International Agenda
Magazine of the Schoolcraft College International Institute (SCII)
Volume 18, Number 1 Winter 2019

Savage Inequalities

The Struggle for Global Health Equity

Jon Lascher / Partners In Health

A child in the Artibonite Valley region of Haiti receives the oral cholera vaccine in Spring 2012. Since an outbreak in that valley in Oct. 2010, the disease has killed more than 9,000 Haitians. The vaccine, Shanchol, must be retaken every six months, and Haiti is so poor that it must rely on outside aid agencies for much of its medical care.

See pages 8-33 for coverage of the 2019 Focus project,
"Exploring Physical & Mental Health Issues in a Global Environment".

International Agenda

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SCII
SCHOOLCRAFT COLLEGE INTERNATIONAL INSTITUTE

International Institute

Schoolcraft College
18600 Haggerty Road
Livonia, MI 48152-2696
http://www.schoolcraft.edu/scii/international-institute

The mission of the Schoolcraft College International Institute is to coordinate cross-cultural learning opportunities for students, faculty, staff, and the community. The Institute strives to enhance the international content of coursework, programs, and other College activities so participants better appreciate both the diversities and commonalities among world cultures, and better understand the global forces shaping people's lives.

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Take Our Survey!

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After looking through these pages, kindly complete a brief online survey about *International Agenda*. The survey collects feedback about this issue, and suggestions for future issues.

The survey can be accessed at this URL:
https://www.surveymonkey.com/r/3WJNBQB

SCII Meeting Schedule

International Institute meetings are open to all who want to learn or to help out. New folks are always welcome. Meetings are on Fridays at 12-2 pm in the Liberal Arts Building:

- January 25, 2019
- February 15, 2019
- May 10, 2019.

GlobalEYEzers

GlobalEYEzers, a group affiliated with SCII, meets over lunch to discuss current events relevant to international/ intercultural issues. Faculty and staff, as well as students and community members, are welcome. Meetings are on Fridays at 12-2 pm in the Liberal Arts Building, the next one on:

- February 22, 2019.

For more information, contact English Prof. Anna Maheshwari at amaheshw@schoolcraft.edu or 734-462-7188.

Campus News & Kudos

Kudos to the **Asian Students Association**, its faculty advisor **Anna Maheshwari** (English), and **Todd Stowell** (Student Activities Office), who led in organizing Schoolcraft's 12th annual Navratri Garba celebration on Friday, Oct. 12 at 7-12 pm in the VisTaTech Center. A catered dinner, authentic music, costume, and dance, and a marketplace were all part of celebrating this Hindu festival, which is traditionally a nine-day event held at the beginning of Autumn to regale the goddess Durga in hopes of a bountiful harvest. The ASA also organized a "Let's Naacho!" Bollywood dance competition on Sat., Oct. 20 at 4-9 pm at Northville High School. All proceeds from both events went to the Schoolcraft College Food Pantry to help students in need.

Schoolcraft's **Theatre Dept.**, under the direction of **Paul C. Beer**, presented Henrik Ibsen's play, "A Doll's House", in six performances between Oct. 26 and Nov. 10. On Sep. 24-25 the **Pageturners Book Club** screened a film version of the same play followed by discussion. This Winter, the Pageturners book discussions include, among others, Agatha Christie's *Murder on the Orient Express: A Hercule Poirot Mystery* in January, and Eric Weiner's *The Geography of Bliss: One Grump's Search for the Happiest Places in the World* in March. For more information, contact the Pageturners coordinator, English Prof. **Elzbieta Rybicka**, at tel. 734-462-7191 or e-mail erybicka@schoolcraft.edu.

The **Native American Club** organized a celebration of the Mexican festival *Dia de los Muertos* (Day of the Dead) on Oct. 31, featuring a potluck supper, a traditional *ofrenda*, and a screening of the PBS-TV documentary "Food for the Ancestors". Prof. **Karen Schaumann-Beltrán** (Sociology and Anthropology) is faculty advisor for the club. Students from her Sociology 209 class attended the event, along with others from Prof. Helen Ditouras's section of English 102 and Sandy Roney-Hays's section of Anthropology 211. The NAC also sponsored a cornhusk doll making workshop on Nov. 1, led by student **Chelsea Bridges**, a member of the Sault Ste. Marie Tribe of Chippewa.

John Brender, Director of the Confucius Institute at Wayne State Univ., gave a presentation about "Chinese and Japanese Values" on Nov. 8 in the Forum Theater. Dr. Brender has conducted ethnographic research on international and second-generation students at American colleges (Japanese, Chinese, Chaldean, and Asian Indian), and makes frequent presentations on cross-cultural communication in China and the U.S. In the past, he has taught Japanese, Spanish, linguistics, foreign-language teaching methodology, and English as a second language. •

On Fri., Nov. 16 in Lower Waterman, the **International Student Organization** (ISO) presented its third annual international fashion show (above). Accompanying the show was a Thanksgiving meal provided by the **Culinary Arts Program**, and a street fair that included traditional African bracelets and jewelry, along with free head-wrapping and henna styling. To learn more about ISO, visit https://www.facebook.com/SchoolcraftISO.

Discover Peru

May 25- June 3, 2019

Schoolcraft College World Languages Prof. Anita Süess Kaushik (asuess@schoolcraft.edu) is co-leading a 10-day Discover Peru tour this Spring. It will be the 12th such foreign study tour that Dr. Süess has led, with logistics handled by Explorica. The trip is not tied to any credit course, and community members are also welcome to join. Sites include the capital Lima, the Indian Market in Pisac, the ancient city of Cuzco and the Sacred Valley of the Incas, a train up to Machu Picchu (7,970 ft.), and Lake Titicaca. Go to www.explorica.com/SuessKaushik-1120 for more info and to sign up (deadline is Feb. 4 to avoid a late fee).

Students!

Enter the Winter 2019 *International Agenda* Writing and Artwork Contest

First Prize: $250 Scholarship
Second Prize: $150 Scholarship

…in each of the two categories, writing and artwork.

Winners from Fall 2018
Troy Priebe: First Prize, Artwork ($275) (see p. 6)
Pinky Patel: Second Prize, Artwork ($150) (see p. 6)
Marie Chantal Nyirahategekimana: First Prize, Writing ($275) and Third Prize, Artwork ($100) (see pp. 12, 44)

Prize funds are provided by Schoolcraft's Office of Instruction.

Submission Deadline: April 8, 2019

Guidelines:

1. Students (or their faculty mentors) may enter essays, research papers, persuasive writing, creative writing, poetry, or 2D or 3D artwork suitable for publication in *International Agenda*.
2. Works may deal with any topic of international or cross-cultural interest.
3. Submit a digital version of the writing or artwork as an e-mail attachment to the address below.
4. Submissions will be judged by a panel of faculty and staff volunteers based on content, originality, and aesthetics.
5. Entrants will be asked to sign a form affirming that the work is their own and permitting it to be used in the magazine.

For copies of the entry form and the complete set of rules, go to http://www.schoolcraft.edu/scii/international-agenda or else contact:

Randy Schwartz
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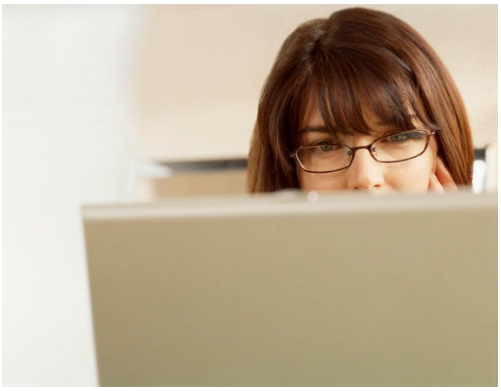
Readers!



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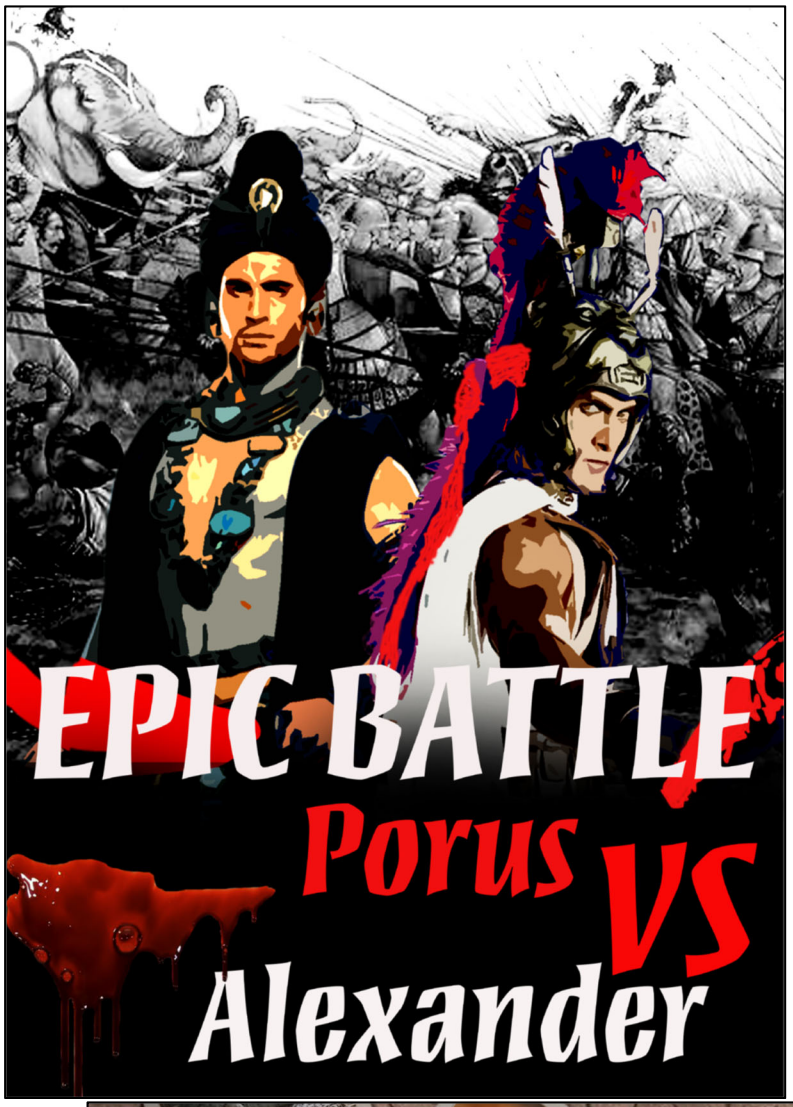


The Past and the Future

These two artworks were both created last Fall semester as part of a class project in a Wednesday night section of Computer Graphics Technology 226 (Digital Imaging 2 with Photoshop), taught by Prof. Michael Mehall.

