creation of a local development plan. Facilitation of the planning,

and then follow-up to assist in the review and adjustment of these plans, were the only external support offered by the programme: absolutely no material or financial resources were available through CMPP.

One of the first of these workshops was held with a village co-op near Kilosa in the Morogoro Region of Tanzania. During the workshop, villagers decided to finally complete construction of a small 'clinic' -- a simple 20 square metres building so that village women would have a place to go to give birth in a sanitary environment and rest for a few days afterwards. Construction on the building had begun two years earlier when UNICEF provided a small grant to the village for this purpose. The money, however, had run out before the building was completed: it had stood half finished ever since as the village waited for UNICEF to return with more money. It was decided during the meeting to make the clinic a top priority (the idea was brought to the fore by a large number of women, many of whom were attending a village planning meeting for the first time). Shortly afterwards, they organised the making of mud bricks, completed the walls, and made wooden shutters for empty windows. When a national cooperative officer happened to visit the village a few weeks

later, the villagers explained that they were close to finishing the building: next week they were going to remove old rusting tin sheets from a collapsed co-op storage shed to complete the clinic by laying the roof. The official was extremely impressed with the way people were working together and using their own meagre resources to accomplish things. To support and encourage their efforts, he told them that his organisation would buy the village new roofing sheets so there was no need for them to use the old rusting ones. The villagers cancelled their workday anticipating the arrival of the new metal sheets. Unfortunately, the official could not make good on his commitment and the materials

never arrived. When the facilitators returned to the village three months later to conduct a progress review on the village development plan, the clinic remained unfinished and was beginning to deteriorate once again.

Mini-grants as the 'leading' catalytic strategy and its relationship to face-to-face facilitation.

This is certainly not an either/or issue. After three and a half years of work in Ethiopia, the primary proposal from those of us who worked closest with the 'Community Empowerment Programme' was to establish 'District Development

Funds' that would manage and oversee mini-grants to local kires. Though funding for this was not secured (so it never happened), it does seem an appropriate complement to face-to-face facilitation – especially in the more mature stages of a strategy based on face-to-face interactions.

Because of my limited experience with community foundations, I have questions about using mini-grants as a leading, or initiating, catalytic strategy (i.e., without much face-to-face catalytic interaction). This is especially true in Africa. My questions are primarily concerned with other ways of nurturing a 'learning environment' within local communities. The practical skills and institutional infrastructure of rural villages in Africa are far different from those found in North America. I would like to personally learn more about different experiences of community foundations in the 'south.'

I would especially like to learn more from Latin America where I have no experience at all. What practical mechanisms have they found for enabling a learning environment to occur in the absence of the face-to-face interaction. Or am I being too narrow in my thinking with the assumption that mini-grants strategies are overly constrained (at least in the early stages of proposal

writing and project formation) by paper interactions? Clearly, I need to learn more.

How long should an outsider be involved in the catalytic process?

In Africa, I have favoured quickly moving into action without overly long preparation stages of data gathering and analysis. The emphasis has been on structuring and systematising the minimal external stimulus that can effectively occasion significant change within a large number of communities. These are clearly aspects of a broad expansive strategy for catalysing change. This is sharp contrast to a more in-depth intensive strategy that focuses on a smaller number of communities – perhaps as small as one. The intention among intensive strategies is to widely influence other communities through the power of their demonstration. Expansive strategies imply more brief engagement over shorter periods of time while intensive strategies imply lengthy involvement over the long haul. Indeed, it seems that within an intensive strategy, if involved for a truly long time, an outsider almost loses one's identity as such and becomes more or less a member of the community. Their immersion is a confirmation of vocational commitments manifest in where they live and how they work.

Neither strategy is better than the other, but they are different. Playing the role of an external catalyst is an art and not a science. There is no one 'right' way to do it. Forming

a particular coherent strategy depends upon aligning a range of factors within the local context. The big issue, I'd suggest, is consistency and transparency in making the alignment. To summarise my experience, the structure of a bare bones 'minimal external stimulus' of an expansive strategy working with several communities in near proximity (e.g., a district) might look like this:

1) An initial meeting with established local leaders in their home villages to discuss the idea of doing development based on local resources; a contextual discussion about expanding inclusiveness via gender and age in the planning and management; agreement (or not) to host a community planning event and clarifying preparation issues.

2) A two-day community-wide planning event that identifies key assets and creates local action plans based on the connection and utilisation of local resources.

3) Four quarterly community-wide 'review' meetings where progress reports are given, physical inspections are made, and everyone at the meeting is engaged in reflections about lessons learned; this is followed by preparation of action plans for the next quarter.

4) At least one district-wide meeting during the course of the year where representatives

of communities and government officials come together to celebrate local accomplishments, share ideas about accelerating the process, and draw together lessons learned about bottom-up development.

5) Regular learning events (at least quarterly) for outsider catalysts to meet together, share their experience, reflect upon lessons learned, and make modifications for their next steps of interaction with local communities.

Since I have worked with several programmes along these lines over the years, I am always asked about long-term change within this 'minimalist' approach. Though short-term effects are modest, I believe them to be significant. While I have extensively studied many communities in the short-term (e.g., I followed activities in two Tanzanian villages through annual visits over a three-year period – the cases are available to those interested), I, too, am curious about long-term change. Now that ten years have passed, it would be valuable to visit those same two villages in Tanzania again (or some of the kires in Ethiopia) and learn what has happened since.

How do outsiders learn to become catalysts?

An environment for mutual learning is crucial. The environment (participants in attendance, location for site visits, a participatory format) is as important as the composition of topics to be considered.

Since there is no one right way to be a catalyst, the more diversity of experience and perspective the better. When I have facilitated such events, I've structured time and participatory exercises around subjects that allow for a lot of interaction and group reflection. Contextual frameworks are provided primarily to stimulate conversation and creative thinking. Good topics and exercises for enabling outsiders to learn about catalytic action might include:

- how does change occur?
- what happens to a community when it focuses on assets? what happens to a community when it focuses on needs? how is the difference between the two informative to someone who desires to be a catalyst?
- site visits to successful examples of an ABCD approach.
- a review of various facilitation techniques; practical experience of using such techniques.
- designing engagement plans for catalytic action in the group members' home situations.
- sharing and reflection (and creative critique and feedback from others).
- lessons learned about funding and leveraging external resources.
- what are the most appropriate ways for an outsider to enter a community? what is a genuine 'invitation' (and what isn't)?
- what lessons have been learned about what an effective catalyst does and does not do?

In making this list, I realise that these are the 'hot topics' that I personally want to explore! Which is appropriate since learning is at its strongest when it is a shared experience and a lifetime pursuit. It does offer an insight, however, for designing any learning event: topics and exercises, etc., are tailored around the interests and questions of the particular people who have come together to learn.

What lessons can be offered to intermediary organisations in the effective design and management of ABCD-oriented activities?

For those of us who are working within an ABCD context, there is an inherent skepticism to interventions designed, managed, and controlled by organisations outside of a local community. Most have been fostered within a needs perspective and treat community residents like clients. Social service agencies, municipal governments, united ways, and various humanitarian organisations have sprung from this tradition and are susceptible to its perpetuation. In many ways ABCD is an alternative defined over against this perspective. In the 'south,' non-governmental organisations (NGO) have emerged as a major presence in the social development landscape. While they are not the only form of intermediate organisations working in the field of community development, they are a dominant one.

Problems and criticisms are as easy to list for intermediary organisations in

the 'south' as they are elsewhere. The project orientation of their work is usually short-term: it feeds upon problem identification and a quick fix. They are accountable primarily to donors, board of directors, or other external authorities – and not, in the first instance, to the people they serve. It is in their self-interest to remain problem-focused because it secures their own role as problem solvers. Many NGOs, accordingly, have begun to closely resemble businesses that hawk their wares (i.e., services), and in doing so provide ongoing employment for their professional staff. In regards to packaging their projects and programmes, there is a strong tendency to co-opt new sexy language (ABCD could easily become one) without substantially changing practices that perpetuate the professional-client relationship. As one recent book points out, many have turned the creative insights of 'participation' into a new tyranny. There are times when 'lords of poverty' isn't much of an exaggeration.

Though it is easy to see a glass half empty, it is also possible to find and build upon the assets of NGOs and other intermediary organisations. Though actual practice may lag far behind the rhetoric that these groups commonly use about community-based development, many individuals within these organisations have a genuine vision to which they aspire. Through

them, there is an opportunity for an ABCD faculty to enable wider institutional learning to occur.

Within any particular intermediary organisation, this means holding up a mirror and letting it reveal naked realities. The selection below is a 'mirror' that I held up to a programme in Zambia (see Box 6). It served as the central reference point for a two-day workshop with staff and senior management of the NGO. Admittedly, deep discussions in learning environments like this don't immediately overcome complex contradictions. After all, the 'mirror' revealed structural flaws as well as issues in daily practice. But they can call forth new perspectives that encourage and enrich personal convictions. Besides altering practices in the present, it may also lead toward different ways of approaching community building in the future. A major challenge is to engage donors in a similar learning process for it is they who often have an extremely influential role in establishing overall frameworks. Publications and documentation of good examples of 'building communities from the inside out' is obviously another way that the dialogue can be intensified.

Box 6: Mixed Messages

The Programme of Support for Poverty Elimination (PROSPECT) in Zambia gives an example of an inadvertent gap between rhetoric and practice. This multi-million

pound project is funded by the British government and implemented by CARE. Its objective is the alleviation of poverty and improved household livelihoods in the para-urban 'slums' of Lusaka through locally planned and initiated projects. Capacity building of community institutions is a central part of the entire programme and PRA techniques have been used throughout its operation. In the first instance, it is not a typical intervention with a focus on a particular sector but it does include provisions for funding infrastructure projects selected by the community. It is intended that local capacity building and organizational development should take place around these inputs. More often than not the infrastructure development desired by the community is an improvement in water supply.

Yet 'mixed signals' are caused by an emphasis on bottom-up development and local capacity-building on one hand and the completion of large infrastructure projects on the other. They lead to immense confusion and conflict in regards to community participation, ownership, and service. Community residents with whom PROSPECT works are told that they are the 'owners' of the water project but soon discover that the municipal water company is really the 'legal' owner while the community is

merely the 'symbolic' owner. They are told that ongoing 'sustainable' development can only occur through local initiatives, and the labour spent on water construction should therefore be voluntary, but previous work within the programme's immediate predecessor (which was also implemented by CARE) was paid with 'food for work.' In planning implementation schedules and work plans, community residents discover conditions and externally imposed deadlines.

When such 'blended' approaches are employed (combining traditional 'blueprint' projects with open-ended 'process' programmes), even when the ultimate intention declared in programme documents is empowerment and local capacity building, 'external management' during the phases of project implementation, to one degree or another, is a very difficult problem to overcome. Handovers in ownership clearly imply transfers. People may be consulted and given a role to play in various phases of a project's life through actively seeking their participation in one form or another; this may include the use of PRA techniques. Ultimately, however, authority for such projects resides outside of the community and is largely governed by interests of external agencies. Though characterization of 'external management' may be seen as a harsh judgment by NGOs like CARE (especially within participatory capacity-building programmes like

PROSPECT), introduction of major infrastructure projects greatly enhances the potential risks of externally determined objectives that must be fulfilled in one way or another. This external agenda greatly influences, or even drives, the process, regardless of how enlightened programme intentions may be.

What practical advice might be offered to intermediary organisations in the 'south?' A good approach begins with a good design. Good here essentially means 'consistent.' The gap between rhetoric and practice usually arises when a programme design attempts to 'blend' approaches. Historically, needs-based approaches have attempted to do things for people. There is a lot of discussion today about doing development with people. An asset-based approach emphasises development by people themselves. Blended approaches are a result of cut-and-paste efforts to marry together activities from two or more of these approaches. The primary contradiction for most community-based programmes, I believe, is one of mixed messages. Blending approaches creates a structural recipe that virtually ensures confusion. Good intermediary organisations strive to identify these contradictions

and work very hard to alleviate mixed messages wherever they might creep in. Ultimately, this is where the integrity of an outside catalyst is truly at stake; this is also where an external catalyst is most vulnerable.

Conclusion

During the January meeting in Evanston, it was pointed out that focusing on detailed categories is an academic tendency to break things down into manageable parts. My reflections above have done just that. Being an effective catalyst, however, is an artful matter of aligning actions into a holistic, unified undertaking. May we all continue the journey of learning from each other about the effective orchestration of the whole.

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DESIGN THINKING FOR SOCIAL INNOVATION

By Tim Brown & Jocelyn Wyatt

Designers have traditionally focused on enhancing the look and functionality of products. Recently, they have begun using design techniques to tackle more complex problems, such as finding ways to provide low-cost healthcare throughout the world. Businesses were the first to embrace this new approach—called design thinking—and nonprofits are beginning to adopt it too.

In an area outside Hyderabad, India, between the suburbs and the countryside, a young woman—we'll call her Shanti—fetches water daily from the always-open local borehole that is about 300 feet from her home. She uses a 3-gallon plastic container that she can easily carry on her head. Shanti and her husband rely on the free water for their drinking and washing, and though they've heard that it's not as safe as water from the Naandi Foundation-run community treatment plant, they still use it. Shanti's family has been drinking the local water for generations, and although it periodically makes her and her family sick, she has no plans to stop using it.

Shanti has many reasons not to use the water from the Naandi

treatment center, but they're not the reasons one might think. The center is within easy walking distance of her home—roughly a third of a mile. It is also well known and affordable (roughly 10 rupees, or 20 cents, for 5 gallons). Being able to pay the small fee has even become a status symbol for some villagers. Habit isn't a factor, either. Shanti is forgoing the safer water because of a series of flaws in the overall design of the system.

Although Shanti can walk to the facility, she can't carry the 5-gallon jerrican that the facility requires her to use. When filled with water, the plastic rectangular container is simply too heavy. The container isn't designed to be held on the hip or the head, where she likes to carry heavy objects. Shanti's husband can't help carry it, either. He works in the city and doesn't return home until after the water treatment center is closed. The treatment center also requires them to buy a monthly punch card for 5 gallons a day, far more than they need. "Why would I buy more than I need and waste money?" asks Shanti, adding she'd be more likely to purchase the Naandi water if the center allowed her to buy less.

The community treatment center was designed to produce clean and

potable water, and it succeeded very well at doing just that. In fact, it works well for many people living in the community, particularly families with husbands or older sons who own bikes and can visit the treatment plant during working hours. The designers of the center, however, missed the opportunity to design an even better system because they failed to consider the culture and needs of all of the people living in the community.

This missed opportunity, although an obvious omission in hindsight, is all too common. Time and again, initiatives falter because they are not based on the client's or customer's needs and have never been prototyped to solicit feedback. Even when people do go into the field, they may enter with preconceived notions of what the needs and solutions are. This flawed approach remains the norm in both the business and social sectors.

As Shanti's situation shows, social challenges require systemic solutions that are grounded in the client's or customer's needs.

This is where many approaches founder, but it is where design thinking—a new approach to creating solutions—excels.

Traditionally, designers focused their attention on improving the look and functionality of products. Classic examples of this type of design work are Apple Computer's iPod and Herman

Miller's Aeron chair. In recent years designers have broadened their approach, creating entire systems to deliver products and services.

Design thinking incorporates constituent or consumer insights in depth and rapid prototyping, all aimed at getting beyond the assumptions that block effective solutions. Design thinking—inherently optimistic, constructive, and experiential—addresses the needs of the people who will consume a product or service and the infrastructure that enables it.

Businesses are embracing design thinking because it helps them be more innovative, better differentiate their brands, and bring their products and services to market faster. Nonprofits are beginning to use design thinking as well to develop better solutions to social problems. Design thinking crosses the traditional boundaries between public, for-profit, and nonprofit sectors. By working closely with the clients and consumers, design thinking allows high-impact solutions to bubble up from below rather than being imposed from the top.

Design Thinking at Work

Jerry Sternin, founder of the Positive Deviance Initiative and an associate professor at Tufts University until he died last year, was skilled at identifying what and critical of what he called outsider solutions to local problems. Sternin's preferred approach to social innovation is an example of design thinking in

action.¹ In 1990, Sternin and his wife, Monique, were invited by the government of Vietnam to develop a model to decrease in a sustainable manner high levels of malnutrition among children in 10,000 villages. At the time, 65 percent of Vietnamese children under age 5 suffered from malnutrition, and most solutions relied on government and UN agencies donations of nutritional supplements. But the supplements—the outsider solution—never delivered the hoped-for results.² As an alternative, the Sternins used an approach called positive deviance, which looks for existing solutions (hence sustainable) among individuals and families in the community who are already doing well.³

The Sternins and colleagues from Save the Children surveyed four local Quong Xuong communities in the province of Than Hoa and asked for examples of “very, very poor” families whose children were healthy. They then observed the food preparation, cooking, and serving behaviors of these six families, called “positive deviants,” and found a few consistent yet rare behaviors. Parents of well-nourished children collected tiny shrimps, crabs, and snails from rice paddies and added them to the food, along with the greens from sweet potatoes. Although these foods were readily available, they were typically not eaten

because they were considered unsafe for children. The positive deviants also fed their children multiple smaller meals, which allowed small stomachs to hold and digest more food each day.

The Sternins and the rest of their group worked with the positive deviants to offer cooking classes to the families of children suffering from malnutrition. By the end of the program’s first year, 80 percent of the 1,000 children enrolled in the program were adequately nourished. In addition, the effort had been replicated within 14 villages across Vietnam.⁴

The Sternins’ work is a good example of how positive deviance and design thinking relies on local expertise to uncover local solutions. Design thinkers look for work-arounds and improvise solutions—like the shrimps, crabs, and snails—and they find ways to incorporate those into the offerings they create. They consider what we call the edges, the places where “extreme” people live differently, think differently, and consume differently. As Monique Sternin, now director of the Positive Deviance Initiative, explains: “Both positive deviance and design thinking are human-centered approaches. Their solutions are relevant to a unique cultural context and will not necessarily work outside that specific situation.”

One program that might have benefited from design thinking is mosquito net distribution in Africa.

The nets are well designed and when used are effective at reducing the incidence of malaria.⁵ The World Health Organization praised the nets, crediting them with significant drops in malaria deaths in children under age 5: a 51 percent decline in Ethiopia, 34 percent decline in Ghana, and 66 percent decline in Rwanda.⁶ The way that the mosquito nets have been distributed, however, has had unintended consequences. In northern Ghana, for instance, nets are provided free to pregnant women and mothers with children under age 5. These women can readily pick up free nets from local public hospitals. For everyone else, however, the nets are difficult to obtain. When we asked a well-educated Ghanaian named Albert, who had recently contracted malaria, whether he slept under a mosquito net, he told us no—there was no place in the city of Tamale to purchase one. Because so many people can obtain free nets, it is not profitable for shop owners to sell them. But hospitals are not equipped to sell additional nets, either.

As Albert's experience shows, it's critical that the people designing a program consider not only form and function, but distribution channels as well. One could say that the free nets were never intended for people like Albert—that he was simply out of the

scope of the project. But that would be missing a huge opportunity. Without considering the whole system, the nets cannot be widely distributed, which makes the eradication of malaria impossible.

The Origin of Design Thinking

IDEO was formed in 1991 as a merger between David Kelley Design, which created Apple Computer's first mouse in 1982, and ID Two, which designed the first laptop computer, also in 1982. Initially, IDEO focused on traditional design work for business, designing products like the Palm V personal digital assistant, Oral-B toothbrushes, and Steelcase chairs. These are the types of objects that are displayed in lifestyle magazines or on pedestals in modern art museums.

By 2001, IDEO was increasingly being asked to tackle problems that seemed far afield from traditional design. A healthcare foundation asked us to help restructure its organization, a century-old manufacturing company wanted to better understand its clients, and a university hoped to create alternative learning environments to traditional classrooms. This type of work took IDEO from designing consumer products to designing consumer experiences.

To distinguish this new type of design work, we began referring to it as "design with a small d." But this phrase never seemed fully satisfactory. David Kelley, also the founder of Stanford University's

Hasso Plattner Institute of Design (aka the “d.school”), remarked that every time someone asked him about design, he found himself inserting the word “thinking” to explain what it was that designers do. Eventually, the term design thinking stuck.⁷

As an approach, design thinking taps into capacities we all have but that are overlooked by more conventional problem-solving practices. Not only does it focus on creating products and services that are human centered, but the process itself is also deeply human. Design thinking relies on our ability to be intuitive, to recognize patterns, to construct ideas that have emotional meaning as well as being functional, and to express ourselves in media other than words or symbols. Nobody wants to run an organization on feeling, intuition, and inspiration, but an over-reliance on the rational and the analytical can be just as risky. Design thinking, the integrated approach at the core of the design process, provides a third way.

The design thinking process is best thought of as a system of overlapping spaces rather than a sequence of orderly steps. There are three spaces to keep in mind: inspiration, ideation, and implementation. Think of inspiration as the problem or opportunity that motivates the search for solutions; ideation

as the process of generating, developing, and testing ideas; and implementation as the path that leads from the project stage into people’s lives.

The reason to call these spaces, rather than steps, is that they are not always undertaken sequentially. Projects may loop back through inspiration, ideation, and implementation more than once as the team refines its ideas and explores new directions. Not surprisingly, design thinking can feel chaotic to those doing it for the first time. But over the life of a project, participants come to see that the process makes sense and achieves results, even though its form differs from the linear, milestone-based processes that organizations typically undertake.

Inspiration

Although it is true that designers do not always proceed through each of the three spaces in linear fashion, it is generally the case that the design process begins with the inspiration space—the problem or opportunity that motivates people to search for solutions. And the classic starting point for the inspiration phase is the brief. The brief is a set of mental constraints that gives the project team a framework from which to begin, benchmarks by which they can measure progress, and a set of objectives to be realized—such as price point, available technology, and market segment.

But just as a hypothesis is not the same as an algorithm, the brief is not

a set of instructions or an attempt to answer the question before it has been posed. Rather, a well-constructed brief allows for serendipity, unpredictability, and the capricious whims of fate—the creative realm from which breakthrough ideas emerge. Too abstract and the brief risks leaving the project team wandering; too narrow a set of constraints almost guarantees that the outcome will be incremental and, likely, mediocre.

Once the brief has been constructed, it is time for the design team to discover what people's needs are. Traditional ways of doing this, such as focus groups and surveys, rarely yield important insights. In most cases, these techniques simply ask people what they want. Conventional research can be useful in pointing toward incremental improvements, but those don't usually lead to the type of breakthroughs that leave us scratching our heads and wondering why nobody ever thought of that before.

Henry Ford understood this when he said, "If I'd asked my customers what they wanted, they'd have said 'a faster horse.'" ⁸ Although people often can't tell us what their needs are, their actual behaviors can provide us with invaluable clues about their range of unmet needs.

A better starting point is for designers to go out into the

world and observe the actual experiences of smallholder farmers, schoolchildren, and community health workers as they improvise their way through their daily lives. Working with local partners who serve as interpreters and cultural guides is also important, as well as having partners make introductions to communities, helping build credibility quickly and ensuring understanding. Through "homestays" and shadowing locals at their jobs and in their homes, design thinkers become embedded in the lives of the people they are designing for.

Earlier this year, Kara Pecknold, a student at Emily Carr University of Art and Design in Vancouver, British Columbia, took an internship with a women's cooperative in Rwanda. Her task was to develop a Web site to connect rural Rwandan weavers with the world. Pecknold soon discovered that the weavers had little or no access to computers and the Internet. Rather than ask them to maintain a Web site, she reframed the brief, broadening it to ask what services could be provided to the community to help them improve their livelihoods. Pecknold used various design thinking techniques, drawing partly from her training and partly from ideo's Human Centered Design toolkit, to understand the women's aspirations.

Because Pecknold didn't speak the women's language, she asked them to document their lives and aspirations with a camera and draw

pictures that expressed what success looked like in their community. Through these activities, the women were able to see for themselves what was important and valuable, rather than having an outsider make those assumptions for them. During the project, Pecknold also provided each participant with the equivalent of a day's wages (500 francs, or roughly \$1) to see what each person did with the money. Doing this gave her further insight into the people's lives and aspirations. Meanwhile, the women found that a mere 500 francs a day could be a significant, life-changing sum. This visualization process helped both Pecknold and the women prioritize their planning for the community.⁹

Ideation

The second space of the design thinking process is ideation. After spending time in the field observing and doing design research, a team goes through a process of synthesis in which they distill what they saw and heard into insights that can lead to solutions or opportunities for change. This approach helps multiply options to create choices and different insights about human behavior. These might be alternative visions of new product offerings, or choices among various ways of creating interactive experiences.

By testing competing ideas against one another, the likelihood that the outcome will be bolder and more compelling increases.

As Linus Pauling, scientist and two-time Nobel Prize winner, put it, "To have a good idea you must first have lots of ideas."¹⁰ Truly innovative ideas challenge the status quo and stand out from the crowd—they're creatively disruptive. They provide a wholly new solution to a problem many people didn't know they had.

Of course, more choices mean more complexity, which can make life difficult, especially for those whose job it is to control budgets and monitor timelines. The natural tendency of most organizations is to restrict choices in favor of the obvious and the incremental. Although this tendency may be more efficient in the short run, it tends to make an organization conservative and inflexible in the long run. Divergent thinking is the route, not the obstacle, to innovation.

To achieve divergent thinking, it is important to have a diverse group of people involved in the process. Multidisciplinary people—architects who have studied psychology, artists with MBAs, or engineers with marketing experience—often demonstrate this quality. They're people with the capacity and the disposition for collaboration across disciplines.

To operate within an interdisciplinary environment, an individual needs to have strengths in two

dimensions—the “T-shaped” person. On the vertical axis, every member of the team needs to possess a depth of skill that allows him or her to make tangible contributions to the outcome. The top of the “T” is where the design thinker is made. It’s about empathy for people and for disciplines beyond one’s own. It tends to be expressed as openness, curiosity, optimism, a tendency toward learning through doing, and experimentation. (These are the same traits that we seek in our new hires at IDEO.)

Interdisciplinary teams typically move into a structured brainstorming process. Taking one provocative question at a time, the group may generate hundreds of ideas ranging from the absurd to the obvious. Each idea can be written on a Post-it note and shared with the team. Visual representations of concepts are encouraged, as this generally helps others understand complex ideas.

One rule during the brainstorming process is to defer judgment. It is important to discourage anyone taking on the often obstructive, non-generative role of devil’s advocate, as Tom Kelley explains in his book *The Ten Faces of Innovation*.¹¹ Instead, participants are encouraged to come up with as many ideas as possible. This lets the group move into a process of grouping and sorting

ideas. Good ideas naturally rise to the top, whereas the bad ones drop off early on. InnoCentive provides a good example of how design thinking can result in hundreds of ideas. InnoCentive has created a Web site that allows people to post solutions to challenges that are defined by InnoCentive members, a mix of nonprofits and companies. More than 175,000 people—including scientists, engineers, and designers from around the world—have posted solutions.

The Rockefeller Foundation has supported 10 social innovation challenges through InnoCentive and reports an 80 percent success rate in delivering effective solutions to the nonprofits posting challenges.¹² The open innovation approach is effective in producing lots of new ideas. The responsibility for filtering through the ideas, field-testing them, iterating, and taking them to market ultimately falls to the implementer.

An InnoCentive partnership with the Global Alliance for TB Drug Development sought a theoretical solution to simplify the current TB treatment regimen. “The process is a prime example of design thinking contributing to social innovation,” explained Dwayne Spradlin, InnoCentive’s CEO. “With the TB drug development, the winning solver was a scientist by profession, but submitted to the challenge because his mother—the sole income provider for the family—developed TB when he was 14. She

had to stop working, and he took on the responsibility of working and going to school to provide for the family.” Spradlin finds that projects within the InnoCentive community often benefit from such deep and motivating connections.¹³

Implementation

The third space of the design thinking process is implementation, when the best ideas generated during ideation are turned into a concrete, fully conceived action plan. At the core of the implementation process is prototyping, turning ideas into actual products and services that are then tested, iterated, and refined.

Through prototyping, the design thinking process seeks to uncover unforeseen implementation challenges and unintended consequences in order to have more reliable long-term success. Prototyping is particularly important for products and services destined for the developing world, where the lack of infrastructure, retail chains, communication networks, literacy, and other essential pieces of the system often make it difficult to design new products and services.

Prototyping can validate a component of a device, the graphics on a screen, or a detail in the interaction between a blood donor and a Red Cross volunteer. The prototypes at this point may be expensive, complex, and even indistinguishable from the real

thing. As the project nears completion and heads toward real-world implementation, prototypes will likely become more complete.

After the prototyping process is finished and the ultimate product or service has been created, the design team helps create a communication strategy. Storytelling, particularly through multimedia, helps communicate the solution to a diverse set of stakeholders inside and outside of the organization, particularly across language and cultural barriers.

VisionSpring, a low-cost eye care provider in India, provides a good example of how prototyping can be a critical step in implementation. VisionSpring, which had been selling reading glasses to adults, wanted to begin providing comprehensive eye care to children. VisionSpring’s design effort included everything other than the design of the glasses, from marketing “eye camps” through self-help groups to training teachers about the importance of eye care and transporting kids to the local eye care center.

Working with VisionSpring, IDEO designers prototyped the eye-screening process with a group of 15 children between the ages of 8 and 12. The designers first tried to screen a young girl’s vision through traditional tests. Immediately, though, she burst into tears—the pressure of the experience was too great and the risk of failure too high. In hopes of diffusing this stressful situation, the designers asked the

children's teacher to screen the next student. Again, the child started to cry. The designers then asked the girl to screen her teacher. She took the task very seriously, while her classmates looked on enviously. Finally, the designers had the children screen each other and talk about the process. They loved playing doctor and both respected and complied with the process.

By prototyping and creating an implementation plan to pilot and scale the project, IDEO was able to design a system for the eye screenings that worked for VisionSpring's practitioners, teachers, and children. As of September 2009, VisionSpring had conducted in India 10 eye camps for children, screened 3,000 children, transported 202 children to the local eye hospital, and provided glasses for the 69 children who needed them.

"Screening and providing glasses to kids presents many unique problems, so we turned to design thinking to provide us with an appropriate structure to develop the most appropriate marketing and distribution strategy," explained Peter Eliassen, vice president of sales and operations at VisionSpring. Eliassen added that prototyping let VisionSpring focus on the approaches that put children at ease during the screening process. "Now that we have become a design thinking organization, we continue

to use prototypes to assess the feedback and viability of new market approaches from our most important customers: our vision entrepreneurs [or salespeople] and end consumers." ¹⁴

Systemic Problems Need Systemic Solutions

Many social enterprises already intuitively use some aspects of design thinking, but most stop short of embracing the approach as a way to move beyond today's conventional problem solving. Certainly, there are impediments to adopting design thinking in an organization. Perhaps the approach isn't embraced by the entire organization. Or maybe the organization resists taking a human-centered approach and fails to balance the perspectives of users, technology, and organizations.

One of the biggest impediments to adopting design thinking is simply fear of failure. The notion that there is nothing wrong with experimentation or failure, as long as they happen early and act as a source of learning, can be difficult to accept. But a vibrant design thinking culture will encourage prototyping—quick, cheap, and dirty—as part of the creative process and not just as a way of validating finished ideas.

As Yasmina Zaidman, director of knowledge and communications at Acumen Fund, put it, "The businesses we invest in require constant creativity and problem solving, so design thinking is a real success factor for serving the base

of the economic pyramid." Design thinking can lead to hundreds of ideas and, ultimately, real-world solutions that create better outcomes for organizations and the people they serve.

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SOCIAL ENTREPRENEURSHIP: THE CASE FOR DEFINITION

By Roger L Martin & Sally Osberg

Social entrepreneurship is attracting growing amounts of talent, money, and attention. But along with its increasing popularity has come less certainty about what exactly a social entrepreneur is and does. As a result, all sorts of activities are now being called social entrepreneurship. Some say that a more inclusive term is all for the good, but the authors argue that it's time for a more rigorous definition.

THE NASCENT FIELD OF social entrepreneurship is growing rapidly and attracting increased attention from many sectors. The term itself shows up frequently in the media, is referenced by public officials, has become common on university campuses, and informs the strategy of several prominent social sector organizations, including Ashoka and the Schwab and Skoll foundations.

The reasons behind the popularity of social entrepreneurship are many. On the most basic level, there's something inherently interesting and appealing about entrepreneurs and the stories of why and how they do what they do. People are attracted

to social entrepreneurs like last year's Nobel Peace Prize laureate Muhammad Yunus for many of the same reasons that they find business entrepreneurs like Steve Jobs so compelling – these extraordinary people come up with brilliant ideas and against all the odds succeed at creating new products and services that dramatically improve people's lives.

But interest in social entrepreneurship transcends the phenomenon of popularity and fascination with people. Social entrepreneurship signals the imperative to drive social change, and it is that potential payoff, with its lasting, transformational benefit to society, that sets the field and its practitioners apart.

Although the potential benefits offered by social entrepreneurship are clear to many of those promoting and funding these activities, the actual definition of what social entrepreneurs do to produce this order of magnitude return is less clear. In fact, we would argue that the definition of social entrepreneurship today is anything but clear. As a result, social entrepreneurship has become so inclusive that it now has an immense tent into which all manner of socially beneficial activities fit.

In some respects this inclusiveness could be a good thing. If plenty of resources are pouring into the social sector, and if many causes that otherwise would not get sufficient funding now get support because they are regarded as social entrepreneurship, then it may be fine to have a loose definition. We are inclined to argue, however, that this is a flawed assumption and a precarious stance.

Social entrepreneurship is an appealing construct precisely because it holds such high promise. If that promise is not fulfilled because too many “nonentrepreneurial” efforts are included in the definition, then social entrepreneurship will fall into disrepute, and the kernel of true social entrepreneurship will be lost. Because of this danger, we believe that we need a much sharper definition of social entrepreneurship, one that enables us to determine the extent to which an activity is and is not “in the tent.” Our goal is not to make an invidious comparison between the contributions made by traditional social service organizations and the results of social entrepreneurship, but simply to highlight what differentiates them.

If we can achieve a rigorous definition, then those who support social entrepreneurship can focus their resources on building and strengthening a

concrete and identifiable field. Absent that discipline, proponents of social entrepreneurship run the risk of giving the skeptics an ever-expanding target to shoot at, and the cynics even more reason to discount social innovation and those who drive it.

Starting With Entrepreneurship

Any definition of the term “social entrepreneurship” must start with the word “entrepreneurship.” The word “social” simply modifies entrepreneurship. If entrepreneurship doesn’t have a clear meaning, then modifying it with social won’t accomplish much, either.

The word entrepreneurship is a mixed blessing. On the positive side, it connotes a special, innate ability to sense and act on opportunity, combining out-of-the-box thinking with a unique brand of determination to create or bring about something new to the world. On the negative side, entrepreneurship is an *ex post* term, because entrepreneurial activities require a passage of time before their true impact is evident.

Interestingly, we don’t call someone who exhibits all of the personal characteristics of an entrepreneur – opportunity sensing, out-of-the-box thinking, and determination – yet who failed miserably in his or her venture an entrepreneur; we call him or her a business failure. Even someone like Bob Young, of Red Hat Software fame, is called a “serial entrepreneur” only after his

first success; i.e., all of his prior failures are dubbed the work of a serial entrepreneur only after the occurrence of his first success. The problem with ex post definitions is that they tend to be ill defined. It's simply harder to get your arms around what's unproven. An entrepreneur can certainly claim to be one, but without at least one notch on the belt, the self-proclaimed will have a tough time persuading investors to place bets. Those investors, in turn, must be willing to assume greater risk as they assess the credibility of would-be entrepreneurs and the potential impact of formative ventures.

Even with these considerations, we believe that appropriating entrepreneurship for the term social entrepreneurship requires wrestling with what we actually mean by entrepreneurship. Is it simply alertness to opportunity? Creativity? Determination? Although these and other behavioral characteristics are part of the story and certainly provide important clues for prospective investors, they are not the whole story. Such descriptors are also used to describe inventors, artists, corporate executives, and other societal actors.

Like most students of entrepreneurship, we begin with French economist Jean-Baptiste Say, who in the early 19th century described the entrepreneur as one who "shifts

economic resources out of an area of lower and into an area of higher productivity and greater yield," thereby expanding the literal translation from the French, "one who undertakes," to encompass the concept of value creation.¹

Writing a century later, Austrian economist Joseph Schumpeter built upon this basic concept of value creation, contributing what is arguably the most influential idea about entrepreneurship. Schumpeter identified in the entrepreneur the force required to drive economic progress, absent which economies would become static, structurally immobilized, and subject to decay. Enter the *Unternehmer*, Schumpeter's entrepreneurial spirit, who identifies a commercial opportunity – whether a material, product, service, or business – and organizes a venture to implement it. Successful entrepreneurship, he argues, sets off a chain reaction, encouraging other entrepreneurs to iterate upon and ultimately propagate the innovation to the point of "creative destruction," a state at which the new venture and all its related ventures effectively render existing products, services, and business models obsolete.²

Despite casting the dramatis personae in heroic terms, Schumpeter's analysis grounds entrepreneurship within a system, ascribing to the entrepreneur's role a paradoxical impact, both disruptive and generative. Schumpeter sees

the entrepreneur as an agent of change within the larger economy. Peter Drucker, on the other hand, does not see entrepreneurs as necessarily agents of change themselves, but rather as canny and committed exploiters of change. According to Drucker, "the entrepreneur always searches for change, responds to it, and exploits it as an opportunity,"³ a premise picked up by Israel Kirzner, who identifies "alertness" as the entrepreneur's most critical ability.⁴

Regardless of whether they cast the entrepreneur as a breakthrough innovator or an early exploiter, theorists universally associate entrepreneurship with opportunity. Entrepreneurs are believed to have an exceptional ability to see and seize upon new opportunities, the commitment and drive required to pursue them, and an unflinching willingness to bear the inherent risks.

Building from this theoretical base, we believe that entrepreneurship describes the combination of a context in which an opportunity is situated, a set of personal characteristics required to identify and pursue this opportunity, and the creation of a particular outcome.

To explore and illustrate our definition of entrepreneurship, we will take a close look at a few contemporary American

entrepreneurs (or pairs thereof): Steve Jobs and Steve Wozniak of Apple Computer, Pierre Omidyar and Jeff Skoll of eBay, Ann and Mike Moore of Snugli, and Fred Smith of FedEx.

Entrepreneurial Context

The starting point for entrepreneurship is what we call an entrepreneurial context. For Steve Jobs and Steve Wozniak, the entrepreneurial context was a computing system in which users were dependent on mainframe computers controlled by a central IT staff who guarded the mainframe like a shrine. Users got their computing tasks done, but only after waiting in line and using the software designed by the IT staff. If users wanted a software program to do something out of the ordinary, they were told to wait six months for the programming to be done.

From the users' perspective, the experience was inefficient and unsatisfactory.

But since the centralized computing model was the only one available, users put up with it and built the delays and inefficiencies into their workflow, resulting in an equilibrium, albeit an unsatisfactory one.

System dynamicists describe this kind of equilibrium as a "balanced feedback loop," because there isn't a strong force that has the likely effect of breaking the system out of its particular equilibrium. It is similar to a thermostat on an air conditioner: When the temperature rises, the

air conditioner comes on and lowers the temperature, and the thermostat eventually turns the air conditioner off.

The centralized computing system that users had to endure was a particular kind of equilibrium: an unsatisfactory one. It is as if the thermostat were set five degrees too low so that everyone in the room was cold. Knowing they have a stable and predictable temperature, people simply wear extra sweaters, though of course they might wish that they didn't have to. Pierre Omidyar and Jeff Skoll identified an unsatisfactory equilibrium in the inability of geographically based markets to optimize the interests of both buyers and sellers. Sellers typically didn't know who the best buyer was and buyers typically didn't know who the best (or any) seller was. As a result, the market was not optimal for buyers or sellers. People selling used household goods, for example, held garage sales that attracted physically proximate buyers, but probably not the optimal number or types of buyers. People trying to buy obscure goods had no recourse but to search through Yellow Page directories, phoning and phoning to try to track down what they really wanted, often settling for something less than perfect. Because buyers and sellers couldn't conceive of a better answer, the stable, yet

suboptimal, equilibrium prevailed.

Ann and Mike Moore took note of a subpar equilibrium in parents' limited options for toting their infants. Parents wishing to keep their babies close while carrying on basic tasks had two options: They could learn to juggle offspring in one arm while managing chores with the other, or they could plop the child in a stroller, buggy, or other container and keep the child nearby. Either option was less than ideal. Everyone knows that newborns benefit from the bonding that takes place because of close physical contact with their mothers and fathers, but even the most attentive and devoted parents can't hold their babies continuously. With no other options, parents limped along, learning to shift their child from one hip to the other and becoming adept at "one-armed paper hanging," or attempting to get their tasks accomplished during naptime.