"Epic Battle: Porus vs Alexander" is by Pinky Patel of Novi, MI. It depicts what's known by Western historians as the Battle of the Hydaspes, fought in 326 BCE between the troops of the Macedonian king, Alexander the Great, and those of King Porus, who ruled in what is now Punjab, Pakistan. Alexander was so impressed by the fierce resistance that after the battle, he asked Porus how he wished to be treated. When Porus replied, "Treat me as a king would treat another king", Plutarch reports: "Alexander not only permitted him to govern his former kingdom, giving him the title of satrap, but also added to it the territory of the independent peoples whom he subdued, in which there are said to have been 15 nations, 5000 cities of considerable size, and a great multitude of villages." The victory by Alexander opened up South Asia to Greek influence, which endured for centuries.

Troy Priebe's "The Future", below, asks: "What will we leave behind for our Great-Grandkids?". Troy told us, "When I was designing this piece I wanted people to feel a connection to it and get them really thinking about how their family members could be affected by what's happening today." Troy, 33, of Westland, MI, is majoring in web and interactive media. •

R U READY 4 THE WORLD?

In today's world, you can get a lot further if you're knowledgeable about other peoples, countries, and cultures. We asked a few successful people to write brief summaries of how international awareness has figured into their careers. Here's what they sent us…

I grew up in New York City, the melting pot of the world. I went to a school where families spoke more than 40 different languages. I learned about different countries and cultures and was able to see the world and the issues we face in the world through different lenses. I believe having this global exposure benefited me. For most of my 25 years working in the "real world", I have worked for global companies, companies that have offices and operations all over the world. I work on teams whose members are from faraway regions and where global competency skills are critical to the teams' success. Technology is making the world smaller and more connected. This is why I believe that along with problem solving, critical thinking, and collaboration skills, global competency is an essential skill to develop.

— Jaime Casap, Chief Education Evangelist, Google, Inc. (Phoenix, AZ)

At the White House, July 2015

I had little international awareness until my college years, when backpacking across Europe expanded my world view and interest in different cultures. After getting my studio arts degree, I worked as a private teacher for two American families who spent their Winters in Acapulco. The families were immersed in the fabric of Mexico: people, culture, cuisine, customs, music, language, and history. My everyday moments became charged with possibilities; the idea that we are influenced and swayed both by the seen and the unseen changed my life forever as a person and as an artist. In 2017, I was an invited artist in "Ofrendas: Celebrating el Día de Muertos", an exhibit at the Detroit Institute of Arts marking the Mexican Day of the Dead. These and many other experiences have enriched my life and international awareness. There is an inherent reward in knowing and connecting with people who are culturally diverse and who have much from which we can learn.

— Jeanne Penney, Detroit artist

The world has become a very small place. Throughout history, people separated by time and distance have evolved extremely diverse languages, cultures, philosophies, and religions. Each of these adaptations has something important to tell us. Today, this knowledge is accessible to everyone, and it is increasingly necessary that we engage with and learn from others the hard-won lessons of their unique histories. As a biologist and engineer, travelling and living in many countries on four continents, the knowledge, wisdom, and spirit of the wonderful people there have greatly enriched my life. Happily, it is not necessary to travel widely to encounter people from other places. Right here in Detroit, I have worked with engineers from countries too numerous to mention, and have volunteered with the Confucius Institute at Wayne State Univ. Our colleges host scholars from practically every country. Get to know them— what you discover about yourself and the world will amaze you.

— David R. Gimby, Engineer with Ford Motor Co. Global Fuel Systems

Savage Inequalities: The Struggle for

Should the quality of health care depend on the postal address of the patient? Should a child in El Salvador die from an illness that is curable in the United States?

"With childhood leukemia, the single biggest predictor of whether you recover or not is where you happen to have been born" laments Dr. Carlos Rodriguez-Galindo, Chairman of the Global Pediatric Medicine Department at St. Jude Children's Research Hospital in Memphis. The five-year survival rate for children with acute lymphocytic leukemia (ALL) is more than 80% in the U.S., but less than 20% in many poor countries. Dr. Rodriguez-Galindo has worked for years to transfer leukemia treatment know-how from the U.S. to El Salvador, pointing out: "We're talking about many thousands of young children dying every single year of diseases that we have known how to cure for decades."[1]

With so many lives in the balance, it's appropriate to use the term *savage inequalities* to describe such gaping health care disparities. It's also appropriate to bring this situation to the attention of young people, many of whom could devote their lives to what is already shaping up to be one of the great challenges of our century: the struggle for global health equity. This is why the International Institute selected the theme of "Exploring Physical & Mental Health Issues in a Global Environment" as a campus-wide focus of study for calendar year 2019. These annual focus projects have been hugely educational, challenging, and fun, helping to spread global awareness on campus and in the surrounding communities.

Since human health and human society are complex, the subject of global health is wide-ranging, encompassing all disciplines of the natural sciences, social sciences, and humanities. Even students in engineering and technology have a big role to play (see Ayush Arora's article on page 22-23). Our theme encourages a broad exploration of factors affecting health in regions around the world, including the impact of diet, hunger, exercise, and sports in various cultures; how attitudes and behaviors affect health and health treatments; the effect of nationality, class, gender, and urban/rural status on the incidence and treatment of depression, suicide, and other psychologies; the roles played by economics, politics, and race in the delivery of medical care; the importance of cultural awareness among health professionals; global health effects of climate change, environmental pollution, and war; women's health and reproductive health; maternal, neonatal, and infant mortality; the battle to control infectious diseases in diverse ecosystems; the danger of pandemics; the global pharmaceutical industry; the role of emerging technology in reaching underserved populations; the work of national and international medical organizations, foundations, and NGOs; the global history of medicine; and the status of traditional medicine.

A Public Health Transition on a World Scale

In 2018, we reached a tipping point: more than 50% of the world's population is now either middle-class or wealthy as defined by the World Data Bank. Further, the majority of those middle-class or wealthy people are now living in Asia, not in the West.

Daniel Berehulak/*New York Times*, Oct. 17, 2014

In 2014, Dr. Steven Hatch carries a malnourished, Ebola-stricken 9-year-old girl, Blessing Gea, into the high-risk Ebola ward established in Suakoko, Liberia by the Los Angeles-based charity International Medical Corps. Dr. Hatch, 45, an infectious disease specialist in Worcester, MA, volunteered to be part of the emergency response. After three days of treatment, Blessing recovered from the infection.

But a profound shift in public health is occurring in Asia and other developing regions. Back in 1990, in 16 of China's 33 provinces the main causes of premature loss of life were either respiratory infections or complications of premature births. Just one generation later, in 2013, in 27 provinces the leading cause was chronic cerebrovascular disease.[2]

Decades ago, countries such as the U.S. and Canada that have long been industrialized went through an *epidemiological transition*, a social shift in the preponderance of diseases from those of infants (such as respiratory infections, complications of premature birth, and malnutrition) to those of adults (such as cardiovascular and cerebrovascular diseases), placing correspondingly huge burdens on the health care systems of those countries. Today, however, as reflected in the above figures from China, we are increasingly seeing the *globalization* of this epidemiological transition. The consequences for the whole planet will be profound.

A Force for Global Unity?

Because the human body is fundamentally the same on every continent, and subject to the same afflictions, globalization has also laid the basis for coordinated assaults on public health problems. As Courtenay Holden puts it in her article about Our Children's Vision on pages 16-17, "A global challenge needs a global partnership."

Dr. Joia Mukherjee has recently written an undergraduate textbook on global health care delivery[3] that is grounded in the

Global Health Equity

social and historical factors underlying health disparities, as well as in the struggle to reduce those disparities by establishing sustainable access to care. Dr. Mukherjee is chief medical officer of the Boston-based Partners in Health (PIH), an organization that goes wherever health care needs are acute— Haiti, Peru, Sierra Leone, etc.— and forms long-term relationships with the poor there, with sister organizations, and with local governments to establish care programs, clinics, hospitals, health delivery training schools, and other infrastructure for medical treatment. In 2015, PIH founded the University of Global Health Equity in Kigali, Rwanda. Reflecting on the outlook that underlies her organization and her textbook, Dr. Mukherjee said: "Human beings to me are not more or less human depending on the nation state in which they were born. I want everyone to have access to health care."[4]

In a public address in Washington last Fall, Dr. Rita Charon (Columbia Univ.) suggested that the battle to protect and advance public health could become the primary force for world unity in the 21st Century:

> Maybe our medicine and science are forms of diplomacy, able to bridge divides, to transcend the interior conflicts…. By virtue of our commitment to human health, perhaps we can fuse these horizons between continents, between ideologies, between states, and envision and articulate a universal commitment to safeguard human health and to safeguard our planet.[5]

Universal Health Care: A Global Need

Since chronic diseases affect nearly all adults as they age, the epidemiological transition is accentuating the need for health care systems that cover everyone. Among public health experts, a consensus is emerging that the global emphasis needs to shift from trying to eradicate infectious diseases one by one, to in-

continued on next page

An Acute Crisis: Maternal Health and Infant Mortality

The physical rigors of pregnancy can take a hard toll on otherwise healthy women, and especially young girls; their susceptibility to influenza and many other diseases increases. Complications in pregnancy are the leading worldwide causes of death in girls aged 15-19. In Sierra Leone, about 1.2% of pregnant women end up dying from the pregnancy or childbirth.[15] The rate of life-threatening complications for African American mothers in New York City is comparable to that in Sierra Leone, and is 12 times as high as for white mothers in the same city.[16]

About 70% of the 1.4 billion people in the world who live in extreme poverty are women, and poverty compounds the lack of access to maternal health care. Lack of emergency obstetric care is especially serious. Around 5% of births may require a Caesarean section, but in a survey of East African countries in 2005, less than 1% of women there had access to such a procedure. Globally, about one billion women would be unable to get the urgent care needed if they had complications in pregnancy.[17]

Zack DeClerck / Partners In Health, 2018

Flora Tigone holds her 7-month-old son, Chisomo, during his treatment for severe malaria at Lisungwi Community Hospital in Neno District, Malawi, in Sep. 2018.