In the case of Fred Smith, the suboptimal equilibrium he saw was the long-distance courier service. Before FedEx came along, sending a package across country was anything but simple. Local courier services picked up the package and transported it to a common carrier, who flew the package to the remote destination city, at which point it was handed over to a third party for final delivery (or perhaps back to the local courier's operation in that city if it was a national company). This system was logistically complex, it involved a number of handoffs,

and the scheduling was dictated by the needs of the common carriers. Often something would go wrong, but no one would take responsibility for solving the problem. Users learned to live with a slow, unreliable, and unsatisfactory service – an unpleasant but stable situation because no user could change it.

Entrepreneurial Characteristics

The entrepreneur is attracted to this suboptimal equilibrium, seeing embedded in it an opportunity to provide a new solution, product, service, or process. The reason that the entrepreneur sees this condition as an opportunity to create something new, while so many others see it as an inconvenience to be tolerated, stems from the unique set of personal characteristics he or she brings to the situation – inspiration, creativity, direct action, courage, and fortitude. These characteristics are fundamental to the process of innovation.

The entrepreneur is **inspired** to alter the unpleasant equilibrium. Entrepreneurs might be motivated to do this because they are frustrated users or because they empathize with frustrated users. Sometimes entrepreneurs are so gripped by the opportunity to change things that they possess a burning desire to demolish the status quo. In the case of eBay, the frustrated user was Omidyar's

girlfriend, who collected Pez dispensers.

The entrepreneur thinks **creatively** and develops a new solution that dramatically breaks with the existing one. The entrepreneur doesn't try to optimize the current system with minor adjustments, but instead finds a wholly new way of approaching the problem. Omidyar and Skoll didn't develop a better way to promote garage sales. Jobs and Wozniak didn't develop algorithms to speed custom software development. And Smith didn't invent a way to make the handoffs between courier companies and common carriers more efficient and error-free. Each found a completely new and utterly creative solution to the problem at hand.

Once inspired by the opportunity and in possession of a creative solution, the entrepreneur takes **direct action**. Rather than waiting for someone else to intervene or trying to convince somebody else to solve the problem, the entrepreneur takes direct action by creating a new product or service and the venture to advance it. Jobs and Wozniak didn't campaign against mainframes or encourage users to rise up and overthrow the IT department; they invented a personal computer that allowed users to free themselves from the mainframe. Moore didn't publish a book telling mothers how to get more done in less time; she developed the Snuggly, a frameless front- or backpack that enables parents to carry their babies and

still have both hands free. Of course, entrepreneurs do have to influence others: first investors, even if just friends and family; then teammates and employees, to come work with them; and finally customers, to buy into their ideas and their innovations. The point is to differentiate the entrepreneur's engagement in direct action from other indirect and supportive actions.

Entrepreneurs demonstrate **courage** throughout the process of innovation, bearing the burden of risk and staring failure squarely if not repeatedly in the face. This often requires entrepreneurs to take big risks and do things that others think are unwise, or even undoable. For example, Smith had to convince himself and the world that it made sense to acquire a fleet of jets and build a gigantic airport and sorting center in Memphis, in order to provide next-day delivery without the package ever leaving FedEx's possession. He did this at a time when all of his entrenched competitors had only fleets of trucks for local pickup and delivery – they certainly didn't run airports and maintain huge numbers of aircraft.

Finally, entrepreneurs possess the **fortitude** to drive their creative solutions through to fruition and market adoption. No entrepreneurial venture proceeds without setbacks or unexpected turns, and the entrepreneur needs

to be able to find creative ways around the barriers and challenges that arise. Smith had to figure out how to keep investors confident that FedEx would eventually achieve the requisite scale to pay for the huge fixed infrastructure of trucks, planes, airport, and IT systems required for the new model he was creating. FedEx had to survive hundreds of millions of dollars of losses before it reached a cash-flow positive state, and without a committed entrepreneur at the helm, the company would have been liquidated well before that point.

Entrepreneurial Outcome

What happens when an entrepreneur successfully brings his or her personal characteristics to bear on a suboptimal equilibrium? He or she creates a new stable equilibrium, one that provides a meaningfully higher level of satisfaction for the participants in the system. To elaborate on Say's original insight, the entrepreneur engineers a permanent shift from a lower-quality equilibrium to a higher-quality one. The new equilibrium is permanent because it first survives and then stabilizes, even though some aspects of the original equilibrium may persist (e.g., expensive and less-efficient courier systems, garage sales, and the like). Its survival and success ultimately move beyond the entrepreneur and the original entrepreneurial venture. It is through mass-market adoption, significant levels of imitation, and the creation of an ecosystem around

and within the new equilibrium that it first stabilizes and then securely persists.

When Jobs and Wozniak created the personal computer they didn't simply attenuate the users' dependence on the mainframe – they shattered it, shifting control from the “glass house” to the desktop. Once the users saw the new equilibrium appearing before their eyes, they embraced not only Apple but also the many competitors who leaped into the fray. In relatively short order, the founders had created an entire ecosystem with numerous hardware, software, and peripheral suppliers; distribution channels and value-added resellers; PC magazines; trade shows; and so on.

Because of this new ecosystem, Apple could have exited from the market within a few years without destabilizing it. The new equilibrium, in other words, did not depend on the creation of a single venture, in this case Apple, but on the appropriation and replication of the model and the spawning of a host of other related businesses. In Schumpeterian terms, the combined effect firmly established a new computing order and rendered the old mainframe-based system obsolete.

In the case of Omidyar and Skoll, the creation of eBay provided a superior way for buyers and

sellers to connect, creating a higher equilibrium. Entire new ways of doing business and new businesses sprang up to create a powerful ecosystem that simply couldn't be disassembled. Similarly, Smith created a new world of package delivery that raised standards, changed business practices, spawned new competitors, and even created a new verb: “to FedEx.”

In each case, the delta between the quality of the old equilibrium and the new one was huge. The new equilibrium quickly became self-sustaining, and the initial entrepreneurial venture spawned numerous imitators. Together these outcomes ensured that everyone who benefited secured the higher ground.

Shift to Social Entrepreneurship

If these are the key components of entrepreneurship, what distinguishes social entrepreneurship from its for-profit cousin? First, we believe that the most useful and informative way to define social entrepreneurship is to establish its congruence with entrepreneurship, seeing social entrepreneurship as grounded in these same three elements. Anything else is confusing and unhelpful.

To understand what differentiates the two sets of entrepreneurs from one another, it is important to dispel the notion that the difference can be ascribed simply to motivation – with entrepreneurs spurred on by money and social entrepreneurs driven by altruism. The truth is

that entrepreneurs are rarely motivated by the prospect of financial gain, because the odds of making lots of money are clearly stacked against them. Instead, both the entrepreneur and the social entrepreneur are strongly motivated by the opportunity they identify, pursuing that vision relentlessly, and deriving considerable psychic reward from the process of realizing their ideas. Regardless of whether they operate within a market or a not-for-profit context, most entrepreneurs are never fully compensated for the time, risk, effort, and capital that they pour into their venture.

We believe that the critical distinction between entrepreneurship and social entrepreneurship lies in the value proposition itself. For the entrepreneur, the value proposition anticipates and is organized to serve markets that can comfortably afford the new product or service, and is thus designed to create financial profit. From the outset, the expectation is that the entrepreneur and his or her investors will derive some personal financial gain. Profit is *sine qua non*, essential to any venture's sustainability and the means to its ultimate end in the form of large-scale market adoption and ultimately a new equilibrium.

The social entrepreneur, however, neither anticipates nor organizes

to create substantial financial profit for his or her investors – philanthropic and government organizations for the most part – or for himself or herself. Instead, the social entrepreneur aims for value in the form of large-scale, transformational benefit that accrues either to a significant segment of society or to society at large. Unlike the entrepreneurial value proposition that assumes a market that can pay for the innovation, and may even provide substantial upside for investors, the social entrepreneur's value proposition targets an underserved, neglected, or highly disadvantaged population that lacks the financial means or political clout to achieve the transformative benefit on its own. This does not mean that social entrepreneurs as a hard-and-fast rule shun profitmaking value propositions. Ventures created by social entrepreneurs can certainly generate income, and they can be organized as either not-for-profits or for-profits. What distinguishes social entrepreneurship is the primacy of social benefit, what Duke University professor Greg Dees in his seminal work on the field characterizes as the pursuit of "mission-related impact."⁵

We define social entrepreneurship as having the following three components: (1) identifying a stable but inherently unjust equilibrium that causes the exclusion, marginalization, or suffering of a segment of humanity that lacks the

financial means or political clout to achieve any transformative benefit on its own; (2) identifying an opportunity in this unjust equilibrium, developing a social value proposition, and bringing to bear inspiration, creativity, direct action, courage, and fortitude, thereby challenging the stable state's hegemony; and (3) forging a new, stable equilibrium that releases trapped potential or alleviates the suffering of the targeted group, and through imitation and the creation of a stable ecosystem around the new equilibrium ensuring a better future for the targeted group and even society at large.

Muhammad Yunus, founder of the Grameen Bank and father of microcredit, provides a classic example of social entrepreneurship. The stable but unfortunate equilibrium he identified consisted of poor Bangladeshis' limited options for securing even the tiniest amounts of credit. Unable to qualify for loans through the formal banking system, they could borrow only by accepting exorbitant interest rates from local moneylenders. More commonly, they simply succumbed to begging on the streets. Here was a stable equilibrium of the most unfortunate sort, one that perpetuated and even exacerbated Bangladesh's endemic poverty and the misery arising from it.

Yunus confronted the system, proving that the poor were extremely good credit risks by lending the now famous sum of \$27 from his own pocket to 42 women from the village of Jobra. The women repaid all of the loan. Yunus found that with even tiny amounts of capital, women invested in their own capacity for generating income. With a sewing machine, for example, women could tailor garments, earning enough to pay back the loan, buy food, educate their children, and lift themselves up from poverty. Grameen Bank sustained itself by charging interest on its loans and then recycling the capital to help other women. Yunus brought inspiration, creativity, direct action, courage, and fortitude to his venture, proved its viability, and over two decades spawned a global network of other organizations that replicated or adapted his model to other countries and cultures, firmly establishing from poverty. Grameen Bank sustained itself by charging interest on its loans and then recycling the capital to help other women. Yunus brought inspiration, creativity, direct action, courage, and fortitude to his venture, proved its viability, and over two decades spawned a global network of other organizations that replicated or adapted his model to other countries and cultures, firmly establishing microcredit as a worldwide industry.

The well-known actor, director, and producer Robert Redford offers a

less familiar but also illustrative case of social entrepreneurship. In the early 1980s, Redford stepped back from his successful career to reclaim space in the film industry for artists. Redford was struck by a set of opposing forces in play. He identified an inherently oppressive but stable equilibrium in the way Hollywood worked, with its business model increasingly driven by financial interests, its productions gravitating to flashy, frequently violent blockbusters, and its studio-dominated system becoming more and more centralized in controlling the way films were financed, produced, and distributed. At the same time, he noted that new technology was emerging – less cumbersome and less expensive video and digital editing equipment – that gave filmmakers the tools they needed to exert more control over their work.

Seeing opportunity, Redford seized the chance to nurture this new breed of artist. First, he created the Sundance Institute to take “money out of the picture” and provide young filmmakers with space and support for developing their ideas. Next, he created the Sundance Film Festival to showcase independent filmmakers’ work. From the beginning, Redford’s value proposition focused on the emerging independent filmmaker whose talents were neither

recognized nor served by the market stranglehold of the Hollywood studio system.

Redford structured Sundance Institute as a nonprofit corporation, tapping his network of directors, actors, writers, and others to contribute their experience as volunteer mentors to fledgling filmmakers. He priced the Sundance Film Festival so that it appealed and was accessible to a broad audience. Twenty five years later, Sundance is credited with ushering in the independent film movement, which today ensures that “indie” filmmakers can get their work produced and distributed, and that filmgoers have access to a whole host of options – from thoughtprovoking documentaries to edgy international work and playful animations. A new equilibrium, which even a decade ago felt tenuous, is now firmly established.

Victoria Hale is an example of a social entrepreneur whose venture is still in its early stages and for whom our criteria apply ex ante. Hale is a pharmaceutical scientist who became increasingly frustrated by the market forces dominating her industry. Although big pharmaceutical companies held patents for drugs capable of curing any number of infectious diseases, the drugs went undeveloped for a simple reason: The populations most in need of the drugs were unable to afford them. Driven by the exigency of generating financial profits for its shareholders, the pharmaceutical

industry was focusing on creating and marketing drugs for diseases afflicting the well-off, living mostly in developed world markets, who could pay for them.

Hale became determined to challenge this stable equilibrium, which she saw as unjust and intolerable. She created the Institute for OneWorld Health, the first nonprofit pharmaceutical company whose mission is to ensure that drugs targeting infectious diseases in the developing world get to the people who need them, regardless of their ability to pay for the drugs. Hale's venture has now moved beyond the proof-of-concept stage. It successfully developed, tested, and secured Indian government regulatory approval for its first drug, paromomycin, which provides a cost-effective cure for visceral leishmaniasis, a disease that kills more than 200,000 people each year.

Although it is too early to tell whether Hale will succeed in creating a new equilibrium that assures more equitable treatment of diseases afflicting the poor, she clearly meets the criteria of a social entrepreneur. First, Hale has identified a stable but unjust equilibrium in the pharmaceutical industry; second, she has seen and seized the opportunity to intervene, applying inspiration, creativity, direct action, and courage in launching a new

venture to provide options for a disadvantaged population; and third, she is demonstrating fortitude in proving the potential of her model with an early success.

Time will tell whether Hale's innovation inspires others to replicate her efforts, or whether the Institute for OneWorld Health itself achieves the scale necessary to bring about that permanent equilibrium shift.

But the signs are promising. Looking ahead a decade or more, her investors – the Skoll Foundation is one – can imagine the day when Hale's Institute for OneWorld Health will have created a new pharmaceutical paradigm, one with the same enduring social benefits apparent in the now firmly established microcredit and independent film industries.

Boundaries of Social Entrepreneurship

In defining social entrepreneurship, it is also important to establish boundaries and provide examples of activities that may be highly meritorious but do not fit our definition. Failing to identify boundaries would leave the term social entrepreneurship so wide open as to be essentially meaningless.

There are two primary forms of socially valuable activity that we believe need to be distinguished from social entrepreneurship. The first type of social venture is social service provision. In this case, a courageous and

committed individual identifies an unfortunate stable equilibrium – AIDS orphans in Africa, for example – and sets up a program to address it – for example, a school for the children to ensure that they are cared for and educated. The new school would certainly help the children it serves and may very well enable some of them to break free from poverty and transform their lives. But unless it is designed to achieve large scale or is so compelling as to launch legions of imitators and replicators, it is not likely to lead to a new superior equilibrium.

These types of social service ventures never break out of their limited frame: Their impact remains constrained, their service area stays confined to a local population, and their scope is determined by whatever resources they are able to attract. These ventures are inherently vulnerable, which may mean disruption or loss of service to the populations they serve. Millions of such organizations exist around the world – well intended, noble in purpose, and frequently exemplary in execution – but they should not be confused with social entrepreneurship.

It would be possible to reformulate a school for AIDS orphans as social entrepreneurship. But that would require a plan by which the school itself would spawn an entire network of schools and

secure the basis for its ongoing support. The outcome would be a stable new equilibrium whereby even if one school closed, there would be a robust system in place through which AIDS orphans would routinely receive an education.

The difference between the two types of ventures – one social entrepreneurship and the other social service – isn't in the initial entrepreneurial contexts or in many of the personal characteristics of the founders, but rather in the outcomes. Imagine that Andrew Carnegie had built only one library rather than conceiving the public library system that today serves untold millions of American citizens. Carnegie's single library would have clearly benefited the community it served. But it was his vision of an entire system of libraries creating a permanent new equilibrium – one ensuring access to information and knowledge for all the nation's citizens – that anchors his reputation as a social entrepreneur.

A second class of social venture is social activism. In this case, the motivator of the activity is the same – an unfortunate and stable equilibrium. And several aspects of the actor's characteristics are the same – inspiration, creativity, courage, and fortitude. What is different is the nature of the actor's action orientation. Instead of taking direct action, as the social entrepreneur would, the social activist attempts to create change through indirect action, by influ-

encing others – governments, NGOs, consumers, workers, etc. – to take action. Social activists may or may not create ventures or organizations to advance the changes they seek. Successful activism can yield substantial improvements to existing systems and even result in a new equilibrium, but the strategic nature of the action is distinct in its emphasis on influence rather than on direct action.

Why not call these people social entrepreneurs? It wouldn't be a tragedy. But such people have long had a name and an exalted tradition: the tradition of Martin Luther King, Mahatma Gandhi, and Vaclav Havel. They are social activists. Calling them something entirely new – i.e., social entrepreneurs – and thereby confusing the general public, who already know what a social activist is, would not be helpful to the cause of either social activists or social entrepreneurs.

Shades of Gray

Having created a definition of social entrepreneurship and distinguished it from social service provision and social activism, we should recognize that in practice, many social actors incorporate strategies associated with these pure forms or create hybrid models. The three definitions can be seen in their pure forms in the diagram to the right.

In the pure form, the successful social entrepreneur takes direct

action and generates a new and sustained equilibrium; the social activist influences others to generate a new and sustained equilibrium; and the social service provider takes direct action to improve the outcomes of the current equilibrium.

It is important to distinguish between these types of social ventures in their pure forms, but in the real world there are probably more hybrid models than pure forms. It is arguable that Yunus, for example, used social activism to accelerate and amplify the impact of Grameen Bank, a classic example of social entrepreneurship. By using a sequential hybrid – social entrepreneurship followed by social activism – Yunus turned microcredit into a global force for change.

Other organizations are hybrids using both social entrepreneurship and social activism at the same time. Standards-setting or certification organizations are an example of this. Although the actions of the standards-setting organization itself do not create societal change – those who are encouraged or forced to abide by the standards take the actions that produce the actual societal change – the organization can demonstrate social entrepreneurship in creating a compelling approach to standards-setting and in marketing the standards to regulators and market participants. Fair-trade

product certification and marketing is a familiar example of this, with organizations like Cafédirect in the United Kingdom and TransFair USA in the U.S. creating growing niche markets for coffee and other commodities sold at a premium price that guarantees more equitable remuneration for small-scale producers.

Kailash Satyarthi's RugMark campaign provides a particularly striking example of a hybrid model. Recognizing the inherent limitations of his work to rescue children enslaved in India's rug-weaving trade, Satyarthi set his sights on the carpet-weaving industry. By creating the RugMark certification program and a public relations campaign designed to educate consumers who unwittingly perpetuate an unjust equilibrium, Satyarthi leveraged his effectiveness as a service provider by embracing the indirect strategy of the activist. Purchasing a carpet that has the RugMark label assures buyers that their carpet has been created without child slavery and under fair labor conditions. Educate enough of those prospective buyers, he reasoned, and one has a shot at transforming the entire carpet-weaving industry.

Satyarthi's action in creating RugMark lies at the crossroads of entrepreneurship and activism: In itself, the RugMark label represented a creative solution and required direct action, but it is a device meant to educate and

influence others, with the ultimate goal of establishing and securing a new and far more satisfactory market-production equilibrium.

Social service provision combined with social activism at a more tactical level can also produce an outcome equivalent to that of social entrepreneurship. Take, for example, a social service provider running a single school for an underprivileged group that creates great outcomes for that small group of students. If the organization uses those outcomes to create a social activist movement that campaigns for broad government support for the wide adoption of similar programs, then the social service provider can produce an overall equilibrium change and have the same effect as a social entrepreneur.

Bill Strickland's Manchester Bidwell Corporation, a nationally renowned inner-city arts education and job-training program, has launched the National Center for Arts & Technology to advance systematically the replication of his Pittsburgh-based model in other cities. Strickland is spearheading an advocacy campaign designed to leverage federal support to scale up his model. So far, four new centers are operating across the U.S. and several more are in the pipeline. With a sustainable system of centers in cities across the country, Strickland will have succeeded in establishing a new equilibrium. It is because of that campaign that the Skoll Foundation and others are investing in Strickland's efforts.

Why bother to tease out these distinctions between various pure and hybrid models? Because with such definitions in hand we are all better equipped to assess distinctive types of social activity. Understanding the means by which an endeavor produces its social benefit and the nature of the social benefit it is targeting enables supporters – among whom we count the Skoll Foundation – to predict the sustainability and extent of those benefits, to anticipate how an organization may need to adapt over time, and to make a more reasoned projection of the potential for an entrepreneurial outcome.

Why Should We Care?

Long shunned by economists, whose interests have gravitated toward market-based, price-driven models that submit more readily to data-driven interpretation, entrepreneurship has experienced something of a renaissance of interest in recent years. Building on the foundation laid by Schumpeter, William Baumol and a handful of other scholars have sought to restore the entrepreneur's rightful place in "production and distribution" theory, demonstrating in that process the seminal role of entrepreneurship.⁶ According to Carl Schramm, CEO of the Ewing Marion Kauffman Foundation, entrepreneurs, "despite being overlooked or explicitly written

out of our economic drama,"⁷ are the free enterprise system's essential ingredient and absolutely indispensable to market economies.

We are concerned that serious thinkers will also overlook social entrepreneurship, and we fear that the indiscriminate use of the term may undermine its significance and potential importance to those seeking to understand how societies change and progress. Social entrepreneurship, we believe, is as vital to the progress of societies as is entrepreneurship to the progress of economies, and it merits more rigorous, serious attention than it has attracted so far.

Clearly, there is much to be learned and understood about social entrepreneurship, including why its study may not be taken seriously. Our view is that a clearer definition of social entrepreneurship will aid the development of the field. The social entrepreneur should be understood as someone who targets an unfortunate but stable equilibrium that causes the neglect, marginalization, or suffering of a segment of humanity; who brings to bear on this situation his or her inspiration, direct action, creativity, courage, and fortitude; and who aims for and ultimately affects the establishment of a new stable equilibrium that secures permanent benefit for the targeted group and society at large.

This definition helps distinguish social entrepreneurship from social service provision and social

activism. That social service providers, social activists, and social entrepreneurs will often adapt one another's strategies and develop hybrid models is, to our minds, less inherently confusing and more respectful than indiscriminate use of these terms. It's our hope that our categorization will help clarify the distinctive value each approach brings to society and lead ultimately to a better understanding and more informed decision making among those committed to advancing positive social change.

The authors would like to thank their Skoll Foundation colleagues Richard Fahey, chief operating officer, and Ruth Norris, senior program officer, who read prior drafts of this essay and contributed important ideas to its evolution.

¹ Jean-Baptiste Say, quoted in J. Gregory Dees, "The Meaning of 'Social Entrepreneurship,'" reformatted and revised, May 30, 2001.

http://www.fuqua.duke.edu/centers/case/documents/Dees_SEdef.pdf.

² Joseph A. Schumpeter, *Capitalism, Socialism, and Democracy* (New York: Harper, 1975): 82-85.

³ Peter F. Drucker, *Innovation & Entrepreneurship* (New York: Harper Business, 1995): 28.

⁴ Israel Kirzner, quoted in William J. Baumol, "Return of the Invisible Men: The Microeconomic Value Theory of Inventors and Entrepreneurs." http://www.aeaweb.org/annual_mtg_papers/2006/0107_1015_0301.pdf.

⁵ Dees, 2.

⁶ Baumol, 1.

⁷ Carl J. Schramm, "Entrepreneurial Capitalism and the End of Bureaucracy: Reforming the Mutual Dialog of Risk Aversion," 2. http://www.aeaweb.org/annual_mtg_papers/2006/0107_1015_0304.pdf.

SOCIAL ENTREPRENEURSHIP: THE CASE FOR DEFINITION PART TWO

By Roger L Martin & Sally Osberg

Introduction to Part 2

Part I of this continuing education (CE) article defined cultural competence, discussed cultural competency, terminology and demographics, and outlined some considerations for physical therapists who are working with diverse patient populations.

This two-part CE offering presents examples of the diverse cultural landscape in which patients live. However, physical therapists manage individual patients and clients and not a population. Broad categories are practical for descriptive purposes, but they also can be used inadvertently to perpetuate racial or ethnic stereotyping and prejudices. Not only is there interethnic diversity, there is intraethnic diversity. Clinicians should not make general assumptions about an entire ethnic group any more than they would make such assumptions with a patient with a stroke, Parkinson disease, or joint degeneration.

Special Considerations for Managing a Diverse Patient Population

In part I, the discussion of special considerations when

working with diverse patient populations included the degree of acculturation, socioeconomic status, racism, and the incidence and prevalence of disease and disability in different groups. Part II continues the discussion of these special considerations by looking at comparative value orientations, methods of communication, learning styles, and health beliefs and behaviors.

Comparative Value Orientations: The Individual Versus the Group

In contrast to material culture (the more easily observed and understood parts of culture, such as clothing, food, music, forms of greeting, ceremonial rites of passage), a person's nonmaterial culture (which includes values and morals) is more difficult to assess. Sometimes similarities in the material cultures of the patient and the physical therapist obscure profound differences in their nonmaterial cultures that are very relevant to the therapist-patient interaction. In fact, comparative value orientations may provide important clues that can help the physical therapist and the patient to better understand each other.

Table 1 lists recurrent themes and patterns in cultures that many

observers have identified.¹⁻³ These cultural elements may be the core of a person's worldview, or they may be the values that a person lives by. People from groups that have been most heavily influenced by European culture typically will have the values listed in the left-hand column, whereas people from those groups influenced by Hispanic/Latino, Asian, Middle Eastern, or African cultures typically will have the values listed in the right-hand column. However, a person's worldview also can be heavily influenced by personality traits, socioeconomic status, level of acculturation, and other factors. Moreover, a person does not necessarily fit into a rigid category; he or she may fall at the far end of one dichotomous scale, in the middle of a second, or at the other end of a third.^{1,3}

The defining element represented in Table 2 may be the comparison between types of social organization and relationships—individualism/privacy versus collectivism/group welfare. There are innumerable ways in which these two “value orientations” can influence the therapeutic encounter. For example, European values emphasize the importance of the individual and the ability of each person to affect his or her future through hard work.² In this type of cultural orientation, both time and nature are commodities to be used profitably, and the success—or lack of success—

of each person is credited to that person. A patient with an individualistic worldview may prefer to use assistive technology in order to live independently. Health care professionals with this type of worldview might emphasize the autonomy and personal responsibility of their patients and expect them to work hard at therapy.

What if patients have a cultural value system that emphasizes the importance of the group over the individual? To illustrate, in the Hispanic/Latino culture, many cultural characteristics reflect the values of a collectivist society. One of the most significant values is familismo, or family commitment and responsibility. The welfare and honor of the family are preeminent concerns. Traditional gender roles within the family—known as machismo for men and marianismo for women—are related to familismo. The oldest man or the father is typically the authority figure and the final arbiter. The mother is central within the household and is responsible for child rearing and the cultural and social stability of the family. She is often described as having a sacrificing nature. Women are considered to be morally and spiritually superior to men; however, men typically make the final decisions within the household.⁴

In collectivist cultures, kinship bonds across generations are common. Thus, a patient may arrive at the clinic with several family

members. The patient may feel there is little point to working too hard because the family will provide care and because the patient believes that much of what happens to people—including disease and disability—is predetermined by fate (fatalism). In order for both the patient and the clinician to “save face,” the patient might act very polite and accommodating when, in fact, he or she may not understand the clinician’s instructions. Patients also might recognize that their goals and the clinician’s goals are not the same. For instance, the patient may not want to use assistive technology because independence is not the goal.

Related collectivist cultural values associated with the Hispanic/Latino culture may include, but are not limited to, *respeto* (respect toward individuals based on age, gender, and social position or authority), *personalismo* (friendliness and individualized attention and responsiveness to interpersonal interactions), *simpatia* (kindness, being nice), and fatalism.^{5,6}

Pace of life and the notion of time. Perhaps the most difficult cultural differences to overcome, especially for those with a European cultural viewpoint, relate to pace of life and the notion of time.⁷

Monochronism is the belief that time is an important concept, that events happen in chronological

order, that there is a separation of work tasks and socializing, and that adherence to schedules is important. Many whites are monochronistic: they are action oriented and value punctuality.^{7,8}

Polychronism, on the other hand, is the belief that events can happen concurrently and that fixed schedules are insignificant. The focus is on a more personal interaction, with less concern about completion of the task at hand (ie, the value of personalism). Work orientation and the acquisition of material goods may not be present among people who value a relaxed, relationship-oriented lifestyle more highly.

Imagine the potential for misunderstanding if a Hispanic/Latino man, for example, arrives late for an appointment and expects the therapist to chat for a few minutes about nontherapeutic issues—such as the well-being of his family—and the therapist, already annoyed about her schedule being interrupted, immediately launches into a discussion about how to do exercises. These differences can also have an economic impact; late patients can disrupt a therapist’s schedule and decrease his or her efficiency.

In a rehabilitation setting, even the development of group exercise programs may be influenced by comparative value systems. For example, does the patient value competition or cooperation? Would a patient rather work hard

and increase the number of repetitions, or would the patient not want to “show off” to others? Is the patient comfortable exercising among both men and women?

The patient’s opinion on the role and status of medical personnel may be different depending on his or her culture. On one hand, an older patient from Cuba may expect the health care provider to demonstrate respect by addressing them first, by using the proper titles, and by asking about the family. On the other hand, a patient from a Middle Eastern subculture might tend to defer to the health care professional, who is considered to be an authority figure worthy of high esteem. The patient may be especially reluctant to express negative feelings and may be unlikely to share concerns about taking medication ordered by a physician or to ask questions that may be perceived as “stupid.” An interactive conversation about health care options is less likely to occur.⁹

Values across the life span. Comparative value systems may affect the behaviors of patients of a particular age group. For instance, expectations for the behavior of Asian American adolescents may be different from those for the behavior of a typical white adolescent. Older Asian American children are expected to be well disciplined and to

take on some adult roles. An older adolescent sibling may be expected to accept personal sacrifice and to care for young children in the extended family while simultaneously working hard to maintain a strong academic record. A sense of duty or obligation to the family may be pronounced and is learned through role modeling. If the older sibling misbehaves, he or she might be rebuked for not setting a good example for the younger ones.

High expectations may be a source of stress. Adolescents are likely to be recipients of a parenting style that is somewhat controlling, restrictive, and protective. This may lead to distancing behaviors or a distrust of outsiders. Discussions about sensitive topics such as sexuality may need to be avoided, and the patient’s willingness to discuss personal issues related to treatment might be minimal.¹⁰

Similarly, there may be special considerations when working with older people. Respect for older people is a value prevalent among many ethnic groups. Signs of respect may include using terms of address such as “Ma’am” or “Sir” or asking for tales of wisdom. In many cultures, it is expected that adult children will provide an economic and social base for their older parents. Older Asian and Hispanic/Latino people are more likely to live with other family members or friends and are less likely to be segregated, to live alone or in a nursing home or other

institution, or to use professional home nursing services. Mutual assistance, especially in times of illness, is counted on both because of cultural preferences and because of strategic adjustments to American society.^{4,11,12}

Giftgiving. The issue of gifts is of practical import to the physical therapist. APTA's Guide for Professional Conduct states that the physical therapist should at all times ensure that his or her professional judgment is not affected by a patient's gift.* The physical therapist should also ensure that the gift has not created an obligation for either the therapist or the patient. The physical therapist, however, needs to consider the patient's value system when deciding whether accepting a modest gift from the patient or the patient's family is ethically appropriate. In many cultures, it would typically be a great insult to refuse a gift; a person's pride may be at stake.

Communication Styles

Communication and language are intertwined with and are inseparable from culture. The ability to communicate effectively, therefore, is an exceptionally important variable when working cross-culturally or seeking to understand a patient's cultural value system and "explanatory model" (ie, how a patient makes sense of an illness and how they choose treatments).

English is the primary language in the United States. Spanish is the second most commonly used language, followed by French, which lags far behind.¹³ However, there are dozens of other languages that are used by large numbers of people in the United States.

Ideally, the physical therapist and patient would speak the same language. More realistically, physical therapists should learn a few key words in the primary language of their patients. Translators are often a necessity, and typically family (often children) or friends are called upon to act as translators. Although this may be the only available alternative, it is fraught with problems. The US Department of Health and Human Service's Office of Minority Health strongly advises that children should not be used as interpreters, especially for adults.¹⁴ When a family member or friend is the translator, physical therapists should be aware that they are dealing with an untrained third party who may be "interpreting" the information before passing it on to them and that some topics may be inappropriate to discuss with the translator because they are of a more personal or sensitive nature (eg, family planning, spousal abuse, terminal illness).

If possible a professional translator should be used. Translation requires knowledge of medical terminology, a good memory, the ability to concentrate, and the ability to know how and when to edit messages so that the true meaning can be

accurately transmitted. The ideal professional interpreter is bicultural and has a good grasp of both medical and cultural nuances.¹⁵

Limited proficiency in English is one of the most important variables associated with poor health status and is a barrier to accessing the health care system.^{5,16,17} Because language barriers are such a significant and prevalent obstacle to good health care, the Office of Civil Rights in the US Department of Health and Human Services has developed policies to better serve people with limited English proficiency, including language assistance appropriate to the needs of each facility.¹⁵

Interactive styles. In addition to the spoken word, there are obvious and subtle differences in the interactive styles. For example, verbal communication in individualistic societies is associated with direct, "low-context" communication. Patients with this cultural background may expect that the physical therapist will get right to the point and may assume that they do not have to rely on the surrounding context for interpretation. They would expect that what is found in the verbal message is what is being communicated. The notion of privacy is important, and questions of a more personal nature might be considered off-limits.^{7,8,18}

In contrast, a person from a collectivist culture may speak indirectly, in a more circular fashion, always keeping in mind the need for everyone to "save face." Communication is more "high-context" and listener-focused (ie, sensitive to situational and contextual features). There may be more "spiral" (or indirect) logic, more indirect verbal negotiation, and subtle nonverbal nuances. The notion of privacy is less pervasive, but no party should be embarrassed or "lose face." The focus is more on human relationships (eg, personalismo). It may take a long time to establish a solid, trusting relationship, but once it exists, it is likely to be strong and lasting.^{8,10,13}

Another difference in verbal communication is the amount of "wait time" or time gaps that occur during conversation.¹⁹ Native Americans typically have a longer wait time than whites because the pace of conversation is slower. Physical therapists should wait until the person has finished speaking before interrupting or asking questions. European Americans typically are uncomfortable with silence. Wait time is also increased when patients need to translate the words into their own language before responding.¹⁹ In some cultures, many people may speak at once.

Different cultural groups also may have many nonverbal, observable differences in communication style. In fact, Mehrabian²⁰ suggests that as

much as 93% of the total meaning of an encounter is communicated by nonverbal factors such as body language (55%) and tone of voice (38%). Differences in interpretation occur with regard to eye contact, facial expression, body movement, personal space, and overall formality. The physical therapist may believe a patient is acting disinterested if eye contact is not direct, when in reality, the patient may believe it is impolite to look directly at someone who is perceived as the authority figure. A physical therapist may always give a firm handshake upon introduction to a patient and may presume that this is an appropriate, friendly, and polite gesture. Native American or traditional Asian American patients, however, may consider this aggressive or hostile, because a subtle, "soft," nonthreatening handshake is the norm in their cultures.

What is the patient's preferred requirement for personal space? How close does the patient like to stand when speaking with health care providers? Physical therapists should observe their patient's response when they stand closer or further away during a general conversation. During a treatment session, does a person of the opposite sex seem more uncomfortable than might be expected? How do people from different cultures stand with each other as compared with

how they stand with the therapist? Touch can provide reassurance and kindness, or it can be a discomfort and annoyance.

Gender and age are important variables influencing personal space. For example, people from Hispanic/Latino and Middle Eastern subcultures tend to prefer standing close and are comfortable with physical contact between members of the same sex.¹⁸ People who are members of the orthodox branches of Islam or Judaism, meanwhile, might not be comfortable being touched by someone of the opposite sex.

Learning Styles

The physical therapist who is educating a patient about a diagnosis or a home program must also recognize that many cultures have different methods of teaching and learning. The existence of different learning methods becomes an especially important consideration when the physical therapist is working with a patient who was educated outside the United States or who is a recent immigrant. People of European ancestry, for example, often rely on note taking and studying written texts as well as intense discussions with a great deal of interaction between physical therapist and patient. People of other cultures, in contrast, may rely more on a lecture format with few questions and little discussion. Members of other cultural groups, such as blacks and African Americans, may rely

almost entirely on oral training and demonstration. A written list of exercises, even with diagrams, may not be as effective as “hearing and feeling” these exercises. When possible, physical therapists should include family members in discussions about home programs and other aspects of patient care; inclusion of the family is especially important for patients from cultures that have collectivist values.²¹

Written patient instructions should be translated into grammatically correct, simple language using appropriate, meaningful vocabulary to help ensure that these materials are used as intended and are culturally relevant to the patient. The material should be translated back into the original language to see if something does not make sense.

If the patient has limited proficiency in English, it is wise to speak slowly (not loudly) and to avoid colloquialisms and idioms. Statements should be rephrased often, and physical therapists should check to be sure that their patient or client understands their meaning.

Rapport is also likely to be enhanced if the clinic environment has been adapted to make someone from a different cultural background feel more welcome. Therapists should consider the types of magazines that are placed in public meeting spaces or in the waiting area. Are these

publications and the signs around the workplace in more than one language? Do pictures in the literature look like the people who frequent the facility? What images decorate the space? A consideration of these questions, an understanding of a range of communication styles (both verbal and nonverbal) and learning styles, and the ability to properly interpret an interaction will undoubtedly minimize barriers that may otherwise exist.

When Differences in Cultural Values And Communication Are Not Considered

If the physical therapist does not consider differences in cultural values and does not act on them appropriately, miscommunication and misunderstanding between the patient and the clinician may be more likely.²² Based on reports in the medical literature regarding the impact of language and cultural differences on the patient-provider relationship,^{22–27} it could be inferred that problems in communicating might result in the following:

1. the physical therapist could make errors in the examination and diagnostic process,
2. the patient might not fully participate in the therapy program, or
3. the patient may report overall dissatisfaction with the physical therapy service.

“Folk” Health Beliefs and Behaviors

Historically, models for the provision of care generally have relied on the

values and belief systems of the “majority” (ie, the white middle-class). These models are culturally insensitive because they deny the existence of “non-Western” systems of thinking.

What is disability? The World Health Organization defines disability as “an umbrella term for impairments, activity limitations and participation restrictions. It denotes the negative aspects of the interaction between an individual (with a health condition) and that individual’s contextual factors (environmental and personal factors).”^{28(p190)}

Although many health care professions, including physical therapy, have embraced this or similar definitions of disability,[†] the concept of disability is not a cultural universal.

As Ingstad and Whyte state, “In many cultures, one cannot be ‘disabled’ for the simple reason that ‘disability’ as a recognized category does not exist. There are blind people and lame people and ‘slow’ people, but ‘the disabled’ as a general term does not translate easily into many languages.”^{29(p7)}

In cultures in which disability does not define who a person is, people with a disability are expected to follow the same life cycle as everyone else.

It is not necessary to catalog every known variation in disability beliefs, but it is appropriate for practitioners to understand how other people conceptualize

disability and rehabilitation. This understanding can have a positive effect on the manner in which rehabilitation professionals are received and regarded and on their ability to serve their patients.³⁰

Causes of disability and disease.

Although there are general similarities among folk beliefs about the causes of illness and disability—including psychological states such as fear, envy, and family turmoil; environmental or natural conditions such as bad air and excess cold or heat; and supernatural causes such as witchcraft or bad spirits—these beliefs also vary. Physical and mental illnesses are sometimes intertwined, and emotional, spiritual, social, and physical factors can be major contributing forces to illnesses. Overall, however, physical disabilities are more accepted by the community and the family than mental disabilities.^{4,31–34}

Although many people hold folk health care beliefs and Western health care beliefs simultaneously, traditional beliefs from a patient’s cultural background may be brought to the forefront during times of stress or uncertainty, especially in patients with lower levels of education. In an ethnographic study conducted in rural Jamaica, Leavitt³⁵ recorded that one mother explained that her child’s disability originated from jaundice because the hospital did not have the ability to “burn” the jaundice out when her child was born. Another mother stated that, because she did not eat more

nutritious food while she was pregnant, her daughter was born with a disability, when in fact her daughter had Down syndrome. Physical therapists need to recognize that patients express beliefs based on their personal worldview.