Currently, about 5.4 million children under the age of 5 die every year, and more than half of the deaths result directly or indirectly from starvation.[18] The health and nutrition of the mother is intertwined with that of her children:

- When a pregnant woman has any of various illnesses such as malaria, there is an increased likelihood of low birth weight and perinatal mortality.
- A healthy mother's breast milk provides the baby with crucial nutrients, antibodies, lactoferrins, and lymphocytes. Unfortunately, large corporations such as Nestlé and Danone have endangered infant health by internationally promoting the use of commercial infant formula, which has a different nutritional profile than breast milk and sometimes has chemical or microbial contaminants.[19]
- Kristin Lawless, a nutritionist and independent journalist, argues that infants' healthful microbiota have been disappearing due to the rise in Caesarean sections, overuse of antibiotics, and displacement of breastfeeding by commercial infant formula.[20]
- Since women tend to have disproportionate responsibility for infant and child care, they are more likely than men to transmit contagious illnesses to children.

The article on pp. 18-19 describes a program that has increased the accessibility of maternal health care in a small, remote area of Ghana.

Savage Inequalities *continued from page 9*

stead creating systems that are responsive to a broad variety of factors that endanger public health, including chronic diseases and mental illness.

What most drove home the need for such a new approach, however, was not a chronic illness but a communicable disease emergency— the Ebola virus outbreak that killed over 10,000 people in Sierra Leone, Liberia, and Guinea in 2013-16. When the epidemic struck Sierra Leone, there was only one doctor there for every 50,000 people, compared to 1:400 in the U.S. and 1:275 in China. Vast stretches of West Africa are "healthcare deserts" where medical help is essentially unavailable. There isn't even any surveillance for disease outbreaks. Infectious diseases in West Africa, such as Ebola, tuberculosis, and HIV, often coincide with malnutrition, greatly worsening their effect.

By contrast, in other parts of Sub-Saharan Africa great progress has been made. Rwanda, whose per-capita GDP is only US$750, has a health care system that covers more than 90% of the population. Each Rwandan village is required to have three community health workers, elected by the villagers; even if they have a minimal education, they are able to offer basic services and make referrals. As a result, infant mortality was chopped in half in just one decade. Speaking to the British magazine *The Economist* last year, Dr. Bailor Barrie, a physician in Kono, Sierra Leone, contrasted his own country— where there is "no health system", he said— to Rwanda, with its wide coverage, concluding: "Ebola would not have happened there."

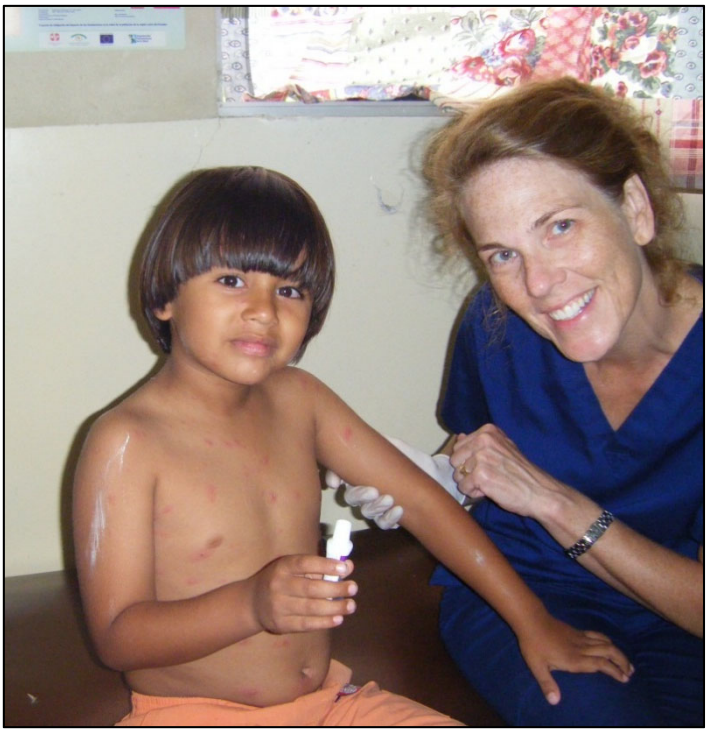
Based on its investigation, *The Economist* published a Special Report that argued that the Ebola epidemic "was an avoidable tragedy." More broadly, the report argued that global progress in improving physical and mental health will be limited until universal health care is achieved, one of the Year 2030 sustainable development goals set by the United Nations in 2015.[6]

England and Wales initiated universal coverage 70 years ago, in 1948. Only universal coverage on a world scale, *The Economist* argued, can redress a situation in which too many people in the world face the choice of either being pushed into poverty by their health care costs, or risking their lives and the lives of others by not seeking treatment. A Dec. 2017 joint report by the World Health Organization (WHO) and the World Bank found that at least half of the world's people have no access to essential services such as blood pressure checks, prenatal care, or basic treatment for malaria, HIV, and TB. A 2015 study in the British medical journal *Lancet* found that about 5 billion people cannot get basic surgeries such as bone repairs, C-sections, or laparotomies. The lack of universal health coverage in the vast majority of countries helps explain the statistical findings of a pair of British epidemiologists: health problems tend to be worse when a country has lots of income inequality, regardless of the country's average income level.[7]

Low Cost, High Impact

People imagine that every game-changing advance for global health will require an investment of billions of dollars. But in fact, many breakthroughs require relatively small investments, in some cases by adapting already-existing drugs or technologies. A few examples give a sense of the dramatic steps that are possible:

- A traveling eye doctor can now convert their smartphone into a portable ophthalmoscope in under 30 seconds, giving the ability to diagnose retinopathies in remote areas (see the article by Our Children's Vision on pages 16-17).
- Factories in Thailand, China, and the Philippines can manufacture "reader" versions of eyeglasses for less than 50 cents a pair, or prescription versions for $1.50, potentially changing the lives of the 1-2.5 billion people in the world who need glasses but can't afford them.[8]
- A 20-foot recycled shipping container was turned into a pop-up ophthalmology clinic that is being used successfully in Jamaica (see the report on the Deep Impact Monitoring project on pages 13-15).
- The use of insecticide-treated mosquito bednets can control the spread of diseases such as malaria and chikungunya.[9]
- Modest drug doses can save millions of lives when administered on a mass scale. When the antibiotic Zithromax was administered to control blinding trachoma in Africa, it was discovered that the two oral doses per year also effectively reduced infant mortality.[10] Schistosomiasis, a neglected tropical disease (NTD), is treatable with a single oral dose per year of praziquantel, at a cost of only 20 cents per child per year.[11]



Schoolcraft College Nursing Prof. Nancy Palmer (now retired) applies medication to soothe the itching of chicken pox for a boy in the Galápagos Islands, Ecuador. A chicken pox vaccine became widely available in the U.S. in 1995, dramatically reducing the number of cases there, but there is no similar mass administration of the vaccine in this underdeveloped area. This family had several other children, all in various stages of the illness. During 2002-12, Nancy and her husband, physician Thom Palmer, made many trips to Peru and Ecuador on medical missions with non-governmental organizations based in the U.S. or in South America.

- Significant government policy shifts can also work wonders. Ethiopia, for example, in 2004 instituted a network of rural health extension workers, who are high-school graduates given just one year's training; they helped cut child and maternal mortality by 32% and 38%, respectively.[12] In the years when the South African government officially denied the existence of HIV/AIDS (1999-2008), that country led the world in the number of people infected with HIV, with about 20% of the planet's total. But once the government acknowledged the problem and the need to deal with it, the country made huge strides in public awareness, diagnosis, and successful treatment of AIDS.[13]
- The diets of impoverished groups can be critically enhanced via *biofortification*, the breeding of nutrient-enriched varieties of foods. When a deeper-orange variety of sweet potato was introduced to Uganda and Mozambique, for example, it dramatically reduced vitamin A deficiencies that are responsible for blindness and several illnesses.[14]

How *You* Can Participate

Faculty, students, and other readers can participate in this Focus project in a variety of ways.

Instructors can integrate relevant topics directly into coursework and campus programming by developing presentations, course readings and assignments, or student projects. Use the concepts and resources contained in this issue of the magazine as a jumping-off point. With a little creativity, instructors in many disciplines can participate fully.

SCII Faculty Co-Chair Helen Ditouras has played the lead role in organizing a free, year-long speaker series on the Schoolcraft College campus for students, staff, and the general public (see upper sidebar at right). These annual Focus Presentation Series have been hugely educational and popular (see lower sidebar). The entire faculty is urged to recommend this series to students as an excellent way to gather insight and information. Some instructors might want to bring a whole class to a given event in the Focus Series (contact Helen at 734-462-7263 or by e-mail at hditoura@schoolcraft.edu). Others might want to fold these into extra-credit opportunities for selected students.

To supplement these events and the articles in this magazine, you can extend your learning using materials from the Bradner and Radcliff Libraries on our campus. The library staff can help you locate a wide variety of books, videos, and other resources.

If you have relevant expertise or experience, offer to write an article for this magazine or to be part of our speaker series.

Let us know how you and your colleagues bring some global and multicultural perspective into your coursework this year! •

Endnotes

1. Quoted in "A Step in Tackling Childhood Cancer", *New York Times* Editorial, Sep. 30, 2018.

continued on next page

Winter 2019 Focus Series

Look for more details at
http://www.schoolcraft.edu/scii/focus-series

Feb. 1: Emily Camiener (Nutrition and Food Science, Schoolcraft College), "History and Benefits of the Mediterranean Diet"

Feb. 27: Suzanne M. Selig (Public Health, Univ. of Michigan-Flint), "Cultural Competency in Public Health"

Mar. 14: Steven L. Berg (History and English, Schoolcraft College), "Chips Provided: A Global History of the Potato and Its Impact on Health"

Mar. 19: Steven Fischer (clinical psychologist and nutritionist at Younique Wellness, Southfield, MI), "Physical and Mental Benefits of Sleep"

Mar. 28: At the annual Schoolcraft College Multicultural Fair, there will be an exhibit of health-related artifacts displayed with research and commentary by students of Steven L. Berg (History and English) and Jessica Worden-Jones (Anthropology)

Apr. 2: Felix Fernando (Sustainability Studies, Univ. of Dayton), "Physical and Mental Stress on Climate Refugees"

Apr. 4: Dr. Anthony White, "Mental Health First Aid and Its Racial/ Ethnic Dimensions".

Fall 2018 Focus Series a Big Success

The Focus Series presentations at Schoolcraft last Fall drew large audiences and left deep impressions. There were 5-6 talks to round out the year-long focus on "Spirituality and Religion in Today's World".