In some cultures, people may believe that illness and disability are forms of divine punishment. A person may have sinned or violated a taboo, either in this life or a previous life, thereby causing the wrath of God, which may take the form of an illness or disability visited on the offender or a family member. Many people throughout the world believe in the "evil eye." The evil eye typically is a spell, usually motivated by envy, that is believed to cause the victim to fall ill. In an article about disability by Mardiros,³⁶ one Mexican American woman claimed that one of her husband's previous lovers asked a bruja (a sorcerer or witch) to put a hex on them, which the woman blamed for all of their "bad luck."

In any culture, there may be people who believe that an imbalance of elements is responsible for an ailment. This "elemental" system resembles the ancient Greek concept of an imbalance of the four humors, and it includes a system of classification for diseases, body organs, herbal remedies, and foods. All four of these mutually complementary forces

are required for a person to be in harmony with nature, and a belief in this concept might affect the patient's decision regarding what medicines to use and foods to eat. In India, the Ayurvedic system equates health with balance. Traditional Chinese medicine requires a balance of yin and yang. The Navajo believe that their health depends on harmony with family, community, self, and nature, and they do not have a concept of communicable disease. Their language, for example, does not have a word for germ.³⁷

In some communities, harmony between the physical and spiritual world requires a balance of "hot" and "cold." Examples of diseases considered to be "hot" by the Hispanic/Latino culture are hypertension, diabetes, acid indigestion, and other diseases characterized by vasodilation and a high metabolic rate. "Cool" remedies such as bananas, passion flowers, and lemon juice are used for a "hot" illness. "Cold" diseases include menstrual cramps, pneumonia and other respiratory diseases, colic, and anemia. If a person is anemic, he or she might eat more "hot" foods, such as organ meats with a lot of blood products. Blood is "hot" and is associated with strength, virility, and machismo. For a cold, orange juice (vitamin C) might be recommended by a physician, but the Hispanic/Latino folk tradition is to treat a "cold" with a "hot" remedy such as red chili peppers (which, by the way, also have vitamin C).³⁸⁻⁴⁰

Selection of interventions.

Decision making about health behaviors can be complex. In some cultures, when a person is sick, the family and a hierarchy of lay healers are often the first line of defense. Next, people seek out either a Western biomedical health care professional or a folk healer who practices traditional medicine. Sometimes, health care professionals and traditional healers are seen simultaneously. Typically, people are more likely to partake in indigenous health care practices if they are less acculturated, poorer, and live in rural areas.⁴¹ Practical matters such as cost, severity of illness, and availability of practitioners often determine the utilization of traditional health care practices.⁴¹

Treatment for a disease or disability is also culturally specific, although intraethnic variation abounds. Indigenous folk healers, or practitioners of traditional medicine, are prevalent in every society. The curanderos may be preferred by Mexican Americans, the singer by the Navajo, the voodoo priest by Haitians, the santería by Cubans, the herbalist by the Chinese, and so on. For the Laotian Hmong, the shaman may use herbal concoctions and animal sacrifice.⁴² In Jamaica, the obeah may use materials such as blood, feathers, parrots' beak, grave dirt, egg shell, and medicinal herbs to treat a person with a disability.³⁵

In Puerto Rico, an *espiritista*, usually a female medium, helps people with physical or emotional problems by connecting them with good spirits and exorcising evil spirits.³⁸ For many Native American tribes, "talking circles"—where stories are shared—are used to demonstrate the interconnectedness of life, the cycle of life and death, and the balance in the natural world required for good health. In fact, "talking circles" may be used by health care professionals to educate people about preventive and treatment measures so that the notion of fatalism can be replaced with the idea of control over one's health.⁴³

There are 2 theoretical explanations for why ritual healing practices may be successful. The first explanation is neurobiological. Endorphins may play a role in diminishing pain.⁴⁴ The release of these neurochemicals, produced by the brain, may be influenced by psychological experiences (eg, transcendental meditation).⁴⁵ The second explanation is the placebo effect, which may help the body to heal itself.⁴⁶ A placebo may be a word or an action, not just a pharmaceutical substance. By engaging the patient's mind and emotions, the healer may aid physiological repair.³⁸

Traditional practices may also influence the responses of a patient or client to a Western medical protocol. Many Vietnamese believe that Western medicine is designed to suit the body size of people in Western cultures. Thus, the

quantity of drugs prescribed may be seen as inappropriate for the Vietnamese person, who is typically much smaller than the average white American.⁴⁷ Likewise, the physical therapist working in the area of women's health might want to know that there may be special considerations associated with childbirth. Different Asian subcultures, for example, prepare special dishes to assist with the involution of the uterus, chase the "bad blood" away, and regulate menstrual flow.¹⁰

Often, the use of an alternative treatment is the source of misunderstanding and conflict. A practitioner of Western medicine may perceive that Asian practices used to draw "evil" from the body—such as coin rubbing, in which a coin is rubbed on the skin until a raised red mark appears, or cupping, in which a heated glass is placed on the body to create a vacuum that causes the skin to rise and become red—are harmful to a child.¹⁰ On the other hand, a traditional Hmong person may have superstitions about health care practitioners in the United States. Some Hmong believe that US surgeons cut out body parts of the deceased to eat them or to sell them as food.⁴²

The importance of asking the right questions cannot be over-emphasized. Masin⁴⁸ shares a story about a toddler in an early intervention program in Florida

who continued to have seizures even though the child's mother, a Haitian immigrant who spoke Creole, assured the staff that she was administering the appropriate dose of phenobarbital. When a staff person asked the mother to demonstrate how she was giving the medicine, a cultural variable became apparent. As is customary in many Caribbean nations, the mother was bathing the child in the medicine rather than administering the medicine orally. Other relevant questions in a multicultural pediatric setting might cover infant feeding patterns, family sleeping customs, play routines, and child-rearing practices.

Many texts and studies detail patients' beliefs in folk illnesses and their use of herbal and other home remedies and alternative healers for conditions as diverse as asthma, diabetes, AIDS, and depression. Yet, most patients do not report the use of complementary and alternative medicines to their health provider.³⁷ Sometimes, home remedies are harmful. One remedy, known as greta or azarcon, which is used for gastroenteritis, has a very high lead content and is considered dangerous.^{37,39,49}

When using typical Western physical therapy interventions, it is necessary to consider whether they are appropriate in the context of the patient's culture.

For example, people from many Asian subcultures usually squat rather than sit and thus require

greater range of motion in the hip, knee, and ankle, even at the expense of stability. Also, eating with hands or chop sticks may require different movement patterns and range of motion than are typically used by people from European-influenced subcultures.

Pain across cultures. The way people react to and feel about pain is very important, because their response to pain can be guided by cultural rules. Researchers on the psychosocial and behavioral aspects of pain have found significant relationships among ethnic variation, perception of pain intensity, and the responses to pain.^{50,51}

In a seminal study, Zborowski⁵⁰ compared different white populations—including Jewish, Italian, Irish, and “old” or “Yankee” Americans—and determined that some cultural groups, such as Italian Americans, allowed their members to complain about pain, whereas other groups, such as “old” Americans, expected their members to “report” pain in a dispassionate manner. Zborowski also found that members of some groups, including Italian Americans, wanted immediate relief of pain from painkillers, whereas others, including Jewish Americans, worried more about the long-term implications of pain and did not want to use medications for fear that

they would mask a more serious problem. Societal rules regarding pain tolerance also promote gender or age differences, but these are not cultural universals.

During the late 1980s, Bates and Edwards⁵¹ investigated patients’ meanings and explanations associated with pain. United States–born “old” American (mostly Protestants), Hispanic, Irish, Italian, French Canadian, and Polish people, all of whom were outpatients in a Massachusetts pain treatment facility, were studied. Variation in ethnic identity and locus-of-control style were consistently associated with differences in pain intensity and response. The Hispanic group demonstrated the highest pain expressiveness, the greatest interference with work and social activities, and the highest degree of emotional and psychological stress. The Italian group was second in each of these categories, and either the Polish or “old” American group was the lowest in each category. According to the authors, the results of the study supported the idea of interethnic group variation in the response to pain.

In addition, Bates and Edwards⁵¹ reported that intragroup variation analysis demonstrated within-group differences in the response to pain based on both generation and degree of heritage consistency (ie, the degree to which a person’s lifestyle reflects his or her traditional culture). More recent immigrants or people who are

the first generation born in the United States, people who have high degrees of heritage consistency, and people who believe that they have a strong support system report less severe responses to pain.⁵¹ It also should be noted that physiological or biological differences can result in different responses to and side effects from drugs. Chinese patients, for instance, appear to metabolize drugs differently than white patients and require lower dosages of some pain medications.^{52–55}

The role of religion. Health beliefs and behaviors that are closely intertwined with comparative value systems can be related to the role that religion plays in a person's explanatory model. Religious beliefs and customs may affect the acceptance and the administration of more standard rehabilitation practices. This may be an area in which health care professionals may have difficulty accepting someone else's moral and ethical viewpoint and actions.

One well-known point of conflict is the refusal of a person who is a Jehovah's Witness to allow a medical intervention if it requires a blood transfusion. Conflicts also may occur when patients have a strong faith that a supreme spiritual being (eg, God, Allah, Brahma) will cure them, and they, therefore, avoid treatment. A Lubavitcher orthodox Jew may

turn to a rebbe for healing prayers or an African American may turn to a "tent meeting." People from Southeast Asia may adhere to karma, a belief that one's present life is based on a previous existence, and they thus accept a misfortune as predestined.

Religious beliefs can also affect care delivery. A traditional Muslim woman is forbidden to expose her skin (except for the hands and face) to a man other than her husband, and, therefore, she would require a woman for a physical therapist. The "Sabbath" days mean different things in different religions, and how these religions celebrate the Sabbath may affect patient care. For example, the Jewish Sabbath begins at sundown on Friday and extends to sundown on Saturday, which would affect the times that therapists can provide care, especially in the home.

Culture-bound syndromes.

Culture-bound syndromes, sometimes referred to as folk illnesses, exist in most cultures. They are associated with unique beliefs about the cause of an illness and may require specific culturally prescribed treatments. Susto is perhaps the most studied culture-bound, psychosomatic illness within Hispanic/Latino subcultures. Susto, or "shock," occurs when a frightening event causes the soul to leave the body. Symptoms of susto include sleepiness, loss of appetite, insomnia, and generalized depression. Psychiatrists consider these symptoms to be body

metaphors for psychological distress.⁴⁰

A culture-bound syndrome from the Haitian culture is “arrested pregnancy syndrome,” in which a woman who expects to be carrying a child and feels as though she is pregnant is not actually pregnant. It is often associated with infertility in a culture that highly values the ability to have children.⁵⁶

Anorexia nervosa, a psychological disorder with which most US physical therapists are familiar, is considered a culture-bound syndrome of white North Americans.⁵⁷

End of life. Health beliefs and behaviors associated with end-of-life decisions deserve special attention by physical therapists specializing in geriatrics. Although physical therapists do not typically deal with end-of-life decisions, it is, nevertheless, a possible topic of conversation, especially with family members. Because of language and cultural barriers, people of color may not have adequate knowledge of the purpose and availability of hospice services.

In Asian and Hispanic/Latino subcultures that have a belief in fatalism, disclosure of a terminal disease may take away any hope that the patient may have. The family, especially the eldest son, has a very strong obligation to protect loved ones from emotional distress. In actuality, it

is not common for elderly Chinese people to discuss the likelihood of death at all, because it is believed to be a bad omen. The Navajo feel similarly; negative thoughts would be in conflict with the concept of hozho, which involves goodness, harmony, and a positive attitude.

Older adults are likely to have varied attitudes toward advance directives. For example, elderly Chinese people may be less likely to write something down, because they honor the spoken word. Elderly Japanese people tend to place great faith in family and professional relationships, and it is less likely that decisions would be made by the individual alone. For the Navajo as well, major decisions are collaborative, and the family and the tribe would have input into any advance directives.³⁷

Hispanic/Latino people generally are less knowledgeable about, and less likely to write, living wills than other ethnic groups.³⁷ According to Berger,³⁷ Mexican Americans have a more negative attitude toward advance directives than whites or African Americans, although there is a correlation to degree of acculturation. In general, it is less likely that the Hispanic/Latino person would make these decisions alone. As with many other cultural groups, major decisions are collaborative, and the family would have input into any advance health directives.

Once death occurs, some cultural groups (eg, Orthodox Jews,

Christian Scientists) are less likely to consent to an autopsy because they believe a mutilated body may cause suffering in the afterlife.³⁷

With regard to bereavement, grief responses also depend on personal characteristics and culture. In contrast to the European American culture, in which people are encouraged to grieve and “move on,” many non-Western cultures encourage people to continue their relationship with the deceased, possibly through a specific altar dedicated to the loved one where they can pray or bring food and other offerings.⁵⁸

In sum, although one cannot say with certainty how many individuals have non-Western health care belief systems, physical therapists must consider that these belief systems are more prevalent than they expect. Variables such as the patient’s level of acculturation and place of origin can influence a belief system.

Researchers often have a difficult time uncovering a respondent’s belief system because they do not ask the right questions or the respondent may fear looking “ignorant” or “backward.” It is wise to expect that traditional beliefs are somewhere in a person’s cultural background and may be brought to the forefront during times of stress or uncertainty.

Physical therapists as culture brokers. Many people, to varying degrees, intertwine “modern” or “Western” medicine with “indige-

nous” or “folk” medicine. This intertwining results in medical pluralism (the existence and use of many different health care alternatives within societies).^{41,59}

The physical therapist should learn as much as possible about the relevant traditional practices and practitioners in the community. Therapists might ask their patient or client to bring them to a traditional healing ritual. A physical therapist working in an Hispanic/Latino neighborhood or with Hispanic/Latino patients might become familiar with the local *botonica* (herbal and religious shop).

Physical therapists should be concerned about patient welfare if the traditional healer prescribes an unhealthy, dangerous remedy. Clinicians may want to think in terms of multiple treatment options—each serving its own purpose. In theory, the best scenario for avoiding or reducing conflict and encouraging collaborative relationships among health care providers would involve the therapist serving as a “culture broker,” or a link that connects the patient, the traditional healers, and the mainstream health care system.

Footnotes

* APTA’s Guide for Professional Conduct states, “A physical therapist shall not accept or offer gifts or other considerations that affect or give the appearance of affecting his/her professional judgment.” (Guide for Professional Conduct. Accessed on: November 7, 2002.)

† The Guide to Physical Therapist Practice defines disability as “the

inability or restricted ability to perform actions, tasks, and activities related to required self-care, home management, work, community, and leisure roles in the individual's sociocultural context and physical environment." (Interactive Guide to Physical Therapist Practice With Catalog of Tests and Measures. Version 1.0. Alexandria, Va: American Physical Therapy Association; 2001.)

Health Promotion and Disease Prevention

Although an in-depth discussion of health promotion and disease prevention is outside the scope of this article, some general guidelines are useful. The Guide to Physical Therapist Practice states, "Physical therapists are involved in prevention; in promoting health, wellness, and fitness; and in performing screening activities."⁶⁰

Health promotion and disease prevention programs should be culture-specific and address a person's explanatory model. One size does not fit all.

After an adequate assessment of individuals and the community (eg, statistics on individual health status, community needs, available resources) has been completed and goals have been established, a program targeted to the specific population can be developed. Certain considerations are likely to be apparent: people may not speak English fluently, the group may have a relatively large number of uninsured people (except for Medicare), and there may be identifiable normative cultural value systems (eg,

importance of family, respect for elders, desire for personalismo). Key program elements will ideally include:

- hiring personnel who are from the community and who are bicultural, not just bilingual,
- using media in the languages spoken in the community for health education,
- teaching people, especially those who have not completely acculturated, to advocate for their health care and patient rights, and
- collaborating with clergy, community leaders, and like-minded agencies.

Role of Culture in Tests and Measures: The Research Imperative

To be culturally proficient as members of a profession, physical therapists must continue to do cross-cultural research. They must examine the interview techniques and functional and cultural scales that they use to assess patient status, and they must evaluate intervention efficacy.

Most tests and measures have been standardized for European-influenced cultures and lifestyles. For example, an analysis of the Denver Developmental Screening Test (DDST), a commonly used pediatric instrument, has indicated that some developmental skills emerge at significantly different ages for Alaska Native children compared with a group of white, middle-class children in the United States.⁶¹

In order for the profession of physical therapy to become culturally proficient, it must make the development of culturally valid standardized screening instruments and culture-specific functional outcome measures and patient satisfaction scales an important goal.

—Ronnie L Leavitt, PT, PhD, MPH

Similarly, Gannotti et al⁶² found differences in the scores on the Pediatric Evaluation Disability Inventory (PEDI) when comparing the scores obtained from a population of children living in Puerto Rico with the norms developed in the United States. Gannotti et al noted several social customs that affected the age at which developmental skills were expected to occur. For example, young children in Puerto Rico, in contrast to white children in the United States, typically use a bottle at night for up to 6 or 7 years, might not use a fork for fear of injury, might wear diapers for public outings to avoid the use of public restrooms, and might not learn to put on socks or tie their shoes because they wear sandals secured with Velcro all year. Puerto Rican parental expectations for their children with disabilities are influenced by the Puerto Rican

values of interdependence, *añoñar* (pampering or nurturing behaviors), and *sobre protectiva* (overprotectiveness). Is the PEDI appropriate to use to evaluate children's development if the expected developmental age is different for this population?

A new Stroke Impact Scale has been developed for use by physical therapists. Duncan⁶³ noted that this scale has been culturally and linguistically validated for 14 European cultural and linguistic groups. This is an excellent beginning, but further research needs to be done to validate this scale (and other tests) for other prevalent cultural groups in the United States, most notably Mexicans, Asians (eg, Chinese, Indians), Native Americans, and others.⁶³

Many functional tests do not take into account activities that may be everyday requirements for people in certain cultures. Examples of such culture-specific activities include eating with chopsticks, eating with hands, or frequently moving in and out of the squat position. Determining culture-specific norms for functional activities also can help the clinician avoid using ethnocentric standards when assessing areas such as cognition, language skills, learning style, gross motor skills, and fine motor skills.

Preparing for Immersion in a Multicultural Environment

Knowledge about a person's and a cultural group's way of life and worldview is bound to help physical therapists practice in a cross-cultural environment. Yet, clinicians are still likely to experience "culture shock." This term describes the more pronounced reactions to the psychological disorientation most people experience when encountering a culture markedly different from their own.

Culture shock is a cyclical phenomenon, in which a person moves through four basic phases of adjustment: excitement in a new environment, withdrawal and hostility, adjustment and appreciation of differences, and adaptation.⁶⁴ Admitting your own ethnocentrism and understanding your own culture are the first steps to moving through this sequence. Physical therapists also should continue to learn about the culture of their patients, ask questions, and be observant. They should have realistic expectations of themselves and others and remember that problems and challenges are inevitable.

What personal characteristics are likely to foster a more successful cross-cultural encounter? A sense of adventure, patience, flexibility, tolerance for ambiguity and differences, a sense of humor, and cultural sensitivity are high on the list. Ironically, many successful

health care professionals have some of the characteristics that are not conducive to working cross-culturally—that is, they are task oriented, overachievers, and fearful of "failure."

Building on Diversity

In this millennium, national population patterns will continue to shift, and physical therapists will increasingly be required to practice in less familiar multicultural settings. The challenges to delivering effective and humanistic care will become even greater than they are today.

In order to ensure that the American health care system better responds to the needs of an increasingly diverse patient population, a growing number of health care organizations and agencies are addressing the issue of cultural competence. For example, the Office of Minority Health in the US Department of Health and Human Services has developed national standards for culturally and linguistically appropriate services. These 14 standards are organized by themes: culturally competent care (standards 1–3), language access services (4–7), and organizational supports for cultural competence (8–14).¹⁴

Although these standards are intended to be inclusive of all cultures, they are particularly designed to help eliminate racial and ethnic disparities in health care in the United States by making the health care environment more

inviting to those groups that historically have not had equal access to health care services. Specific ways to incorporate culturally and linguistically appropriate services can be found in the standards. The use of proactive incentives, mentoring programs, and staff education and training are all suggested as ways to avoid conflicts.¹⁴

An understanding of the sociocultural variables in the health care setting and of an individual patient's or client's worldview is believed to lead to an improved clinical encounter.^{22,65} The term "cross-cultural efficacy" implies that the health care provider has an "ethno-relative" (as opposed to ethnocentric) perspective and believes that there is more than one valid belief system or behavior.⁶⁶ Clinicians increasingly understand that a health care interaction that incorporates negotiation and preservation of cultural health-related beliefs and practices will likely increase treatment adherence and self-efficacy for both parties.⁶⁵

As Helen Hislop stated in her address to the World Confederation of Physical Therapy: "The value of diversity, individuality, and improvisation should be apparent to all of us. We are a group of independent clinicians, all playing the same game with the same objective, but each of us produces individual

variations on the same basic theme, expressing individuality and talent that can combine to produce a unique effect, never twice the same, but powerful and beautiful...." ⁶⁷(p58)

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MIND BACKGROUND INFORMATION

CULTURE MATTERS

CULTURE IS AN AGGREGATION OF HABITS on a societal level, including learned practices, history, memory and community. Regardless of the definition, culture matters. It affects how we do business, how we spend time, and the lens we use to understand the world. It can change over time, and it can also be entrenched.

“PEOPLE ARE PEOPLE EVERYWHERE.”

This is our approach to social change. If someone has the ability or the potential to build opportunity in one place, it is possible across the globe. We put our cultural differences aside to understand what is common among all people: everyone needs food and water, and enjoys entertainment and relationships.

FOCUS ON 3 INNOVATION PRINCIPLES TO APPROACH THE PROCESS WITH COURAGE AND CURIOSITY:

- People are People Everywhere
- Innovate around Experiences
- It's about the Opportunity, not the Challenge

The mindset you need to successfully impact the community is one of learning. Our collective habits lead to a culture of curiosity. The entire team takes risks and works hard to design experiences that change the world. You and your team will develop your own culture: one that captures your essence, values and beliefs. Use the Innovator to support you.

HOW YOU (WE) MAKE AN IMPACT

Shifts in mindsets are at the core of ThinkImpact's approach. We seek to engage all stakeholders in the program with this shift, including you. Your primary role is to learn from another culture and share ideas that may never have reached the community otherwise.

After the Institute, what are scholars and community members doing differently? The adoption of high impact behaviors will determine whether the Institute has had a meaningful impact in the community and your life.

Specific outputs: number of scholars that participate each year; number of community members involved through interviews, design teams, exhibitions and trainings; and

new innovations or enterprises that reach the market. Some innovations and enterprises will succeed and some will fail; in either case there is a meaningful outcome from the Institute.

Scholars often dive into the Institute determined to make an impact on their homestay, design team, and the wider community. Questions arise about the methods used to evaluate this impact, such as:

1. What value can I add?

Your professional experience + your academic studies = strategies valuable to community members

High impact results are in every moment you engage, decision you make, and relationship you build. Aim to make an impact on ONE community member, ONE design team member, or ONE fellow scholar.

Few consider the impact this experience will have on their mindset. Yet, by the end of the program, scholars often feel the community has given them more than they could ever offer in return.

2. How will my contribution here be measured?

Changes in daily activities, skills and perspectives, type and frequency of risks taken, and ideas scholars and community members pursue, provide baseline information to assess our impact over time.

We measure if innovations continue after 3 months, 6 months, and a year, focusing on those creating employment opportunities and those which are environmentally sustainable and healthy for the community. We meet with entrepreneurs who experienced failure to learn if they are pursuing new opportunities.

After the program, scholars may elect to pursue their ideas. Outcomes may be raising capital for ideas born in the Institute and establishing formal entities in the United States and abroad.

Scholars will face opportunities: graduate school, majors, internships, jobs. We track our alumni's decisions along with other education and career choice.

POWER OF HABITS

We all know nothing is sustainable if it is a single action. Repetition creates lasting value. Complex change emerges from small personal adjustments: a powerful place to begin is with your individual habits. Begin to look at the details in your life. How do you function? It is the “how” that will give you the key to “impact”.

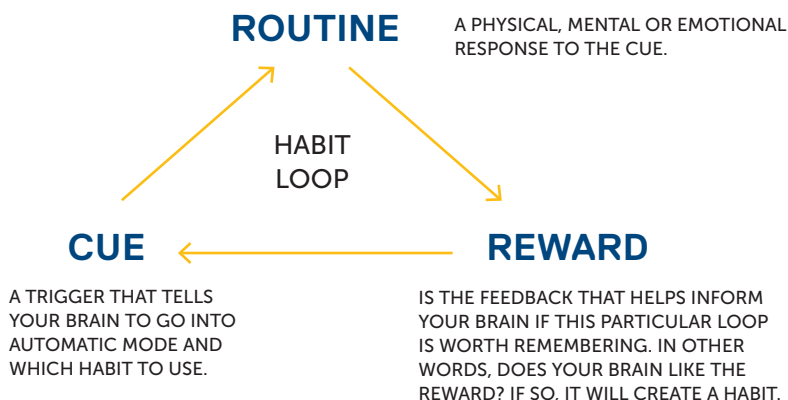
Charles Duhigg, author of “The Power of Habit: why we do what we do in life and business”, argues that a “neurological loop is at the core of every habit, a cue, a routine, and a reward.” Your brain can’t differentiate between good and bad habits. Both result from a cue and reward loop that becomes ingrained in our brain.

“When a habit emerges, the brain stops fully participating in decision making. It stops working so hard, or

diverts focus to other tasks. So unless you deliberately fight a habit—unless you find new routines—the pattern will unfold automatically.” Routines should support you in achieving the task at hand, and ideally become so consistent they make it effortless to focus.

Over time you have built, tested and modified your daily routines. As you immerse in a new community, you may realize that your daily habits are extremely difficult to apply. Even brushing your teeth and eating will put you outside your comfort zone. You will begin to appreciate how much change you can handle.

But such change can be disruptive. You may feel overwhelmed or exposed in the community. With kids running around, locals pointing, smiling or even laughing at you, you may feel like there is no privacy.



Be an explorer, learn the landscape or even where to put your stuff when you sleep. Acquainting yourself with the area and getting into a flow will take time. Some good habits we want you to acquire at the Institute are to use your space and time purposefully to clear your mind and achieve your goals.

Here are some different ways of conceptualizing “Space” to address when you get to the community:

WORKSPACE: This is your physical place of work where you sit down and get things done. Think of your desk at school or in an office. Now you have the additional challenge of creating space where there might be very little room for flexibility. Creating a workspace at your homestay and a “portable workspace” as you move around the community will be a tremendous asset in the innovation process.

TOOLS: You will need tools for your workspace. Pens and pencils, rulers, staplers, tape are typical office tools. We want to take that a step further. You don’t have a local office supply shop for everything you might need, so imagine every asset around you as a tool for your success.

THE FOLLOWING CATEGORIES WILL HELP YOU OWN YOUR SPACE AND TIME:

POSTURE: Everyone in business says your greatest asset is your people. In this case, your greatest asset is your person—your body, your mind, and your health. The way you carry yourself matters. Lying down can help you relax, or sitting straight up in a chair can help you stay focused. Think about your posture and be intentional with it. Your posture will help you achieve your goal at any given moment.

SURFACE: A desk is a critical tool. But it is only one type of surface that helps you work. The walls in ThinkImpact’s office create our open brainstorming space. The floors indicate where people stand at different times of the day (we literally have a meeting where everyone stands on a green circle). Which surfaces inspire you? Sitting on a tree stump next to a river might help you process a reflection more than lying in bed in the dark. Think about what surface you will use to write on, sit on, think on.

ENVIRONMENT: In a rural community people use different spaces at different times of the day. Intuitively, the local community works where they believe they are most comfortable and will achieve their goals. In a new environment, think about where you feel most effective. Working in a cement room with poor halogen lighting is not going to energize and inspire you. Similarly, being cramped among a large crowd is a terrible place to hold a meeting. Select your environment carefully for each task. Test options out. As you figure out where works best for you for different tasks, put that into your daily planning routine. Where do you need to be to succeed?

SIZE: When it comes to space, size matters. Similar to environment, you cannot be cramped and expect to be operating at your peak capacity. Find space to work, then build the workspace.

STORAGE: It's important to think about where to keep materials when you aren't using them. We don't just mean a closet for paper or clothes. We're talking about everything you might need to store so it's readily available when you need it. Where will you store your thoughts? Where will you store your index cards while you

are walking around the community? Where will you store your water bottle so it is not a hassle to carry around? Think about convenient storage tools that you need to operate: small notebook, Ziploc bag, backpack, small cardboard boxes, plastic, rubber bands, string and more.

STATE OF MIND: Know yourself. We discussed above how the environment around you might affect your ability to work. Similarly, everyone has a different cycle in the day and certain activities are best executed or enjoyed in the morning, afternoon or evening. Know your state of mind at different times of the day. Then choose to engage those activities when you are most likely to succeed. In fact, we even think that "Impact" is a state of mind.

One frustrating feeling that may arise is not being able to articulate your ideas, big or small, or being stressed about all the things that you want to do that aren't written down in a reliable place. Process your experiences in the community by writing down your thoughts, or sitting with friends at the end of the day to review. Use your journal like a field notebook and employ disciplined practices to keep yourself organized so the information you record there is useful. Some basic tips:

- Write the date at the top of the page. ALWAYS.
- Give each entry a heading—especially if you’re completing an action.
- Record right below where you are and a three-word description of what you were doing that inspired the entry.
- Try out different types of entries—reflections, lists, sketches, diagrams, pictures.

COMMUNICATE EFFECTIVELY

Leadership is one of the most discussed, intangible, yet powerful qualities in the entire world. Think what leaders have accomplished: Microfinance, Civil Rights, Women’s Suffrage. But the way each leader makes decisions, works with others, and achieves success is unique.

BUT LEADERSHIP DOES NOT COME EASILY. Even for the natural born leader, leadership habits and skills are developed through repetition across experiences. Every moment that one can lead, and does, is a moment that person becomes a more effective leader overall.

LEADERSHIP IS ESSENTIALLY A COMMUNICATION CHALLENGE. In order to lead, you must communicate your vision and goals clearly to yourself, your team, and others. Communication skills help us be a leader and a team player, especially in new situations and environments. During the Institute, you will learn not only how to communicate with others but also how to communicate your ideas into actions. Communication takes place between elements of a system, and that includes teams and projects. Ideas, roles and operations as well as people need to exchange information and work together.

MANAGE AROUND EXPERIENCES

Management is a particular kind of leadership. It is a sticky topic, one that has perplexed professors and leaders for generations. Some get a bad taste in their mouth at the word “management”, feeling boxed in at the thought. Others see power and control, or a tool for doing great things. We identify the essential ingredients for entrepreneurial management (our favorite flavor of management) in the 21st century and provide you with some tools to practice throughout the Institute.

AS PETER DRUCKER NOTED, management is primarily about getting “things done right.” This means relentlessly improving process, developing systems, executing efficiently and producing remarkable results.

AS A GENERAL PRINCIPLE, treat everyone you work with like a customer. Everyone has a perspective and deserves to be listened to, but more importantly, we need to understand their experience to increase satisfaction. That includes satisfaction with the team, the manager and the results. Management can and should be a process of building up through concrete actions.

CONSIDER THE EXPERIENCES around working in teams, following a clear process, or conquering a goal and seeing the results. Each can be inspiring. The question is, how can an organization institutionalize such an inspiring concept and make it common?

EVERY MANAGER MUST BE ABLE TO ANSWER THE FOLLOWING 3 KEYS TO MANAGEMENT:

1. WHAT WILL WE ACHIEVE?
2. HOW WILL WE ALLOCATE RESOURCES (TIME, TALENT, TREASURE)?

3. WHO WILL DELIVER RESULTS?

ANSWERING THESE QUESTIONS helps you see the path ahead. As an entrepreneurial manager, it is critical to communicate the answers to the three questions above to your team, and often. Ari Weinzweig, co-founder and CEO of the world famous Zingerman's Deli, explains that managers must communicate something in 9 different ways to get the message across. You read that correctly: 9.

HOW YOU MIGHT DELIVER SOMETHING USING THE 9 WAYS TO COMMUNICATE:

1. ONE ON ONE MEETINGS
2. GROUP MEETINGS
3. LETTER WRITING
4. DRAWING
5. JOKE TELLING
6. ROLE PLAYING
7. STORYTELLING
8. BODY MOVEMENT
9. SHARING MANTRAS

ENTERING THE COMMUNITY

THE INSTITUTE IS A TRULY INTENSE EXPERIENCE. There is no skirting around that fact. At times you will feel like you have been pushed to your limits. Your host families will try hard to make sure you are comfortable,

sometimes making you feel uncomfortable, as though you are an intruder. The Country Team will be working every day to ensure that your time in the community is high impact. Energy, expectations, and emotions will run high.

THE KEY TO SUCCESS is responding appropriately to situations. Impulsively reacting can cause you even more frustration, discomfort or even embarrassment.

YOU WILL NEED TO COMMUNICATE THE INNOVATION PROCESS AS CAPTURED IN THE INNOVATOR TO COMMUNITY MEMBERS. When you need to share ideas, remember that the Innovator is a complex tool for uncovering assets, building relationships, establishing teams and testing ideas. Consider how difficult it is for people in a different country, with a different language and cultural heritage, to understand! Creating circumstances for you to become deeply familiar with the Innovator actions and for your new friends to use it as well requires precise and thoughtful communication skills.

SOMETIMES YOU WILL DOUBT THE PROCESS and your purpose in the community. You will likely question the Innovator itself. Manage doubt through open and honest dialogue. The quality of your communication with others directly relates to the trust you and other scholars will share.

THE MOST DIFFICULT COMMUNICATION CHALLENGE for scholars (from our experience), other than the language barrier, is constantly responding to requests for money. While the community has been told that you are not here to provide donations, grants, or to distribute cash, you will get the question all the time. In some communities, children will routinely ask for candy, goodies, food, or even your iPod.

PLEASE DO NOT GIVE PEOPLE MONEY, PROMISES OF SCHOLARSHIPS, SHOES OR ANYTHING ELSE.

WE COMPENSATE homestays fairly and we cannot confuse our role in the community.

EXPECTATIONS IN THE COMMUNITY

THINKIMPACT takes the health and safety of its team extremely seriously. Every program practice and norm is the product of thoughtful review of what health and safety risks visitors face during a full immersion program. You have agreed to and signed a behavior policy codifying these practices and norms. They are for your benefit and the community's well being.

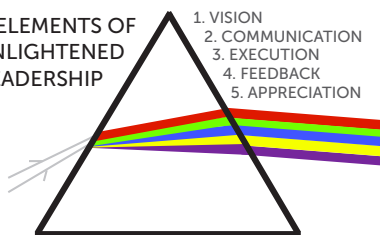
LEADERSHIP PRISM

WHEN YOU BECOME A LEADER, EVERYTHING YOU DO IS REFRACTED THROUGH A PRISM. Refining the characteristics of that prism can determine your effectiveness. What kind of a leader will you be?

To answer this question, ThinkImpact developed a Leadership Prism to help you sift through questions that leaders face. Use the prism to prepare for leadership opportunities.

You can use the leadership prism to analyze opportunities you have to lead:

5 ELEMENTS OF
ENLIGHTENED
LEADERSHIP



1. ESTABLISH YOUR VISION

by thinking about the goals and outcomes that inspire your team, and your opportunity to make a difference. Think about the ideal scene to achieve this outcome, and identify the next steps you need to take to make the scene a reality.

2. DESCRIBING WHERE YOU ARE GOING

or how you hope to work with others is immensely challenging. Everyone has their own interpretation of events, ideas and experiences. Leaders capture the essential pieces that relate to the entire group. Make sure the ideas you share are communicated effectively. When you are communicating, respect people's time and opinion and be mentally present in the conversation.

KEEP YOUR MESSAGE SIMPLE by running through different scenes:

- You are at a bar and someone asks you to share your vision. How would you answer?
- You're running a 10k and someone asks you to share your vision, but can only hear every other word, which words are most important to share?
- You have 35 seconds with the one person who can make your vision real, what will you tell them?
- You're sharing with a 7 year old, how will you explain it to them so you keep their attention?

BE CONSISTENT with the messages you give about the vision. Is it grand or is it small? Will it require many people? What information is available and where did you get it? Why are you committed to the vision? Who is with you?

CHECK YOURSELF to see if your messages are contradictory. Is anything different from what you have said in the past? If so, why? Does your message reflect reality? Is there anything unpredictable that could undermine your credibility? How will you achieve the vision every day? Is it sustainable? Will you become burnt out? Where will you find the energy to continue even when things get difficult?

COMMUNICATE CHANGES: There will be bumps in the road, deadlines missed, new ideas and frustrations working with others. Embrace change! Once you appreciate that it's inevitable, you can communicate changes and seek opportunities from them. Consider changes that may occur in:

- TIMING
- QUALITY
- ENVIRONMENT
- RELATIONSHIPS
- COMPETITION
- TECHNOLOGY
- RESOURCES

ISOLATE CHANGES THAT HAVE AFFECTED YOUR PLANS: What change has occurred and why? How can we innovate around this change? Is the change causes friction between two people, remember two invaluable practices:

- Don't waste energy looking for what others are doing wrong. Look for what you could do to improve the situation.
- Don't label others and don't label yourself. Everyone is multidimensional and every solution requires more than 1 part of each person.

3. EXECUTE EFFICIENTLY by defining roles and supporting, preparing and motivating people to achieve the vision. **LEADERSHIP IS ONE ROLE IN AN OPERATION.** Other roles are often required to get something done. Think about a standard company: there might be people in the strategy role, the engineering role, the administrative role and the sales role. All of these roles make the whole possible. Leaders make sure others are in the roles that fit with their skills and desires, and support them to be successful.

AS YOU EXECUTE THE VISION, CHECK HOW YOU'RE DOING THROUGH THESE LENSES:

RIGHT SEAT ON THE BUS LENS

Is each member of your team in a position to succeed? Do they have the habits, skills and perspectives required for the tasks ahead?

CONSISTENCY LENS As the leader are you sending a consistent message? Is the vision changing? When things change are you ruffled or do you hold strong?

INNOVATING LENS Are you leaving room for others to share ideas or test them out? Are you holding on to old ideas that are stifling opportunity?

OPTIMIST LENS Do you convey a sense of opportunity to your team? Have you been able to reframe small or menial tasks into critical pieces to achieving the vision?

OPERATIONS LENS Is the team working cohesively to achieve the goal? Is information being communicated efficiently? Are ideas being shared? Are tasks moving from one person to the next on time? Do people know what they are responsible for?

OWNERSHIP LENS Is the individual working on the task or project feeling truly in charge? Are you focusing on what they are doing wrong? If so, redirect your energy towards how you can be more supportive.

4. GATHER AND PROVIDE

FEEDBACK to present growth opportunities. Everyone wants to know how he or she did when they complete a task. Think about how excited you are to get exam results on a test you prepared for.

FEEDBACK COMES IN MANY FORMS. HERE IS HOW TO MAKE FEEDBACK HIGH IMPACT:

RECEIVING FEEDBACK: If feedback feels negative, remember that you are learning. Don't let it undermine your ambitions. Simply put, don't be too hard on yourself. We are often our harshest critics. Feedback is meant to help, not to destroy.

Seek improvement. Nothing was built in a day and nobody is perfect. No matter what feedback you are receiving, make it constructive. Identify how you can be better, and be proud of that. Reflect on the feedback. Reject the impulse to react. Sit on it without letting your ego or pride get in the way. Come back around to it after a couple hours or days, then move on. Don't misinterpret positive feedback as meaning you are perfect. Be grateful for the affirmation but recognize that we can always improve.

Once you have received feedback and processed it, think about how you can **APPLY IT EARLY AND OFTEN** and see if there are tangible improvements in your outcomes.

GIVING FEEDBACK: Offer feedback in the right physical space. Don't sit above or below the other person. Be at eye level and have a conversation. Offer feedback privately to avoid embarrassment.

Establish the context of the feedback first. Avoid words like

“always” or “never.” Blanket statements lack context. Organize your feedback. Begin with something positive (be authentic!) then offer something constructive, and find a way to end on a positive note. Discuss next steps. Consider setting goals and check in points to track progress. Explore ways that you can be a resource.

5. APPRECIATE ALL AROUND

and make every moment high impact. The easiest way to do this is to “VALUE PEOPLE”. But be cautious. Being authentic will determine if your appreciation is taken the right way. Using specific examples is the most powerful way to show your appreciation.

Every day people do remarkable things, big and small, on our behalf. How we appreciate their efforts will determine if they want to continue to help us with our vision.

ASK YOURSELF: Who has done something you truly appreciate? Beyond saying “thank you,” how can you appreciate their efforts?

CONSIDER: recognizing someone in front of the whole team and showing your appreciation through reciprocation. Give a specific example of how a team member has contributed toward the goal.



LETTER FROM SAUL TO SCHOLARS POST-INSTITUTE

This is a note that Saul Garlick, sent to Alumni in 2013 after the summer Institute.