"African Spirituality Across the Atlantic", for example, was a vivid slide presentation on Sep. 25 by Kimberly Oliver, a doctoral student in anthropology at Wayne State Univ. (Detroit). Attended by 66 people, mostly SC students, the talk depicted the key characteristics of African religion that have influenced culture in Louisiana, the Caribbean, and Brazil. On an evaluation form after the talk, one student wrote that she had learned that traditional African spirituality is based on living faith experiences rather than doctrines and history, and that it seeks harmony rather than the forcing of beliefs on people. She added, "I usually would say the speaker needs to love their subject more and be excited to share, but Kim was amazing and I'd listen to any lecture she gives." Another student wrote that the most interesting thing they had learned was that "voodoo practices, such as the voodoo doll and the pins, are often taken with a negative connotation when in reality it is mostly used for healing practices and not for harm. Also, learning about all the spirits and their comparisons to Catholic saints was interesting."

Nov. 1 brought a talk by Rachel O'Neill, founder of Little Dresses for Africa, a local Christian organization that annually ships and hand-delivers hundreds of thousands of newly-sewn clothes to needy areas in Africa. One of the many student attendees wrote that she was impressed "how genuine the efforts are, the cultural awareness and how the help is beyond just sending dresses for morale. It won't change their world tremendously, but it is making a positive effort for improving their community."

Savage Inequalities *continued from page 11*

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I Thought

by Marie Chantal Nyirahategekimana

I remember Cameroon
The food was delicious
The seasonings, the best in the world.

I remember going to school,
My uniform freshly washed,
Excited to see my friends.

I remember my mother giving me taxi money,
She did not want me walking the thirty minutes to school.

I remember the boy breaking rocks across the street
He was twelve years old, with a mother and five siblings to feed.

I remember Marie's dress,
Same dirty, torn dress
"My father died back home, we don't have electricity."

I remember coming to America,
Afraid, because I did not speak English,
Afraid they'd think I was too tall,
Little did I know my skin color would be the problem.

I remember my first school,
"Go back to Africa", they'd say.

I remember my parents switching me to an all white private Catholic school,
In hopes that there will be less physical bullying.

I remember being called a nigga,
"She's too dark" they'd say.

I remember the girl at the cafeteria throwing away money,
Everyone laughed,
Except me.

I did not laugh, because at that moment
I remembered the twelve year old boy breaking rocks morning 'til dusk,
I remembered Marie, walking without shoes,
I remembered school friends, who could not afford more than one meal a day.

They do not know, I thought.

Schoolcraft student Marie Chantal Nyirahategekimana migrated from Africa. Read more about her on page 44.

Advanced Health Monitoring for Underserved and Remote Populations

by David T. Burke

David Burke, Ph.D., is a Professor of Human Genetics at the Univ. of Michigan School of Medicine and is Director of the Deep Impact Monitoring project, which he describes in this article. In addition to low-cost technology systems for health care delivery, his lab is also studying the mouse genome to identify complex, multi-gene traits, and is developing a low-cost, highly-automated genotyping system. Dr. Burke completed his bachelor's degree in biological sciences and biochemistry at the Univ. of Rochester (1982), and his Ph.D. in molecular biology at Washington University in St. Louis (1988).

A pop-up eye clinic inside a shipping crate, deployed by the Univ. of Michigan to Sandy Bay, Jamaica.

Each day, one-fourth of the elderly adult population, worldwide, struggles with chronic illness. Chronic diseases like diabetes, glaucoma, dementia, and hypertension disable individuals, burden families, and impoverish communities. Many chronic diseases can be managed through routine monitoring, but management requires resources that underserved populations lack. Diagnosed individuals must obtain information about their bodies— frequently and precisely— to optimize disease control. Tens of millions of adults need to know, frequently and precisely, about their own health. They also need to communicate and record that information accurately with their physicians and families. Unfortunately, many chronic disease patients live in areas of the world that are underserved by health care providers, either because of low economic resources or remote locations. The demand for high-quality, personal, and inexpensive health monitoring, health communication, and health education remains unfulfilled.

At the University of Michigan, we have assembled a multidisciplinary team of faculty and students to address the complex, intertwined challenges in health monitoring. As a top-10 research university that includes a million-member health care system, we are in a unique position to think about solutions to multi-factor problems and to test those solutions in real-world settings. Few institutions, public or private, have a comparable infrastructure that can address multiple levels of complexity *and* can deploy systems to patients.

For over a decade, the members of our team have explored the complex, interrelated aspects of personal health **monitoring**, **communication, data recording**, **and education** in underserved communities. Our strategy integrates technologies for physiological measurement, digital communication, rapid deployment, and individualized education. These components are incorporated into low-cost, self-contained, manufacturable facilities that we term *HealthStations*. The HealthStations, designed and implemented in collaboration with local communities to address their needs, are more than just buildings, places, or machines— they are a focus for individual and community empowerment.

The foundational feature of our development strategy is **adaptation**. Adaptation means building new health care monitoring systems based on existing hardware and software. The components that we incorporate typically come from commercial consumer products or "do-it-yourself" markets. These products are robust and relatively inexpensive: robust because prior to sending their products to market, each company invests thousands of hours on engineering, testing, and redesign; and inexpensive because of efficient, large-scale manufacturing to meet popular demand. We co-opt decades of commercial investments to provide novel systems that are strong enough to function in the real world. The program emphasizes technologies like machine vision, microelectronic sensors, 3-dimensional imaging, custom manufacturing, expert systems, modular intermodal shipping containers, and high-speed digital communication. We are committed to the integration of such existing technologies to create transformative change in real-world health care.

We have focused our strategy on two systemic levels or "workstreams". At the highest level (**Workstream A**), complex health monitoring systems are designed and deployed to patients in the communities where they live. Each community requires a tailored, robust, and controlled environment for data collection. We employ intermodal shipping containers and linked transportation systems to enable rapid, low-cost deployment, both locally and globally.

Systems that address the challenge of personalized interaction with patients and monitoring technologies are developed in **Workstream B**. The work is physician-guided, using the resources of the Michigan Medicine health care system. We design, build, and test systems for autonomous, non-invasive physiological data acquisition and patient education. Patients interact with the technologies in comfortable settings, guided by visual and auditory assistance in their native language. Machine vision technologies and 3D sensing allows precise spatial recording and determination of patient interaction with the monitoring system. Workstream B targets digital communication and optimized integration of

continued on next page

Health Monitoring *continued from page 13*

multiple data streams. The personal health measures are for monitoring chronic disease, and include vision, blood pressure, body mass, stamina, movement, balance, respiration, and cognition.

Workstream A: Designing and Deploying the Facilities

To reach all patients equitably, health monitoring must be locally-accessible, convenient, rapid, and inexpensive. Communities that do not have a permanent health care facility face significant obstacles to frequent, high-quality health monitoring of their citizens. In Workstream A, we employ intermodal shipping containers (and the compatible transportation systems) to reach locations across the globe. Our community/ patient interface facilities— HealthStations— are designed to serve both as walk-up health clinics for chronic disease monitoring and as community centers. The HealthStations can be manufactured efficiently, at high volume in a central location, and then shipped to sites across the world. The monitoring or health delivery systems are **customized for the requirements of the target community**.

In 2016, the Project Team deployed a HealthStation to Sandy Bay, in rural Hanover Parish, Jamaica (see Fig. 1). The HealthStation is an intermodal 20-foot shipping container and was transported from a manufacturer in Michigan. The HealthStation has solar power and telecommunication capabilities and is designed for eye examination and eyeglass fabrication/fitting. It includes a shaded public meeting and educational area, and all structural and health-monitoring components were shipped inside the container. At delivery, local community members opened the container, assembled the exterior structure, and installed the medical equipment. The HealthStation is fully active for eye exams and is used by the community as a meeting location. After over 18 months on location, hundreds of local citizens have benefited from the facility, with over 300 eye exams and eyeglasses dispensed (UM created a two-minute video, https://youtu.be/_qfhuoYZoIY).

The Workstream A effort adapts HealthStations to the unique features of each population and environmental conditions. Since the distribution of chronic diseases varies according to regional diets and lifestyles, pre-placement assessment surveys are performed at each location and community focus-groups are convened to determine the local concerns and issues. The goal is to estimate a target size for patients with chronic diseases and compare with extant health management strategies. Construction is also subject to local environmental constraints. For example, a unit located in a tropical climate will be equipped with an air conditioner and dehumidifier, as well as shade cover. Each HealthStation includes photovoltaic power on the roof, battery storage, and high-bandwidth wireless (or satellite) digital communication.

We employ a design method called "open-architecture product", which is based on the concepts of modular design and "product families". Such structures use a platform with interfaces to integrate three types of modules: common modules shared across the product family, customized modules for the customer to choose, and individualized modules allowing for customer design. In this way, cost-effective but tailored products can be created.

Workstream B: Connecting Health Monitoring with Patients

The Project Team is building autonomous health monitoring systems using repurposed and integrated hardware and software developed for consumer digital technologies. Workstream B integrates systems, software, and sensors to establish a friendly two-way communication interface with chronic disease patients. The interface guides the patients' use of the sensors in real-time, asks questions of the patient, and processes the information. Machine vision and expert systems algorithms, along with validated medical questionnaires, are used to explore each patient's personal health, and to obtain high-quality, quantitative physiological data. Once acquired, the digital medical information is returned to the patient or, if approved by the patient, remotely sent to a physician. The measurement systems operate easily at low-resource sites, are robust to environmental challenges, and require minimal medical knowledge. Individualized assessment can occur at locations convenient to the patient and at a skill level commensurate with the patient.

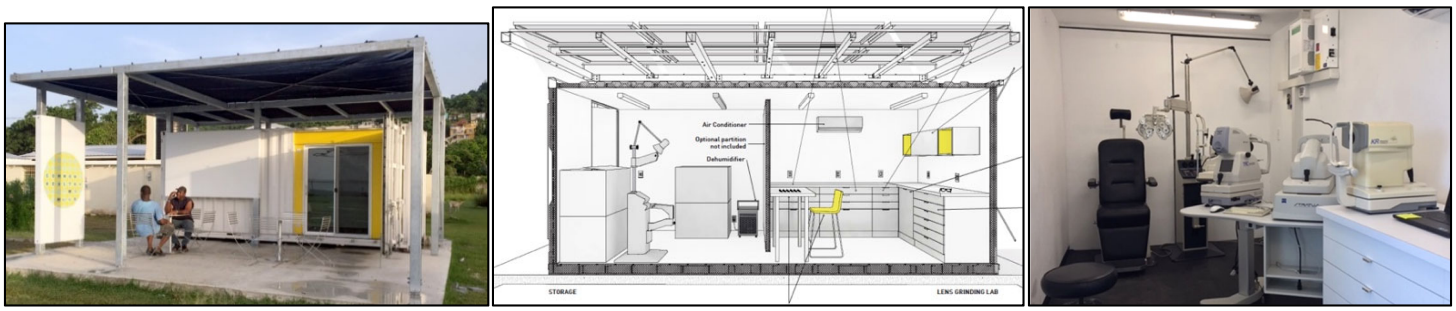

Figure 1. HealthStation1 (l to r): Completed installation exterior, interior schematic drawing, interior eye exam room.