The full text is included and provides useful information about managing assumptions and expectations about relationships and money in the community.

Dear Innovators,
I hope you are all doing well and enjoying the fall. We have recently learned that a few of you have been dealing with some difficult, and at times, awkward conversations relating to money with friends from the community where you spent the Institute.

Inevitably, you represent opportunity. Coming from a wealthier country, with the resources to travel the world and gain a world-class education, it is inevitable that some community members will believe that you can help them through financial support. It is a logical idea, then, for community members to ask for that support from you.

However, we don't believe that the support you might provide will be sustainable, and it runs against our model for social change. This

is why we urge students not to promise anything to community members or to give money away.

You have just had an intense learning experience – and so has the community. Community members report being significantly better off due to the learning experience of working with students throughout the Institute.

But it is essential for you to remember that you nor ThinkImpact operates in a vacuum. While we speak our own language and promote our unique values and opinions when it comes to community development and engagement (Assets! Opportunities! Design! Empowerment!), we are part of a much larger system where traditional “aid” has been the norm for generations. When we enter a community, we begin to work in a place steeped in a history of complex power dynamics and broken promises.

All of this to say that it may not be uncommon for one of your partners to ask you for money for school or personal use. Here are some key points we want to highlight about that possibility:

- Asking for money is actually not an awkward conversation for many of our community partners. In many of the communities where we operate, asking family, friends or even just acquaintances for money or support is not uncommon or taboo as it may be in the US. The norms here are different.

- Even though, we don't make promises or come into a community with money or any kind of financial support, people will still assume otherwise. If even one student gives a community member a large gift or money, it creates ripple effects that extend well beyond. We cannot control your decision to do this, but we do strongly discourage it.

- You may feel disappointment if your friends in the community ask you for money. It makes sense that you would. You put your blood, sweat and tears into the experience and walked away with life-long friendships and relationships that have forever changed your perspective on people and what is possible. This may seem to cheapen that relationship. But it doesn't. It is simply a request from a friend to a friend. You can say no and the friendship will continue.

- It feels like all of the "mindshift" work you did through the Institute to empower your local partners didn't really work after all. This is also not the case. Community members are more likely to start businesses after working with you, feel more empowered and want to continue to work with

ThinkImpact. Change takes time. Whether someone requests money is not the only metric for change.

The solution is not so simple and there is no right way to approach these types of inquiries and questions from your local partners. But here are a couple thoughts for how to embrace this potential interaction as a learning opportunity:

- Shifting mindsets takes time. Not everyone in every community will get it right away. That is why we are committed to working in a community for 2-3 years through multiple programs, so that community members can continue to engage with the process and scholars can continue to empower local leaders, thinkers and entrepreneurs through the assets they have in their community.

- Don't take it personally. You are not a failure if after a lot of work your partners still come to you asking for financial support.

- Be firm in your response with such questions. It is okay to say, "no, I will not provide you with this support." Be blunt. You will not hurt anyone's feelings while remaining consistent with this message.

Explain that you are a friend and can be there to offer advice and consultation.

We strongly encourage all alumni to refrain from giving monetary

handouts of any kind to homestay families or design team members. Just imagine how you will set up future groups of scholars and ThinkImpact staff members in our communities. Monetary contributions will become something that is expected, perpetuating cycles that we are seeking to disrupt through our programs and philosophy. Indeed, under such circumstances we may be forced to leave the community all together. Very few students over the years have made this decision, please keep that trend alive and well.

You all have accomplished amazing things on the Institute and we are excited to support you in continuing this work!

If anyone has any questions or wants to get in touch to discuss further please feel free to send me an email or give us a call at 303-377-3776.

Best Regards,

A handwritten signature in black ink, appearing to read 'Saul Garlick', with a stylized, cursive script.

Saul Garlick, ThinkImpact



IMMERSE BACKGROUND INFORMATION

THE HOMESTAY EXPERIENCE

WELCOME TO YOUR NEW HOME. We have spent many hours meeting with the local community, training host families, and preparing the community for your arrival. Host families know that you are coming and are excited to have you. Everyone has been selected through a careful process to have you as their guest. Each homestay typically has two scholars of the same gender and you are expected to share a room.

You should get to know the community by spending meaningful time with your host family, learning about daily routines, likes and dislikes, eating habits and cultural norms. Remember, the host families are an incredible resource for you to engage more effectively with the community. Learn from them at every opportunity! Your homestay experience should be enriching and enjoyable and help you build connections to your host family, and will help you understand the role of ThinkImpact and scholars in a broader context.

Some visitors might want to give a small token of appreciation to their homestay; check with your country associate on the appropriate time to do this (it may be at the end!).

REMEMBER that what you are doing is extraordinary! You are about to experience life in a new place, living with a culture and community that is new to you. Sometimes you might say something with a thick accent or community members might be shy. Along the way, your attempts at the language may make people laugh or giggle. Don't be discouraged. Everyone is warming up.

ASSET-BASED COMMUNITY DEVELOPMENT

THROUGHOUT ITS HISTORY, ThinkImpact has explored different approaches to development. We began with a needs-based perspective that is still popular among various governments and international aid organizations. We joined the army of development organizations raising funds for schools, libraries, and water projects. After supporting dozens of projects,

we realized we were perpetuating the cycle of dependency among community members. The needs-based approach created a reality in which communities identified themselves based on deficiencies and dependence. We needed an approach that would empower community members to tackle social problems on their own terms, to shift the mindset from dependence to independence.

IN THE FALL OF 2008, we learned about Asset-Based Community Development (ABCD), pioneered by John McKnight and John Kretzmann of the ABCD Institute at Northwestern University. Through years of experience working in Chicago's low-income areas, they found that asset-based community development empowers communities by focusing on a community's skills, knowledge, resources, associations, and abilities. This encourages sustainable development in contrast to a needs-based approach.

WE ADAPTED THIS APPROACH for our program. McKnight and Kretzmann recommend that an outsider remain a facilitator throughout the development process, rather than becoming an active participant. Through design teams, we encourage scholars to fully engage partners in the creation of a product or service that will have a social benefit in the community. Rather than focusing

exclusively on development as a general concept, ThinkImpact takes it to the marketplace where business is born, tested, and grown. As co-creators of products and services, we think there is a higher likelihood for social change.

ADOPTING AN ASSET-BASED strategy marked a turning point in how we approach communities. We value meaningful relationships with local residents, marginalized community members, associations, and institutions. Such relationships are built over time through trust, empathy, and mutual understanding. Together, we can leverage local resources and promote self-sufficiency, with the aim of changing the paradigm (leading a mind-shift) in the way that communities view themselves. Informed by this shift, we have adopted the philosophy that no one is poor: everyone has assets and something to contribute.

WE DEFINE ASSETS as resources with inherent value that can be leveraged to create change. This includes institutions, associations, material resources, skills, physical spaces, and more.

EXPLORE WITH FRESH EYES

Getting your mind around the experience you will have in the beginning is challenging. Get in a mindset of calm and patience. Be open to learning about everything around you, and most importantly, engage with the community whenever possible.

IT'S TIME TO GET THE LAY OF THE LAND! BRING YOUR INQUISITIVE SIDE as you explore the community. See things with fresh eyes and a beginner's mindset. Differentiate what you know from what you assume, and challenge assumptions. Take the mind of an anthropologist who simply seeks to understand other people's values, beliefs and behaviors. Being a beginner is an asset, it allows you to see things with a fresh perspective.

THE INNOVATION INSTITUTE IS ALL ABOUT EMPATHY, not sympathy. Empathy is "the intellectual identification with or vicarious experiencing of the feelings, thoughts, or attitudes of another." In other words, put yourself in someone else's shoes. We have built a number of ways for empathy to be part of your immersion process. First, we encourage you to share cultural experiences. We also believe in a concept called shared austerity, meaning you should experience some of the hardships of community life. Collecting water

early in the morning or sweeping the dirt in your hut are some examples. By living as locals live, you gain insight into daily community life.

People work together, build together, and live together in any community around the world, and getting a deeper sense of how people spend their time, expand their skill sets, and bring value to the community is inspiring and helpful for the design process.

WHAT PEOPLE TELL YOU and what they experience on a daily basis can be quite different. Active engagement in tasks and cultural experiences reveals information, challenges, and opportunities that might not come up during a conversation. Learn by doing!

AS YOU ENGAGE IN AN ACTIVITY, THINK ABOUT AN ASSETS-MOTIVATION-EXCHANGES TRIANGLE:

- **ASSETS:** Did you learn about a new asset or resource that you overlooked before?
- **MOTIVATION:** Have you learned anything new about what motivates community members to perform a particular activity?
- **EXCHANGES:** Have you observed any exchanges (financial, barter, etc.) that helped the community member complete a daily task?

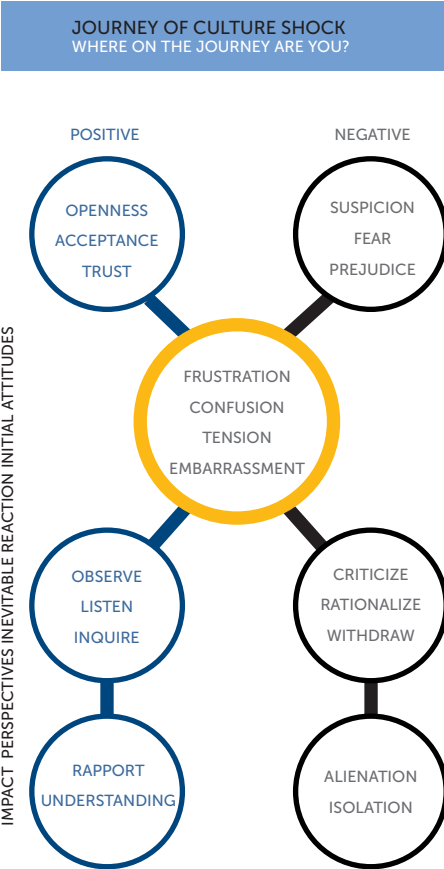
SEEK UNDERSTANDING

AS YOU GAIN A DEEPER UNDERSTANDING of local culture, you will likely experience competing views and emotions. Sometimes you'll feel incredible, other times deflated. This array of emotions—indeed, a roller coaster of emotions—can be attributed to culture shock, a normal and useful personal process.

THE SECRET THAT NOBODY TELLS YOU when you travel to a new country or environment: your attitude drives how you deal with each phase of culture shock.

HERE IS AN EXAMPLE of a scenario and two ways to approach the situation:

At the beginning of the Institute you meet several community leaders and wonder if they are corrupt. You have read about corruption in Africa and Latin America, you have mapped assumptions, and you cannot get the idea that local leaders steal from their population out of your head.



Which would be your approach?

1. When you arrive at the Welcome Ceremony, you meet the chief. You look into his eyes, smile, and determine, this guy is definitely corrupt. You decide that he is suspicious. His shoes are too nice in a community where everyone else wears sandals or no shoes at all. This feeling extends to his subordinates—the four sub-chiefs. As the program progresses, you avoid working with the local leadership and at times find yourself frustrated, critical and generally a bit isolated throughout the Institute.
2. You learn the same facts about corruption, but decide that you don't have enough information to judge the chief. Perhaps the chief gets shoes for his status as a leader? Perhaps he hates those shoes? You simply don't know, but you are excited to gain information. You trust that the complexities of a community reach far beyond the surface—for better and for worse. You listen a lot, ask great questions, and eventually build a deeper sense of belonging and understanding, even when you encounter frustrations along the way.

INNOVATION COMES at the nexus of two radically different cultures. As you gain more exposure to this culture, you will be laying the foundation for a dynamic innovation process.

DIG DEEP

Exploring and understanding will involve some planning. Think carefully about who you want to talk to, what you want to learn and make a plan to accomplish your goals and translate them into action. The secret to success at the Institute is fully digesting your experiences. As you complete actions it is important to process the information that you collect and plan follow-ups when you have gaps. Taking the time to process the influx of information will yield incredible rewards as the program progresses.

YOU WILL BE PUSHED to meet individuals across the entire community. You should make special effort to meet with people of varied socioeconomic statuses, as well as a variety of ages and genders. Ideally, you will really connect with a couple of these individuals. They may be a starting point or a direct partner later on as you build your design teams.

IT IS INCREDIBLY IMPORTANT to remember names. It is also extremely difficult because they may be difficult to pronounce. Remembering names will help you connect with community members. Some would say that a person's name is their favorite word to hear. If that's true, it's good to use a person's name in whatever work you're doing.

HERE ARE SOME TRICKS we pulled from Mindtools to help you DIG DEEP.

1. **FACE ASSOCIATION:** Examine a person's face discreetly when you are introduced. Find an unusual feature: ears, hairline, forehead, eyebrows, eyes, etc. Create an association among characteristic, face and name. Maybe you link the person with someone else you know with the same name. Or, associate a rhyme or image of the name with the person's face or defining feature.
2. **REPETITION:** When you are introduced, ask for the person to repeat their name. Use the name yourself as often as possible (without overdoing it!). If it is unusual, ask how it is spelled. The more often you hear and see the name, the more likely it is to sink in. Also, after you leave that person's company, say the name to yourself a couple times. You might even decide to write it down and make notes.

ARE YOU AN ACTIVE LISTENER?

Spend a few minutes thinking about that question. We ask because active listening is an important skill for building meaningful relationships and networks. You can only really process what someone is telling you if you are an active listener. Superb active listeners are completely present in each conversation and spend time during the conversation working through ideas, connecting dots, and finding inspiration through others. The alternative is to be absorbed in your own thoughts, aloof to other people's feelings, and incurious about their work and lives.

HERE ARE SOME TIPS TO INCREASE ACTIVE LISTENING:

1. **PAY ATTENTION:** Give the speaker your undivided attention, and acknowledge the message.
 - Recognize that non-verbal communication also "speaks" loudly.
 - Look at the speaker directly.
 - Put aside distracting thoughts.
 - Avoid being distracted by environmental factors.
 - "Listen" to the speaker's body language.
 - Refrain from side conversations when listening in a group setting.

2. SHOW THAT YOU ARE LISTENING.

- Use your own body language and gestures to convey your attention.
- Nod occasionally. Smile and use other facial expressions.
- Note your posture and make sure it is open and inviting.
- Encourage the speaker to continue with small verbal comments like "yes."

3. PROVIDE FEEDBACK. Our personal filters, assumptions, judgments, and beliefs can distort what we hear. Your role is to understand what is being said. This may require you to reflect and ask questions.

- Paraphrase: "What I'm hearing is" and "Sounds like you're saying" are great ways to reflect back.
- Ask questions to clarify certain points: "What do you mean when you say?" or "Is this what you mean?"
- Summarize the speaker's comments periodically.

4. DEFER JUDGEMENT.

INTERRUPTING IS A waste of time. It frustrates the speaker and limits full understanding of the message.

- Allow the speaker to finish.
- Don't interrupt with counter arguments.

5. RESPOND APPROPRIATELY.

we IS A model for respect and understanding. You add nothing by attacking the speaker or otherwise putting him or her down.

- Be candid, open, and honest in your responses.
- Assert your opinions respectfully.
- Treat the other person as he or she would want to be treated.

FINALLY, PLAN WHICH ACTIVITIES YOU NEED A TRANSLATOR FOR.

WHEN YOU HAVE TO USE A TRANSLATOR TO COMMUNICATE, REMEMBER THESE TIPS FROM THE CDC ON THE FOLLOWING PAGE:

CDC TIPS ON WORKING WITH A TRANSLATOR

1. When communicating through a translator, speak slowly and clearly.
2. Use a positive tone of voice that conveys your interest in the community member.
3. Face the community member, not the translator.
4. Speak in short units of speech, allowing sufficient time for the interpretation.
5. Avoid jargon or slang. Clear, simple, lay language is generally most effective.
6. Encourage the translator to translate the community members words as closely as possible and not to paraphrase, polish, or omit anything that may result in loss of the community member's true meaning.
7. Pay attention for nonverbal communication such as silence, distance between individuals, eye contact, emotional expressiveness, and body movements.
8. Feel free to ask the translator for clarification of the meaning of any nonverbal cues to be sure you have understood correctly any cross-cultural meaning.
9. Above all, be patient: Careful interpretation often takes considerable time.

ADDITIONAL HOMESTAY INFO: GREETING YOUR FAMILY

So much of the Institute is about relationships. Your host family will be a resource as you begin to build personal ties to locals in the village. The first moments of any homestay can be a little bit awkward. Language barriers and different cultural practices for hosting guests will undoubtedly factor into how you and your host family are feeling in those first few moments of your arrival.

Try to use the local language to say hello. Speak in the language as much as possible and don't worry about pronunciation. Your hosts will appreciate your effort!

Example questions: Who is in the family (brothers, sisters, grandparents, other extended family)? What do the children do for fun? Do the host siblings study at the local school? What does the family eat? Are there any special holidays that they celebrate and how do they celebrate them? Does the family have any questions about life in the U.S.?

We recommend bringing a few pictures (could be printed out or saved on your camera/iPad/iPhone) of your family, where you went to school, activities that you

like to do in your spare time, etc. This helps you to teach the family about yourself even when you are facing a language barrier.

If you brought a gift from home (something small that represents where you come from is recommended) then you will want to give it at the end of the program.

Keep in mind that not every culture accepts or even opens gifts in the same way we might in our home countries. Don't take offense for how they embrace your gift. See this as another cultural learning opportunity.

UNDERSTAND ENTERPRISE

1. Learn about how the business operates and their history with the business. When did they start selling this product? Why are they in this type of business? What is the business cycle? When are things busy?
2. Learn the basics about the price of the product and how much it costs to buy the inputs for each product. Where do they buy the inputs? How much does it cost to ship things into the community? Do they pick things up in the city? How much is a taxi ride?
3. Does the entrepreneur keep a record of every transaction? Where do they keep it? Do they ever add up the totals from the week, month, or year? Do they keep a bank account? Which banks are available in the area?
4. Who are their customers? How do they reach their customers?

These are just a few questions you can ask while spending time with an entrepreneur in the community.



ETHNOGRAPHIC RESEARCH: A KEY TO STRATEGY

By Ken Anderson

Corporate ethnography isn't just for innovation anymore. It's central to gaining a full understanding of your customers and the business itself. The ethnographic work at my company, Intel, and other firms now informs functions such as strategy and long-range planning.

Ethnography is the branch of anthropology that involves trying to understand how people live their lives. Unlike traditional market researchers, who ask specific, highly practical questions, anthropological researchers visit consumers in their homes or offices to observe and listen in a nondirected way. Our goal is to see people's behavior on their terms, not ours. While this observational method may appear inefficient, it enlightens us about the context in which customers would use a new product and the meaning that product might hold in their lives.

Ethnography at Intel initially focused on new markets. The company had provided products only for the workplace, but in 1995 managers wondered whether users at home would become a distinct market. Ethnographic research

showed so much potential that Intel set up a business unit to concentrate on processors and platforms for home use.

Recently, Intel ethnographers have veered into strategic questions. Like many high-tech companies, Intel makes long-term bets on how markets will play out. Will television and PC technology converge? Are baby boomers retaining their PC and TV habits as they age, or are they comfortable shifting to new media? Will smartphones take over most of the functions of personal computers?

Intel can analyze the latest buying patterns and customer surveys for useful data. But people often can't articulate what they're looking for in products or services. By understanding how people live, researchers discover otherwise elusive trends that inform the company's future strategies. With smartphones, for example, we can contrast the technology perspectives of teenagers, who have used cell phones since they were in elementary school, with those of older generations, who came to them only after becoming proficient with PCs. Our job as anthropologists is to understand the perspective

of one tribe, consumers, and communicate it to another, the people at Intel. Our experiences in both worlds make this translation possible. Ethnography has proved so valuable at Intel that the company now employs two dozen anthropologists and other trained ethnographers, probably the biggest such corporate staff in the world.

High-tech companies have to date employed the lion's share of corporate ethnographers. But I believe that ethnography is so beneficial that it will spread widely, helping firms in every industry truly understand customers and adapt to fast-changing markets.



INSPIRE BACKGROUND INFORMATION

IDENTIFY OPPORTUNITIES

IN THIS PHASE of the Institute, the daily structure of your work in the community becomes increasingly unpredictable. You are responsible for planning carefully, collaborating with community members fully, and successfully making difficult decisions that will determine the types of innovations you develop.

YOUR JOB IS TO IDENTIFY OPPORTUNITIES, not be a consultant. You're here to explore design opportunities, think creatively, and devise new ideas for products and services with locals. You're not here to tell local business owners how to run their businesses better. You simply aren't in the position to analyze the economic environment sufficiently and tell a community member how to do what they do more effectively.

WE REALIZE THAT THIS MIGHT SEEM LIKE A CONTRADICTION: Go to rural communities, work with locals to develop a product or service, perhaps an innovative way of delivering it, and even go as far as developing a business model around it, but don't be a consultant? Seems inconsistent.

HERE IS WHY IT ISN'T: WHEN SOMEONE HAS an established business, they have figured out a way to make their business work. They are living off of it, and hopefully generating a small profit that covers their basic needs. It is fine to explore ideas and ask questions about how they operate, but not to push local businesses to behave like businesses we were raised around. We can always provide help through general education (e.g.. how to keep records), but we should not try to show them how to scale an existing business based on our aspirations for it. Rather, we are there to be creative with community members and explore ideas, solutions, and possibilities that have eluded the community until now.

HERE ARE SOME OTHER INSIGHTS AS YOU GET STARTED:

1. **SHARING IDEAS IS THE ROOT OF ALL OPPORTUNITY.** Actively listen and process collaboratively to maximize opportunity. Think of all the life experiences available when people problem-solve together.
2. **STAY FOCUSED.** Your goal is to build partnerships with community members who you will work with on brainstorming, choosing a challenge, and prototyping.

3. **WORK WITH PEOPLE YOU LIKE SPENDING TIME WITH.** Everybody enjoys working with people who share your interests and enthusiasm. Look for the right fit in the community, and you will enjoy more success.
4. **HOLD YOURSELF ACCOUNTABLE.** This whole process will be at times be exhilarating and disappointing. You may look for excuses, displace the blame, or otherwise disconnect. Set high expectations for yourself, be your best, and solve problems when they arise.
5. **BE OPEN-MINDED.** You may think you have the answers or know where your design team is heading, it's always healthy to keep an open mind—otherwise, your team may miss out on great opportunities.
6. **TAKE RISKS WITH INNOVATION.** You are not here to ask simple questions or dream small. Work with community members to define challenges that really push you to your intellectual limits. You never know what creative solutions might be born out of the right challenge.

INSPIRE IS THE PHASE WHEN YOU GET TO EXPERIENCE THIS DYNAMIC PROCESS AND PROACTIVELY BUILD ON IT. YOU ARE NOW READY TO ESTABLISH A DESIGN TEAM.

DESIGN THINKING

THE DESIGN THINKING METHODOLOGY PROVIDES A CRITICAL BRIDGE from understanding the community to working collaboratively and implementing meaningful ideas for social impact. The concept originates with the work and philosophy of IDEO, an award-winning global design-consulting firm that uses a human-centered design approach toward product innovation.

This approach is “powered by a thorough understanding, through direct observation, of what people want and need in their lives and what they like or dislike about the way particular products are made, packaged, marketed, sold, and supported.”

TIM BROWN, CEO of IDEO, explains that this approach assumes three “lenses”: desirability, feasibility and viability. These lenses help you first examine what the community wants, then think about products and services that are technically feasible, and analyze whether or not an innovation is financially viable.

ENGAGING IN DESIGN-THINKING as equal partners with locals will allow your design team to generate sustainable products and services that address social challenges grounded in the community's culture and context, including preferences, aspirations, assets, resources, likes and dislikes.

DESIGN THINKING includes a variety of activities within a continuum of innovation. While some design processes comprise orderly steps, design thinking sometimes feels chaotic. But ultimately, it will yield the desired outcomes. The chaos stems from the creativity and flexibility needed to design social innovations.

YOU WILL GET A CHANCE TO LEARN DESIGN THINKING THROUGH A GROUP WORKSHOP, THEN APPLY WHAT YOU LEARN TO YOUR DESIGN TEAM.

GET INSPIRED

INNOVATION REQUIRES INSPIRATION AND NEW WAYS OF LOOKING AT THE WORLD.

BIOMIMICRY is one of these “new lenses”: it is a powerful framework for understanding what is possible by learning directly from the natural order of things. Biomimicry sounds like a scary word, but don’t be alarmed. Below you will learn how to make the most of it.

BIOS means life; MIMICRY means imitate.

BIOMIMICRY IS the practice of learning from and emulating life’s genius to solve human problems and create more sustainable designs. It is a design and leadership discipline that seeks sustainable solutions by emulating nature’s time-tested ideas. Biomimicry is a branch of

science, a problem-solving method, a sustainability ethos, a movement, a stance toward nature, and a new way of viewing and valuing biodiversity. Think of how nature solves its problems when you design innovations for communities.

IT’S TIME to imagine what is possible. Social change through market forces is only accomplished when great ideas are uncovered. In rural communities in Africa and Latin America, great ideas will always meet local consumers where they are: attuned to local preferences, social challenges and daily routines.

BRAINSTORMING IS ANOTHER GREAT WAY TO GET INSPIRED AND BE CREATIVE.

TIPS FOR BRAINSTORMING

1. Defer judgment, think as large-scale and broadly as possible and build on the ideas of others.
2. Welcome unusual ideas and combine and expand those that inspire you.
3. Set a time limit for each brainstorming session.
4. Document every idea.
5. Seek to multiply your options, considering as many of the assets and skills the community has and as many challenges as it is facing as you can. Include all insights and visions that surface.

6. Do not jump to solutions in the form of a made-to-order product or service as this will limit your thinking.
7. Take a step back.

THE PATH STATEMENT

IN THIS PHASE, YOUR DESIGN TEAM WILL BRAINSTORM AND PICK A Path Statement.

START WITH THE TEAM'S PURPOSE. "Purpose" is why the design team exists: for example, to identity a powerful opportunity for community or individual improvement and understand experiences related to improving that opportunity.

"PRINCIPLES, VALUES, HABITS" ARE HOW YOUR DESIGN TEAM WILL OPERATE.

RECALL THINKIMPACT'S 7 HIGH IMPACT PRACTICES. They embody our values and principles and make them concrete.

1. BELIEVE IN THE PROCESS
2. VALUE PEOPLE
3. LISTEN TO LEARN
4. LAUGH OFTEN
5. SEEK MINDFUL COURAGE
6. BREATHE
7. BRING IT HOME

A Path Statement MOVES YOU TOWARDS creating a product or service. It is an exciting turning point for the Institute. Everything you've done thus far led you here. Now, utilize your facilitation and leadership skills to bring ideas to life and identify a series of possible paths to discuss and review with your design team. Picking the right path will set you up for success.

THE PATH STATEMENT is a formal declaration of where your team is going. It provides a clear statement of the ultimate outcome and the changed experience you will offer the customer or individual.

PICKING A PATH will determine your team's direction throughout the Innovate phase. It could determine what people end up doing for the rest of their lives. This is an exciting opportunity and you may be tempted to tackle several paths. However, your team has to pick one path, no exceptions.

WE FOCUS ON EXPERIENCES, not products, at this stage of the innovation process. THE INNOVATION PROCESS is human-centered, driven by the belief that ideas are powerful but people make every moment high impact. To remain human-centered, we must resist the urge to solve problems first and instead focus on the experiences of daily life. Solutions emerge from a deep understanding of how people live and what they do, not just what they use.



NOTE: It is a common tendency to jump to conclusions about what people need. This happens because scholars become unsure about the process that is offered here. Doubt is healthy; after all, you are creating space for innovation to happen, and that is unclear and uncomfortable. However, successful innovation emerges by deepening your participation in the process, not by blowing past it.

CREATE YOUR DESIGN TEAM

YOUR DESIGN TEAM should be composed of 1-2 scholars and 4-10 community members. These are the community members who will be CO-CREATORS IN THE DESIGN PROCESS. YOU NEED LOCAL CO-FOUNDERS FOR ANY SOCIAL ENTERPRISE OR INNOVATION TO BE SUSTAINABLE.

WE HAVE CREATED A MULTI-STEP process for developing your design team (which at times may seem onerous) to avoid some mistakes and set you up for success.

First, we want you to find community partners who can commit the required time to the program.

Second, we want to reduce overlap in pursuit of design team members.

Third, the more time and effort you spend understanding the relationships you've built in the community and with other scholars, the more likely you are to have a productive and successful working relationship.

IT IS EXTREMELY IMPORTANT TO WORK WITH COMMUNITY MEMBERS WHO YOU TRUST AND YOU BELIEVE WILL WORK COLLABORATIVELY THROUGH THIS PROCESS.

THROUGHOUT THIS PROCESS, remember that you have limited information about the individuals you hope to work with, and there will be unexpected changes to your plans as you build your design team. Keep an open mind about your partners.

FINALLY, YOU SHOULD not dictate who becomes a member of the design team. Rather, it should be a collaborative process between you and community members you think would be interesting to work with. Enlist them as you consider who is available to work with. Locals know more people in the community, and they know what different community members might bring to the table.

SET EXPECTATIONS WITH THESE 4 PRINCIPLES:

1. NO MONEY for grants, gifts, or projects beyond the prototype phase.

2. THE DESIGN TEAM comprises individuals who have agreed to be Partners in Innovation.
3. EVERYONE WILL have to commit a considerable amount of time to the project.
4. EVERYONE WILL have to agree to do their best, share their networks, and work together.

UNDERSTAND AND COLLABORATE

DON'T FORGET THE LESSONS YOU LEARNED IN MIND: COMMUNICATE! COMMUNICATE!

COMMUNICATE! Those are the three most important words in any organization or team. Often we hold thoughts in our head because we assume people know what we are thinking, or we fear the consequences of speaking up. We may not want to be overbearing or cause anxiety by offering too much input on mundane tasks. There is a balance to communicating effectively. It is one of the most important leadership skills.

FIVE TIPS FOR ENGAGING WITH DESIGN TEAM MEMBERS

TAKE A LOOK AT the list and brainstorm effective ways to implement the 5 tips.

1. BUILD TRUST:

PAY ATTENTION to nonverbal cues

MAKE SURE you're not only asking questions - share something about yourself.

SET CLEAR EXPECTATIONS about why you're in the community.

ALWAYS KEEP RELATIONSHIPS friendly but professional.

2. EXEMPLIFY A GENUINELY democratic style of leadership by creating equal partnerships with community members. Everyone must contribute to your team.
3. ALWAYS SHOW UP PREPARED, on time, and ready to work.
4. SET AND REVIEW GOALS for each member individually and for the team as a whole.
5. CARPE DIEM. Seize each and every day. Things take longer than you expect, so get the ball rolling soon and be patient about the inevitable delays in the process.

REMEMBER: If you need a translator, ask for one. Ideally, you will push through these activities and communicate without language if that is the primary barrier.

DESIGN TEAM LAUNCH MEETING

TEAM-BUILDING: ICEBREAKERS

OVERVIEW: All design teams are different. And within each team, each member will have a different style of communication and participation, and different perspectives. To work effectively together, you will need icebreakers to get to know each other and build trust. Icebreakers (also sometimes called energizers) can accomplish specific needs.

What do you expect the design team to accomplish? Prepare with your scholar partner (if applicable) and run through the preparation together to divide responsibilities. Identify a convenient time for people to meet. Think of a creative way to facilitate introductions, icebreakers and questions. Implement planned introduction activities. Invite everyone in the design team to share with the group what they are most excited about.

CHOOSE FROM THESE DIFFERENT ICEBREAKERS:

1. The Talent Show: To bring out skills and confidence in your group.

Everyone selects one talent or special gift that they possess and can demonstrate for the group. They introduce themselves, explain what their special talent is, and then perform their special talent for the group.

2. The Artist Game: To stir up creative confidence, learn how people see themselves.

Give everyone a piece of paper and a pencil. In 5 minutes they must draw a picture that conveys who they are with out writing any words or numbers. At the end of 5 minutes the host collects the pictures. Show the pictures to the group one at a time and have them try to guess who drew it. After this allow each of the artists to introduce themselves and explain how their work clearly conveys who they are.

3. One Word Icebreaker: To get initial thoughts on what brought you together

Choose the issue that made people want to join the team: i.e. a goal, experience, or issue Divide into groups of 2-3 by numbering off. Tell each group to spend one minute thinking and deciding on one word that describes this issue.

Example:

If your common thread is opportunities for women in the community, ask the groups to find one word that describes the current state of women's roles.

STEPS FOR CRAFTING A PATH STATEMENT

Steps for crafting a Path Statement:

1. Write down the following Path Statement for all to see (this is what you're working towards):

**ACHIEVE X
BY
IMPROVING Y
EXPERIENCE**

2. Ask the team the following questions:

WHAT CHANGE DO WE HOPE TO ACHIEVE IN THIS COMMUNITY? Think about your daily experiences and interactions in the community. What could enhance people's quality of life? An issue may seem small but might have larger issues behind it. Consider quality of life through different lenses. Think of opportunities for innovation in health, education, business, energy, technology or other areas of daily life.

WHAT HUMAN EXPERIENCES WILL WE FOCUS ON TO UNDERSTAND the opportunity and achieve change? We're not interested in what people might use. We want to identify what they will use. Daily experiences are meaningful data points for what people would like to do differently or more efficiently. Carrying water, posting jobs, renting services, delivering babies, fixing bikes and countless other daily tasks can be enhanced through great products and services. Understand what people like doing (don't change that!) and what they find cumbersome, difficult or even dangerous.

WHAT DO WE HAVE TO GET STARTED? Recall mapped assets and ask the team to provide examples of resources. Start with categories to get your design team thinking - people, spaces, things, skills, relationships. Then think about people's desires and aspirations and what assets they are currently using to approach them. Consult your notes and other documentation to dig up information that may help.

3. Use your brainstorming tips to capture the full array of ideas you have shared as a team.

4. As a team, discuss and write out key words, highlights, or topics that seem to have priority.

5. EVALUATE:

What do you want to achieve? What goals are inspiring?

What experiences impact the bigger goal you hope to achieve? Which experiences stood out?

Have you gotten to something truly fundamental—the root of a problem?

What surprised you? Did you notice any patterns or themes?

6. Organize your thoughts so everyone can understand.

SOARING FROM SWOT: FOUR LESSONS EVERY STRATEGIC PLAN MUST KNOW

By Jen Hetzel Silbert & Tony Silbert

Traditional Approaches: Top-down SWOT!

For many, traditional approaches to strategy development begin with an analysis of external and internal factors, followed by some visioning, then planning. Included in the analysis phase is often a "SWOT," a thorough examination of internal Strengths and Weaknesses, as well as external Opportunities and Threats. SWOTs are praised for capturing both the positive (strengths and opportunities) and negative (weaknesses, threats); and organizations embrace this approach with the hope of gaining a "balanced" analysis of itself, inside and out.

By exploring the weaknesses and threats, however, organizations often cause more harm than good. More than an avoidable pothole or roadblock, gaping canyons and immovable mountains emerge, giving way to downward-spiraling feelings of hopelessness and fear. These conversations, stemming from repeated analysis of what's wrong or missing, highlight awareness around what isn't desired, which

carries little momentum to inspire compelling visions of a most desired future.

A second typical characteristic of traditional strategy development is top-down, planning, where small groups of senior leadership are responsible for strategy creation. Upon completion, much time is spent developing a roll-out plan (a "plan for the plan"), such as steps to get buy-in from employees, communicate the strategy both internally and externally, and align operations accordingly. Having excluded key implementers from the planning process, there is a need to persuade staff to execute ideas they're not fully committed to, causing significant time delays that boost costs and threaten morale. In our experience, this was usually a 12 – 18 month process, during which people continued to question the direction and how best to operationalize a strategy they did not either fully understand or support.

For years we took on traditional approaches to strategy development... and the employee

resistance, doubt, and time-consuming roll-outs that went with it. Then came Appreciative Inquiry.

Appreciative Inquiry: Rethinking Strategy Development

AI is grounded by two deceptively simple concepts:

(1.) What you seek, you find more of – The more positive and inspiring the strategy development process, the more innovative ideas that will be created and possibilities that can be explored.

(2.) People commit to what they help to create – The more participative the plan creation, the more committed people will be to implementation success.

Having embraced these concepts, we exchanged SWOT for SOAR, facilitating environmental scans that examined key Strengths and Opportunities (similar to SWOT), but with an intentional focus on Aspirations and Results – keeping our eye on what we wanted to move toward (outcomes most desired), not the potholes and canyons to be avoided.

Secondly, we insisted on using participative approaches to strategy development, replacing top-down with more whole system invitations to the planning table. This meant bringing

implementers to the beginning of the planning process (rather than just in the end), as well as gathering input from customers, partner organizations, policy makers, and more.

Based on our experiences applying a SOAR framework to numerous clients and to our own company, we have learned four key lessons.

Lesson #1: Shift the focus to the positive

In the fall of 2006, a public charity promoting biological conservation and ecological sustainability in Central America came to us seeking a strength-based, participative approach to their ongoing strategic planning efforts. They had recently conducted a SWOT analysis, only to find their daunting list of threats—many beyond their span of control—left staff with feelings of hopelessness and disinterest, stalling subsequent planning and implementation.

Nonetheless, they were hopeful to build on these labors. By shifting their prior focus on weaknesses and threats to aspirations and results using SOAR, they were able to articulate their goals around influence, innovation, and impact in a manner that focused on what's right, while soaring beyond what's missing or wrong into new realms of possibility.

This resulted in the creation of an engaging strategy within 3 weeks that significantly elevated staff creativity and excitement for implementation, allowing the strategic plan to serve as a “living document” to guide the direction of the organization.

Lesson #2: Involve those who will impact and who will be impacted by the strategy

To maximize participation in an ambitious timeframe (3 months), headquarters staff, partners, field staff, and board members were invited to this non-profit’s planning summit. Persons unable to attend were encouraged to engage in appreciative interviews that probed for strategy input, such as best practices, opportunities for improvement, and aspirations for 2010.

While inclusive by design, some board members were unable to engage based on scheduling conflicts. In presenting the plan to the directors for approval, there was some disagreement with regard to plan layout and content, which was eventually resolved, but taxing nonetheless. Having not participated in plan development, commitment from this small, yet critical sampling of stakeholders, was not immediate.

In another example, a distribution and logistics holding company successfully recruited broad stakeholder engagement in

their strategic planning process. Business partners, suppliers, and customers collaboratively engaged in the SOAR analysis and planning, resulting in the creation of breakthrough strategies a mere internal perspective could not have envisioned alone.

Lesson #3: Prototype and empower

Later that year we worked with a private equity firm specifically requesting a more future-focused approach to strategy development, such as SOAR. During the summit, participants engaged in rapid prototyping of key opportunities/initiatives in which they were able to boldly test new—even wild—ideas together, gaining clarity on what might (or might not) work.

Within two weeks of the summit, many of these pilot programs had already taken shape in the office—even with the project manager away on vacation. By holding the image of results they most wanted to achieve—consistent with the company’s mission/vision and supported by empowering leadership—participants naturally moved in the direction of their compelling goals, owning what they themselves created, and not needing leadership guidance beyond their own inspired authority.

Lesson #4: Sustaining the momentum – nurturing a “living” strategy

As previously noted, a key to sustaining planning momentum was the broadening of stakeholder involvement to include other contractors, alumni, and partners, using an Integration Summit within 3 months of the initial summit. This also afforded the company a quick means of “seeing the big picture” and more effectively integrating similar initiatives between goal areas.

Sustainability necessitated simplicity in communicating the key components of the strategic plan to the diverse parties involved. This called for a “less is more” approach to the plan write-up and presentation, or what we refer to as “Strategy on a Page,” a concept our own company, Innovation Partners International, has adopted for its own strategic plan.

Utilizing mind-mapping tools as an alternative to detailed narrative and data capture, our planning team created a 1-page mind-map that is easy to read and visually appealing. This keeps subsequent planning efforts focused, inspiring action and follow-through with clear direction. More than an event, strategic planning was—and continues to be—a robust and

engaging process. This is the essence of a “living” strategy that can be easily communicated and sustained for years to come.

In Summary

Appreciative Inquiry and SOAR approaches to strategy development lend tremendous potential for success where traditional approaches, such as SWOT, fall short. The lessons presented in this article are just a hint of the learnings yet to come, all of them underlining the essentiality of keeping strategy development positive and participative.

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REFLECTING ON 3 WHATS FOR CONTEXT

Evaluate:

- What groups are most involved in addressing the issue?
- How is information delivered?
- How are products or services delivered?
- Who ultimately benefits?
- How do design team members feel when they experience such a deep and open assessment of activities in the community?

SMART GOAL SETTING INSTRUCTIONS

By Wake Forest University
Office of Personal & Career Development
SMART Goal Setting Instructions, pg. 102, Dec. 11, 2013.

Improving your performance as a student is a noble goal, but take the time to do it right. Think about how to set goals that are specific, measurable, achievable, relevant, and timely, and you find that achieving your goals is an easier task than you thought. Knowing how to set goals is an important skill for students, and one that you will need in the working world.

As a college student, what are your goals? Do you know specifically what you would like to achieve, or do you have vague goals such as “doing well in class” or “raising my GPA”?

What are SMART goals? Follow the SMART model of goal setting.

Specific: First, goals need to be specific. That is, you need to spell out exactly what you want to accomplish. Vague goals can feel overwhelming and unachievable. For example, “I’m going to be a better person,” is vague, and someone who sets this goal may not even know where to start. Instead, it’s better to set specific steps such as, “I’m going to

volunteer twice a month,” or “I’m going to be more patient with my family.”

The same is true for school goals. “I’m going to study better,” is too vague and overwhelming. Be specific. Goals such as “I will set aside three hours every weeknight to do nothing other than my school work” or “I will start my papers at least one week before the deadline,” are less overwhelming because they call for a specific task.

Measurable: Successful goals also need to be measurable or else there is no way to determine if you have achieved them. For example, “I’m going to lose weight” is a popular goal that works better with a measurable out-come such as “I’m going to lose 15 pounds by September.”

Setting measurable goals as a student can be easy because you’re surrounded by measurements. Instead of “I’m going to get better grades,” try, “I am going to raise my GPA to a 3.0 by the end of the year,” or “I’m going to get at least a B in all of my classes this semester.”

Achievable: When setting goals, it's important to choose ones that you are actually capable of attaining. Eliminate impossible or highly unlikely objectives. "I'm going to bench press 300 pounds" may be a goal that is physical impossible. "I'm going to be in the NBA" is a goal that's possible, but highly unlikely.

Keep this in mind with student goals. "I'm going to graduate in the top 10 percent of my class" may be impossible if it's junior year and you only have a 2.8. "I'm going to get a 4.0 this semester," may be highly unlikely if you're taking lots of extra credits and all your classes are upper level."

Relevant: Goals should be set with the "big picture" in mind and should have a clear purpose. If you're trying to build a table, relevant goals include sanding the wood and carving the legs. If you get side tracked and spend several days shopping for the perfect china, your goal of building a table will be slowed down. China to put on the table would be nice, but this is not relevant to your overall goal.

The same is true with student goals. If your goal is to ace a calculus test that's three days away, don't get started on a paper that's not due for another week, and don't decide that it's time to organize your closet. Stay focused.

Timely: Finally, it's important to set goals that you actually have time to complete. Losing 20 pounds might be a good idea, but not if you want to do that in three weeks. Planting a garden might be nice, but not if the first frost is due soon.

As a student, be realistic about what you have time to accomplish. Writing a senior honor's thesis might be a good idea, but not if you also have an internship, a part time job, and lots of other obligations. Taking on an ambitious group project topic might sound like a good idea, but not if you only have a few weeks to get the work done.

In using this method, you will be able to set specific, measurable, achievable, relevant, and timely goals.

INNOVATE BACKGROUND INFORMATION

JUGAAD

INNOVATION IS AT THE HEART OF SOCIAL CHANGE, but it's not easy. Creating high impact products and services with your design team requires that you push yourself and your teammates beyond your intellectual comfort zones. By bringing together different cultures and ideas, opportunities emerge that can radically improve the daily lives of community members. Job creation, economic growth and development, empowerment, and dignity all follow.

INNOVATION IS LIMITLESS. It offers the promise of solving nearly any problem in the world. As you think about your products and services, think about how you can contribute to the future through connecting people and ideas, how the right mix of existing resources could spell the end to some of the world's greatest suffering.

TAKE a moment to consider Jugaad, a Hindi word that means "an innovative fix": an improvised solution born from ingenuity and cleverness; resourcefulness. Think of it as DIY: Do-It-Yourself solutions.

THESE ARE THE SIX PRINCIPLES OF JUGAAD

1. SEEK OPPORTUNITY

Use constraints as an invitation to innovate.

2. DO MORE WITH LESS

Work with what you've got.

3. THINK AND ACT FLEXIBLY

Adapt readily; move past old structures.

4. KEEP IT SIMPLE

Don't overthink solutions; they should be roughly and rapidly produced.

5. INCLUDE THE MARGIN

Seek out marginal, underserved customers.

6. FOLLOW YOUR HEART

Intuition, empathy, and passion are more than fuzzy emotions.

KNOW THY STAKEHOLDERS (Customer, User, & Context)

Before you begin prototyping you must understand your customer, end user and different stakeholders involved in the process. These are the people you're designing for and with.

CUSTOMERS

Products and services need to have customers to have impact, though they may not be the ultimate beneficiary. Ex: A business that sells vaccines may sell them to a clinic. However, the clinic does not need vaccines. Patients who go to the clinic need vaccines.

Designing a business model that can succeed requires understanding that there is a market dynamic between your product, the buyer, and the ultimate beneficiary.

IT IS TIME TO BETTER

UNDERSTAND your customer: the individual, company, clinic, school, or other entity that will actually buy the product in a direct transaction. What do they want?

END USERS

**YOU ARE GETTING MORE
ADVANCED** in your thinking about the business dynamics in the community, including who works where, who sells what, and how people use materials. It's time to put your new thinking and knowledge into context.

**FIRST THINK ABOUT THE
INDIVIDUALS** who will ultimately use your product or service. This is called the **END USER** in some business jargon. Think about buying a computer. You go to Amazon.com to buy the computer. But Amazon.com is not the creator of the product, they just think about the retail process. The more successful computers—the ones that sell the most—will be the ones that best meet the final consumer's needs. The retailer, who can charge more for the product and make a bigger margin, will then purchase the best product in larger quantities.

SECOND, THINK ABOUT THE GOALS that your end user might have.

How do they make money? What's their role in the community and the advantage of the product? Would you need a go-between to reach this customer?

**NOW THINK ABOUT ALL YOUR
STAKEHOLDERS. UNDERSTANDING
THEIR INCENTIVES AND
MOTIVATIONS**—in other words, what your stakeholders want—is critical for developing a product or service that is high impact. In many ways, social enterprises and social innovations uncover new ways to align incentives. If incentives to improve the world (say, reduce your carbon footprint) can be aligned with the incentive to make money through creativity and innovation, the impact can be far reaching.

PROTOTYPE, TEST & ITERATE

ONCE YOU UNDERSTAND YOUR CONTEXT AND THE EXPERIENCE YOU WANT TO IMPROVE, YOUR DESIGN TEAM will select ideas and begin prototyping a product or service as a solution to your "Path Statement".

THE KEYS TO SUCCESS in this program is an eagerness to explore ideas, a willingness to adjust and redirect one's approach, and most importantly, a honed capacity to listen. We like to use a phrase that our friends at For Impact came up with, "Think big, Build simple, Act now!" We offer an important addendum: "Listen, Iterate, Learn!"

PROTOTYPES ARE a powerful form of communication and force us to think in realistic terms about how someone would interact with a concept. Prototypes are not precious. They should be built as quickly and cheaply as possible. They can be made from basic, simple materials and should be crude and ugly. A prototype is "anything tangible that lets us explore an idea, evaluate it, and push it forward." They are disposable tools used throughout the concept development process, both to validate ideas and to help generate new ideas.

THIS IS THE MOST EXCITING STAGE of the Institute; you will begin to see the fruits of all your

efforts to develop an innovation. Yet, the process of prototyping and testing ideas is also the most challenging and intense. It's easy to hit a creative block or become overwhelmed by the scope of your design team's ideas while running into limitations of time and resources. We have established opportunities for you to share your progress with people outside of your design team. These feedback sessions will challenge you to keep up with the flow of the Innovation phase and are designed to support your team.

GATHER FEEDBACK & ITERATE

THESE ARE TWO IMPORTANT PRINCIPLES FOR PROTOTYPING: ALWAYS GET FEEDBACK WHEN YOU TEST YOUR IDEAS, AND ITERATE FROM THAT FEEDBACK.

ONCE YOU HAVE a working prototype, you can begin gathering feedback from your target audience. It is important to include as many stakeholders as possible in the feedback stage: people from new places (as well as familiar faces), the end users, and even the people along the supply chain (potential producers, distributors, etc.).

INVOLVE some of the different perspectives you explored at the beginning of Innovate. The most important point for your design team to remember when soliciting feedback is that you are seeking honest responses. If feedback is negative, it's best to know early on how people respond to a given

innovation and work with that new information to improve upon your ideas.

FEEDBACK CAN be gathered by asking individuals directly, or by conducting feedback sessions during which groups of consumers may try out the product and then provide their thoughts and reactions in smaller groups. For example, consumers should be able to test, taste, sample, try, and generally experience your suggested innovation.

WHEN YOU TEST AN IDEA FOR FEEDBACK, MAINTAIN A NEUTRAL TONE rather than selling the product. Seek advice for how you might improve the product. Encourage users to build on ideas with more questions.

DON'T TAKE CRITICISMS PERSONALLY. Listen to the feedback and determine where you can improve. The user might say one thing but mean another. Try analyzing the feedback with the 5 Whys to find out the root of the problem.

WHEN YOU PRESENT IDEAS, such a storyboard of your user's experience, gather feedback with the POINT Technique.

P PROBLEM

What Problems did they identify with your storyboard or target audience profile?

O OBSTACLE

Did they foresee any obstacles that would be a barrier to you proceeding forward?

I INSIGHT

Did they highlight any insights into your target audience that you had overlooked?

N NEED

Did they highlight anything in particular your presentation was lacking or needed?

T THEME

Did they highlight any themes, such as commonalities, differences, and relationships in the information you presented that provided additional meaning.

UNSTICK YOURSELF

IF YOU ARE FEELING FRUSTRATED or feel like you are getting carried away with your prototype, complicating matters in the hot pursuit of innovation, you may need a fresh perspective.

CONSTRAINTS

THIS IS A TECHNIQUE FOR LIMITING the actions that can be performed by a system. Proper application of constraints makes design easier to use and dramatically reduces the probability of error during interaction. Think of the few buttons on an iPad. Sometimes less is more. There are two basic types of constraints: physical constraints and psychological constraints. Physical constraints limit the range of possible actions by redirecting physical motion in specific ways. Psychological constraints limit the range of possible actions by leveraging the way people perceive and think about the world. Would there be value to using constraints?

HIERARCHY OF NEEDS

IN ORDER FOR A DESIGN to be successful, it must meet people's basic needs before it can attempt to satisfy higher-level needs. What basic needs does the product or service meet? What are higher level needs that the product or service might address?

AFFORDANCE

THIS IS A PROPERTY in which the physical characteristics of an object or environment influence its function. Whenever possible, you should design objects and environments to afford their intended function, and negatively afford improper use. For example, a knob affords twisting, and perhaps pushing, while a cord affords pulling. What is an example of affordance in your prototype?

COLOR

COLOR IS USED IN DESIGN to attract attention, group elements, indicate meaning, and enhance aesthetics. Number of colors, combination of colors, saturation, and symbolism are all variables that can explain the meaning of different objects (for example, red emergency boxes for fire extinguishers). Color can make designs more visually interesting and aesthetically pleasing, and can reinforce the organization and meaning of elements in a design.

80/20 RULE

THERE IS A COMMONLY HELD BELIEF that approximately 80 percent of the effects generated by a system are caused by 20 percent of the variables in the system. For example, 80 percent of a product's usage involves 20 percent of its features. Is this true for your product? Do you want it to be? All elements in a design are not created equal. Get rid of anything that is excess. Use the 80/20 rule to assess the value of elements and keep the 20 percent that matters!

AGILE DEVELOPMENT

ADAPTING THROUGHOUT the Innovation phase is essential for success. Adapting is a proactive action; it does not happen by accident. In fact, you can view adapting in two ways, one positive and the other negative. Imagine that you say in the Innovation process, "This didn't work well, but I can see why, and I am excited to adjust my assumptions and find ways to be more resourceful," rather than saying, "This didn't work well, and we are failing to solve problems in the community." The difference in attitude and the embrace of the constant need to adapt is apparent.

WE LEARN the most when we confront a challenge with our full energy and when we reflect on what we have done. As your team explores your "Path Statement" with various prototypes, try not to think about how you've seen the problem solved before, and if your prototype is as good or better than what already exists.

ADAPTING INVOLVES frequent team meetings where your design team can openly discuss the ongoing development of your project. During these meetings, encourage your team to place an emphasis on the individual user and their interactions over processes and tools you've been using. Remember the big picture!

IF ISSUES ARISE, keep in mind that effective communication is often the greatest challenge for any team. Spend extra time to explain what you mean when you say something; to listen more carefully to what others' views are; and to flesh out an issue more thoroughly. In the context of the Institute—rural communities with different cultures and languages—communication is particularly difficult.

NOW IS YOUR CHANCE TO REALLY HONE YOUR SKILLS AND BECOME AN EXCEPTIONAL COMMUNICATOR NO MATTER THE ENVIRONMENT.

AS YOU'RE EXPERIENCING, innovating is an iterative process. Agile development meetings will support your team in reflecting on Innovation's key objectives, abandoning formalized processes and establishing a time to discuss how your service is developing and reflecting on your next actions. Keeping your project agile is key to developing a true innovation.

YOU'LL WANT TO CREATE an action-oriented culture among your team. Putting this action-oriented culture into play means taking small steps, like spending a "few minutes at the end of every meeting to go around the table and allow each person to recite the action steps that he/she is responsible for executing."

WHEN WORKING IN A TEAM, it is extremely important to define roles clearly, and to follow up. Often groups



make the mistake of assuming someone will take care of required tasks and a few team members end up scrambling to make up for these gaps. Think through every person's role in the process. Everyone should know what he or she is responsible for, when it needs to be completed and what success looks like (what the goal is for their work). At Thinkimpact we call this a framing meeting.

For this phase, you must work together as a team and be on the same page with actions, which will take coordination and collaborative effort. Make sure you read the required design team actions' ACTION STEPS to plan appropriately, especially if you need to prepare for certain actions.

WHEN DEVIANTS DO GOOD

By Tina Rosenberg
New York Times

Jerry and Monique Sternin and their son were among the very first Americans to move to Hanoi when they arrived in Vietnam in 1990. They had come from the Philippines, where Jerry had been director of Save the Children's program there.

At the time, Vietnam was losing its imports of subsidized rice from ideological backers and shifting from collectivized to private agriculture. The dislocation was deadly—"a near-famine situation," Monique Sternin said in an interview from Addis Ababa this weekend. About two-thirds of children were malnourished. International feeding programs had helped, but when the programs ended, villages fell back into hunger. The government had asked Save the Children to try to find a lasting solution. Some officials didn't like having Westerners brought in. You have six months to show results, the government warned. If you don't, you're out.

The Sternins had seen in their previous work how big programs run by outsiders created dependency. "The essence of development is to help people build capacity to do things themselves," said Monique (Jerry died in 2008). "We were struggling to find something."

They had just read a book, however, by Marian Zeitlin, a professor of nutrition at Tufts University, called "Positive Deviance in Nutrition." The word deviant usually has negative connotations, but Zeitlin wrote about children who thrived even as those around them were poorly nourished. Zeitlin suggested that nutrition could be improved if a village looked at what these children's families were doing right.

The Sternins were not experts in fighting malnutrition. But they thought they knew where to find some. They went into villages and asked for volunteers to weigh all children under 3, and to characterize each family's level of income. The volunteers concluded the obvious: the poorer the family, the more likely the children would be malnourished. Then the Sternins asked if any of the families characterized as "very, very poor" had well-nourished children.

The volunteers checked the list and excitedly reported that there were some.

"So it's possible for a very, very poor child in the village to be well nourished?" asked the Sternins.

"Let's go see what their families are doing differently," the volunteers said.

The volunteers fanned out to interview these “positive deviant” families—in each village there were a few, perhaps 5 or 6. They found several practices in common. Children in the village were fed twice a day, mostly rice. Local custom held that an adult diet was harmful for young children. But the positive deviant parents were collecting tiny crabs or shrimps from rice paddies and giving them to the children along with the greens from sweet potatoes. While village wisdom held that you don’t feed a child who has diarrhea, the positive deviant families did. They also fed their children often throughout the day, and washed their children’s hands before they ate.

The Sternins knew that helping villagers to learn about these deviant behaviors would not be enough. “Knowledge doesn’t change behavior,” said Monique. “Practice changes behavior.” They convened meetings of villagers to discuss how best to spread the behaviors. The villagers decided that parents of malnourished children would gather with their children daily at a neighbor’s house for two weeks. Each family had to collect a handful of shrimps, crabs or greens and bring it to the gathering. With a trained health volunteer, the families cooked meals using the nutritious foods and tried out the new practices. If they didn’t become habit and the children were still malnourished,

the families could do another two-week cycle the next month. “Trying something new always makes you a little scared. People got confidence through their peers,” said Monique.

Five and a half months after the Sternins had arrived in Vietnam, authorities weighed the children in the district who had participated in the program. More than 40 percent were now well nourished, and another 20 percent had moved from severe to moderate malnutrition. The Sternins got their visa extended. Vietnam eventually replicated the program in 250 communities.

Poor-country development usually works like this: Outsiders come into a community where there is a problem. They bring in “best practice” ideas that have worked elsewhere, and design ways to teach the community to change its culture and adopt these new ideas.

And then they leave.

If they come back later, however, they might find that not much has changed: a few people adopted the new idea, but not many. And since that was not the way the community did things, even those adventurous few might abandon their new practices.

Here’s how the positive deviance approach is different:

- Outsiders don’t bring in ideas to change a community’s culture. Instead, they ask the community

to look for its own members who are having success. Those local ideas, by definition, are affordable and locally acceptable—at least to some people in the community. Since they spring from a community's DNA, the community is less likely to feel threatened by these ideas and more likely to adopt them.

- The focus is not a community's problems, but its strengths.
- Outsiders don't design a communication or training strategy to teach the idea. Outsiders can bring people in the community into one room, but local people design a way to spread the new behaviors.
- Local leaders are not the ones who come up with solutions. That is the job of everyone on the front line dealing with the problem. The leaders' job is to facilitate the process of finding and spreading these solutions.
- Outsiders don't monitor success. They show people in the community how to do that. "If they see that things are getting better, that's further incentive to continue the new behavior," said Monique.

Positive deviance has now been used in dozens of countries to attack a wide variety of problems. The nutrition program has been replicated all over the world—in each place using different, local solutions. Positive deviance has

helped to reduce rates of female genital mutilation in Egypt, improved prisons in Denmark, helped the mentally ill in Pittsburgh strengthen social connections and cut infections at Veterans Affairs hospitals across the United States. Tufts University is host to the Positive Deviance Initiative, which has a staff of four and several consultants who teach the process around the world (Monique is a senior consultant), and the Sternins wrote a book, "The Power of Positive Deviance."

In 1997, the Pittsburgh Regional Healthcare Initiative was formed to try to improve hospital care. One of its goals was to reduce the infection rate of MRSA, a deadly resistant form of staph, in local hospitals. The city's V.A. Pittsburgh Healthcare System agreed to run a pilot program beginning in 2001, adopting the Toyota Production System. (Paul O'Neill, the former treasury secretary, was one founder of the Initiative; he had used Toyota's manufacturing and logistics strategies when he ran Alcoa.) "This went a long way in solving some of the technical problems—providing soap, gowns and gloves where they were needed in quantities they were needed," said Jon Lloyd, a prominent Pittsburgh surgeon. "But the so-called behavioral problems were untouched. Once resources were withdrawn from the Toyota model it fell apart. The frontline staff didn't own it. Physicians, especially, were not washing their hands—nurses were at 70 percent for hand hygiene, but physicians were at 15 percent."

Lloyd read an article in Fast Company about positive deviance, and invited Jerry Sternin to come speak. He agreed, with the condition that Lloyd produce everyone in the hospital who touched patients in any way. In July 2005, Jerry asked those 150 people who they felt was responsible for preventing infection; they pointed to nurses and the hospital's infection control officers.

"Six months later Jerry asked the same question, and every hand went up," said Lloyd, who became the hospital's positive deviance adviser and coach, and now does the same with other Pittsburgh organizations. "The housekeepers at the VA turned out to be world authorities on infection prevention—people who are never asked for their opinions."

Ideas came from all over. Edward Yates, on the housekeeping staff, was a wellspring of anti-infection ideas; his unit chose him to brief the staff (including high-ranking doctors) on the unit's progress. One hospital pastor told his colleagues that he kept his Bible from spreading germs by gowning it with paper hats. He changed the hat with each new patient.

Lloyd said that the other pastors began to do the same. "No one had to tell the others to do this," he said. "There was just a quiet understanding of a solution that came from somebody who shared their professional DNA."

Six months later, the infection rate had fallen by more than half, and the gains did not go away. (Since this was not a randomized control trial, there's no way to know how much of the gains came from the use of positive deviance.) The V.A. then adopted these changes in virtually all its hospitals, recommending that hospitals use the positive deviance approach and offering training in it. From October 2007 to June 2010, MRSA infections in intensive care units at the 153 V.A. hospitals in the program dropped by 65 percent; in nonintensive care units they dropped by 45 percent. (Again, we don't know if the intervention can take credit, although it is significant that there had been no change in MRSA infection rates during the two years before the intervention.)

Pittsburgh's experience, ultimately successful, also shows why positive deviance can fail. "It's particularly difficult for donors who want to have a clear sense of what outcomes will be," said Roger Swartz, the executive director of the Positive Deviance Initiative. Donors have solutions they like, and they will finance programs that use those solutions. But with positive deviance, you don't know what the solution will be; it has to emerge as part of the process.

The approach can also be threatening to people at the top. They are used to being the experts, but with positive deviance, it's the people in the field who are the experts. In hierarchical institutions like hospitals,



housekeeping staff members do not usually brief physicians. But where managers can accept revolutionary new ways of doing business, positive deviance can succeed. "I don't know how this is going to work," the Pittsburgh V.A. chief Rajiv Jain told his workers when they began the program. "But I have total confidence that you as the front line staff will know."

KNOW THY CUSTOMER

As we mentioned in the background information, products and services require customers to have impact. The goal is to better understand your customer and what they want so they will actually buy the product.

Example: A business that sells vaccines may sell them to a clinic. However, the clinic does not need vaccines. Patients who go to the clinic need vaccines.

1. Create a customer profile that aggregates attributes from many actual customers. This profile represents a character or business that your design team can engage throughout the prototyping process that would likely be a buyer.
2. From your efforts to establish context answer the following question: Who is the best consumer to ensure that benefit is delivered efficiently to improve your Path Statement's experience?
3. Draw a picture of your customer and create a character profile, answering the following questions:
 - What are the unique elements of the customer? What makes them unique?
 - How do they think about their role in the community?
 - Do they keep a budget and plan, or do they live a subsistence life?
 - When is revenue likely to spike or drop?
 - What is their willingness to pay for a product or service?
 - How do they make money? Does your idea help them make more money?
4. Evaluate: Is this the customer you think you should work with? Can you really provide value to this customer? How do you know that they might be interested in this idea?

GAIN CONTEXT: 2X2 MATRIX

In order to identify opportunities to redesign and understand experiences, you should understand the problems that community members experience. We want to design around assets, but we also want to solve problems. To do that we need to understand what is urgent and important, as well as what constraints exist that lead to problems. Mapping them out can help us pursue opportunities that respond to the greatest need and have the most impact. This action can help you prepare for reframing your Path Statement and prototyping by helping you choose what problems to solve and understand barriers that create these problems.

1. Draw a 2x2 matrix. On one axis put urgency and the other importance.
2. Make a list of all the problems you and your design team see in the community. Start broad, and then narrow in on problems that relate to your Path Statement experience.

3. Ask them which problems are most urgent, and which are more important.
4. Map them out on the axis. Rearrange, refine.
5. Then create a list of constraints under which these problems operate (e.g. money, time, relationships, distance). What are the barriers that make these problems problems? What makes them so difficult, important, and urgent?
6. Select the top two constraints and draw another 2x2 matrix, with one constraint on each axis.
7. Plot the problems again into this matrix.
8. EVALUATE: Does this change your design direction? How?

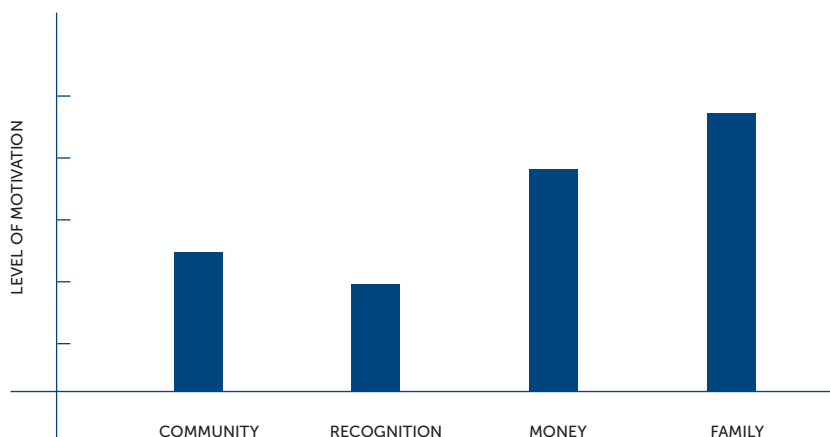
STAKEHOLDER MAP EXAMPLE

Example: Consider a businesswoman whom you are working with in the town. You have drawn her “Motivations” out, and decided that community, recognition, money, and family play key roles in her decision-making.

Now take a look at the stakeholders you have analyzed. What do they each demand from your product or service? What value is easiest to deliver? Where are motivations unclear?

Draw or write the stakeholders that threaten the idea because their incentives are not well aligned with the design team’s goals.

Did you uncover any surprising motivations? Did you uncover opportunities for building partnerships, aligning individuals and other stakeholders that could lead to high impact?



MORE ABOUT PROTOTYPING

WHY prototype to test

Prototyping to test is the iterative generation of low-resolution artifacts that probe different aspects of your design solution or design space. The fundamental way you test your prototypes is by letting users experience them and react to them. In creating prototypes to test with users you have the opportunity to examine your solution decisions as well as test your perception of your users and their needs.

HOW to prototype to test

Think about what you are trying to learn with your prototypes, and create low-resolution objects and scenarios which probe those questions. Staying low-res allows you to pursue different ideas without committing to a direction too early on. The objective is not simply to create a mock-up or scale model of your solution concept; it is to create experiences to which users can react. Think about the context and testing scenario you will create to get meaningful feedback. It is not always the case that you can just hand an object to someone on the street and get real feedback. Test in the context that your

solution would actually be used.

For example, if you are creating a consumer food storage system, let users test it in their kitchens at home – some of the nuanced but important issues will only emerge there.

Some tips for prototyping to test:

Start building. Even if you aren't sure what you're doing, the act of picking up some materials (paper, tape, and found objects are a good way to start!) will be enough to get you going.

Don't spend too long on one prototype. Move on before you find yourself getting too emotionally attached to any one prototype.

Build with the user in mind.

What do you hope to test with the user? What sorts of behavior do you expect? Answering these questions will help focus your prototyping and help you receive meaningful feedback in the testing phase.

ID a variable. Identify what's being tested with each prototype. A prototype should answer a particular question when tested.

PROTOTYPING TECHNIQUES

- SKETCHING

SKETCH IDEAS that inspire you. DON'T WORRY ABOUT your artistic talent because creating beautiful sketches doesn't guarantee that you will be able to solve problems elegantly.

THE PURPOSE OF SKETCHING is to think and communicate with drawings.

SKETCHING WILL HELP YOU visualize concepts and communicate many ideas quickly; this will be useful for figuring out details.

GET IDEAS OUT of your head and begin to make them take form on paper so that others can visualize.

INVOLVE COMMUNITY MEMBERS throughout! They may be great at sketching insights you overlook.

- USER LIFECYCLE MAP

VISUALIZE a user's overall relationship with the service.

EX: A series of user journeys over time, from the user's initial contact with a service, right through to the point where they eventually stop using it altogether.

HIGHLIGHT THE KEY STAGES a typical customer would pass through when using this service.

AT EACH OF THESE STAGES,, incorporate information about the customer's drive and motivation.

- EXPECTATION MAPS

INVESTIGATE AND CHART what customers expect when they interact with a service.

INVITE X NUMBER of potential customers to share with you their expectations for what, when, how, and why they would need a solution.

HIGHLIGHT EXPECTATIONS that need attention from your customer and support you in building a stronger system.

- SERVICE STAGING

ACT OUT A SCENARIO PROTOTYPE in a situation that resembles a theater rehearsal.

BRING YOUR EARLIER STORYBOARD to life to help you understand a consumer's interaction with the service.

FOCUS ON THE SMALL

DETAILS of people's reactions and emotions, which are crucial to understanding the real-world situations in which a service is delivered.

ACT OUT THE SITUATION

in an iterative cycle, moving from the starting storyboard to a new design.

DESIGNATE SOMEONE the director to help coordinate the group.

- MIMICRY

MIMICRY REFERS to copying properties of familiar objects, organisms, or environments in order to improve the usability, likeability, or functionality of an object.

DRAW INSPIRATION from these three basic kinds of mimicry

1. Surface: Making a design look like something else

2. Behavioral: Making a design act like something else

3. Functional: Making a design work like something else

MIMICRY IS AN EFFECTIVE STRATEGY to begin exploring a design problem, but it should not be assumed that mimicked solutions are correct or best.

- 3D MODELING

A PHYSICAL MODEL a product, quickly mocked up using rough materials, is a simple means of prototyping that allows you to consider your ideas in 3 dimensions.

TIP Form follows function.

NEEDS TO CLEARLY be a model, not a first draft of the real thing.

EX: Use wood not actual soap.

USE structures, fasteners, and surfaces to develop a model that you can engage.

BRING YOUR IDEAS into the real world for further assessment and to answer questions such as desirability, usefulness, usability, viability, or feasibility

DESIGN TEAM CAPABILITIES

Focus on the solution you have identified and begun prototyping. Write out Distribution on a chart and list all actors who could deliver the solution possible actor, asking:

- Where, when, how and why might the customer experience this solution?
- Which actors and channels touch the solution?
- What other channels could be used to reach customers?
- What is the range of possible ways this solution could be delivered?

Write out Capabilities on another sheet and list where they are located, answering:

- What human, manufacturing, financial and technological capabilities are required for creating and delivering this solution?
- Which of these capabilities do we have in the community? Which do we have in the country? Which do we have internationally? Which capabilities will our partners need?
- Will we need to grow any capabilities on this list?

Write out Potential Partners and create a list, asking:

- What organizations or individuals have capabilities that we do not?
- What is our relationship with them currently?
- How might we reach out to them and show the value of engaging with our organization on this solution?

Narrow down the partner list. Identify next steps:

- First steps the design team would have to take to pursue the partners needed
- Next steps the design team would have to take to gain necessary capabilities
- How you will modify your design to make it more feasible and viable



SHIFT BACKGROUND INFORMATION

LEAVING THE COMMUNITY

TAKE A STEP BACK AND BREATHE. Before going further, reflect on all that you have learned, grown and achieved. It's remarkable.

IN SHIFT, we focus on how you can Bring it Home. Bringing it home means finding closure from the experience, preparing to transition back to your home country, and, for long term impact, applying the Innovator to your daily lives.

DURING THE INSTITUTE you have developed habits, skills and perspectives that can enhance your ability to operate in a highly competitive, interconnected world. The same value has been created in the community. The following actions are about sustaining momentum, building better habits, and tackling anything.

COMMUNITY ACTION PLAN

ONCE YOUR TEAM has developed a prototype and received customer feedback, you want to set your local community partners up for success. It is critical that you deliberately transition away from being the driving force behind the product or service so that community members may assume

full control. This should not be a handoff. The local community has been involved all along. This action should, however, lead to a framework that you have co-created for the local community members to work with after you depart.

IN MANY WAYS, this is where impact can become sustainable. Six months down the line, community members should be able to say, "I partnered with a wonderful scholar to identify an opportunity and for the last many months, I have built something I am proud of that is growing."

ENVISION THAT FOR A SECOND.

THINK HOW POWERFUL it is to have been a catalyst for new livelihoods, personal growth and economic development.

THE KEY TO SUCCESS here is planning. You are going to need a strategy.

WHAT IS STRATEGY? At ThinkImpact we think of strategy as a series of interrelated decisions. Some are difficult, others less so. The key is to set goals within a given timeframe that you can execute upon. You want to keep goals concrete so you can see where you are, measure success and adjust appropriately.

BY DOING THIS, you will have broken the idea into its component parts.

THIS INFORMATION WILL inform your Community Action Plan, which begins with the “Integrated Cascade of Choices” from *Playing to Win* by A.G. Lafley and Roger L. Martin.

SAYING GOODBYE

IT MIGHT SEEM ODD that the Innovator includes an “exit” section. However, leaving the community can be as difficult as entering. It’s an emotional time, it always feels rushed, and it can set you up for a positive post-Institute experience if done right.

HOW YOU CAPTURE the memory of being in the community, the systems you set up to share information and stay in touch when you return to the United States, and the way you leave your family and team will stay with you for days after you return home.

LEAVING THE community is an emotional time on the Institute. You may feel awkward as well as sad. You may wonder, “What am I leaving behind to help?” Don’t give in to the urge to promise something. You’ve made your mark. The relationships, the connections, the lessons you’ve learned, the teams you’ve built and more are your legacy. Don’t undermine your time in the community by making quick-fix promises.

WE WANT TO HELP YOU TO LEAVE EFFECTIVELY. HERE’S HOW:

MAKE NO PROMISES.

IN SOME RURAL COMMUNITIES, promises are extremely serious and locals will expect you to follow through. You may have good intentions when making a promise, and then accidentally forget or quite innocently fail to follow up. It may not seem like a big deal to you, but it is to them. When you make a promise you can’t (or forget) to keep, this is a deep offense to your community members and they will wait EVERY DAY for you to fulfill it. This reflects poorly on not only you, but also the culture you inherently represent: the U.S., foreigners, your school, and ThinkImpact. Beyond being a scholar, remember that you are also a cultural ambassador! Your promises will ultimately impact future programs and scholars.

WE STRONGLY DISCOURAGE making promises. Here are a few examples that will do more harm than good:

“I promise to return to the community.” Don’t make that promise. You have no idea what your future travel plans are. Things change. Life happens fast.

“I will send you money for school.” When you do this you create a new dependence and unfounded hope. You also face a tricky set of new questions: How will I send the money? How much? When? Don’t promise to send money. Don’t send money!

"I will send goods for your house/business/child." Getting things into Africa often costs more time and money than the good itself. Don't go there.

INSTEAD OF MAKING PROMISES...

THINK ABOUT THE MEMORIES YOU WANT TO CAPTURE.

CAPTURE MEMORIES. In the last couple days in the community, make sure to find the most appropriate way to capture the memories you want to have. Is it a video, sketch, letter, photo or small memento that will help your hosts or you remember the times you've shared? Breathe in. Mentally note the uniqueness of the place, its smells, its community.

Identify some time when you can share what you have appreciated about the experience, how they have made an impact on you, and so you can learn how you have impacted them. Discuss what they will do with the future.

ESTABLISH COMMUNICATION CHANNELS. Staying in touch with your host family and your team is never easy. Time change, limited cell reception and simply the feeling of distance can cause you to lose touch with the community. Think about all of your options: Facebook, Email, What's App, SMS and phone calls all keep you connected. Which would your host family prefer to use? Which communication channel will you consistently check? What is the

time difference between your host country and your home? What time will be best to reach you when you return?

Invite them to stay in touch. Communicate when they should call—they may know the time difference.

SAYING A "GOOD" GOODBYE AND GIFT GIVING

Set up an opportunity to see the whole family together. Don't rush the goodbye. Find some time so you can really show your appreciation. Leave something that will remind your host family of you (photo, book, poem, etc.).

Think about how you will thank each family member and in what order.

As you think about the gift you will leave for your host family, consult the Country Team for additional guidance.

ACKNOWLEDGE YOUR FEELINGS about leaving the community. Write down how you're feeling about leaving, use an activity from the Innovator to put ideas on paper, or simply take a slow walk around the community to reflect.

TI GRADUATION

COMPLETING THE INSTITUTE is a truly remarkable achievement. ThinkImpact Graduation is an important moment to recognize what you have accomplished.

EVERY GRADUATE WILL BE CALLED UP AND RECOGNIZED FOR:

- Identifying a Path Statement and developing an innovation.
- Community service.
- Completing the Mind, Immerse, Inspire, Innovate and Shift phases of the Innovator.
- Becoming an Innovator in your own right having learned about asset-based development, design thinking, and social innovation.

SELECTED GRADUATES WILL BE RECOGNIZED FOR:

- Best in Community Innovation
- Best in Country Innovation

YOUR PARTICIPATION in the Institute is a milestone in your personal development. It represents a transitional period when you decided to learn to tackle any opportunity no matter the location, the language or the enormity of the challenge.

COMPLETING THE PROGRAM as a scholar entitles you to the benefits of being a ThinkImpact Innovator, a member of a select community of individuals who are engaging people through experiences to make every moment high impact.

BRING IT HOME

During the Institute you have developed habits, skills and perspectives that can enhance your ability to operate in a highly competitive and interactive world. The same value has been created in the community. The following actions are about sustaining momentum, building better, and tackling anything.

Bringing it home means finding closure from the experience, preparing to transition back to your home country, and for long-term impact, applying the Innovator to your daily lives.

SCHOLARS MAKE EXTENSIVE preparation before the Institute. Many expect culture shock when they arrive to their destination. It's common to go through a sharp learning curve about local customs and norms.

WHAT MANY SCHOLARS don't expect is how difficult it is to return home. You will find that people have different priorities than you. They may value material belongings more than you do, or not think South Africa is a particularly inspiring place. Each interaction with people upon your return will offer a new set of surprises, disappointments, and opportunities.

WHEN YOU GET BACK HOME you will be excited to share your experiences. You will not want to wait even one minute before launching into the details of the people you lived and worked with, the places you have seen and the things you have achieved.

CONSIDER TAKING it a little more slowly. When you arrive home, make sure to ask how others have been doing and what they experienced. To become completely absorbed in your own story can shut people out. Some may even feel bad about their own experiences. Make sure not to impose your views or dominate the conversation.

THINKIMPACT FAMILY

WELCOME TO THE GROWING
COMMUNITY OF INNOVATORS!

"A TRIBE IS A GROUP OF PEOPLE CONNECTED TO ONE ANOTHER AND CONNECTED TO AN IDEA. FOR MILLIONS OF YEARS, HUMAN BEINGS HAVE BEEN PART OF ONE TRIBE OR ANOTHER. A GROUP NEEDS ONLY TWO THINGS TO BE A TRIBE: A SHARED INTEREST AND A WAY TO COMMUNICATE."

—SETH GODIN, TRIBES

When you confirmed your participation on the Institute, you did not merely sign up for a one-off study abroad or internship placement program. You took the first step in joining a community, a family, and a tribe to which you will belong for the rest of your life. Your experience with ThinkImpact is linked to the experiences of others before you and the community partners that continue to push the boundaries on what is possible in emerging economies.

WE BELIEVE...

1. We are the generation that is going to shift the way people seek opportunities.

2. We have the skills, resources and community needed to make change real.
3. We are the future of social innovation. We all have something to bring to the table.

We stand ready to act every day and make every moment high impact.

ThinkImpact is here for you as you take on this opportunity.

At first, we will provide you with a number of resources as you return to the United States or home country: writing opportunities, events, and social networking tools. As the year (and years!) progress we will continue to provide you new, exciting ways to make every moment high impact—in your education, your career, your travels, your life.

The responsibility to make use of these resources and to share your assets across the community of scholars and advisors is yours. We look forward to all that you will create!

GET PUBLISHED

Do you have a project that needs some good publicity? Are you an avid blogger and writer?

Well, you are officially a lifelong contributor to the ThinkImpact Blog.

Please send your blog and corresponding photos and videos to info@thinkimpact.com!

JOB BOARD

ThinkImpact has partnered with ReWork.jobs to provide ThinkImpact Innovators Fast Track access in their nationwide talent search.

Apply to ReWork's talent pool for the chance to get matched with "clients" looking for all-star talent to fulfill a multitude of roles with companies and organizations that truly think impact.

ReWork is building a tight-knit community of talented professionals that are interested in addressing the big social and environmental challenges of our time. ReWork helps these professionals find meaningful work by connecting them to paid opportunities with companies and organizations that are making the world a better place.

And, of course, don't forget to follow ThinkImpact on LinkedIn.

THINKIMPACT INNOVATORS (ALUMNI) ONLY FACEBOOK GROUP

TIPS TO CONSIDER WHEN USING THE FACEBOOK GROUP:

1. **BRING "ASKS" TO YOUR COMMUNITY.** Looking for a job? Need a couch to surf on in a new city for the weekend? Want to attend an event with a fellow alum? Ask your community...but don't forget to give back!