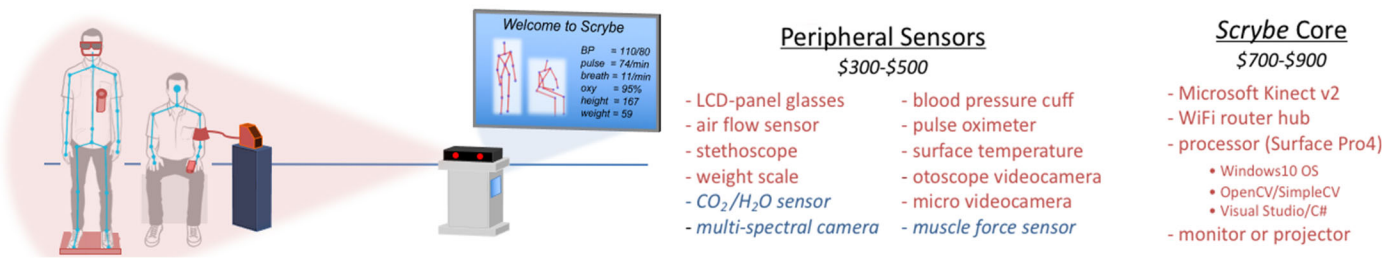

Figure 2: Schematic and costs associated with the autonomous, non-invasive Scrybe health monitoring system.

The initial physiological interaction system is called "Scrybe" (see Fig. 2). Scrybe uses a commercially-available infrared 3D human-interface mapping system and associated software (Microsoft Kinect). A modest commercial computer runs the software and controls the accessory sensor components. The interface uses either a video monitor or digital projector, depending on the viewing conditions. Scrybe includes a high-bandwidth local area Wi-Fi system to communicate with the associated peripheral health monitoring sensors. Scrybe also provides Internet connection and data security measures. To date, the Scrybe system has been tested extensively in a research setting and is now deployed at the UM Health Service patient waiting area. The system is compact and robust. We estimate a cost of less than $4000 per unit.

The 3D interactive interface allows human-level, intuitive communication. As a patient enters the room, the morphometric software recognizes the human form. If needed, two individuals can interact with the system simultaneously (for example, a medical assistant or family member). Scrybe communicates commands to the patient using a recorded voice or text on screen to perform specific movements or to interact with sensor devices. The 3D mapping system monitors the movements of the patient with high accuracy. For example, Scrybe can prompt the individual to balance on one foot and can measure physical mobility, muscle performance, and balance sensory functions. Scrybe can ask health questions and assess responses by simple hand or head motions or voice. Peripheral sensor systems are connected to the Scrybe processor using wireless communication, allowing observation in real-time and in three dimensions to confirm the appropriate synchronous patient actions. For example, Scrybe can guide an individual through the use of a conventional blood pressure cuff.

Workstream B will continue to be optimized. We are developing the Scrybe system software to include surveys in multiple languages (e.g., English, Arabic, Mandarin, Spanish). The surveys will include general health questions, specific questions for chronic disease management, and assessment tools for user experience and for economic impact of the health monitoring. In addition, educational software is being developed for verbal communication to train caregivers and patients. Examples include basic diabetic care, neuropathy monitoring, use of blood pressure cuffs, eye drop instillation, visual field test, drug schedule adherence, and movement and memory performance. Our educational and training technologies will also employ interactive movement detection, projected displays, voice recognition, and machine learning algorithms. The patient educational system is designed to recognize each individual and to customize health queries to match their chronic disease as well as their age, language, and other characteristics. Similar personalized health education platforms have been shown to have a strong positive impact on patient treatment adherence. Additionally, our education system can support autonomous distant learning and video telecommunication strategies. We will use the system to provide guided assessment and training for both patients and caregivers, adapting to appropriate educational levels.

To successfully deploy this technology in under-resourced global settings, we recognize that significant operational challenges must be overcome, including identifying appropriate patients, fully educating and consenting them, providing technological support, collecting and storing data, and coordinating all caregivers and other personnel involved. Our ongoing work will ensure that our research is not only technically sound but also safe and appropriate for the target population.

This research addresses multiple aspects of personal health monitoring in low-resource, underserved communities. Our current goal is to scale-up construction and deployment of our integrated HealthStations. Therefore, our primary measures of success are the number of HealthStation and Scrybe units installed in, and used by, communities. We will also measure the impact of the HealthStations on chronic disease outcomes.

The emerging fields of personal health monitoring and health education are poised to radically change health care and health research. We have three foundations for this optimism. First, the demand for chronic disease monitoring will expand in the next 30 years as the average age of the world population increases, leaving too few providers to care for patients. Second, the technologies for digital communication, computation, microsensors, and intelligent software will improve in power, efficiency, and usability. Third, manufacturing and transportation will become increasingly efficient. Taken together, technologies that once were exotic are now replicated and distributed, in millions of units, at very low cost. We anticipate that the trajectory of improved technology performance seen over the past two decades will continue. •

A Global Campaign for Children's Vision Services

by Courtenay Holden

Courtenay Holden is Marketing and Communications Manager for Our Children's Vision in Sidney, Australia.

> I first knew about my sight problem when I was nine years old. Slowly my difficulty of seeing from a distance and near objects became worse in school as well as at home.
> — Billal, an elementary school pupil in Ethiopia

In April 2016, Our Children's Vision was launched with the ambitious goal of reaching 50 million children with vision services by 2020. In 2018, through the hard work of our 79 partner organizations in 55 countries, the half-way milestone for this ambitious project was met and passed ahead of schedule.

As a result, some 27 million children around the world, from America to Zimbabwe, have had their vision tested. Over 1,700,000 pairs of glasses have been handed out. That's over 1,700,000 children whose worlds have suddenly grown brighter and larger with easier access to education, with full participation in their communities, and with all of the possibilities that exist in a child's dreams for their future.

Billal knew that he was at a major disadvantage at school. Then Vision Aid Overseas, a partner in Our Children's Vision, came to his school in Ethiopia, provided him with the eyeglasses that he needed, and changed his life. He reported, "Now I can sit anywhere in the classroom as the other students. I am very happy with my eyesight and last semester I was ranked first in my class."

Billal, and the millions of other children who will be seen before the end of 2020, are the first to benefit from the global drive of Our Children's Vision to put in place policies and support programs that will see their little brothers and sisters, and one day their own children, taking lifelong clear vision for granted.

Glasses, a "Simple" Solution to a $272 Billion Problem

Vision impairment is a huge global health problem. About 1.1 billion people worldwide can't see properly because they have near-vision impairment and don't have access to affordable reading glasses. Almost two billion more suffer from other sight conditions that are treatable with glasses.

An estimated US$272 billion worth of productivity is lost every year because of vision impairment and other sight conditions (T. S. T. Smith, et al., "Potential Lost Productivity Resulting from the Global Burden of Uncorrected Refractive Error", *Bulletin of the World Health Organization*, vol. 87, 2009). With about 90% of the world's vision-impaired people living in developing countries, the burden of this lost productivity and its economic and social consequences fall heavily on the most vulnerable families, populations, and world regions.

Reaching these populations, especially those living in rural or remote locations, with trained professionals who can assess their vision is a massive challenge that is global in scale. Our Children's Vision was established to meet that challenge.

A Global Challenge Needs a Global Partnership

Our Children's Vision was co-founded by two partner organizations: Brien Holden Vision Institute based in Sidney, Australia (formerly the Institute for Eye Research) and Vision for Life, the global strategic giving fund of French-based lens provider Essilor. We launched knowing that even with the co-founders' decades of experience in combatting vision impairment in developing countries, we would need the help of additional partners— each with their expertise, unique experience, and local knowledge— to achieve our goal.

Children line up for a vision screening session in south-central Ethiopia. A program carried out there by Vision for Life (Essilor) and the Global Poverty Action Fund (UK) facilitated school screenings, taught teachers and children about the importance of eye care, and increased the number of eye care professionals and optometrists in local communities.

Photo: Vision Aid Overseas

"Brien Holden Vision Institute, and our founder Professor Holden, had been calling out for years for vision health screening in children", recalled Amanda Davis, Chief Executive Officer of the Brien Holden Vision Institute Foundation. "By starting Our Children's Vision, we saw a chance to not just help today's children but also to reduce global levels of uncorrected vision impairment in future generations— but we knew that we couldn't do it alone."

An example of a partner organization that has since joined up with this global campaign is CharityVision (Provo, UT), a 501(c)(3) non-profit that provides surgeries to restore curable sight impairment in developing nations. "We are proud to be a part of what Our Children's Vision represents: a group of people from different cultures and countries coming together to support a hopeful future for the world", stated Haleigh Cole Perry, CharityVision's International Programs Director. "Without collaboration, meeting the global eye care need would be hopelessly impossible."

Our Children's Vision now has 79 partners, and we want even more. The goal of reaching 50 million children around the world is more than ambitious. It is inspiring and it is a rallying point for not just helping today's children, but for doing the research, developing policies, lobbying governments, and putting into place programs around the world to address the eye health of children today and tomorrow.

Reaching Children through Their Schools

The insight that drives us is the centrality of school in children's lives, and the important role that education plays in their future. "Vision issues can negatively impact a child's development and performance in school" noted Jeff Todd, President and CEO of Prevent Blindness, a Chicago-based volunteer group for vision screening and advocacy in the U.S. "Ensuring that these children are identified, have access to and receive quality eye care, and have access to prescribed treatments, makes a tremendous impact today and beyond childhood."

Teachers play the central role in our strategy, but to be successful the rest of the community also needs to be addressed. Elizabeth Kurian is CEO of Mission for Vision, a non-governmental organization fighting blindness by supporting equitable eye health care in Mumbai, India. She explained:

> There are many players involved when it comes to eradicating avoidable blindness among school children— particularly adults within a child's inner circle. Teachers can be skilled to recognize and diagnose basic eye problems, parents can be educated to identify uncommon behavior and know how to access care. They can be at the front lines of ensuring that children receive the eye care they need.

Jayanth Bhuvaraghan, Chief Mission Officer for Essilor International and Chairman of Vision for Life, identified the broader impact of this strategy: "By giving children access to vision correction, we are empowering them to achieve their full potential at school, but we are also hoping to give them access to a better future and ultimately to reduce inequalities and poverty in their country."

Governments around the world have recognized that schools are not just centers of education, but also valuable access points for delivering health services to children. However, these health services have rarely included even basic vision tests. This is why as some partners are visiting schools, others are meeting with

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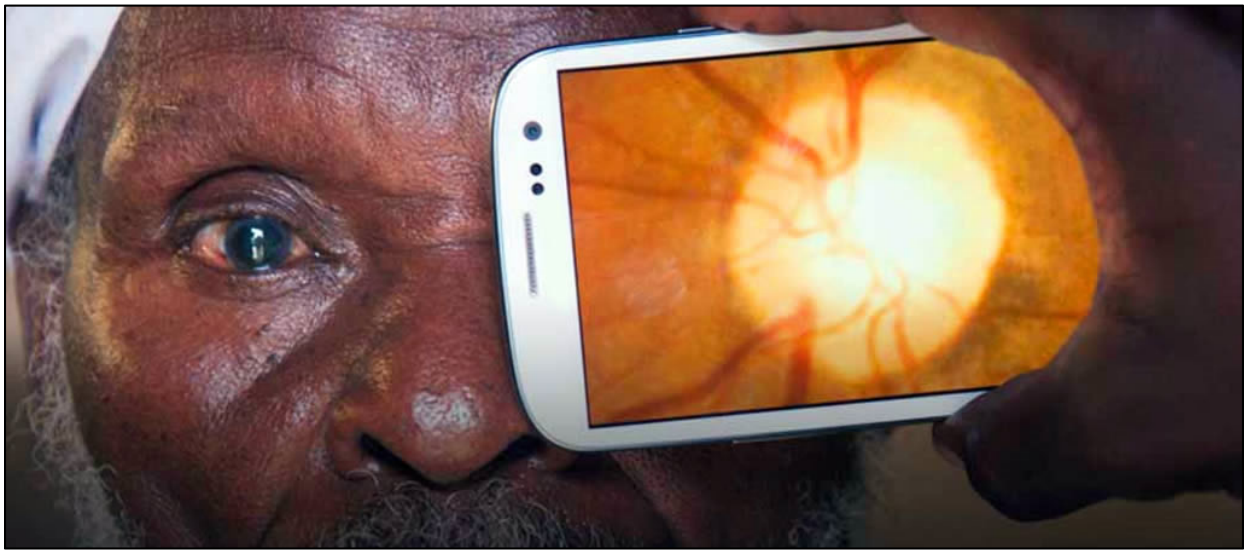

Commonwealth Eye Health Consortium (London School of Hygiene & Tropical Medicine)

Thanks to a new medical device called Peek Retina, a traveling optical professional can convert their smartphone into a retinal camera in under 30 seconds. They can then use this portable ophthalmoscope to view and capture retinal images of a patient's dilated eye, examine the optic nerve and macula, and identify diseases such as glaucoma, cataracts, diabetic retinopathy, and age-related macular degeneration. The images can immediately be shared with the patient and with other professionals, and stored for further analysis. The device was developed through collaboration between the International Centre for Eye Health (London School of Hygiene & Tropical Medicine), the Univ. of Strathclyde, and the Glasgow Centre for Ophthalmic Research. It is being sold by Peek Vision Ltd. for about US$228 and was used by Peek Vision, a partner of Our Children's Vision, in a dramatically successful field trial in Kenya.

Maternal Health Care Accessibility in Ghana: Minimizing the Three Delays

by Christina Schuler and Judith van Neck

Christina Schuler and Judith van Neck have worked for the Ghana Health and Education Initiative (GHEI) since early 2018 as the Health Program Coordinator and the Communications Officer, respectively. They are based in Humjibre, Ghana. Christina is from Switzerland. She has worked in two local hospitals in Ghana and obtained her degree in International Health at the Swiss Tropical and Public Health Institute, for which she wrote her thesis in Ghana. Eager to return to Ghana and with 10 years of experience working as a pediatric and neonatal nurse, Christina ended up in her role at GHEI. Judith grew up in the Netherlands. She finished a bachelor's degree in Communications at the Erasmus University Rotterdam and a master's degree in Political Science at Leiden University. She is interested in development work, which led to her move to Ghana to work for GHEI.

In many African countries, including Ghana, access to healthcare is a persistent problem. Financial and logistical barriers are often more serious dilemmas than quality of the care itself. Through its health and education programs, a local Ghanaian-American non-governmental organization called the Ghana Health and Education Initiative (GHEI) aims to minimize delays that occur at different stages in seeking and receiving treatment.

GHEI is located in the remote village of Humjibre, Ghana. The majority of the health programs that it has implemented in its communities are focused on maternal and early childhood health. For example, one of its health programs supports first-time mothers throughout the pregnancy, after birth, and during the first two years of the child's life.

The *three delays model* is used in the maternal health discipline to identify the three stages in which delays might prevent individuals from receiving quality healthcare:

1. delays in recognizing a sickness and deciding to seek treatment
2. delays in determining where to go for treatment and how to get there
3. delays in receiving adequate treatment.

For example, malaria during pregnancy is associated with low birth weight and increased perinatal mortality, so recognizing it and being treated promptly are very important. Likewise, after giving birth one of the most important things that new mothers are taught is how to recognize symptoms of malaria or other infections in their child. Identifying when you or your child is sick is the first phase in the three delays model. Throughout its programs, GHEI aims to help community members tackle all three delays, so that everyone can have access to effective healthcare.

The three delays model can illustrate the influence of GHEI's programs during each of the stages, and their impact in improving the health of its community members.

Delays in Deciding to Seek Care

Whereas individuals in the Western hemisphere can sometimes be a bit too eager when it comes to identifying their own illnesses and Googling their symptoms, in Ghana and in other African countries this is sometimes not happening often or accurately enough.

Especially for newborns, recognizing symptoms of illness is important, as there is a high mortality rate among this group in Ghana. Within the group of newborns, the most vulnerable are babies in the first week of life. Thus, spotting an infection or identifying a symptom of malaria at this stage can be a matter of life or death.

Even after determining that healthcare is needed, there might still be hesitance among individuals to seek treatment because of the anticipated costs. Although there is a national health

Abena and her daughter Stella, right, are visited by Mother Mentor Alice as part of GHEI's Mother Mentors Program for Child Development.

Aggie, far left, a Health Program Administrator with GHEI, gives pregnant women advice on where to give birth as part of the Health Facility Delivery Incentive Program.

insurance system in place in Ghana since 2003, only 58% of the population is insured, according to the Ghana Demographic and Health Survey (2014). Even those who do have insurance sometimes are still forced to bring cash to the hospital in order to receive treatment, as the insurance does not cover all treatments. The costs attached to receiving treatment is an obstacle for many families,

The Ghana Health and Education Initiative aims to reduce these obstacles. One of the ways this is done is through the Mother Mentors Program for Child Development. In this program, pregnant women and those who have just delivered are visited biweekly by GHEI's 'Mother Mentors', experienced mothers from the community. During these visits, the new and about-to-be moms are informed on what practices they can engage in to prevent infections and how they can recognize danger signs. As part of infection prevention, each household is provided with a latrine to encourage hygienic disposal of the baby's stool, as well as with a veronica-bucket and soap to ensure that the participants have access to running water. Perhaps most importantly regarding health care accessibility, all the participants in the Mother Mentor Program are provided with health insurance by GHEI.

Delays in Deciding Where to Get Treatment and Getting There

The second stage of the three delays model revolves around the problem of finding an adequate health facility and getting there. The delay can be caused by poor roads, the distance to the nearest health facility, or by the costs and availability of transport.

In Ghana, although there are private and public hospitals in both urban and rural areas, there can be huge disparities in physical access to health facilities because the availability of transport and paved roads varies.

In 2014, the proportion of women in Ghana who gave birth at home was 9% for women in urban areas, yet 46% for women in rural areas, according to the Ghana Demographic and Health Survey (2014). This is a huge difference and one that GHEI aims to minimize. Residing in a rural area, the percentage of women in Humjibre who gave birth at home was 29% in 2017. With regard to which hospitals or clinics to go to for delivery, GHEI gives advice to all participants in the Mother Mentor program as well as those in the Health Facility Delivery Incentive program. The latter program aims to incentivize pregnant women to deliver their babies in the presence of a skilled health worker. Both groups also receive a delivery incentive package, which is filled with items that hospitals require women in labor to bring with them, such as bleach, soap, and disinfectant.

Delays in Receiving Adequate Health Care

Together with the first phase of the three-delay model, this stage poses major limitations for individuals to receive quality treatment. A delay in receiving quality care at the health facility might occur due to a lack of adequate training and/or necessary equipment there.

Over the years, the Ghanaian government has made enormous strides in improving the health care system. However, although national guidelines and protocols have been developed, they are not always correctly implemented. One of the factors preventing efficient implementation is the limited availability and supply of drugs, medical equipment, and technologies. Moreover, health workers do not always receive the adequate and continuing education that would enable them to provide quality care treatments.

To stimulate the improvement of health care service, the Ghana Health and Education Initiative hosts a pediatric physician in Humjibre every year to provide training to local midwives and nurses from the community. In Jan. 2018, training on neonatal resuscitations was delivered to health workers from the Bibiani district hospital. GHEI has also donated medical supplies to local health clinics and facilities.

GHEI's Ambitions

It is a goal of GHEI that participants in our health and education programs will share the knowledge that they have acquired with their family members, children, and friends. In this way, GHEI aims to empower community members so that they are able to identify danger signs and decide to seek treatment. Through its collaboration with local health facilities,

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The Risk of a Global Pandemic is Not Diminishing

by Amesh A. Adalja

Amesh A. Adalja, MD, practices infectious disease, critical care, and emergency medicine in the Pittsburgh metropolitan area. He is board-certified in internal medicine, emergency medicine, infectious diseases, and critical care medicine, and is a senior scholar at the Center for Health Security, which is based at the Johns Hopkins University's Bloomberg School of Public Health. Dr. Adalja also serves on the City of Pittsburgh's HIV Commission and on the advisory group of AIDS Free Pittsburgh. Readers can follow him on Twitter at @AmeshAA.