2. **ORGANIZE A MEET-UP.** Use a poll to ask who in your area is interested in a ThinkImpact alumni meet-up. Designate a theme or topic of conversation for the event.
3. **SHARE ALBUMS FROM YOUR TIMELINE!** It is easy to share albums from the Institute or alumni meet-ups in your community to the group: open an album and click "share" at the bottom of the page, then designate that you would like to share with the "ThinkImpact Innovator (Alumni) Only" Facebook group.

JOIN THE CONVERSATION!

STORYTELLING

Market Your Experience

Consider the advice on how to market your experience on LinkedIn or in your latest resume.

Go the extra mile and give your advisor or your fellow scholars a recommendation on LinkedIn for the hard work they did. All you have to do is "CONNECT" with your scholars or Advisor and "RECOMMEND" their work on the ThinkImpact Institute. This is a great way to help craft their story and journey through the Institute in a professional setting.

DEVELOPING A SUSTAINABILITY PLAN

This content was drawn from “A business planning guide to developing a social enterprise,” developing by Forth Sector and Royal Bank of Scotland.

Although you will have some unanswered questions, it is at this point that you should begin to get a clearer idea of the type of business you want to run and a clearer idea of the social impact you might want to make. The key question is, how do ensure that you get your ‘balance of aims’ right? This is a common challenge for many social enterprises. You might also like to think about how this will affect the balance between your commercial and non-commercial income.

Achieving a balance of aims

Remember that your motivation is your starting point and your business is the vehicle by which you hope achieve your social aims. When trying to conduct a commercial appraisal, we’ve found it can be useful to consider your commercial purpose, the potential idea/business option, alongside your social purpose.

As an example, below we’ve outlined some of the questions that an organisation seeking to set up a social firm might ask. Social enterprise bridges the divide (where you see the dotted line) seeking to achieve commercial success in so far as it has a positive impact upon any stated social purpose. In this particular case, there may be some

potential to reduce overheads but if the purpose of the social enterprise is to provide employment opportunities it is highly unlikely that a reduction in staff costs would be considered appropriate. Where there is no conflict of aims, there is potential to take action.

Commercial purpose

How much growth potential is there in the market?

How much profit can I make on each product?

How far can I reduce the costs of my overheads (e.g. staff) in order to increase my profit margin?

Social purpose

Does the business provide the opportunity for a supportive working environment?

How many jobs will the business create?

How varied is the range of jobs you think might be created by the business?

It is impossible to be prescriptive about the questions that you should ask, as they will largely depend on your specific business idea, the related market potential, the motivation of your organisation and the social impact that you are seeking.

Achieving a Balance of Income

You might find it useful to look at the balance of incomes that you are going to need to sustain your business. Some social enterprises, e.g. co-operatives, employee-owned business and social businesses, aim to generate 100% of their income from commercial activity. Others, such as social firms and development trusts, might only look for 50-75% of their income to come from commercial activity – because this may be more achievable given the social impact they are seeking.

You should aim to generate more and more of your income from commercial activity, as you move towards the social enterprise becoming viable and sustainable. This will give you greater security and release your reliance upon grant funding. However, it may be that you never achieve 100% commercial income and getting the balance of commercial and non-commercial income right will be a key factor to your success. The information below illustrates the key differences between commercial and non-commercial income.

Non-commercial income

Grant aid – grant funding from either public sector funders, charitable trusts or other funding bodies such as The Big Lottery

Service Level Agreements – outcome related grants where the public sector provides a ‘fee’ for a specified service

Donations – charitable giving by individuals or businesses (can be cash or ‘in-kind’)

Commercial income

Sales – selling goods or services to individual customers

Contracts – legally binding contractual arrangements to supply goods and services to other organisations, businesses or public agencies

Sponsorship – receiving payment in return for advertising or publicity

There is no right funding composition for a social enterprise. This will depend upon which market you will be operating in, your stage of development and the social impact that you hope to achieve.

SHARING YOUR STORY

Evaluate:

1. Does sharing your story help you process your experience?
2. What parts really enliven the conversation?
3. Is there a common question everyone asks? How do you handle it?
4. Do you feel that people are able to relate to the experience in any way? Are they just confused?

If nobody relates to your experience, use the resources you have for support:

- ThinkImpact Innovator
- Facebook group
- Your Advisor
- ThinkImpact HQ
- Campus groups focused on Africa/Latin America, Social Entrepreneurship or International Development

APPLYING THE INNOVATOR BACK HOME

APPLYING THE INNOVATOR BACK HOME

THE INNOVATOR WAS NOT DESIGNED JUST FOR THE INSTITUTE. IT WAS DESIGNED FOR YOU. As you know by now, the Innovator is a complex tool for uncovering assets, building relationships, establishing teams and testing ideas. You have become deeply familiar with the actions the Innovator can offer you. Now think about how you can apply them in your daily life back in the United States or home country.

FOR EVERY ACTION in the Innovator, think about how you might identify a goal that is relevant in your daily life at home.

WHENEVER YOU FACE a new project, want to create something new, or simply understand something in a different way, turn to your Innovator first. Leafing through the pages will reveal myriad learning tools and opportunities. There are infinite applications for the activities in your daily life.

WHAT ACTIONS DO YOU GO
BACK TO MOST FREQUENTLY?
WHY?

When has understanding context
proven valuable?

Have you built teams where you
otherwise might not have?

Have you tested an idea and been
pleasantly surprised with the
results?

ANNOUNCING: THINKIMPACT TEAM LEADS

ThinkImpact has launched an exciting new opportunity for alumni to deepen their experience with social entrepreneurship and innovation abroad—by becoming Team Leads. The Team Lead role is an incredible opportunity to grow the movement for social innovation on campus and develop invaluable leadership skills.

ThinkImpact invites all alumni to apply for the Senior Team Lead opportunity. Students who are selected will return to campus to recruit for and lead their own custom Institute. Senior Team Leads can select the dates (1-8 weeks), country and topic (from a select list) of the program and will have direct input into the Innovator, our social innovation curriculum for their group's Institute.

Senior Team Leads recruit their peers, invite them to apply, review applications, and select participants to join the program. Senior Team Leads must recruit at least 8 scholars to participate on the custom Institute. **All of the Senior Team Lead's expenses—airfare, accommodations, meals and program fee—will be fully funded by ThinkImpact.** As with all of our Institutes, all country-related program logistics will be handled by ThinkImpact staff in-country.

Benefits

- Scale your impact through an entire Institute launched by you!
- Support for recruitment
- Build a campus community around social innovation
- Gain valuable leadership and curriculum development experience
- **All expenses paid international experience**
- Continue your involvement with ThinkImpact and your design team**
- Add “Team Lead” to your resume and demonstrate to potential employers a variety of skills and experiences to set yourself apart
- Gain subject area credibility

*Pending University approval in some cases

**If you choose to return to your previous Institute country

SAMPLE TIMELINE FOR SUMMER INSTITUTES

August 29

Deadline to apply to lead a winter program

September 1

Skype Interview with Group Institutes Director

September 8

Team Leads are chosen. ThinkImpact sends them a kit and invites them to their own Unleash Path

September 30

Deadline to submit topic, select country, and select dates (minimum of 9 days, including travel days)

October—December

Recruit students (minimum 8)

2 weeks before trip start date

Pre-departure orientation

Custom Institute Abroad

Lead reflections in the field and guide scholars through curriculum.

WHAT IS PUBLIC HEALTH?

QUIZ: WHAT DO YOU KNOW ALREADY?

Everyone is coming in with a different set of knowledge and experiences. This quiz will help you assess what you know and don't know. It will help you figure out your role within the group. Perhaps everything will be new to you.

Or perhaps you have had more exposure than others and can help facilitate? Either way, the collection of your quiz and those of others in the group will help the facilitator better tailor the course to the group's starting point.

1. Public health is:

- a. A requirement for medical students to become board certified
- b. Only for poor people
- c. Prevention of death and disease of populations

2. All of the following disciplines are part of public health except:

- a. policy
- b. epidemiology
- c. statistics
- d. orthopedic surgery
- e. nursing
- f. health education
- g. reducing pollution

3. Public health is controversial...

(select all that apply)

- a. because it is so much more expensive than medical treatment
- b. because tax payers usually pay for it and often do not see the benefits
- c. because sometimes the government overrides personal freedom to keep people safe

4. What is the difference between non-communicable diseases versus communicable diseases?

- a. diseases that do not spread through human contact vs. conditions that spread through human contact
- b. current health problems vs. problems that were significant health problems historically
- c. diseases that are deadly vs. diseases that are not deadly
- d. expensive to treat vs. inexpensive to treat

5. Environmental health might include all of the following except:

- a. testing water systems for contaminants
- b. fracking regulation
- c. pouring cement to build more sidewalks
- d. putting bags in parks for dog waste disposal
- e. providing incentives to doctors to live in rural environments

INTERVIEW WITH A GLOBAL HEALTH DOC

Everyone knows something about what it means to be a doctor. Much fewer people are able to define public health. We've reached out to a doctor who is also a public health professional. Think of this interview as a bridge from your concrete understanding of what it means to be a doctor, to your likely less concrete understanding of what it means to "do public health abroad". This is just one perspective on a multifaceted topic, but it is a great place to start.

Meet the doctor

Sebastian Rodriguez-Llamazares is a Mexican physician. Sebastian earned his medical degree at the Autonomous University of San Luis Potosí and holds a Master in Public Health degree from Harvard University. He currently works as Chief Innovation Officer at Salauno, a social enterprise committed to eliminate unnecessary blindness in Mexico. As a physician, Sebastian discovered the great need for sustainable solutions that bridge the gap of inequities in developing countries. Furthermore, during his work in rural communities around Mexico, he has become passionate about developing projects that provide high quality interdisciplinary health services. He will start his clinical training in Pulmonology in early 2015.

What does global health mean to you?

There are many concepts out there about what global health really means. What first comes to mind usually involves grabbing a transcontinental flight, immersing into an unknown culture and practicing medicine in a resource-scarce setting. As sexy and appealing as this role might sound it truly limits your scope about what global health truly means. To me, global health doesn't mean traveling around planet earth, it means "health for everyone". (Pause) Global Health is the science that fights to create mechanisms that ensure access to high quality healthcare services. And for that to happen, doctors don't need to travel the world, they just need to cross a street and discover millions of ways to bridge the health inequities that currently paralyze the health system of their own country.

What are the main differences between being a doctor in the developed world. and being a doctor in a developing country?

Leaving countries aside, working in any scarcity setting wherever in the world it may be, will inevitably take you towards creativity. When resources are limited, doctors need to make use of other tools and

skills to help their patients. When painkillers are not available, suddenly acupuncture might not sound so crazy. When nurses are understaffed, having capable non-degree health workers can save your day, which in the end means you will need to learn how to teach and train people who know nothing about your science. When insulin is out of the question because there is no refrigeration system in your clinic, taking 5 more minutes for nutrition counseling isn't optional. solution requires more than one part of each person.

How are concepts of health different in developing countries?

Poor patients have the same concept of health as wealthy patients.

However, this concept is usually very hard to grasp when our perspective is not aligned with the reality of the underserved. Let's say a mother of 5 children comes into your clinic because her youngest son has been diagnosed with moderate malnutrition. You decide to explain to her how to prepare a nutritional supplement for her kid and create a detailed nutrition guide. Next month in his follow-up appointment it turns out your patient did not improve and after a careful conversation you find out that the mother did not give him the supplement at all. In which case you will storm out of the room, rage against this horrible health system that provides free supplements for poor mothers when they don't even care for their children's wellbeing, come back and say that there is no other way you can help her if she is

not willing to cooperate. Guidelines will tell you you've done your job properly and you will leave the outpatient clinic with full certainty that you can't help the poor because they simply don't care.

This case is replicable in many real-life consultations across the globe. Truth being told, research has shown that the main reason for the bad adoption of nutritional supplements has to do with equality. Yes, the mother of 5 cannot provide special care to one of her sons because that will immediately create conflicts with their other children. In a genuine intention of being fair, either she splits for a week the delicious one-month ration of "special milk" between her children or she doesn't give it at all. Or perhaps she can't afford the special milk, or it is only available at store that is an hour away and because she works 12 hours a day, she doesn't have the time to sit on a bus to get there. It is not that she doesn't care, it's just that there are other issues beside health that become as much a priority as health itself. This inequality exists between rich and poor countries, but it also exists between rich and poor people within developed countries such as the U.S.

How are health systems around the world different?

Health systems around the world are very different because they usually have different priorities.

Burden of disease expresses differently according to country conditions and socioeconomic status which means that poor people get sick more often and from more diseases than their wealthy counterparts. Furthermore, most countries are currently living an epidemiological transition: poor people are usually more often afflicted with infectious diseases like diarrhea, pneumonia or malaria, while wealthy people rarely die of a simple diarrhea but have the opportunity to develop non communicable diseases (NCD) such as diabetes, depression and cancer. This opportunity comes from living long enough to develop NCDs rather than dying young from infectious disease. This is not to say that the poor don't get diabetes... if we analyze absolute numbers most of the population living with NCD's live under the poverty line. However, if we just take the poor population we will see that proportionally, they still die more of communicable diseases than from non communicable ones. Therefore, each country must decide where it should invest and work harder, making systems themselves different.

Aside from doctors, who else is involved in health internationally? What roles do they play?

This is probably the most important question to answer, and it is especially important for physicians to hear. For centuries all health knowledge came from people who fought diseases directly, thus doctors became the pillar of medical breakthroughs and

innovation. However, despite the fact that we don't live in the 20th century anymore, many physicians still believe they are the only ones spearheading health initiatives. This is where health has gotten global... health is a topic now discussed in general assemblies at the UN, congresses and parliaments, kitchen tables and even cocktail parties!

Today anyone can decide to apply their skill sets to a health issue: architects (urban planners) build healthier and more livable cities where highway pollution lies far away from residential areas and where bike lanes encourage daily exercise; psychologists improve treatment adoption and behavioral change; business executives create financial schemes that allow new innovations to be implemented; publicists improve how health is communicated; non-educated individuals that train themselves to become health workers in their communities... the list could go on forever. Anyone can get involved, and physicians must learn how to team-up with other professionals, and even with non-professionals, to create sustainable solutions.

Also, don't forget that health is political. Anything that requires competing for resources is political by nature. In many countries health is considered a human right, but no country has infinite resources to address all the health needs of the population. So it falls to politicians,

policy-makers, and government administrators to manage the allocation of health resources. This is yet another important job that does not require a medical degree.

What does public health mean to you?

For me public health answers all the questions that clinical medicine can't. As much as I love to practice medicine and treat patients, there have been thousands of moments in which I have felt powerless to actually make the difference I wanted to make. Prescribing insulin to one diabetic patient at a time is not so gratifying as preventing diabetes from affecting an entire community. The thing about medicine is that it usually happens too late, the patient is already sick. And medicine solves problems at the individual level, not at the systems level. Public health's approach to diabetes is creating an environment that prevents people from acquiring diabetes in the first place by making it easier to eat healthy and stay fit.

Public health has done nothing but to nurture my clinical practice by giving me the tools I need to UNDERSTAND my patient: Where does he come from? What does she eat? Why is she sick? Which is the most pertinent treatment? How can he avoid getting sick again? So, for me, public health is the best complement to my medical practice. Public health makes me a better doctor.

Discussion:

1. What was the most interesting thing you learned from reading this interview?
2. What questions would you like to ask Sebastian?
3. What does public health mean to you in light of this interview?

WHILE YOU WERE SLEEPING

In 1900 the average life expectancy of Americans was 47 years. Today it is 78 years. Most of this improvement in health has been due to public health measures rather than medical advances.

Although public health has been far more important than medicine (curative care) in improving our nation's health, all college undergraduates know about career possibilities in medicine, but few know about careers in public health. We really only think about things like air, food, water, and shelter when they are not available or when their quality is reduced. The same is true for public health. The better it is working, the less we think about it. Thus, the field is frequently unknown and underappreciated. The fairy tale of "The Elves and the Shoemaker," As told by Brothers Grimm, further illustrates this point:

There once was a poor shoemaker who worked very hard, but he still could not earn enough to live on, until at last all he had was just enough leather to make one pair of shoes. He cut the leather and went to bed. In the morning, to his great wonder, he awoke to find the shoes already made. The workmanship was wonderful, and he was able to sell the shoes at a high price. With the money, he bought leather enough for two pairs

of shoes. He cut the leather out and went to bed. In the morning he found two pairs of perfectly made shoes. And so it went. Pretty soon the shoemaker became rich. One evening the shoemaker hid, and around midnight in came two little elves. They sat upon the shoemaker's bench, took the work that was cut out, and began to ply their little fingers, stitching and rapping and tapping at such a rate until the job was done.

Public health practitioners, like the elves, are people who try to make life better – and most of us have no idea who they are or what they are doing behind the scenes. Public health involves assuring that drinking water is safe, that pollution does not despoil the air, and that diseases such as smallpox, polio, measles and tuberculosis are kept in check. It involves reducing rates of substance abuse, heart disease and obesity.

One reason that public health is so underappreciated is that we can't usually identify which specific individuals have been helped by public health measures. If you don't get sick at work because of improvements in indoor air quality, not only do you not know whom to thank, you rarely realize that you have been helped. The same is true

if you don't get poisoned because the food is safe, or you don't get run over because the walkway has been separated from the road. These are all public health initiatives. Thus a problem for public health funding, particularly compared to funding for medical care, is that there are no grateful public health patients.

The focus of public health is prevention. While almost all the resources for medical care go to treating individual patients after they become ill or injured, public health deals with entire populations- while they are healthy. The community is the patient, and the goal is to keep everyone in the community healthy.

Did you know?

Although disease kills more people in the United States than injury, injury disproportionately kills the young. If you die before the age of 40, you are more likely to die of an injury rather than a disease.

Discussion:

1. Why did the author choose to use the metaphor of elves?
2. What other metaphors can you think of for public health?
3. If the general public does not know what public health is does that mean public health professionals are doing their job well or doing their job poorly?

Adapted from:

Hemenway, D. *While You Were Sleeping: Success Stories in Injury and Violence Prevention*. Berkeley: University of California Press, 2009.

Hemenway, D. "Why Public Health is Underappreciated and Underfunded," <http://www.hsph.harvard.edu/hicrc/success-stories>.

DEFINING PUBLIC HEALTH

In 1900 the average life expectancy of Americans was 47 years. Today it is 78 years. Most of this improvement in health has been due to public health measures rather than medical advances.

Charles-Edward A. Winslow, a theoretician and leader of American public health during the first half of the twentieth century, defined public health in 1920 as:

The science and art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organization of medical nursing services for the early diagnosis and preventive treatment of disease, and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health.

Public health is a multidisciplinary field that involves preventing disease, promoting health, and prolonging life among the population as a whole. Its activities aim to provide conditions in which people can be healthy and focus on entire populations, not on individual patients or diseases. Thus, public health is concerned with the

total system and not only the eradication of a particular disease. The three main public health functions are:

- The assessment and monitoring of the health of communities and populations at risk to identify health problems and priorities.
- The formulation of public policies designed to solve identified local and national health problems and priorities.
- To assure that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services.

One way to illustrate the breadth of public health is to look at some notable public health campaigns:

- Vaccination and control of infectious diseases
- Motor-vehicle safety
- Safer workplaces
- Safer and healthier foods
- Safe drinking water
- Healthier mothers and babies and access to family planning
- Decline in deaths from coronary heart disease and stroke
- Recognition of tobacco use as a health hazard.

Source:

World Health Organization. <http://www.who.int/trade/glossary/story076/en/>

Discussion:

1. What is your definition of public health?
2. Was it easy or hard to write this?
3. Ask someone else what his or her definition of public health is and compare it to your answer.

WHY IS PUBLIC HEALTH CONTROVERSIAL?

CULTURE MATTERS: WHY CULTURE MATTERS IN REDUCING THE BURDEN OF NON-COMMUNICABLE DISEASE AND COMMUNICABLE DISEASE

Introduction

In 2011, non-communicable diseases (NCDs) such as diabetes and hypertension were recognized at a UN high-level meeting 'as a threat to the achievement of internationally agreed upon goals'. The statistics are startling. For example, as of 2011, there were 366 million people living with diabetes and this is expected to rise to 522 million by 2030. Currently, over 600 million people are hypertensive and this is predicted to increase to a total of 1.56 billion people by 2025. In 2008 alone, NCDs and their risk factors were responsible for 36 million deaths, with nearly 80 per cent of these deaths occurring in low- and middle-income countries. Also, nowhere is death and disability due to NCDs rising more rapidly than in sub-Saharan Africa, where it is projected that these diseases will outpace reductions in infectious diseases, contributing to a rising 'double-burden' of disease.

The underlying causes of NCDs are preventable risk factors such as tobacco use, unhealthy diets and physical inactivity, mediated by societal and environmental factors coupled with globalization and rapid urbanization. Research indicates that consumption of foods high in saturated and industrially produced trans fats, salt and sugar are responsible for 14 million deaths or 40 per cent of all deaths every year from NCDs, while 3.2 million deaths are attributable to insufficient physical activity.

To alter the course of the epidemic, as called for at the UN high-level meeting, there needs to be a major paradigm shift in current intervention strategies. It is time to move beyond individual-level lifestyle-focused policies and interventions to address the collective contexts (i.e., culture) that influence individual behaviors. Given the available evidence about the influence of culture on health and health behaviors, in this paper we highlight the role culture can play in the design of interventions aimed at reducing the global burden of NCDs such as diabetes and hypertension. The objectives of the paper are: (1) to discuss why culture matters for

priority actions to tackle the NCDs crisis; and (2) to propose a cultural model to support the management and control of NCDs such as hypertension and diabetes, drawing from lessons learned with applying the model in HIV/AIDS research.

To alter the course of the epidemic, as called for at the UN high-level meeting, there needs to be a major paradigm shift in current intervention strategies. It is time to move beyond individual-level lifestyle-focused policies and interventions to address the collective contexts (i.e., culture) that influence individual behaviors. Given the available evidence about the influence of culture on health and health behaviors, in this paper we highlight the role culture can play in the design of interventions aimed at reducing the global burden of NCDs such as diabetes and hypertension. The objectives of the paper are: (1) to discuss why culture matters for priority actions to tackle the NCDs crisis; and (2) to propose a cultural model to support the management and control of NCDs such as hypertension and diabetes, drawing from lessons learned with applying the model in HIV/AIDS research.

Cultural determinants of management and control of NCDs

Whether it is hypertension or diabetes, available evidence demonstrates that culture plays a vital role in determining how these diseases are interpreted or managed by individuals. Culture is essentially a building block for constructing personal understandings of health and illness

whether in relation to perceptions people may have about their health or in describing their health-seeking practices. Indeed, at the center of the priority actions aimed at substantially reducing the burden of NCDs in Africa, considerations of culture are as important as the comprehensive package of primary prevention, sound leadership, health-care interventions and improved surveillance.

For example, to reduce the burden of hypertension, primary prevention through a reduction in population-wide salt consumption is viewed as a top priority action. However, reducing salt intake cannot be separated from cultural factors influencing nutrition-related beliefs and attitudes towards the use of salt in food preparation. In many parts of West Africa, for example, bouillon cubes such as Maggi or Knorr are used in almost every household to enhance or intensify the taste of food. According to Elemo and Makinde, the major active ingredients in bouillon cubes are salt and monosodium glutamate. Yet, while concerns have been raised about their salt content, they continue to be used extensively.

For example, a survey by Kerry et al. found that almost all the participants (98 per cent) in Ashanti, West Africa, reported using salt during cooking with 52 per cent in the rural villages and 56 per cent in the semi-urban villages adding bouillon cubes. Similarly, in the rural and urban areas of Enugu, Nigeria, Henry-Unaeeze observed

that 95.8 per cent of households used bouillon cubes. Although about 71 per cent of the participants were aware of the health problems associated with these cubes, the acquired taste now associated with them seemed a more important factor. As a result, while mass media campaigns help to create awareness about the health problems of salt consumption, these efforts may be futile if the same vigor is not applied to addressing the cultural factors driving patterns and sources of salt intake.

In the context of diabetes management and control, as with hypertension, numerous policies and prevention campaigns are underway to promote the consumption of food low in sugar. While these actions may signal optimism for the management and control of diabetes, their success will also rely on addressing the cultural dynamics that frame everyday management and self-care practices. Indeed, available evidence indicates that cultural influences play a critical role in shaping how individuals and families perceive, diagnose and manage the disease.

For example, in Bafut, Cameroon, Awah et al. observed that there were multiple indigenous labels for diabetes, which was referred to as 'fumbgwuang' or 'shugar' with the prefix 'nighoni' (sickness or disease). 'Nighoni-shugar' thus denotes 'sugar disease' and 'nighoni-fumbgwuang' means 'disease that is sweet'. They noted that these indigenous labels for diabetes subsequently influenced self-diagnosis and management in both traditional and modern biomedical settings. Indigenous

diagnostic tools such as divination were also found to be important in guiding the naming, diagnosis and management of diabetes. The findings of this study underscore how diabetes straddles modern lifestyles and traditional beliefs and how socio-cultural knowledge may influence treatment-seeking choices and practices.

Similarly, in Ghana, De-Graft observed that the Twi term 'esikyere yare', which literally means 'sugar disease', was used to describe diabetes with the notion of 'esikafoo yare' (disease of the wealthy). According to De-Graft, rural and low-income urban respondents argued that 'since sugary and fatty foods were common among the rich, in terms of access and acquired taste, diabetes was likely to be more prevalent within this social group.' These eclectic sources of knowledge informed multiple illness action for diabetes whether in relation to drug treatment, dietary management or spirituality.

Like diagnosis, culture also influences caring behaviors. In Dar-es-Salaam, Tanzania, Kolling and colleagues observed that living with diabetes or caring for someone with diabetes was very much a family matter whether in terms of acquiring medicine, accompanying a family member to a health clinic or in the provision of a healthy diet.

Together, these studies illustrate that culture is central to reducing the burden of NCDs such as hypertension and diabetes. While researchers in and outside of Africa may debate when and

where culture should matter, what is no longer in question is the role of culture in decisions about health and well-being. Indeed, public health and development interventions for hypertension and diabetes in Africa will continue to be inadequate and unsustainable until we are resolute about ensuring that these interventions are anchored in culture. One starting point is the use of the PEN-3 cultural model in the development, implementation and evaluation of health interventions for NCDs.

Cultural response to diseases: lessons from the application of the PEN-3 cultural model

Culture is a collective sense of consciousness with both quantifiable and unquantifiable components. The PEN-3 model (see figure 1) was developed in 1989 to centralize culture in public health and health education programs in Africa. It consists of three primary domains: relationships and expectations, cultural empowerment and cultural identity. Each domain includes three factors that form the acronym PEN: person, extended family, neighborhood (cultural identity domain); positive, existential, negative (cultural empowerment domain); and perceptions, enablers, nurturers (relationships and expectations domain). The PEN-3 emphasizes behavior within the broader context of culture to discern the roles, values and norms that are supportive or not supportive of different types of activities aimed at promoting health. PEN-3 offers a cultural lens

for addressing health issues and problems by first identifying the positive aspects of a culture.

In the 23 years of its application in over 100 studies globally, the most important feature of the model has been the recognition that all cultures have positive aspects to them, particularly in the case of health problems that concern relationships with others and/or the influence of family and community contexts in nurturing the health behavior of interest. While conventional models of health behavior change may focus primarily on ways to change negative health behaviors and practices, the PEN-3 model provides the opportunity to examine the values and beliefs that promote the health behavior of interest or pose no threat to health so that negative values or beliefs are located within the broader context of culture. It shifts away from the exclusive focus on individuals to a much broader emphasis on the relationships and expectations within given contexts and insists that every context includes something positive, something unique and something negative.

Although this paper focuses on the cultural contexts of managing hypertension and diabetes, we can learn important lessons from studies applying the PEN-3 model to HIV/AIDS as they underscore the importance of incorporating culturally relevant factors in the development of effective health

interventions. For example, when the PEN-3 cultural model was used to explore factors that influence HIV disclosure among women in South Africa, Iwelunmor et al. revealed that there could be both positive (e.g., acceptance and support) and negative (e.g., disruptions in mother-daughter relationships) consequences associated with disclosure, while the existential role of motherhood (i.e., breastfeeding) could influence a participant's decision to disclose. This cultural analysis revealed the importance of viewing mothers from a positive and empowering lens while recognizing the unique location of their multiple agencies in the family and community.

In using the PEN-3 cultural model to explore the meaning of HIV/AIDS stigma in South Africa, families and health care centers were found to have both 'positive non-stigmatizing values' enabled through supportive roles, 'existential values unique to contexts' such as the importance of food in contextualizing relationships, and 'negative stigmatizing characteristics' such as the blaming of HIV/AIDS on women. When stigma is framed within a cultural lens, the priorities for change originate from within the culturally defined group. They are driven by collective understandings of what the major problems are, followed by steps on ways these problems ought to be resolved. The contexts of stigma are then transformed through collective discussions that highlight ways to reduce stigma by promoting positive behaviors and changing negative ones.

For diabetes, PEN-3 is considered to be an effective strategy to address the cultural bases of diabetes prevention among African Americans in the United States, among Mexican Americans, and among British Bangladeshis. As illustrated in these studies, at the core of the PEN-3 cultural model is an evaluation of the ways in which culture influences, nurtures or constrains health behavior change. A key point here is that such evaluations are necessary to understand the ways in which health behaviors are constructed and to develop solutions from within a given culture. Moreover, to overlook the apparent role of culture is to risk ignoring positive actions already engaged by people or actions that pose no threat to health.

PEN-3 cultural model applied to HIV/AIDS, diabetes and hypertension.

To fully underscore the key tenets of culture as applied to health outcomes, we present a table that shows briefly the cultural importance of behavior, drawing on lessons learned in HIV/AIDS to illustrate implications for prevention and management of hypertension and diabetes in Africa. In Table 1, we crossed one domain of PEN-3 with the three health outcomes of HIV/AIDS, hypertension and diabetes. Under each of the health outcomes, we used signs for positive, existential and negative. Our intent is to highlight key cultural values and practices that should be promoted, acknowledged and/or discouraged.

The table also demonstrates how culture can contribute to the overall success of priority actions against diabetes and hypertension.

What we want to demonstrate is that every context has something good, something unique and something bad. We should always begin with the positive to affirm and applaud positive actions that exist in the community. We should not blame unique qualities, often represented as culture, for the failure to develop an effective and sustainable intervention. While we focus on the negative to be changed, we should not focus only on the negative without promoting the positive and recognizing the unique/existential cultural qualities.

Conclusions

Culture is central to reducing the burden of NCDs in Africa. We have presented a brief description of a cultural model that has been used to address health problems on the continent by drawing on lessons learned in HIV/AIDS to inform strategies to reduce the burden of hypertension and diabetes. Since these diseases are intricately linked to behaviors we must engage in to survive and thrive – eating and drinking – the role of culture is even more critical than in behaviors that have no value for life, such as smoking.

A critical part of policy and programmatic decisions needed to address these health outcomes

requires an excavating of cultural food ways that were discarded and finding more affirmation in the literature for their health benefits. For example, the nutritional value of coconut as an oil and skin product has never been more lauded as in current times. One only has to recall mothers and grandmothers who made family skin lotions from coconut extracts to acknowledge this cultural production in African countries. Culturally produced foods ranging from cassava and its leaves to yam and palm oil are experiencing resurgence in their value for health. Food preparation patterns of steaming and boiling (never frying) were the norm in many African cultures only to experience a decline in the era of modernity. These practices should be re-examined as cultural practices that are proven to be most sustainable in health promotion and disease prevention. If we are to bring the NCD burden in Africa under control, we must look to African cultures for the way forward.

Source:

Airhihenbuwa, C. and Iwelunmor, J. "Why Culture Matters in Reducing the Burden of NCDs and CDs in Africa," Commonwealth, 2012. <http://www.commonwealthhealth.org/wp-content/uploads/2012/05/107-111.pdf>

Discussion:

- 1. In your own words, why does culture matter for preventing NCDs?
- 2. Explain how the PEN-3 model was used with HIV and how to use this model to prevent and manage diabetes.
- 3. Explain the difference in using an approach that focuses on the positive rather than the negative cultural factors that affect health behavior.

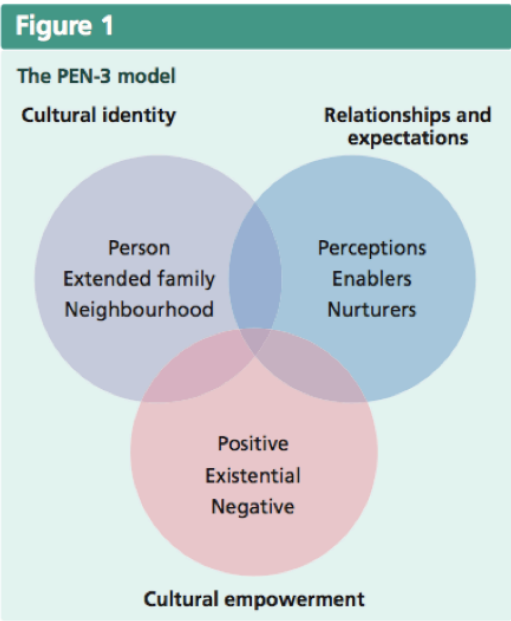


Table 1: PEN-3 and HIV/AIDS, hypertension and diabetes in cultural contexts

PEN-3/ Three health outcomes	HIV/AIDS	Hypertension	Diabetes
PERCEPTIONS	++We should not stigmatise but be supportive of persons living with HIV/AIDS. ==There are language codes used in different cultures to describe HIV. --Knowing about how HIV is contracted has not resulted in changes in risk behavior such as unprotected sex.	++Hypertension can be developed at any age by anyone regardless of your education level. ==There are language codes used to hide hypertension. --Knowing about HBP has not changed the behavior of those who have it or those who do not like dietary change.	++Diabetes can be prevented and those who have it can manage it with the support of family and friends. ==There are language codes used to lament having diabetes. --Knowing about diabetes has not changed the behavior of those who have it or those who do not like dietary change.
ENABLERS	++Health-care workers are supportive of persons with HIV/AIDS. ==African cultures are rich with nutritious food including fruits and vegetables that have proven effective in promoting health. --Health-care providers and government policies that discriminate against persons living with HIV/AIDS.	++Health and nutrition counselling by health-care workers. ==Use of traditional herbs and roots for healing and the role of spirituality in healing. --Lack of screening and treatment for HBP. Lack of the skills and resources for effective stress management and BP monitoring.	++Health and nutrition counselling by health-care workers. ==Use of traditional herbs and roots for healing and the role of spirituality in healing. --Lack of screening and treatment for diabetes. Lack of the skills and resources for effective diabetes management and monitoring.
NURTURERS	++Family members caring for loved ones. ==Home-based care provided by people in the community. --Family rejecting a member of their family at a time they need support because they live with HIV/AIDS.	++Available and affordable nutritious foods rich in vitamins. ==Value placed on sharing meals together as a family. --Cooking with Maggi cubes and bouillon known for excess salt. Local drinks with too much sugar.	++Available and affordable nutritious foods rich in vitamins. ==‘esikyere yare’ (Ghana); fumbgjuang or shugar (Cameroon). --Cooking with Maggi cubes and bouillon known for excess salt. Local drinks with too much sugar.
Key: ++positive to be promoted; == existential to be recognised; -- negative to be changed			



FUNDING PUBLIC HEALTH IN CORRUPT COUNTRIES

Introduction

This paper considers key issues in the aid and corruption debate, focusing specifically on abuses that occur in development assistance targeted at poverty reduction.

Transparency International (TI) views the level of poverty that still prevails in the world as unacceptably high. Aid that aims to increase sharing between rich and poor and to support equitable development processes is vital to reduce poverty. It is critical to ensure that development resources are used for this intended purpose and not diverted by corruption.

Corruption aggravates poverty. Surveys of the very poor in developing countries indicate that corruption has a significant and detrimental impact on their lives. For a poor household, the bribe randomly extorted by a police officer may mean that the family cannot afford school fees for their children. For a poor family's business, it can make buying the inputs needed to keep up their livelihood impossible.

Corruption not only reduces the net income of the poor but also distorts programs aimed at meeting their basic needs — from water and sanitation to education and healthcare. Corruption results in the

misallocation of resources to the detriment of poverty reduction programs.

In both donor and recipient countries there is an increasing awareness that aid is in danger of not fully reaching the poor unless corruption is countered. The discussion is moving towards a more open, serious and constructive search for solutions. The credibility of future flows will depend on the ability of the aid system to show that it can address corruption pro-actively and comprehensively.

The achievement of the Millennium Development Goals (MDGs) may be seriously hindered if corruption is not tackled as an integral part of poverty reduction strategies. Many political leaders of the developing world view corruption as a serious impediment to poverty reduction and are increasingly accounting for corruption risks when designing their national development programs. The growing global consensus on how corruption impedes development is reflected in the ratification of the UN Convention against Corruption (UNCAC) by more than 100 countries.

The connection between aid and corruption

Aid is intended to reduce poverty and support equitable and sustainable development. Its aim is to assist countries in establishing the infrastructure (governmental, social, economic and physical) that is essential for achieving growth and stability. By supporting these structures, the conditions are created for the equal participation of citizens in related social, political and economic processes and for attracting domestic and foreign investment.

The purpose and nature of aid varies considerably across nations. Aid is only one of several factors that play a role in reducing poverty. In addition, aid is unevenly distributed and figures can be deceiving — in many instances actual repayments of past aid loans exceed new transfers.

Aid levels are currently rising. In 2006, leading donor countries gave nearly US \$103.9 billion in official development assistance (ODA) to lower-income countries — a figure set to rise to US \$130 billion in 2010.

Across all countries, China and India remain among the five largest recipients of ODA and aid continues to be a significant source for their poverty reduction Programs. For many of the least developed countries, development financing — whether through grant aid, concessional loans and/or debt relief — provides the dominant share of

government funding. Yet corruption is perceived to be massive and endemic in several of the top ten aid recipient countries: Iraq, the Democratic Republic of Congo, Indonesia, Pakistan and Vietnam.

Aid can be corrupted and the impact dampened

The potential for corruption to compromise the outcomes of development programs is significant. Corruption within recipient countries can seriously undermine the achievement of intended results. Directly, it diverts a percentage of aid away from intended purposes and beneficiaries. Indirectly, it promotes the inappropriate use of aid. Demand-side corruption by public administrations entrusted with development resources is particularly damaging to poverty reduction.

Where corruption is pervasive and economic survival and opportunities are dependent on a system of bribe giving and taking, the effectiveness of aid initiatives is 'dampened'. The development of knowledge and skills is undermined. Efforts to build capacities within regulatory and service-providing institutions and to improve the livelihoods of the poor become compromised.

Empirical research points to a direct link between the quality of governance in recipient countries and positive aid outcomes. The experience gained from combating abuses and delivering sizable

and corruption-free aid flows to beneficiaries has helped to shape discussions around aid effectiveness, governance and anti-corruption. Some of the changed features of development cooperation are based on these insights and make reference to corruption as part of the challenge.

Promising trends include sector-wide approaches in development cooperation and increased efforts by countries to formulate pro-poor strategies that align external contributions with national development plans. The inclusion of anti-corruption assessments and the use of accountability provisions have already become part of the guidelines for some donors (grant-givers or concessionary lenders). For example, final project documents, appraisals and evaluations by donors can be found on many of their websites — although with wide variations in frequency, quality and accessibility.

Aid systems can be corrupt

Corruption can equally occur in the delivery of aid and in the management of resources. Little analysis and information exist in terms of the 'supply chains' and the nature of their 'linkages' along the way — from tax payers in a donor country to beneficiaries in a developing country. For example, what are the formal or real decision-making parameters used? On what basis are projects chosen or sectorial investments made? For the most part, the process of arriving at answers to such questions lies outside the realm of public scrutiny.

Donors play a major role in strengthening or undermining domestic accountability mechanisms in recipient countries. Corruption begins 'upstream' in donor countries when aid priorities are not based on the needs of the poor or a recipient country's long-term national development objectives, but rather are 'supplier driven' and influenced by both domestic and donor industry interests.

As in other areas of public procurement, there are a series of abuses which have been observed for both tied and untied aid. For tied aid, arguments against it may or may not be for reasons of corruption. A majority of bilateral aid agencies continues to tie their aid, which can lead to problems when it comes to obtaining goods and services at internationally-competitive values. The use of closed procurement practices alone can divert a significant percentage of aid away from intended beneficiaries. Estimates for the mark-up from tying aid vary between 15 and 40 percent. In many countries, including Italy (92 percent tied), the United States (72 percent tied) and Canada (47 percent tied), aid remains a highly protected sector.