When it comes to thinking about pandemics in the world today, the wisest maxim— which is almost like a cliché in my field— is this one: "It's not if, it's when." But why do so many experts in the field believe that the world is ripe for a pandemic?

To many people, that might seem counterintuitive, as modern medicine has tamed one infectious disease after another. In effect, people think it is natural that pandemics occurred during medieval times, or even early in the 20th Century, but surely not now. Smallpox is gone, polio finds safe haven in just two countries, measles was eliminated from the Americas, and it takes a prodigious effort to find cases of tetanus and diphtheria in the developed world.

However, despite these successes, there are several forces at play that have heightened the risk of pandemic— arguably to a higher level than ever before in human history.

What is the Nature of the Threat?

Infectious diseases, by their very nature, are much different than all other medical conditions. The fact that many infectious diseases are contagious— spread between humans— and that all of them involve what is akin to an invasion of the body, puts them in a special category. Infectious diseases, caused by tiny microbes (microscopic forms of life or other organic particles), can topple states, change the course of wars, restructure society, and create far-reaching cascading events that impact all corners of society.

Trying to characterize the threat and develop a capability to predict which infectious diseases constitute the highest global catastrophic biologic risks and could cause severe pandemics is a daunting task. However, in my analysis, there are several characteristics of pandemic pathogens that are important factors to consider.

A pandemic pathogen is likely to be transmitted via the respiratory route. Whether truly airborne or spread via droplets, infections that are transmitted through breathing, coughing, and sneezing are very difficult to control. The success of the common cold attests to this fact. Other modes of transmission are much more amenable to public health interventions such as sanitation and behavioral modifications. A pandemic pathogen is also likely to be contagious prior to symptom development, during its incubation period. Such a characteristic makes it nearly impossible to contain an outbreak while the individuals incubating the infection, who are contagious, go about their daily lives and travels, infecting others.

In the field of infectious disease there are many types of infecting agents, ranging in size and complexity from lice to prions. In between are worms, protozoa, amoebae, fungi, bacteria, and viruses. Surveying this landscape, it becomes clear that while a pandemic could arise from any of these classes under the right circumstances, the most likely origin is viral. Viruses replicate to high numbers rapidly, gain new functions through mutation relatively quickly, and have not been amenable to a broad-spectrum all-purpose antiviral agent akin, for example, to an antibacterial agent.

Influenza: The Prototypical Pandemic Pathogen

Among the viral families, the highest risk will almost always be influenza A. Caused by a respiratory-borne virus with a high mutability, and contagious during its incubation period, influenza has been causing pandemics for millennia, most likely since humans first evolved.

Relatively well-recorded pandemics of influenza occurred in 2009, 1968, 1957, and 1918. Each pandemic was heralded by the appearance of a novel strain of the influenza virus that emerged from birds, pigs, or some combination, and then swept the globe. It is estimated that the 1918 pandemic— of which we recently marked the centenary— killed upwards of 100,000,000 people globally.

Myriad strains of flu circulate in avian (bird) species, and new variants— the result of gene-shuffling— are created regularly. It is really only a matter of time before the right combination of genes again emerges to allow efficient human-to-human spread. At that point, the next pandemic will commence.

Other respiratory viruses that have pandemic potential include coronaviruses (e.g., SARS, MERS), parainfluenza viruses, and Nipah virus.

Why the Danger Might Be Increasing

It might seem paradoxical that in 2019— despite sophisticated medical care, a slew of effective pharmaceutical agents, and a firm understanding of the science of infectious disease— pandemic risks are heightened. But that is likely the case.

In 1918 a virus could travel at the speed of a steamship, allowing many infectious diseases to first appear on such a ship. A person on board either lived or died, but since that occurred during transit, pathogens were likely confined to the ship. However, in 2019 a person can travel by jet from one part of the planet to another in the course of just 24 hours, and might become ill only at the destination point, thus exposing other

On Aug. 23, 2014, these health workers prepared to enter a high-risk ward at an Ebola treatment center run by Doctors Without Borders in Monrovia, Liberia.

Daniel Berehulak/
New York Times

people there. A good example is the 2003 SARS outbreak, which emerged in China and circled the globe, causing approximately 8000 cases. Another example is the Sep. 2014 case of Ebola in a man traveling from Liberia to Dallas, Texas, which resulted in the infections of two nurses there and a U.S. national panic.

Coupled with the risks heightened by air travel are those resulting from the rise of mega-cities. Megacities dot the globe and are, in many ways, kindling for outbreaks: over-crowding, slums, lack of sanitation, and population density make it very challenging to control an infectious disease in these settings. Indeed, the past years have demonstrated how much more difficult it is to control Ebola in an urban environment, compared with the usual rural enclaves in which it appeared prior to 2014.

Another factor that impacts pandemic risk is the rise of the anti-vaccine movement. This trend attempts to sow doubt in the minds of the public regarding the efficacy and safety of vaccines, which are the single most effective tool in reducing pandemic risk. The fact that polio finds refuge today only in Afghanistan and Pakistan is the direct result of the anti-vaccine stance of the Taliban. During the 2009 influenza pandemic, concerns regarding the pandemic vaccine also arose, and vaccine uptake was substantially lower than for seasonal influenza vaccines.

Additional factors to consider include the threats posed by bioterrorism and biological weapons, which are often neglected but very real.

Reducing the Risk

To increase resiliency against pandemic threats is a multifaceted endeavor that involves governments, the pharmaceutical industry, the diagnostics industry, non-governmental organizations, and the healthcare industry.

Since September 11, 2001, and the subsequent anthrax bioterrorism attacks in the U.S., the need to view pandemic threats through the lens of national security has generally gained acceptance. Several programs and efforts were undertaken with the aim of reducing pandemic risk, whether from intentional action or natural phenomena.

Salient aspects of these programs in the U.S. include (but are not limited to) the following:

- a strategic national stockpile (SNS) of vaccines, diagnostics, medications, and medical equipment
- a means to develop and procure medical countermeasures (Bioshield, Biological Advanced Research Development Agency [BARDA])
- a laboratory network to identify pathogens
- greater coordination with other countries (Global Health Security Agenda [GHSA])
- vaccine development efforts (Coalition for Epidemic Preparedness Innovation [CEPI])
- a program to prepare hospitals to care for these patients (Hospital Preparedness Program [HPP]).

Preparedness for influenza is likely the most extensive compared to any other disease. As viral surveillance is performed nationally, new strains of the virus are extensively characterized and risk-stratified, case counts and deaths each season are followed meticulously, and vaccine uptake is tracked. Most of these activities are done at the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO), but state and local health departments also play large roles.

Even at the level of the individual physician, rapid advancement in diagnostic technologies can be utilized to diminish pandemic risk as many heretofore undiagnosed respiratory viral infections can now be specifically identified and reported.

The threat of pandemics will not diminish for the foreseeable future. However, humans are now armed with the most formidable tools in their history to prevent such occurrences and minimize their impact. •

At the Intersection of Engineering and Medicine: A Global Perspective

by Ayush Arora

Ayush Arora is a junior this year at the Univ. of Michigan in Ann Arbor, where he is majoring in Biomedical Engineering and minoring in Business Administration. A graduate of Saline High School, he works as an undergraduate researcher in the UM Dept. of Neurology; leads activities among underprivileged youths in the Brightmoor district (Detroit) and among terminally-ill seniors at the Glacier Hills Senior Living Community (Ann Arbor); and, in Summer 2017, served as an intern research fellow in the UM Cancer Summer Research Internship.

Engineering and medicine: initially, it might seem that the two hardly go hand-in-hand. The former is completely quantitative and analytical, utilizing an iterative design process to solve a need, meet essential requirements, and optimize solutions. The latter utilizes biology and the study of disease for the betterment of the human condition. During my freshman year at the Univ. of Michigan, I selected Biomedical Engineering as a major that encompasses a unique intersection of both facets. But it was not until I undertook a major global experience that I came to understand and experience on a deeper level the meaning behind this unique combination.

To gain practical experience with building medical devices, I joined and later became External Vice President of a campus group, Michigan Health Engineered for All Lives (M-HEAL). Established more than a decade back, M-HEAL is a student-run organization that fosters interdisciplinary work in global health, design, and entrepreneurship. The umbrella organization hosts over 10 project teams that develop medical devices for underdeveloped communities all around the world. Involving students from the schools of Engineering, Business, and LSA (Literature, Science, and the Arts), the projects range from developing solar-powered refrigerators that store vaccines to building database systems for efficiently recording patient information.

However, M-HEAL is not an organization that simply develops medical devices and ships them off. Rather, it develops and deploys technology based on the method of *socially-engaged design*. This approach entails the understanding of communities' cultures, social expectations, and unique situations, followed by the engineering of solutions that are tailored to suit those factors. Little did I know that my perspective on engineering, medicine, and their intersection was about to vastly change.

Observing a Medical Need First-Hand

The project that I undertook as part of a team of 15 people was known as PeriOperative. Its goal was to develop an automated feedback system that could warm a patient during surgery. When patients are put under anesthesia for surgery, they generally lose the ability to regulate body temperature. Hospitals that are socially deprived of resources often lack procedures and instruments to warm such patients, and this problem poses a serious threat.

Members of the M-HEAL team getting ready for some hospital observations in the Dominican Republic. From left to right, front row: Elizabeth Bissone, Allison Vittert, Namrata Kadambi; back row: Ayush Arora, Brian Quian.

Our project idea originated during a needs assessment trip to the Dominican Republic, a developing country in the Caribbean. While touring hospitals and making observations in Jarabacoa (a town in the mountainous central interior) and Cabrera (on the northern coast), our team sat in on a surgical procedure and noticed severe shaking from the patient. Multiple times, a critical procedure was interrupted due to such violent shaking. During each occurrence, the anesthesiologists were forced to halt the surgery and wait for the shaking to subside. After coming home, our team decided to pursue a solution to this problem by building a low-cost, energy-efficient heatable mattress with an automated feedback controller that would warm the patient to a consistent body temperature without input from the medical staff.

The academic year that followed was full of technical and practical work. Building the warming system, controllers, power sources, and incorporating materials that could withstand wear-and-tear took a vast technical experience in numerous collaborations with students and professionals from all disciplines. Combining all of the components into a cohesive whole also proved to be challenging. Our team had mentors from the Stryker Corporation, a large medical technologies firm based in Kalamazoo, MI, who regularly advised us on the intellectual property and regulatory aspects of our project.

The prototype and design overview of the PeriOperative team's automated surgical warming mattress.