Where supplier communities are small, tying induces further procurement risks, such as bidder collusion and non-competitive contracting practices.

Aid can cause or encourage corruption

There are many ways in which aid encourages corruption. Where aid has been provided to corrupt systems or under a corrupt leadership, it serves to feed abuses. Both aid and domestic development resources are affected. Where aid has undermined domestic accountability mechanisms, it opens up further opportunities for corruption. Where it is provided outside the lens of citizen oversight in the recipient country, aid is particularly conducive to corruption.

Donor officials and their implementing organizations are receiving increasing public resources with the mandate to accelerate poverty reduction efforts. There is growing acknowledgement⁹ that this has raised the stakes for development cooperation and lent more urgency to efforts to address corruption. Where donors implement higher disbursement targets without supporting partner countries in efforts to address embedded corruption systems, a larger amount of funds may end up being diverted through corruption.

Aid as a form of budget support, when associated with inadequate domestic monitoring and controls, has similarly caused corruption. Conflict, reconstruction and post-disaster contexts are particularly vulnerable and pose an additional set of challenges, for recipient and donor countries alike (see sidebar).

With regard to supply-side corruption in development cooperation, too many private sector firms have offered or accepted bribes. The OECD Anti-Bribery Convention and related regional agreements have criminalized the private sector's use of bribes to obtain government contracts, although most of these accords have been inadequately enforced by many of the ratifying countries.

Structural conditionalities associated with lending by international financial institutions (IFIs), such as the downsizing of the public sector and promotion of privatization, can also create new opportunities for corruption. Where aid-driven cuts in government budgets and staffing¹¹ have not been accompanied by support for improved public sector efficiency and effectiveness, they have contributed to reduced oversight and delivery capacity and increased vulnerabilities to corruption.

Where privatization has been undertaken in the absence of appropriate regulations, corruption has surfaced and has resulted in the lack of genuine competition among the new private entities created. Aid in such cases opens the door for the depletion of public assets through corruption, which has long-term consequences for the citizens of recipient countries.

Source:

Transparency International,
"Poverty, Aid and Corruption,"
2008. <http://www.transparency.de/fileadmin/pdfs/Themen/Entwicklungszusammenarbeit/TI-Policy-Paper-Poverty-Aid-and-Corruption-2007.pdf>

Discussion:

Developing countries need money to develop public health programs. Many developing countries suffer from corruption, which means that money is sometimes diverted away from the people it is meant to serve.

1. Why should donor countries, like the U.S. give money to developing countries that have medium to high levels of corruption?
2. Why should donor countries, like the U.S. not give money to developing countries that have medium to high levels of corruption? Explain the controversy.
3. What can be done to help ensure that the money goes where it is meant to go?

CASE STUDY: EBOLA OUTBREAK

Ebola is a severe, often fatal disease in humans.

The virus is transmitted to people from wild animals and spreads in the human population through human-to-human transmission. It is thought that fruit bats are natural Ebola virus hosts. Ebola is introduced into the human population through close contact with the blood, secretions, organs or other bodily fluids of infected people, and with the surfaces and materials (e.g. bedding, clothing) contaminated with these fluids. Healthcare workers have frequently been infected while treating patients. This has occurred through close contact with patients when infection control precautions are not strictly enforced.

Burial ceremonies in which mourners have direct contact with the body of the deceased person can also play a role in the transmission of Ebola.

People remain infectious as long as their blood and body fluids, including semen and breast milk, contain the virus. Men who have recovered from the disease can still transmit the virus through their semen for up to seven weeks after recovery from the illness.

The average Ebola fatality rate is around 50%. Case fatality rates have varied from 25% to 90% in past outbreaks. Early supportive care with rehydration, symptomatic treatment improves survival. There is yet no licensed treatment proven to neutralize the virus but a number of treatments are under development.

Source:

World Health Organization, "Ebola Virus Disease" Fact Sheet No. 103, Updated September 2014. <http://www.who.int/mediacentre/factsheets/fs103/en>

IN SIERRA LEONE, A LOCKDOWN... OR A TIME TO REFLECT?

Starting just after midnight, residents of Sierra Leone will be confined to their homes for a three-day lockdown. It's the latest government plan meant to stem the tide of Ebola cases, which exceeded 1,500 last week in Sierra Leone. But the plan has not won the support of the international medical community — and is causing concern among Sierra Leoneans as well.

"Everyone is rushing to the markets and stores to stock up on food to get ready for these three days, when they're not going to be allowed to leave their houses," says NPR's Anders Kelto, reporting from Freetown, the capital city.

Stephen Gaojia, head of the Ebola Emergency Operations Center in Sierra Leone, bristles at the word “lockdown.” He says 28,000 volunteers have been recruited and trained to go door-to-door throughout the country, educating families about Ebola.

Earlier this month, the government’s health ministry said it would actively seek out Ebola patients, but now it says it won’t. “This process is not a lockdown, neither is it a shutdown, neither is it a root-out exercise,” Gaojia told All Things Considered Wednesday. “This is more a psycho-educational exercise.”

Instead, Gaojia says, it’s a time for people to “stay together to do some reflection, engage in prayer, generate some kind of family discussion about Ebola.”

A press release from the Emergency Operations Center called it a “house-to-house Ebola talk,” or “Ose to Ose Ebola Tok” in Krio, a local language.

“We want to help rebuild public confidence and trust in the public health care system,” Gaojia says.

International medical professionals think the plan could backfire.

“Large scale coercive measures like forced quarantines and lockdowns are driving people underground and jeopardizing the trust between people and health providers,” Doctors Without Borders said in a statement earlier this month, when

the government first announced its plans. “This is leading to the concealment of cases and is pushing the sick away from health systems.”

In response to such criticism, Gaojia says, “The risk of doing nothing far outweighs the risk of doing something.”

But a quarantine in a Liberian slum neighborhood in August led to violence and riots.

And, says Doctors Without Borders in their statement: “Without enough beds to treat patients who have Ebola we will fail to stop it spreading even further. What Sierra Leone and Liberia urgently need are more beds in case management centers, and they need them now.”

Gaojia says the Emergency Operations Center estimates the country will see a “surge of about 15 to 20 percent of the cases that we have had ... anywhere between 200 or more nationwide.”

But even with a new Red Cross facility in Kenema, the country’s third largest city, there aren’t enough beds at treatment centers. Instead, there are holding centers, which many people view as places where suspected Ebola patients go to die alone.

“These holding centers are very bare bones,” says Kelto. “They don’t have IVs, they don’t have saline solution to keep people hydrated, they don’t have medicine to treat diarrhea or to

stop vomiting. So essentially it's no different than just lying at home in your own bed."

In the meantime, the prospect of a lockdown has caused a spike in food prices in Freetown. "Everything is so expensive, double the price," says Miriam Kallom, a shopper in Freetown. That's a problem in one of the world's poorest countries, where many live on day-to-day wages.

The health ministry plans to send over 7,000 teams of four people each to go door-to-door throughout Sierra Leone "to disseminate information on Ebola virus and enlist family and community support to participate in the response process." Gaojia says. Each team will include a healthcare worker, community volunteer "and possibly a youth within the community."

Gaojia says that they will be "using an encouragement approach," telling people who may be ill or who have ill family members to call a hotline so a rapid response team can transport them to a holding center, where they can be tested for Ebola.

"Military people, police and soldiers are not the face of this campaign at all," says Gaojia. "Of course, the police and military will be in readiness in the event of any lawlessness."

The volunteer teams are set to work between 7 a.m. and 6 p.m. In the evening, people will be able to move three to four doors from their

homes. Vehicular movement will still be restricted.

"We don't expect [Sierra Leoneans] to refuse," Sidie Yahya Tunis, communications director for the health ministry of Sierra Leone, told the BBC earlier this month. "You follow or else you'll be breaking the law. If you disobey then you are disobeying the president."

Initially, the plan was for the volunteer teams to reach every single house in the country of 6 million. Now, their aim is to visit 1.5 million households, each of which will get a bar of soap.

The only protective equipment the volunteers will carry, Gaojia says, is rain gear.

Adapted from:

Bichell, R.E., "In Sierra Leone, A Lockdown ... Or A Time To Reflect?," NPR September 18, 2014. <http://www.npr.org/blogs/>

Discussion:

1. Why is there a lock-down? How will this lock-down affect the economy? How will this lock-down affect public trust of health workers? Do you think this lock-down will be effective in preventing the spread of disease?
2. What are the ethical issues that were raised in this article?
3. Look back over the WHO description of Ebola. Is there anything else that the article about Sierra Leone should have mentioned? Were you left with any unanswered questions?



CASE STUDY: ETHNIC DISPARITIES IN ACCESS TO CARE IN POST APARTHEID SOUTH AFRICA

South Africa's political and economic situation has dramatically changed in the past decade because of the abrupt transition from an apartheid government to a democratic government. During the apartheid era, the ruling National Party's goal was to secure White control and promote racial separation by classifying all South Africans into White, Black, Colored (i.e., those of mixed race), or Asian ethnic categories. The government prohibited interracial marriage; established a segregated employment system in which race was the qualifying factor; and allowed for legal discrimination and many other injustices.

Apartheid laws and policies affected all aspects of the citizen's life, including the health sector. According to the American Association for the Advancement of Science and the Physicians for Human Rights Organization, the South African health care system not only limited access to health care for Blacks and often ignored quality-of-care guidelines but also created an environment in which abuses such as the refusal of emergency care treatment, falsification of medical

records, denial or limitation of Blacks' access to ongoing medical care, and mistreatment of the mentally ill could occur.

Currently, there are 2 health care systems in South Africa: one that is largely publicly funded that serves most South Africans and a privately funded health care system that serves the small percentage of people who are able to afford it, mainly Whites and Asians. During apartheid, most of the national health expenditure was allocated to building a medical infrastructure that would be used by urban inhabitants and the privately insured. Even today, privately insured patients pay a highly subsidized fee for medical care and receive tax benefits for their contributions to the private health sector. From 1992 to 1993, 59% of doctors, 93% of dentists, and 89% of pharmacists worked in the private sector. The competition between the private and public sectors still exists as medical professionals often choose to work in the more profitable private sector.

Marked disparities in health between Blacks and Whites during apartheid have been documented. In 1981, there was 1 physician for every 330

Whites but only 1 for every 91 000 Blacks. Infant mortality was 20% in the Black population compared with 2.7% in the White population. The life expectancy in 1980 was 55 years for Blacks, 58 years for Coloreds, 65 years for Asians, and 70 years for Whites. The incidence (per 100 000) of tuberculosis in 1985 was 211 for Blacks, 429 for Coloreds, 80 for Asians, and 18 for Whites. In the economic sector, 10% of the population accounted for 51% of annual income earned in South Africa, whereas the poorest 40% accounted for less than 4% of annual income earned in South Africa. In addition to income disparity there were also differences in social service provision among ethnic groups because of apartheid policies that allocated different services for each group. These disparities illustrate the inequities experienced not only in the health sector but in other societal structures.

Most authors have concluded that the state of the health care system for Blacks has not improved much since apartheid and that extensive work must be done to comply with new constitutional regulations of equality and access to health care. Although equity is at the top of the current government's agenda, the type and form of this desired equity is not uniformly agreed upon at all levels of government. It is suggested that instead of horizontal equity, in which equity is sought for those within the same socioeconomic level, the goal of the national

government should be to implement vertical equity, in which attempts are made to pull up those in the lower socioeconomic levels and the disenfranchised.

Has health care improved, worsened, or remained the same among South Africans after apartheid? There have been many reports documenting post-apartheid South Africa, with descriptions of isolated events, national statistics, summaries, and testimonials. Few studies have examined the South African health care system using data obtained from surveys of South African citizens. We investigated ethnic disparities in obtaining medical care in post-apartheid South Africa.

Methods

The Afrobarometer: Round II Survey of South Africa sample is a national probability sample that represents a cross-section of the voting-age population of South Africa. Random selection was used in every stage of sampling; the survey was administered in all provinces of South Africa in proportion to the relative size of each province and racial group in the national population. The national sample as a whole was used in this study. The survey, which assesses respondents' perceptions regarding democracy, markets, and civil society in South Africa, is part of a series of surveys that enable researchers to track perceptions over time. The survey included questions addressing respondents' current

economic situation, their perceptions of the government's handling of the national economy, what they believe to be the major political and social issues facing the country, and their political involvement and trust in government and business entities. In addition, it compared individuals' perceptions of various issues during and after apartheid. The survey questions also examined sociodemographic characteristics, access to health care, and other factors that may influence health, such as the presence of a health clinic and piped water in the community. For our study, certain questions have been selected to investigate whether previously documented inequalities in health care in apartheid South Africa still exist in post-apartheid South Africa—especially the question of whether, and how often, the respondent had gone without medical care.

Population and Measures

The sample comprised 1522 individuals divided among South Africa's 4 major ethnic groups: Whites; Blacks; Coloreds, who are of mixed White and Black descent; and Asians, who are predominantly Indian and Chinese.

Our study focused on 1 dependent variable: how often the respondent went without medical care. The question read, "Over the past year, how often, if ever, have you or your family gone without medicine

or medical treatment?" The data were adjusted for the following variables: respondent's education level, household income, and gender; respondent's perception of how the government was handling (1) the improvement of basic health services, (2) the provision of education, and (3) the gap between rich and poor; respondent's perception of how often his or her ethnic group was treated unfairly; how often the respondent or the respondent's family had gone without food or water; and whether or not there was a clinic in the surrounding community.

Results

Blacks had the highest rate of going without medical care during the past year (40.8%), followed by Coloreds (22.9%), Whites (10.9%), and Asians (6.9%). The same trend is found in going without food: 43.9% of Blacks had gone without food at least once the past year, followed by Coloreds (27.6%), Whites (12.4%), and Asians (8.8%).

Asked how the government was handling education, 69% of Blacks and 60% of Coloreds thought it was doing well, whereas among Whites and Asians, most thought that the government was doing badly (57% and 72%; $P < .001$). Asked how well the government was handling the improvement of basic health services, 60% of Blacks and 62% of Coloreds thought the government was doing well, whereas most Whites and Asians thought it was doing badly (67% and 62%; $P < .001$). Asked how

the government was handling the gap between rich and poor, all ethnic groups reported that it was doing poorly (Blacks, 73%; Whites, 85%; Coloreds, 80%; Asians, 86%; $P < .001$). Interestingly, there was a pairing trend in perceptions of how the government was handling education and improving basic services: Blacks and Coloreds seemed more optimistic whereas Whites and Asians were less so.

In one of the models, the largest predictors of how often an individual had gone without medical care across all ethnic groups were how often they had gone without food and how often they had gone without water. The full model was able to explain 30% of the variation in going without medical care for Blacks, 37% for Whites, 37% for Coloreds, and 43% for Asians.

Comparison of the results of the 4 race-specific models makes evident that the strongest predictor of having gone without medical care is having gone without food. Interestingly, the substantive impact of this variable is much greater for Whites and Asians than for Blacks and Coloreds. Having gone without water was also a strong predictor of having gone without medical care, but for this variable, the pairing trend was not observed. Finally, for White and Asians, no other variables were significantly associated with having gone without medical care. For Blacks, those who reported that the government was handling the

gap between rich and poor well went without medical care less often; the same held true for Coloreds.

Discussion

Because of the disadvantaged position of Blacks in South Africa, they lack adequate public health services (e.g., sustainable access to clean water, proper sewer systems, access to health care) and are vulnerable to disease. Blacks are still concentrated mainly in disadvantaged territories, which remain underserved and are the poorest regions of the country. These gross disparities extend into the health care sector and are manifested through racial disparities in health outcomes.

Equity is an issue that must be further explored in South Africa to ensure that resources and services are equally distributed throughout the population. Current efforts to bring the health sector into compliance with constitutional decrees have not been successful. Little has been done to reallocate subsidies from the private to the public health sector. According to May et al., "Despite a strong political commitment to redressing historical inequities, recent government policy actions in these two areas appear to fall short of desirable goals when viewed through a vertical equity lens."

Structural inequalities are promoted when some members of the population are poor and may earn their living through informal methods while the rest are financially stable

and may have jobs in the formal market sector. The latter will demand the type of health care available in advanced market economies, while the former continue to have limited health access. This structural inequality also points to geographic inequalities. This is evident in South Africa, where individuals in rural areas have limited access to health care compared with inhabitants of urban areas, who may be part of the formal market sector.

Health care relies not only on the source of services but also on the infrastructure that supports a population's health. Twenty-two percent of the primary sampling units in which Blacks resided had no piped water system. This weakness in the basic public health infrastructure is indicative of an overburdened public health system that is not capable of providing consistent quality care across ethnic groups. Public health may not be meeting the needs of the Black population nor providing the adequate infrastructure that is essential for a healthy society.

Adapted from:

Kon, ZR and Lackan, N. "Ethnic Disparities in Access to Care in Post-Apartheid South Africa," *Am J Public Health*. 2008 December; 98(12): 2272–2277. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2636545/>

Discussion

1. Explain how politics can be use as a public health tool.
2. Has reading this article changed or enhanced your thinking on the question of the role of race in health? Why, or why not?
3. Do you think South Africa is moving in the right direction with regard to health?

CASE STUDY: INEQUALITIES IN LATIN AMERICA

Persistent social exclusion and inequities in wealth distribution and in access and use of services are reflected in health outcomes. In the Americas, social exclusion and inequity remain as the leading obstacles to inclusive human development, pose barriers to poverty reduction strategies, and hinder social unity and improved health conditions of populations. Social exclusion and inequity are further compounded by racial and gender discrimination.

The Socioeconomic and Political Context

The socioeconomic and political context encompasses the broad set of structural, cultural, and functional aspects of a social system that exert a powerful formative influence on the patterns of social stratification and, thus, on people's health opportunities. It includes the social and political mechanisms that generate, shape, and maintain social hierarchies, including the job market, the educational system, and political institutions.

It is critical not only to acknowledge the impact that the social determinants have on the health of individuals and populations, but also to consider the mechanisms through which redistributive

policies, or lack thereof, can shape the social determinants of health themselves. Thus, social stratification mechanisms, in conjunction with the elements of the socioeconomic and political context, constitute what is referred to as the social determinants of health inequities. Core elements to consider include: governance and its processes, macroeconomic policies, social policies, public policies, cultural and societal values, and epidemiologic findings.

Structural Determinants

The concept of "structural determinants" refers specifically to those attributes that generate or strengthen a society's stratification and define people's socioeconomic position. These mechanisms shape the health of a social group based on its location within the hierarchies of power, prestige, and access to resources. Their designation as "structural" emphasizes the causal hierarchy of the social determinants in the production of social health inequities.

Improvements in income and education have been demonstrated to have an incrementally positive relationship to health. Occupation is also relevant to health, not only in terms of exposure to specific

workplace risks, but mainly due to its role in positioning people along a society's hierarchy. Health statistics demonstrate the influence of this type of variable on health inequalities at different levels of aggregation.

Gender

Together with social position and ethnicity, gender functions as a structural determinant due to its critical influence on the establishment of hierarchies in the division of labor, the allocation of resources, and the distribution of benefits. The division of roles by sex and the differential value assigned to those roles translate into systematic asymmetries in the access to and control over critical social protection resources such as education, employment, health services, and social security.

In the Region of the Americas, women, as a group, have outpaced men in terms of schooling; however, this relative parity has not been reflected in other areas, such as income and political representation. This situation demonstrates that school enrollment, a key determinant of health, is affected by gender and social position. Girls' enrollment in elementary school exceeds that of boys; in secondary school, enrollment for both sexes somewhat evens out; but by tertiary school, girls have higher enrollment ratios than boys in each human development quartile and particularly in the highest quartile.

The following examples further illustrate this point:

- Women's participation in the labor market is significantly lower than that of their male counterparts. Data from 2009 demonstrate that in 14 of 19 Latin American countries, women's share in the labor market was approximately 50%, while men's participation was estimated at 70% in 18 of those 19 countries and even at 80% in 11 of the 19 countries analyzed.
- Where women are part of the labor force, they tend to be overrepresented in the informal employment sector, in which workers generally have more limited access to social security benefits.
- In terms of income disparities by gender, in 2009 Latin American women's average income, as a percentage of men's income, ranged between 62% (Mexico and the Dominican Republic) and 81% (El Salvador).
- In terms of economic autonomy, 31.8% of women, compared to 12.6% of men, in Latin America lacked income of their own.
- The proportion of women in parliaments ranges widely among countries of Latin America, with an average of 22.4%.
- Gender differences do not always result in favorable outcomes for men, however. For example, the greatest mortality gap between the sexes is associated with accidents and violence—in the Americas, men's mortality rates from these causes amount to 106 per 100,000 population, while women's rates are only 28.7 per 100,000 population.

Race and Ethnicity

Racial and ethnic discrimination and exclusion affect all spheres of opportunity throughout an individual's life, including those related to health. But because information disaggregated by race or ethnic group is not readily available, up-to-date, empirical evidence on the effect of racial or ethnic discrimination is fragmented and limited.

Bolivia's indigenous people make up 37% of the working population, they only earn 9% of the total national work income. Furthermore, data published by the Economic Commission for Latin America and the Caribbean (ECLAC) show that in nine Latin American countries there is a widespread lag in schooling among indigenous and African-descendant children compared to the overall population. And in the United States, life expectancy among African Americans, in terms of health indicators, is significantly lower than that of the white population. From 2004 to 2008, for example, although the incidence rate of breast cancer (per 100,000 population) was higher among white women (127.3 per 100,000 population) than among African American women (119.9 per 100,000), the mortality rate from this cause was greater for African American women (32.4 per 100,000 population) than for white women (23.4 per 100,000)

Inequalities and inequities with respect to breast cancer are evident in the United States. Screening, diagnosis, and treatment inequities within and between communities and among women of different race, ethnicity, and socioeconomic background is relevant and significant in the case of breast cancer incidence.

Daily living conditions, such as work opportunities and conditions for women and work-home life balance, affect socioeconomic status, which, in turn, has an impact on behavioral and environmental risk factors for breast cancer in women. A review of social determinants in breast cancer mortality between Black and White women shows that inequalities are evident across the entire breast cancer continuum, from prevention and detection to treatment and survival.

According to Gerend and Pai, inequalities and inequities are related to poverty barriers, which are linked to lack of a primary care physician, geographical barriers to care, competing survival priorities, comorbidities, inadequate health insurance, lack of information and knowledge, risk-promoting lifestyles, provider- and system-level factors, perceived susceptibility to breast cancer, and cultural beliefs and attitudes.

Adapted from:

Pan American Health Organization.

"Health Determinants and Inequalities,"

Health in the Americas, April, 2013. [http://](http://www.paho.org/saludenlasamericas/index.php?option=com_content&view=article&id=58&Itemid=55&lang=en)

[www.paho.org/saludenlasamericas/index.](http://www.paho.org/saludenlasamericas/index.php?option=com_content&view=article&id=58&Itemid=55&lang=en)

[php?option=com_content&view=article&i](http://www.paho.org/saludenlasamericas/index.php?option=com_content&view=article&id=58&Itemid=55&lang=en)

[d=58&Itemid=55&lang=en](http://www.paho.org/saludenlasamericas/index.php?option=com_content&view=article&id=58&Itemid=55&lang=en)

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[php?option=com_content&view=a](http://www.paho.org/saludenlasamericas/index.php?option=com_content&view=article&id=49&Itemid=46&lang=en)

[rticle&id=49&Itemid=46&lang=en](http://www.paho.org/saludenlasamericas/index.php?option=com_content&view=article&id=49&Itemid=46&lang=en)

Discussion:

1. Can you think of a way in which redistributive policies affect health?

2. How do structural determinants act as mechanisms to improve or diminish health?

3. Is inequality a problem to be solved or a reality to get used to?

THE TOOLS OF PUBLIC HEALTH

ENVIRONMENTAL HEALTH

The commonly accepted definition of environmental health and protection was developed in 1992 by the Committee on the Future of Environmental Health.

"Environmental health and protection is the art and science of protecting against environmental factors that may adversely impact human health or the ecological balances essential to long-term human health and environmental quality. Such factors include, but are not limited to: air, food and water contaminants; radiation; toxic chemicals; disease vectors; safety hazards; and habitat alterations."

"Environment" in this context differs from the field of environmentalism. Environmental health means identifying and addressing how the environment impacts human health and the environment.

Who are Environmental Health Professionals?

Environmental Health (EH) professionals perform a wide array of include those who monitor air quality, water and noise pollution, control for toxic substances and pesticides, conduct restaurant inspections and promote healthy land use and housing.

Environmental Health (EH) professionals perform research on a variety of topics including environmental toxins, communicable disease outbreaks, human health impacts of environmental catastrophes such as Hurricane Katrina and more. They are best known for their efforts to ensure safe food, water, air quality and sanitary conditions. The increase in environmental health threats such as E. coli outbreaks, and the emergence of new threats such as the West Nile Virus, SARS, bio/agro-terrorism (intentional tainting of food) and the human health impacts of environmental catastrophes such as 9/11 exemplify the ever-increasing need for a well trained environmental health workforce.

Source:

Association of Environmental Health Academic Programs, "What is Environmental Health?" Seattle, <http://aehap.org/what-is-environmental-health>



SOCIAL AND BEHAVIORAL SCIENCES

Over 50 percent of premature morbidity and mortality is caused by behavioral and social determinants of health such as smoking, diet, exercise, and socioeconomic status.

For doctors to best serve their patients and for policy makers to positively influence the populations, they need to understand why people make the choices they make. For example, we need to understand why people choose to smoke. We must also appreciate social factors, such as peer pressure and advertising, that promote smoking, and the policy interventions, such as tobacco taxes, that greatly curtail smoking rates. Moreover, prevention or treatment of nicotine addiction requires knowledge of the health care system, referral resources, adherence promotion, and effective relationships with allied addiction counselors.

Understanding social dynamics within the health care system and processes improves the effectiveness of the health care team. Behavioral and social sciences support the movement across multiple levels of analysis ranging from molecular biochemistry to individual behavior to social policies.

The U.S. Government's National Institute of Health Office of Behavioral

and Social Sciences Research (OBBSR) was created in 1995 as a result of a growing understanding of the importance of the behavioral and social sciences to health processes and outcomes. According to OBBSR, the term "behavioral" refers to overt actions; to underlying psychological processes such as cognition, emotion, temperament, and motivation; and to bio-behavioral interactions. The term "social" encompasses sociocultural, socioeconomic, and socio-demographic status; biosocial interactions; and the various levels of social context from small groups to complex cultural systems and societal influences.

The core areas of this research have a major and explicit focus on the understanding of behavioral or social processes, or on the use of these processes to predict or influence health outcomes or health risk factors. Levels of study include the individual, family, social group, community, society, and the population as a whole, with units of analysis spanning the molecular to the geopolitical. Much of the behavioral and social sciences research that is relevant to medical practice has grown out of traditional academic fields such as anthropology,

sociology, psychology, economics, communication, education, political science, public health and policy, social work, and, more recently, informatics.

Studying humans in complex (and often chaotic) systems is not straightforward. Therefore, theories provide a conceptual framework and a set of guiding principles that allow behavioral and social scientists to see new relationships and test ideas about how something works in the social world. Unlike the physical and biological sciences, which emphasize theoretical unity, whether or not the guiding theories are explicitly stated, the behavioral and social sciences are generally considered multi-paradigmatic—drawing, that is, on multiple theories at once. This can be disconcerting for those who expect exacting causal internal consistency from a discipline. However, most social scientists regard this as a healthy intellectual diversity that leads to new insights and productive research programs.

The behavioral and social sciences have a long history of struggling with questions about how best to measure, understand, predict, and potentially change human behavior and social structures. Each behavioral and social science discipline has its own standards of scientific and ethical practice when weighing evidence and making inferences. Complex behavioral and social science theories and research methods constantly undergo refinement by

a community of researchers and scholars. Their methods would be familiar to bench scientists: statistical modeling, experimental designs, and randomized clinical trials. However, methodologies might also include questionnaires, interviews, direct observations, laboratory or field experiments, standardized tests, ethnography, computer modeling, or textual analyses.

The study of human life has an essentially interpretive element that requires not only finely honed quantitative measurement skills but also a well-developed qualitative sensibility that allows the researcher to observe social life and make sense of multiple competing interpretations. The researcher using qualitative methods can reliably inspect and describe singular events or a small number of similar events at a granular and contextualized level. The ethnographer who conducts open-ended one-on-one interviews or focus groups with, for example, substance abusers or patients with eating disorders can learn from the ground up how a particular occurrence of a phenomenon might work. This knowledge generates hypotheses about how to examine the next iteration of the same event and, eventually, can unearth fruitful means of thinking about the phenomenon as a whole.

With increasing frequency, investigators combine quantitative and qualitative approaches in mixed-method designs, a practice

encouraged by federal agencies for behavioral and social science research. Behavioral and social science researchers are comfortable with the understanding that human life is multivariate and explanatory factors are always competing, combining, and interacting. Therefore, the interpretation and integration of multiple explanatory factors drive much of behavioral and social science theory and practice.

Adapted from:

Association of American Medical Colleges. Behavioral and Social Science Foundations for Future Physicians: Report of the Behavioral and Social Science Expert Panel. Washington D.C., 2011.

Discussion:

1. Think of a health problem that would best be addressed using social and behavioral sciences? Explain why.
2. For the same health issue, think about another public health discipline that you would also use to support the social and behavioral work. Explain why.
3. What might you study in college to prepare for a career in social and behavioral sciences? Does this interest you?

EPIDEMIOLOGY AND CAUSES OF DEATH

Why do we need to know the reasons people die?

Measuring how many people die each year and why they died is one of the most important means – along with gauging how diseases and injuries are affecting people – for assessing the effectiveness of a country's health system.

Cause-of-death statistics help health authorities determine their focus for public health actions. A country where deaths from heart disease and diabetes rapidly rise over a period of a few years, for example, has a strong interest in starting a vigorous program to encourage lifestyles to help prevent these illnesses. Similarly, if a country recognizes that many children are dying of malaria, but only a small portion of the health budget is dedicated to providing effective treatment, it can increase spending in this area.

High-income countries have systems in place for collecting information on causes of death in the population. Many low- and middle-income countries do not have such systems, and the numbers of deaths from specific causes have to be estimated from incomplete data. Improvements in producing high quality cause-of-death data are crucial for improving health and reducing preventable deaths in these countries.

High-income vs. Low-income Epidemiologic Profiles

In high-income countries, 7 in every 10 deaths are among people aged 70 years and older. People predominantly die of chronic diseases: cardiovascular diseases, cancers, dementia, chronic obstructive lung disease or diabetes. Lower respiratory infections remain the only leading infectious cause of death. Only 1 in every 100 deaths is among children under 15 years.

In low-income countries, nearly 4 in every 10 deaths are among children under 15 years, and only 2 in every 10 deaths are among people aged 70 years and older. People predominantly die of infectious diseases: lower respiratory infections, HIV/AIDS, diarrheal diseases, malaria and tuberculosis collectively account for almost one third of all deaths in these countries. Complications of childbirth due to prematurity, and birth asphyxia and birth trauma are among the leading causes of death, claiming the lives of many newborns and infants.

In terms of number of deaths, 28 million (about three quarters) of the 38 million of global NCD deaths in 2012 occurred in low- and middle-income countries. In terms of proportion of deaths that are due to

NCDs, high-income countries have the highest proportion – 87% of all deaths were caused by NCDs – followed by upper-middle income countries (81%). The proportions are lower in low-income countries (37%) and lower-middle income countries (57%).

GLOBAL HEALTH

SUSTAINABLE DEVELOPMENT: WHY FOCUS ON HEALTH?

The framework for sustainable development in the 21st century must maximize healthy wellbeing at all ages through universal health coverage and pro-health policies in all sectors. Adopting a life course approach that will benefit all persons, we recommend the health goal: Achieve Health and Wellbeing at All Ages.

To accomplish this objective we propose that all countries achieve universal health coverage at every stage of life, with particular emphasis on primary health services, including mental and reproductive health, to ensure that all people receive quality health services without suffering financial hardship. Countries implement policies to create enabling social and environmental conditions that promote the health of populations and help individuals make healthy and sustainable decisions related to their daily living.

Health is crucial for sustainable human development, both as an inalienable human right and an essential contributor to the economic growth of society. Health is also a good summative measure of the progress of nations in achieving sustainable development. It contri-

butes to national development through productive employment, reduced expenditure on illness care and greater social cohesion. By promoting good health at all ages, the benefits of development extend across generations.

Investments in primary health care can promote health across all social groups and reduce health inequities within and between countries. Improving performance of health systems by enhancing financial and human resources, appropriate use of technology, community empowerment and good governance will advance this agenda. The potential for providing large-scale employment as frontline health workers, particularly to women and young persons, should be utilized to strengthen the economy and improve health services.

We believe that universal health coverage (UHC), delivered through an adequately-resourced and well-governed health system, will be capable of addressing these and other health challenges, especially if supported by policies in other sectors which promote health and environmental sustainability and reduce poverty. Universal health coverage must ensure equitable access to afford, accountable appropriate health services of assured quality to all people. These

must include promotive, preventive, curative, palliative and rehabilitative services. This includes public health services such as infectious disease monitoring and ensuring food safety. They must be supported by policies and services addressing the wider social and environmental determinants of health for individuals and populations.

Governments must play the role of both guarantor and enabler, mobilizing all relevant societal resources for the delivery of health services. National commitment to Universal Health Coverage must be legally embedded in a rights-based framework.

Since the determinants of health extend across multiple sectors, the post-2015 development agenda must promote synergies and partnerships that align actions for better health. Improved health of individuals and populations will also help in achieving other development goals such as poverty reduction, gender empowerment, and universal education. Several common determinants also link health to the environment, agriculture and food systems, water and energy security, urban development and transport, trade and investment, communications, and human migration.

Source:

Thematic Group on Health for All of the Sustainable Development Solutions Network, "Health in the Framework of Sustainable Development: Technical Report for the Post-2015 Development Agenda," Sustainable Development Solution Network February 18, 2014 (5-6). <http://unsdsn.org/wp-content/uploads/2014/02/Health-For-All-Report.pdf>

Discussion

1. Do you believe that the WHO goal of "of a level of health that will permit" all people "to lead a socially and economically productive life" has been achieved? Why, or why not?
2. Why is health important for development?
3. Why is development important for health?

HIV/AIDS

Key facts

- HIV continues to be a major global public health issue, having claimed more than 39 million lives so far. In 2013, 1.5 [1.4–1.7] million people died from HIV-related causes globally.
- There were approximately 35.0 [33.1–37.2] million people living with HIV at the end of 2013 with 2.1 [1.9–2.4] million people becoming newly infected with HIV in 2013 globally.
- Sub-Saharan Africa is the most affected region, with 24.7 [23.4–26.2] million people living with HIV in 2013. Also sub-Saharan Africa accounts for almost 70% of the global total of new HIV infections.
- HIV infection is usually diagnosed through blood tests detecting the presence or absence of HIV antibodies.
- There is no cure for HIV infection. However, effective treatment with antiretroviral drugs can control the virus so that people with HIV can enjoy healthy and productive lives.

In 2013, 12.9 million people living with HIV were receiving antiretroviral therapy (ART) globally, of which 11.7 million were receiving ART in low- and middle-income countries. The 11.7 million people on ART represent 36% [34–38%] of the 32.6 [30.7–34.8] million people living with HIV in low- and middle-income countries. Pediatric coverage is

still lagging, in 2013 less than 1 in 4 children living with HIV had access to ART, compared to 1 in 3 adults.

The Human Immunodeficiency Virus (HIV) targets the immune system and weakens people's surveillance and defense systems against infections and some types of cancer. As the virus destroys and impairs the function of immune cells, infected individuals gradually become immune-deficient. Immune function is typically measured by CD4 cell count. Immunodeficiency results in increased susceptibility to a wide range of infections and diseases that people with healthy immune systems can fight off.

The most advanced stage of HIV infection is Acquired Immunodeficiency Syndrome (AIDS), which can take from 2 to 15 years to develop depending on the individual. AIDS is defined by the development of certain cancers, infections, or other severe clinical manifestations.

Signs and symptoms

The symptoms of HIV vary depending on the stage of infection. Though people living with HIV tend to be most infectious in the first few months, many are unaware of their status until later stages. The first few weeks after initial infection, individuals may experience no symptoms or an influenza-like illness including fever, headache, rash or sore throat.

As the infection progressively weakens the person's immune system, the individual can develop other signs and symptoms such as swollen lymph nodes, weight loss, fever, diarrhoea and cough. Without treatment, they could also develop severe illnesses such as tuberculosis, cryptococcal meningitis, and cancers such as lymphomas and Kaposi's sarcoma, among others.

Transmission

HIV can be transmitted via the exchange of a variety of body fluids from infected individuals, such as blood, breast milk, semen and vaginal secretions. Individuals cannot become infected through ordinary day-to-day contact such as kissing, hugging, shaking hands, or sharing personal objects, food or water.

Risk factors

Behaviors and conditions that put individuals at greater risk of contracting HIV include:

- having unprotected anal or vaginal sex;
- having another sexually transmitted infection such as syphilis, herpes, chlamydia, gonorrhoea, and bacterial vaginosis;
- sharing contaminated needles, syringes and other injecting equipment and drug solutions when injecting drugs;
- receiving unsafe injections, blood transfusions, medical procedures that involve unsterile cutting or piercing; and
- experiencing accidental needle stick injuries, including among health workers.

Diagnosis

An HIV test reveals infection status by detecting the presence or absence of antibodies to HIV in the blood. Antibodies are produced by an individual's immune system to fight off foreign pathogens. Most people have a "window period", usually 3 to 6 weeks, during which antibodies to HIV are still being produced and are not yet detectable.

This early period of infection represents the time of greatest infectivity, but transmission can occur during all stages of the infection. If someone has had a recent possible HIV exposure, retesting should be done after 6 weeks to confirm test results, which enables sufficient time to pass for antibody production in infected individuals.

Testing and counseling

HIV testing should be voluntary and the right to decline testing should be recognized. Mandatory or coerced testing by a health-care provider, authority or from a partner or family member is not acceptable as it undermines good public health practice and infringes on human rights.

All testing and counselling services must include the 5 C's recommended by WHO: informed Consent, Confidentiality, Counselling, Correct test results and linkage to Care, treatment and other services.

Prevention

Individuals can reduce the risk of HIV infection by limiting exposure to risk factors. Key approaches for HIV prevention, which are often used in combination, include:

1. Male and female condom use

Correct and consistent use of male and female condoms during vaginal or anal penetration can protect against the spread of sexually transmitted infections, including HIV. Evidence shows that male latex condoms have an 85% or greater protective effect against the sexual transmission of HIV and other sexually transmitted infections (STIs).

2. Testing and counselling for HIV and STIs

Testing for HIV and other STIs is strongly advised for all people exposed to any of the risk factors so that they can learn of their own infection status and access necessary prevention and treatment services without delay. WHO also recommends offering testing for partners or couples.

3. Voluntary medical male circumcision

Medical male circumcision, when safely provided by well-trained health professionals, reduces the risk of heterosexually acquired HIV infection in men by approximately 60%. This is a key intervention in generalized epidemic settings with high HIV prevalence and low male circumcision rates.

4. Antiretroviral-related prevention

4.1 Antiretroviral treatment as prevention (TasP)

A 2011 trial has confirmed if an HIV-positive person adheres to an effective antiretroviral therapy regimen, the risk of transmitting the virus to their uninfected sexual partner can be reduced by 96%. For couples in which one partner is HIV-positive and the other HIV-negative, WHO recommends offering ART for the HIV-positive partner regardless of her/his CD4 count.

4.2 Pre-exposure prophylaxis (PrEP) for HIV-negative partner

Oral pre-exposure prophylaxis (PrEP) of HIV is the daily use of ARV drugs by HIV-uninfected people to block the acquisition of HIV. Studies have demonstrated the effectiveness of PrEP in reducing HIV transmission among serodiscordant heterosexual couples (where one partner is infected and the other is not), men who have sex with men, transgender women, high-risk heterosexual couples, and people who inject drugs. WHO encourages countries to undertake projects to gain experience in implementing PrEP safely and effectively.

In July 2014, WHO released "Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations" which recommended the following:

- All key population groups: Where serodiscordant couples can be identified and where additional HIV

prevention choices for them are needed, daily oral PrEP (specifically tenofovir or the combination of tenofovir and emtricitabine) may be considered as a possible additional intervention for the uninfected partner (conditional recommendation, high quality of evidence).

- Men who have sex with men: Among men who have sex with men, PrEP is recommended as an additional HIV prevention choice within a comprehensive HIV prevention package (strong recommendation, high quality of evidence). Post-exposure prophylaxis for HIV (PEP)

Post-exposure prophylaxis (PEP) is the use of ARV drugs within 48 hours of exposure to HIV in order to prevent infection. PEP is often recommended for health-care workers following needle stick injuries in the workplace. PEP includes counselling, first aid care, HIV testing, and depending on risk level, administering of a 28-day course of ARV drugs with follow-up care.

5. Harm reduction for injecting drug users

People who inject drugs can take precautions against becoming infected with HIV by using sterile injecting equipment, including needles and syringes, for each injection.

A comprehensive package of interventions for HIV prevention and treatment includes:

- needle and syringe programmes;
- opioid substitution therapy for

people dependent on opioids and other evidence based drug dependence treatment;

- HIV testing and counselling;
- HIV treatment and care;
- access to condoms; and
- management of STIs, tuberculosis and viral hepatitis.

6. Elimination of mother-to-child transmission of HIV (eMTCT)

The transmission of HIV from an HIV-positive mother to her child during pregnancy, labor, delivery or breastfeeding is called vertical or mother-to-child transmission (MTCT). In the absence of any interventions HIV transmission rates are between 15-45%. MTCT can be nearly fully prevented if both the mother and the child are provided with antiretroviral drugs throughout the stages when infection could occur.

WHO recommends a range of options for prevention of MTCT (PMTCT), which includes providing ARVs to mothers and infants during pregnancy, labour and the post-natal period, or offering life-long treatment to HIV-positive pregnant women regardless of their CD4 count. New guidelines for PMTCT will be issued in 2013.

In 2013, 67% [62–73%] of the estimated 1.4 million pregnant women living with HIV in low- and middle-income countries received effective antiretroviral drugs to avoid transmission to their children, up from 47% in 2010.

Treatment

HIV can be suppressed by combination ART consisting of 3 or more ARV drugs. ART does not cure HIV infection but controls viral replication within a person's body and allows an individual's immune system to strengthen and regain the capacity to fight off infections. With ART, people living with HIV can live healthy and productive lives.

Approximately 11.7 million people living with HIV in low- and middle-income countries were receiving ART at the end of 2013. About 740 000 of those were children.

In 2013, there was a large increase in number of people on ART in low- and middle-income countries --2 million-- in a single year.

Paediatric coverage is still lagging behind with 1 in 4 children on ART, compared to 1 in 3 adults. Of all adults living with HIV, 38% were receiving treatment however just 24% of all children living with HIV were receiving these lifesaving medicines in 2013.

WHO response

Since the beginning of the epidemic, WHO has been leading the global health sector response to HIV. As a cosponsor of the Joint United Nations Programme on AIDS (UNAIDS), WHO leads on the priority areas of HIV treatment and care, and HIV/tuberculosis co-infection, and jointly coordinates with UNICEF the work on the elimination of mother-to-child transmission of HIV.

In 2011, WHO Member States adopted a new "Global health sector strategy on HIV/AIDS for 2011-2015".

The strategy outlines four strategic directions to guide actions by WHO and countries for five years:

- Optimize HIV prevention, diagnosis, treatment and care outcomes.
- Leverage broader health outcomes through HIV responses.
- Build strong and sustainable health systems.
- Address inequalities and advance human rights.

WHO's core activities on HIV also include:

- synthesizing the evidence on the effectiveness, feasibility and safety of HIV interventions and approaches, and guiding the HIV research agenda;
- articulating policy options for national HIV programmes;
- improving the availability and quality of HIV-related medicines and diagnostics tools;
- setting norms and standards for scaling up HIV prevention, diagnosis, treatment, care and support services;
- providing technical support to countries to build national capacity to plan, implement, monitor and evaluate effective HIV responses;
- monitoring and reporting on progress in the health-sector response towards achieving universal access to HIV services, including coverage and impact of HIV services; and
- leading global efforts and facilitating cohesion and collaboration among partners to

achieve the HIV-related Millennium Development Goals and the targets set out in the Global health sector strategy on HIV/AIDS, 2011-2015.

Source:

World Health Organization, "HIV/AIDS,"
Fact sheet N°360, updated July 2014.
<http://www.who.int/mediacentre/factsheets/fs360/en/>

Learn More:

**Global Update on the Health
Sector Response to HIV/ July
2014, WHO**
<http://apps.who.int/iris/>

Discussion:

1. What did you already know about HIV/AIDS before reading this article?
2. What new things did you learn?
3. If you could tell a friend one thing about HIV/AIDS, what would it be?

MALARIA

Mystery diseases inspire a special terror in the West. Buried in our psyche lies the idea that a new Black Death will one day appear, shattering the medical protection we have built over the years. Horror films are made about killer viruses sweeping Britain but even they look mild compared to some of the hysteria emanating from the Government.

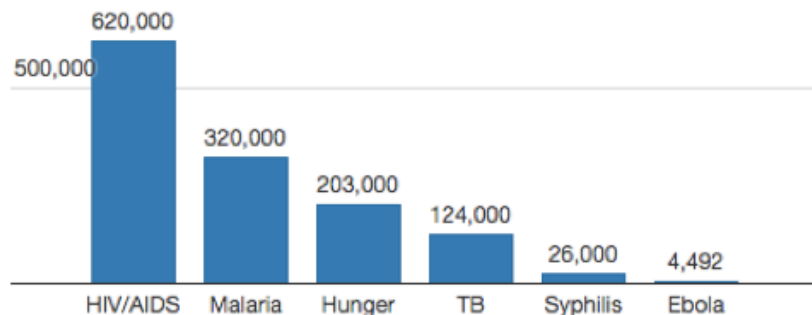
Perhaps this explains the panicky reaction to Ebola. It's hardly a new disease, having emerged (and been defeated) several times before – but it has never been as big as it is now. It's certainly gruesome, killing seven in 10 people it infects with symptoms including bleeding from the eyes and ears. There are 4,500 dead so far and there are fears that

there could be 10,000 new infections a week by the end of the year.

All of this seems to confirm an old suspicion about Africa: that it is a continent of poverty and scourges, capable of incubating what might be the next big pandemic. In fact, the disease has affected just five of Africa's 53 countries, and in two of them – Nigeria and Senegal – its progress seems to have been halted. While it is contagious (through bodily fluids, rather than by air) the largest district of Sierra Leone, Koinadugu, had (until yesterday) been able to say it is Ebola-free after observing basic border checks. The disease is spreading exponentially in certain places but Africa is not, yet, at its mercy.

Africa's killers

The number of deaths from different causes in Africa since the Ebola outbreak began in March this year (estimates based on WHO's 2012 Global Burden of Disease data)



Since Ebola emerged seven months ago it has claimed thousands of lives in Africa, which certainly makes it deadlier than Sars or Avian Flu. But over these same seven months, 40 times as many people will have died from basic hunger and 70 times as many Africans will have been killed by malaria – both basic, avoidable conditions that have dogged mankind from the beginning of time. So where is the anger about this?

If anything, Africans dying from malaria should cause far outrage than Ebola – given that we know perfectly well how to overcome malaria. Basic tools like insecticides, mosquito nets and sanitation can eradicate the disease. With enough resources, malaria can be snuffed out – as was proved in Sri Lanka when a US-led campaign brought the annual death toll down from 92,000 to just 17. And this was in back in 1963, when the tools available to fight malaria were far harder to come by. Various agencies, like the Bill & Melinda Gates Foundation, have made striking progress in recent years, but malaria remains a bigger killer now than Ebola is ever likely to be.

The root problem is a far more basic one: poverty. The countries now battling Ebola – Guinea, Sierra Leone and Liberia – are among the poorest in the world with a pitiful health infrastructure. Foreign aid can help if it encourages a basic health service. But sending armies of aid workers can undermine a country's ability to

set up a normal health service – if the work is being done by outsiders, who are working on specific projects. Jim Yong Kim, a doctor who now runs the World Bank, has said that Ebola would have been contained if it broke out in Rwanda because it used donor money to build a proper health system after its genocide.

One of the greatest stories of the last decade is the extraordinary economic growth of sub-Saharan Africa – and how this is quickly translating into poverty reduction, cutting death rates from its everyday diseases. Child mortality is falling at the fastest rate in history. Malaria, too, is in fast decline as ordinary Africans can afford protection, rather than wait to have it handed out by an aid agency. Deaths from measles are down by 80 per cent over the last 10 years. HIV infections, so long the scourge of Africa, are down by a third over the same period. The United Nations envisages the epidemic being vanquished by the end of the next decade, which would be a monumental achievement.

Only this week, it emerged that hunger in Africa has fallen by a quarter over the past 25 years – an incredible achievement which will have saved millions upon millions of lives. Better-fed bodies can better fight disease; a mother is a hundred times more likely to die in childbirth in a poor country than she is a rich one. Steadily, Africans are closing the gap with the rich world. Blessed with the oil and minerals that fetch such a high price in world markets, the continent is

becoming richer, and converting this into prosperity. The result is a golden age of poverty reduction.

Not all of the continent is growing at the same pace and in the same way, which explains why the Ebola has moved so quickly in countries which have nothing resembling a decent healthcare system. But their story is not Africa's story. The continent is making more progress against its the main killers than at any point time in modern history, so it can realistically look forward not just for to end of Aids, but to end of poverty as we know it today. The Ebola tragedy is a setback in a greater war against disease and poverty – but it is a war which Africans are steadily winning.

Adapted from:

Nelson, F., "Ebola may be gruesome but it's not the biggest threat to Africa," The Telegraph, October 17, 2014.
<http://www.telegraph.co.uk/news/worldnews/ebola/11167158/Ebola-may-be-gruesome-but-its-not-the-biggest-threat-to-Africa.html>

Discussion

1. What role does the media play in setting public health priorities?
2. What role should the media play in setting public health priorities?
3. Why does the author say, "if anything, Africans dying from malaria should cause far outrage than Ebola?"

CASE STUDY: THE FEAR THAT KILLED EIGHT EBOLA WORKERS

They were sent in to help educate villagers about how to ward off the lethal virus. Then fear took over and the machetes came out.

At the time of Wednesday's announcement out of Guinea that seven of nine missing Ebola workers had been found dead, we knew little. Men with knives had abducted members of a group sent there to spread awareness about the disease. Two relief workers were missing; the rest, dead. Six suspects were in custody.

By Friday morning, we knew more. These details, the stuff of horror films. A local government group of relief workers—a mix of doctors, religious leaders, and journalists—had arrived Monday to educate the remote southeastern village of Womey about Ebola. Just 24 hours after their arrival, violence broke out, allegedly sparked by the false belief that a disinfectant being sprayed was actually the disease itself. An angry mob brandishing machetes, stones, and knives lashed out.

Some of the relief workers were lucky enough to escape to nearby villages. At least nine were not. Three had their throats slashed. By then, villagers themselves began to flee. Those

still in Womey cut down trees and fashioned makeshift blockades so no one else could get inside the village. Two days later, when authorities did, they found eight bodies in the latrine system of the local school. Among the dead, three local radio journalists, two medical officers, and a preacher.

It's difficult to refrain from instantly demonizing the perpetrators, or focus on anything other than their crime. In a story so horrific, the grisliest details win the audience. The killers murdered, in cold blood, the very people that came to save them. It's easy to call such actions evil—but entirely irresponsible to declare, with absolute certainty, that they were driven by anything less than unimaginable fear.

In an environment of uncertainty, fixating on the accused is comforting. Men can be captured, arrested, imprisoned. They're a conquerable enemy. But that narrative, the one of senseless, blood-hungry murderers roaming the villages of West Africa serves no one. The truth is likely more nuanced and, as such, more terrifying.

The truth is that a horrific, incurable virus is ravaging Guinea—and at least three other countries in West Africa. That there is a rapidly shrinking

number of doctors left to treat the thousands who are already sick and the millions that could be next. That the vast majority of those who enter hospitals, never come out. That, in the absence of an explanation as to why, paranoia takes over. That a few white and Western-trained doctors have intentionally used disease to harm Africans in the past. That this unfortunate truth makes the heroic ones fighting courageously there now, the object of a very real fear.

We know little about the identity of the six suspects, but a lot about the country in which they live. With an estimated population of 11 million, Guinea has one of the lowest literacy rates in the world. More than half of the population lives below the poverty line, and 20 percent in extreme poverty. UNICEF estimates that less than 50 percent have access to clean drinking water. In 2013, the International Monetary Fund measured Guinea's gross domestic product per capita at just \$564 (in the U.S. the same year it was \$53K). Since March, a country already struggling to meet the basic needs of its citizens has been battling a lethal disease they have never seen. Without a cure for the virus, more than half of those infected die within days of contracting it. With the rate of physicians per 1,000 citizens at less than 1 percent, there aren't enough doctors in the whole country to explain why.

According to the World Health Organization's most recent report, there have already been over 950

confirmed cases of Ebola in Guinea—a set of numbers which the director of the organization called a “vast underestimate” of the reality. Over 600 of those cases have resulted in death. In all of Guinea, there are just two official Ebola Treatment Centres, bringing the total capacity of beds to 130—which meets less than 13 percent of the demand. Out of the small number of health care workers in the nation, 60 have already been infected. Thirty-one have died.

By the time the Ebola workers arrived to Womey—on a vital mission that may have very well helped it—the village was likely overcome by fear and panic. Two months earlier in Kolo Bengou, a remote part of Guinea 400 miles from the capital, terrified villagers attacked ambulances and dismantled bridges to keep doctors out. In Guéckédou the same month, reported *The New York Times*, a local leader perpetuated the mistrust, telling his people: “There is no root, no leaf, no animal that can cure you. Don't be fooled.”

Uninvited strangers in hazmat suits could alarm even the stables of communities. But in a village crippled by poverty, tyrannized by war, and now suddenly overcome with a strange new illness, it is likely scarier than the wildest of nightmares. The men who killed these courageous workers committed a heinous crime. Perhaps they were simply depraved. Perhaps, instead, they had reached a desperation we can't quite fathom. Perhaps they were merely

trying to protect their families, their friends, their community and truly believed that this was the only way. Condemning them obscures the larger message to be taken from this atrocious crime. It is Ebola that is still winning. Ebola, not those who it has driven to commit evil acts, that is the true enemy.

Terry O'Sullivan spent three years treating hemorrhagic fever in neighboring Sierra Leone and saw the need for treating powerless, poor communities with sensitivity. "This tragic event highlights both the tremendous power of rumors and fear of the unknown," he said, now as the director of the Center for Emergency Management and Homeland Security Policy Research. "That applies to both local politicians—who, in countries like Sierra Leone, often treat poor rural villagers callously—as well as outsiders coming in with assurances that what they know what's best."

It's a lesson that's been learned much closer to home, too, O'Sullivan said. "As Americans found out during the early years of the HIV AIDS crisis, fear of a deadly unknown disease can cause people to react negatively—even violently—out of fear."

Adapted from:

Zadrozny, B., "The Fear that Killed Eight Ebola Workers," The Daily Beast, September 9, 2014. <http://www.thedailybeast.com/articles/2014/09/20/eight-ebola-workers-bodies-found-in-latrine.html>

Discussion

Though public health is not often thought of a dangerous field, this article sheds light on a significant occupational risk.

1. What went wrong? Why did it go wrong?
2. What do you think these Ebola workers could have done to prevent the out lash that occurred?
3. What other occupational risks might be associated with public health?

MATERNAL MORTALITY

Key facts

- Every day, approximately 800 women die from preventable causes related to pregnancy and childbirth.
- 99% of all maternal deaths occur in developing countries.
- Maternal mortality is higher in women living in rural areas and among poorer communities.
- Young adolescents face a higher risk of complications and death as a result of pregnancy than older women.
- Skilled care before, during and after childbirth can save the lives of women and newborn babies.
- Between 1990 and 2013, maternal mortality worldwide dropped by almost 50%.
- Maternal mortality is unacceptably high. About 800 women die from pregnancy- or childbirth-related complications around the world every day. In 2013, 289 000 women died during and following pregnancy and childbirth. Almost all of these deaths occurred in low-resource settings, and most could have been prevented.

Progress towards achieving the fifth Millennium Development Goal "Improving maternal health" is 1 of the 8 Millennium Development Goals (MDGs) adopted by the international community in 2000. Under MDG5, countries have committed to reducing maternal mortality by three quarters between 1990 and 2015. Since 1990, maternal deaths worldwide have dropped by 45%.

In sub-Saharan Africa, a number of countries have halved their levels of maternal mortality since 1990. In other regions, including Asia and North Africa, even greater headway has been made. However, between 1990 and 2013, the global maternal mortality ratio (i.e. the number of maternal deaths per 100,000 live births) declined by only 2.6% per year. This is far from the annual decline of 5.5% required to achieve MDG5.

Where do maternal deaths occur?

The high number of maternal deaths in some areas of the world reflects inequities in access to health services, and highlights the gap between rich and poor. Almost all maternal deaths (99%) occur in developing countries. More than half of these deaths occur in sub-Saharan Africa and almost one third occur in South Asia.

Look at the chart below to compare MMR across selected countries.

Country	Maternal deaths per 100,000 live births in 2013
Iceland	4
Denmark	5
Japan	6
United States	28
Panama	85
South Africa	140
Rwanda	320
Zimbabwe	470
Sierra Leone	1,100

Source: <http://data.worldbank.org/indicator/SH.STA.MMRT>

The average maternal mortality ratio in developing countries in 2013 is 230 per 100 000 live births versus 16 per 100 000 live births in developed countries. There are large disparities between countries, with few countries having extremely high maternal mortality ratios around 1,000 per 100,000 live births. There are also large disparities within countries, between women with high and low income and between women living in rural and urban areas.

The risk of maternal mortality is highest for adolescent girls under 15 years old and complications in pregnancy and childbirth are the leading cause of death among adolescent girls in developing countries.

Women in developing countries have on average many more pregnancies than women in developed countries, and their lifetime risk of death due to pregnancy is higher. A woman's lifetime risk of maternal death – the probability that a 15 year old woman will eventually die from a maternal cause – is 1 in 3,700 in developed countries, versus 1 in 160 in developing countries.

Why do women die?

Women die as a result of complications during and following pregnancy and childbirth. Most of these complications develop during pregnancy. Other complications may exist before pregnancy but are worsened during pregnancy. The major complications that account for

nearly 75% of all maternal deaths are:

- Pre-existing conditions
- Severe bleeding
- Pregnancy-induced high blood-pressure
- Infections
- Obstructed labor and other
- Abortion complications
- Blood clots/embolism

The remainder are caused by or associated with diseases such as malaria, and AIDS during pregnancy.

Maternal health and newborn health are closely linked. Almost 3 million newborn babies die every year⁴, and an additional 2.6 million babies are stillborn.

How can women's lives be saved?

Most maternal deaths are preventable, as the health-care solutions to prevent or manage complications are well known. All women need access to antenatal care in pregnancy, skilled care during childbirth, and care and support in the weeks after childbirth. It is particularly important that all births are attended by skilled health professionals, as timely management and treatment can make the difference between life and death.

Severe bleeding after birth can kill a healthy woman within hours if she is unattended. Injecting oxytocin immediately after childbirth effectively reduces the risk of bleeding.

Infection after childbirth can be eliminated if good hygiene is practiced and if early signs of infection are recognized and treated in a timely manner.

Pre-eclampsia should be detected and appropriately managed before the onset of convulsions (eclampsia) and other life-threatening complications. Administering drugs such as magnesium sulfate for pre-eclampsia can lower a woman's risk of developing eclampsia.

To avoid maternal deaths, it is also vital to prevent unwanted and too-early pregnancies. All women, including adolescents, need access to contraception, safe abortion services to the full extent of the law, and quality post-abortion care.

Why do women not get the care they need?

Poor women in remote areas are the least likely to receive adequate health care. This is especially true for regions with low numbers of skilled health workers, such as sub-Saharan Africa and South Asia. While levels of antenatal care have increased in many parts of the world during the past decade, only 46% of women in low-income countries benefit from skilled care during childbirth⁶. This means that millions of births are not assisted by a midwife, a doctor or a trained nurse.

In high-income countries, virtually all women have at least 4 antenatal care visits, are attended by a skilled health worker during childbirth and receive postpartum care. In low-income countries, just over a third of all pregnant women have the recommended 4 antenatal care visits.

Other factors that prevent women from receiving or seeking care during pregnancy and childbirth are:

- poverty
- distance
- lack of information
- inadequate services
- cultural practices

To improve maternal health, barriers that limit access to quality maternal health services must be identified and addressed at all levels of the health system.

WHO response

Improving maternal health is one of WHO's key priorities. WHO is working to reduce maternal mortality by providing evidence-based clinical and programmatic guidance, setting global standards, and providing technical support to Member States.

In addition, WHO advocates for more affordable and effective treatments, designs training materials and guidelines for health workers, and supports countries to implement policies and programs and monitor progress.

During the United Nations MDG summit in September 2010, UN Secretary-General Ban Ki-moon launched a Global strategy for women's and children's health, aimed at saving the lives of more than 16 million women and children over the next 4 years. WHO is working with partners towards this goal.

Source:

World Health Organization. "Maternal Mortality," Fact sheet N°348, Updated May 2014. <http://www.who.int/mediacentre/factsheets/fs348/en/>

Discussion:

1. What disparities are mentioned in this excerpt?
2. What surprised you when reading about maternal mortality?
3. What can be done to prevent maternal (and infant) mortality?

Action:

1. This article presented a lot of statistics. Sometimes, when presented with too many statistics the public loses attention and focus. It is your job to pick the numbers that have the most impact. Pick three statistics to share with the public.
2. Explain why you picked those three statistics.
3. Write a public service announcement or design a poster using these three statistics to communicate your message about preventing maternal mortality.

NUTRITION

Ten Point Plan for Tackling Malnutrition

The Generation Nutrition campaign brings together a diverse and growing group of civil society organizations who wish to see an end to child deaths from acute malnutrition. Below is an excerpt from their Ten-Point Plan report.

We call on governments and other relevant stakeholders to:

1. Recognize acute malnutrition as a leading cause of child death

Twenty-five years from the signing of the UN Convention on the Rights of the Child, states should reaffirm the commitment they made in the text to enable every child to enjoy the "highest attainable standard of health" and "to combat disease and malnutrition". Tackling acute malnutrition should be made a central part of ongoing government efforts to reduce child mortality.

2. Fully acknowledge that acute malnutrition is an 'everyday emergency' by including treatment and prevention in long-term health and development programs.

While acute malnutrition is generally associated with humanitarian crises and famines, most of the children suffering from acute malnutrition live in stable, development settings. Donors and governments in affected countries must ensure that from now on the prevention and treatment of acute malnutrition are also embedded

in long-term health and development programs and are adequately funded (see also point 5 below).

3. Integrate Community-based Management of Acute Malnutrition into child health services and increase coverage for the treatment of severe acute malnutrition. As a first step towards ensuring universal coverage, countries with high rates of acute malnutrition must ensure that the community-based management of acute malnutrition (CMAM) is properly integrated into national health services. To break the 'vicious circle' of acute malnutrition and infectious disease, greater efforts must be made to combine the diagnosis and treatment of acute malnutrition with interventions available for malaria, tuberculosis, diarrhea and pneumonia.

4. Strengthen health systems to enable long-term expansion and affordability of CMAM and other health interventions.

Integrating CMAM into health care services needs to be accompanied by a strengthening of these services overall. National governments, with the support of the international community, should prioritize health system strengthening, with the aim of making services more affordable/free of charge, effective and widely available in different parts of the country.

5. Donors to increase long-term funding for the prevention and treatment of acute malnutrition and (in non-crisis situations) move away from short-term emergency funding mechanisms.

In the case of acute malnutrition, most external funding for CMAM continues to be in the form of humanitarian aid and there is little funding dedicated to prevention programs targeting children under five. International donors should scale up their funding for both the treatment and prevention of acute malnutrition through long-term funding mechanisms which support the implementation of SUN countries' 'costed' national plans.

Another term for acute malnutrition is 'wasting', a word which perhaps better conveys what actually happens to a child with the condition: the body literally wastes away.

6. Establish national wasting targets to help focus efforts on tackling acute malnutrition.

In 2012, the World Health Organization (WHO) agreed a global plan on nutrition, which included a target for reducing the global rate of acute malnutrition to below 5% by 2025. Building on this, all high-burden countries should now establish national wasting targets, which would help focus domestic attention on this task and help ensure a joined-up effort across a range of sectors.

7. Address acute malnutrition in the post-2015 development framework.

A specific target on wasting should be included within the post-2015 development framework, as part of a broader goal on nutrition or food and nutrition security. The target should go beyond the ambition of the 2025 WHA target, committing states to a more significant reduction in the rates of acute malnutrition and setting them on a clear path towards ending under-five deaths from the condition.

8. Support more research on the relationship between wasting and stunting and also on the other long-term health effects of wasting.

We know that there is a causal link between wasting and stunting (for example bouts of acute malnutrition can contribute to stunting) but this area is still not fully understood by academia or development actors. Similarly, there has been little research conducted into the various effects in later life of an episode of acute malnutrition in childhood. Governments should therefore prioritize the funding of more research on these two themes. This would help in the design of more effective prevention programs.

9. Develop new ways to tackle moderate acute malnutrition.

It would probably be too costly to scale up supplementary feeding programs to a national level and there are doubts about their effectiveness (they are probably best suited to crisis situations). Alternative models, including the use of cash-based approaches, are being

piloted and should be supported. In general, there is a need to invest more in the prevention of MAM through cross-sectorial initiatives and improved nutrition-sensitive programming.

10. Ensure that there is a coordinated strategy by UN agencies on acute malnutrition.

At present three different UN agencies are involved in efforts to tackle acute malnutrition (UNICEF, WHO and World Food Programme). This has tended to reinforce a silo approach in relation to SAM and MAM at the national level. These barriers should be broken down, with the development of a coordinated strategy by UN agencies on the issue.

Source:

Hobbs, B. and Bush, A. "Malnutrition: An everyday emergency. A 10-point plan for tackling acute malnutrition in under-fives," Generation Nutrition, April 2014.
http://www.generation-nutrition.org/sites/default/files/editorial/acute_malnutrition_an_everyday_emergency_low_res.pdf

Discussion:

1. What is the role of the donor community?
2. What is the role of the national government?
3. What is the role for the research community?

CASE STUDY: NUTRITION IN NIGER

The Situation

Malnourished children are among the most vulnerable in Niger, one of the world's poorest countries. Niger came in last (182nd) in the 2009 ranking of the Human Development Index¹ and had a poverty rate estimated at 59.5 per cent in 2008.

In normal times, stunting rate of children in Niger is over 50 per cent, one of the highest in the world. Stunted children are those who are too short for their age and have experienced impaired growth and cognitive development, which is generally considered irreversible.

In June 2010, the rate of acute malnutrition (low weight in comparison to height) in Niger was 16.7 per cent in children under five, a figure well above the emergency threshold of 15 per cent and the 12.3 per cent estimated for 2009. In some regions, such as Diffa and Maradi, it stood at 22.1 per cent and 19.7 per cent, respectively, as compared with 17 per cent and 13.1 per cent in 2009. Similarly, the rate of severe acute malnutrition, which considerably increases the risk of infant mortality, raised from an average of 2.1 per cent in 2009 to 3.2 per cent in 2010. In November 2010, the overall rate for severe acute malnutrition reached 15.5 per cent, while the rate for overall acute malnutrition remained unchanged.

Malnutrition, the leading cause of infant mortality and morbidity in Niger, is significantly affected by food insecurity. However, other causes are also important, such as illness, poor sanitary conditions and hygiene practices, and poor infant and young child feeding practices. Dietary practices, limited access to health services and the limited access to drinking water are all factors which are underlying causes of illness and an inadequate diet.⁵ When children suffer from malnutrition, their immune system is affected. Common illnesses like malaria or diarrhoea may lead to complications, and the risk of death is very high. Yet malnutrition can be treated, and preventive action is possible.

As a result of the meagre farming and stockbreeding season for the year 2009–2010, Niger was hit by a serious food crisis in 2010. The analysis of the current food crisis in households conducted by the government in April 2010 shows that severe food insecurity affected 22.2 per cent of the population or some 3.3 million people, whereas moderate food insecurity hit 25.5 per cent of the population or 3.3 million people. Moderate and severe food insecurity affected 47.7 per cent of the population, or 7.1 million people.

Facts and figures

- Today, throughout the world, one billion people suffer from malnutrition.
- Every year, more than six million children die of complications due to malnutrition.
- Every day, 25,000 people, mainly children, die of malnutrition.
- In Africa, one-third of all children suffer from malnutrition.
- In Niger, only 9.9 per cent of children under six months are 100 per cent breastfed, and this percentage is lower still for uneducated mothers.
- Forty per cent of the country's population has no access to drinking water.
- Eighty per cent of households in Niger do not have their own latrines.
- In Niger, 96 per cent of people in the countryside and 57 per cent in cities do not have access to adequate sanitation.
- The Red Cross and Red Crescent combat malnutrition in the countries that are worst affected.
- In Niger, the Red Cross is active in 66 IHCs and three CRENI in district hospitals in the regions of Zinder, Agadez and Niamey.

Action

The French Red Cross has been present in Niger since 1998. It has established cooperation ties with the Niger Red Cross to combat malnutrition in the regions of Niamey, Agadez and Zinder, and has set up programmes to fight against malnutrition on a long-term basis.

Capacity-building

The Red Cross programmes support capacity-building for health agents who are trained in the national protocols for the treatment of malnutrition. Under these programmes, integrated health centres (IHCs) are equipped with anthropometric material (scales and height gauges) for evaluating children's nutritional status, as well as medical equipment to ensure a thorough examination of children when they arrive at the IHC. Therapeutic foods are provided for treatment.

Partnership

The French Red Cross approach focuses on enabling public health centres to treat malnourished children. Integrating programme activities into structures managed by the Ministry of Health is an important approach to ensure sustainable impact of humanitarian action. It supports stronger long-term capacity to address public health and nutrition challenges.

By giving public health centre staff the mandate and training to treat malnourished children, important skills are developed, practiced and institutionalized. Health centres can deal with children's health from a holistic perspective. Working together with the Ministry of Health helps ensure the long-term viability of projects and closer proximity to the public. These public health centres existed before the Red Cross interventions, and will continue to exist after they are completed.

Food Taboos

Food taboos and a lack of knowledge are among the underlying causes of malnutrition and are a real hindrance when it comes to improving children's health and nutritional status. Awareness-raising must be one of the pillars of the integrated programme approach in order to generate behavioural change in the population in general, and among mothers of children under five in particular.

-Ferdows Brah, French Red Cross

Screening and referral

In conjunction with its project "Community-based nutrition", the French Red Cross has trained volunteers from the Niger Red Cross to monitor the growth of children aged 0-36 months by means of active screening (using middle upper arm circumference, i.e., MUAC) and the seven essential family practices⁶ in 85 villages located in the health area of 14 IHCs. The volunteers build community awareness through messages relating to health and child nutrition, monthly growth monitoring (children aged 0-36 months are weighed with results noted on growth charts), as well as active screening of children for acute malnutrition (aged 37-59 months via measurement of MUAC). Children with a MUAC under 125 mm are referred to an IHC, where they are weighed and their height is measured. Their nutritional status is evaluated, and they are treated if they are suffering from moderate or severe acute malnutrition.

In the wake of the 2010 food crisis, the Red Cross introduced active screening in 253 villages in the health areas of 14 IHCs in Tanout health district (within a 10 km radius from the IHCs). Screening was conducted by five mobile teams composed of five members each (four Niger Red Cross volunteers and a male nurse as head of team), two team supervisors and a screening officer.

In all, 24,268 children aged 6-59 months benefited from active screening based on MUAC measurement. All children with a brachial perimeter under 125 mm were weighed and their height was measured by the teams in the villages. Children suffering from moderate or severe malnutrition or severe malnutrition with complications were referred to public health structures for treatment.

A total of 2,356 children were screened and referred to health structures for treatment. Among them, 2,072 were treated, that is 88 per cent (1,534 suffering from moderate acute malnutrition, 517 from severe acute malnutrition and 21 from severe acute malnutrition with complications). The remaining 284 children will be surveyed during the second round of active screening.

This type of screening is essential, because early detection of the pathology boosts a child's chances for survival. Children are referred to public health structures for evaluation of their nutritional status and

quality treatment. Screening is often conducted jointly with UNICEF and other organizations, so as to reach a greater share of the population and estimate the number of children suffering from this pathology. Engaging in awareness-raising in addition to screening is crucial, as this increases the possibility for behavioural change.

Treatment

The treatment of malnourished children varies depending on the degree of malnutrition. Moderately acute malnourished children are systematically treated with Vitamin A, iron, folic acid and mebendazole; their vaccination status is checked (measles vaccination if needed), and the mother is given therapeutic inputs (CSB7, oil and sugar in the form of a premix) to prepare as a baby cereal. In cases of severe acute malnutrition without complications, children are given "plumpy nut", a ready-to-use therapeutic food (RUTF). It is administered according to the child's weight. In the event of severe acute malnutrition with medical complications (malaria, acute upper respiratory infection, diarrhoea), children are referred to a district hospital, where they receive appropriate treatment (the IHCs are not authorized to treat cases involving medical complications). Following the medical consultations, mothers attend awareness-raising sessions organized by Red Cross volunteers, which focus on essential steps to ensure proper child nutrition, an adequate diet and

other preventive measures linked to hygiene and health promotion.

Depending on the type of programme (moderate acute malnutrition or severe acute malnutrition without complications), mothers come back either bi-weekly or weekly to have their child's nutritional status monitored and to receive supplementary food rations or RUTF provided by WFP and UNICEF. In this way, the Red Cross has reinforced existing health structures (in terms of skilled human resources, medical equipment, treatment facilities and medicine), which are now capable of treating malnourished children, regardless of the gravity of their state of health.

Awareness-raising

In addition, the Red Cross runs awareness-raising campaigns to increase knowledge of malnutrition and to identify acutely malnourished children in the villages and treat them in the IHCs.

These awareness-raising campaigns are conducted by Niger Red Cross volunteers, who have been trained in a number of key messages relating to children's health/nutrition, especially early and exclusive breastfeeding, complementary feeding, use of treated bed nets, and the importance of vaccination. The volunteers pass these messages on by means of the awareness-building sessions organized at the village level.

Results

The Red Cross is active in 66 IHCs and three CRENI (intensive nutritional recovery centres) in the district hospitals in the regions of Zinder, Niamey and Agadez.

For the year 2010, the number of beneficiaries by programme and by region may be broken down as follows:

In the centres where the Red Cross operates, the cure rate for acute mal-nourished children is 87 per cent. It is broken down as follows: 84 per cent for moderately acute mal-nourished children; 94 per cent for severely acute malnourished children without complications; and 91 per cent for severely acute malnourished children with complications. This difference is considered to be due to the fact that monitoring for children suffering from severe acute malnutrition is more thorough.

What about the long term?

Infant and young child feeding practices, limited access to health services, household dietary diversity, and the limited availability of drinking water are all factors that impact nutrition and health. The causes of malnutrition are multi-dimensional. Awareness-raising, screening and treatment for acute malnutrition must be supplemented by strengthened health and nutrition services which should also address problems of chronic malnutrition (stunting). Moreover, vulnerable populations must have access to drinking water, sanitation, and the means to practice good hygiene

behaviours. Improvement in food security is critical for vulnerable populations. It is necessary to strengthen livelihoods, thereby facilitating access to food. An integrated approach is critical to achieve impact over the long-term.

Source:

International Federation of the Red Cross and Red Crescent Societies.
<http://www.ifrc.org/PageFiles/113731/Tackling%20malnutrition%20in%20Niger-EN.pdf>

Discussion:

1. List all the causes of child malnutrition that you can think of.
2. What could you do, today, to help prevent child malnutrition?
3. Create a visual representation. Either make a flow chart of the screening process (including numbers of children at each phase) or a visual representation of treatment for various stages of malnutrition.

REFLECT: PAUL FARMER'S VISION FOR GLOBAL HEALTH

REFLECT: PAUL FARMER'S VISION FOR GLOBAL HEALTH

Humanitarian doctor Paul Farmer explains how global health is rooted in community. Paul Farmer is the co-founder of Partners in Health, professor at Harvard and Harvard Medical School, winner of a MacArthur Genius Grant, and author of "To Repair the World: Paul Farmer Speaks to the Next Generation."

He co-founded Partners in Health to help some of Haiti's poorest residents in 1987. Since then, Partners in Health has expanded all over the world, from Mexico, to Kazakhstan, to Peru. And as Partners in Health has grown, Paul Farmer has continued his devotion to caring for those who might never get quality medical care.

Inspiring Change

In 1994, the genocide in Rwanda captured Farmer's attention. The tragedy inspired him to visit the country and do what he could — help minimize the spread of tuberculosis and infectious disease.

"The idea that a million people could be killed in 100 days, I just thought it couldn't possibly be true — and it was true," he remembers. "I had a lot of reasons I wanted to go there,

and I finally did, and my colleagues at Partners in Health were on board. It has been one of the most wonderful experiences of my life to see the rapidity of that turnaround."

In Rwanda, Farmer continued the model that Partners in Health first developed in Haiti. Over the decade that he has worked there, the country has implemented community-based insurance, created clinics that provide the bulk of health care, and trained members of the community to be health workers. The results have been dramatic — Rwandan life expectancy has doubled since the 1994 genocide, and mortality rates have dropped sharply.

Such improvements have moved many, including former President Bill Clinton, to call Partners in Health's methodology innovative. But Farmer shrugs off the praise. "The idea that it's somehow innovative to serve the poor is kind of sad, right? Because it's not a new idea," Farmer says.

Commitment to Community

Partners in Health's work in Rwanda is indicative of the change it hopes to promote worldwide. Today, innovations in preventative medicine, diagnostics, and treatments are developing in tandem with changes in information technology. But despite

these exciting changes, Farmer says, one stubborn problem remains the same: access. Impoverished communities suffer from the inability to access existing medicine and technology. Farmer hopes to change that.

"But if we can build really strong delivery systems so that we have an ability to reach people who are in need ... then [when there are new medical innovations] we'll be able to deliver them," he explains.

As in Rwanda, Farmer promotes strengthening health care delivery by supplementing care from physicians with care by community health workers. These local deputies can help improve patient outcome by supporting individuals through the treatment process — ensuring that they take their medicine in between visits to a clinic, for example. Farmer believes this supplementary care can be vital in treating AIDS, epilepsy, diabetes and other chronic illnesses prevalent in developing countries.

He points to a Johns Hopkins study focusing on the treatment of AIDS, a disease in which patient outcomes corresponded with patient affluence. When researchers focused on facilitating medical delivery to poor AIDS patients, they found they were able to erase the gap in outcome almost entirely.

"[It's] a very powerful reminder that these are not some God-given, natural outcomes, that they are amenable to being addressed by improving our health care delivery system," Farmer says.

Farmer also stresses the importance of a long-term commitment to a community. Government funding and nonprofit involvement is often sparked by major events, like the Haitian earthquake of 2010. But Farmer argues that remaining in the community after normalcy returns, or training members of the community to maintain services in your absence, is essential to effect real change.

"A lot of NGOs and charity groups who came down [to Haiti] after the earthquake, they're gone," he says. "And these are problems that take a decade, two decades to address. So this ADD approach to foreign assistance is not really the right one."

Looking Forward

And with work in health care, there is no "mission accomplished" — only evolution. Farmer has seen child mortality, death during childbirth, and tuberculosis mortality shrink over the decade he has worked in Rwanda. But in their place, new problems emerge. Partners in Health now treats more patients with diabetes, mental illnesses, and other chronic diseases. It's the persistence of medical issues that makes health care a compelling problem we should all be invested in, Farmer argues.

"I think it's everybody's business," he says. "It's kind of like climate change. I wish I could discipline myself to find out more, and know what every citizen of the planet ought to know, because it's not someone else's problem. And that's how I think of health care equity. It's maybe even the ranking human rights problem of our time."

Source:

Miller, K. and Chapin, K. "Paul Farmer's Vision for Health," May 17, 2013. <http://wgbhnews.org/post/paul-farmers-vision-health>

Learn More:

Read his recent Atlantic article about the Rwandan health recovery here: <http://m.theatlantic.com/health/archive/2013/02/rwandas-historic-health-recovery-what-the-us-might-learn/273226/>

Video

Dr. Farmer's Remedy For World Health: Byron Pitts Meets A Man Who Dedicates His Life To Bringing Healthcare To The Poor
<http://www.cbsnews.com/news/dr-farmers-remedy-for-world-health/>

Discussion:

1. According to Dr. Farmer, what is the greatest remaining problem in Rwanda?
2. Explain the community health worker strategy and why you think Dr. Farmer advocates for it.
3. Imagine you have been working in the field of public health for 50 years. Write the speech that a colleague might deliver at a dinner honoring you for your work. Explain what motivated you, what you achieved, and how you did it. Be prepared to share.

THINK —
— IMPACT