Merging Technology with Socially-Engaged Design

It might surprise you to learn that our experience went far beyond a technical framework. At the end of the academic year, in May 2018, our team ventured to selected public hospitals in Jarabacoa and Cabrera with our initial prototype. Our goal was to meet the same anesthesiologists, show them our progress, validate results, and attain feedback for implementing our device.

From that point on, technical skills simply did not matter; instead, the key skill was navigating in a foreign area in a socially appropriate manner. For instance, disparities in health care quality came to the forefront as soon as we entered the hospitals. Obvious examples were lack of supplies, unsterile operating rooms, and the absence of basic air conditioning. Although it was natural to feel shocked at these conditions, we needed to guard against trying to impose any preconceived notions or opinions on anyone present. Throughout the tour and interviews with medical staff, it was critical to be grateful for time given and to understand that even a genuine disapproval of conditions could be viewed by our hosts as a mark of privilege. Thus, we did our best to simply note observations and internalize all reactions.

In each hospital, we followed the same basic schedule. First, we toured the hospital to make general observations and to identify all conditions that might affect our device. For example, even knowing what conditions our automated mattress heater would be stored in, cleaning procedures used, and how the device would be moved were crucial aspects to consider in the next iteration of the design. Following tours, we conducted interviews with anesthesiologists, nurses, and medical staff. A translator relayed all questions and answers, while we would take out the device and have a professional examine the user interface and mattress. After the interviews and observations were completed, we realized that we had made many assumptions in our design that needed to be altered to match the requirements of the specific setting.

Sometimes, events did not go as expected. Certain medical staff for whom we had prepared detailed interview protocols might be unable to speak with us, or we might have to leave the hospital due to a high influx of patients and unforeseen circumstances. Of course, part of learning is to deal with the unexpected. When abroad, any feeling of confusion and unsureness is magnified due to the foreign setting. A valuable lesson learned was to "go with the flow" and expect the unexpected, all the while capturing every moment of the experience.

The Value of Cultural Immersion

We also expanded our understanding of the region on a cultural level. Following the hospital visits, we taught English lessons to 3rd and 4th graders at public schools. I noticed that when I was teaching, it was just as much of a learning experience for me as for the students. For example, in an attempt to get my attention, one of the pupils referred to me as "Indio", and to another instructor in my group as "Chino". At first, I was quite taken aback; after all, calling someone out by their race so directly is hardly tolerated in the United States, especially in an educational setting. But in the Dominican Republic, such a gesture is simply a friendly way of calling someone over, and there is nothing derogatory about the identifiers.

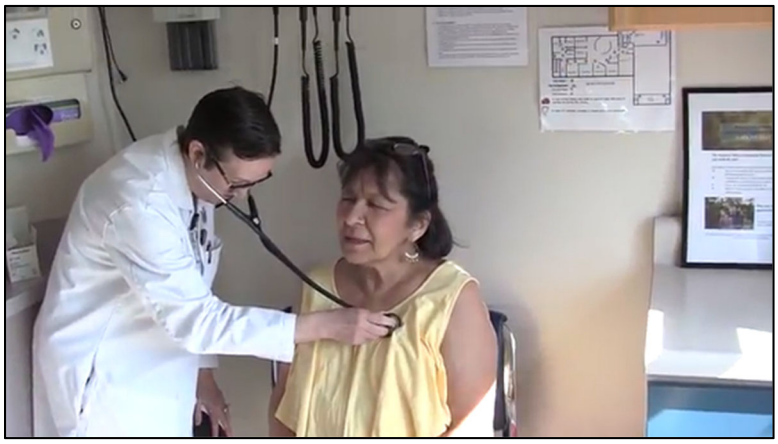
Some might question the necessity for such cultural immersion when our goal from the start was to deploy a medical device. However, the cultural knowledge that we gained was extremely helpful in interacting with our community partners, and this in turn determined the success of our project and continued future developments.

In the end, the intersection of engineering and medicine isn't some obscure technical area. At a deeper level, it isn't simply using engineering skills to build medical devices. It's about people. More specifically, it's about understanding their medical conditions in a context of cultural awareness and social factors, and developing solutions using technical knowledge. A medical device can have all of the design aspects that it needs, yet it can still fail if such factors are not taken into consideration. Going abroad taught me this lesson, and I consider it more valuable than all of the technical skills that I've acquired so far. •

Addressing the Health Disparities Faced by American Indians

by Ashley Tuomi

Dr. Ashley Tuomi is the Chief Executive Officer of American Indian Health and Family Services of Southeastern MI, Inc. She is a member of the Confederated Tribes of Grand Ronde in Oregon, and grew up in a military family traveling around the U.S. She graduated from Portland State University with a B.S. degree in Sociology while working as a Certified Nursing Assistant at a nursing home, then completed a master's degree in Health Policy and Administration at Washington State University. After Ashley interned one Summer with the Centers for Disease Control and Prevention working with American Indian/ Alaska Native grantees, she used the experience to write a master's thesis on Secondary Prevention of Diabetes Complications among the Eastern Band of Cherokee and tribes in Oklahoma. Following graduation she was employed as Assoc. Director of Health Services at United American Indian Involvement in Los Angeles. More recently, she completed a doctorate in Health Sciences from A. T. Still University (Kirksville, MO), with a dissertation on "Dental Anxiety in American Indians and Alaska Natives".



A patient being seen at the AIHFS clinic in Southwest Detroit.

American Indians and Alaska Natives in urban communities throughout the United States are what I like to refer to as the "invisible minority". When I discuss health disparities experienced by native communities and the work that we do at American Indian Health and Family Services, the first question that I'm typically asked is, "Are there actually Natives in Detroit?" In fact, some of you reading this article might be asking that question as well.

American Indian Health and Family Services (AIHFS) is a non-profit health center whose mission is to empower and enhance the physical, spiritual, emotional, and mental wellbeing of American Indian/ Alaska Native individuals, families, and other underserved populations in Southeast Michigan through culturally-grounded health and family services. Headquartered in a facility on Lawndale Street in Southwest Detroit, AIHFS provides these services to individuals living in the greater Detroit area. Our service area actually encompasses seven counties: Wayne, Oakland, Macomb, Washtenaw, Monroe, Livingston, and St. Clair.

According to the 2010 census, there are over 70,000 American Indians/ Alaska Natives (AI/AN) living in our service area. These individuals are representative of the 12 federally-recognized tribes in Michigan; tribal members from throughout the U.S. who relocated to Michigan; state-recognized tribal members; and First Nations individuals who have their tribal recognition through Canada. As you can see, the definition of native can vary depending on the context, and U.S. policy efforts to clarify who is Indian and who is not can still leave a lot of confusion. This also affects policies in our organization, as the definition of native is tied to the type of funding that we receive.

AIHFS was created in 1978, so we just celebrated our 40th anniversary last year. We are currently funded by many federal grants including from Indian Health Services (IHS), the Substance Abuse Mental Health Services Administration (SAMHSA), the Centers for Disease Control and Prevention (CDC), and the Administration for Native Americans (ANA), as well as state and local grants such as the Detroit Wayne Mental Health Authority, the Great Lakes Inter-Tribal Epidemiology Center, the Inter-Tribal Council of Michigan, and the Michigan Nutritional Network. We also rely on third-party billing for our medical and behavioral health services for individuals who do not meet our Indian Health Services patient criteria.

Federal Policy Eras

Before I get into the specific health disparities that exist in the native community, I want to take you on a brief walk through history by discussing the eras of federal policy that profoundly changed Indian Country and the health and livelihoods of our people.

In the Treaty Era, which began in 1789, the new U.S. government pursued multiple objectives including peace efforts, war alliances, and obtaining Indian land. Health care was one of the promises that tribes received as a part of the treaties, and this is the basis for the federal government's obligation to tribal members' health. A period that many people are aware of is the Removal Era (1828-87), widely known as the Trail of Tears. Natives were moved from East of the Mississippi to reservations in the West, opening up more land to white settlement. Traditional indigenous foods were increasingly replaced with fry bread and other foods that were convenient to make with the rations of white flour, lard, dried beans, and cheese that the government supplied to Indian reservations, paving the way for chronic health problems such as diabetes.

In the Era of Allotment and Assimilation (1887-1934), the reservations were dissolved and replaced with small family parcels of land that made hunting and gathering impractical, and farming on private plots the only viable way to produce food. There were additional land transfers (a theme you will see throughout these different eras) and the beginning of the boarding school movement. In the U.S., the boarding school

movement started in 1879 with the Carlisle Indian Industrial School in Pennsylvania, whose school motto was "Kill the Indian, Save the Man". Kids from as far away as Alaska were sent to this boarding school and over 20 similar ones throughout the U.S.; there were many such schools in Canada as well. Carlisle was operated until 1918 as a half-and-half system that included both education and physical labor. In addition to having their culture and language stripped from them (assimilation), these children experienced many additional hardships through harsh military discipline and forced Christianity. In fact, over 150 children actually died at Carlisle alone. Those of you who are sports fans might know about one of the iconic students who attended Carlisle, Jim Thorpe, who helped shape the game of football as it is played today. If you are interested in learning more about the relationship between football and Carlisle, I recommend that you read *The Real All Americans: The Team That Changed a Game, a People, a Nation* (Doubleday, 2007) by Sally Jenkins.

The other big influence on health was the Era of Termination and Relocation (1945-68). Termination was officially adopted in 1953 as a policy to terminate federal recognition of 109 tribes across the U.S. and to cease federal aid to them; treaty-established sovereignty was ignored. This particular policy is very personal for me, as my own tribe, The Confederated Tribes of Grand Ronde, was one of those that were terminated. When I was born, my tribe did not officially exist, and my mom was not a tribal member. Fortunately, my tribe's status was restored shortly after I was born, and thus we were able to regain our federal status 30 years after termination. The additional major policy change during this period was the Indian Relocation Act of 1956, which provided incentives for natives to move to specific cities. Urban tribal members were promised all of the help and resources that they would need: education, training, housing, medical care, etc. Of course, for many individuals these things turned out not to be readily available, and many people struggled to survive in their new urban surroundings. Both the Termination and Relocation Acts were major drivers in the increase of the urban Indian population. Many tribes disappeared, and today most native people in the U.S. live in cities.

Health Disparities

As you can see from this brief walk through history, the AI/AN population has experienced many decades of historical trauma— emotional and psychological wounding across the lifespan of individuals and across generations. Historical trauma induces many different responses, including survivor guilt, fixation to trauma, depression, suicide, and self-destructive behaviors. Studies have linked traumas experienced in childhood to poor health outcomes in adulthood, and we also know that these responses have led to intergenerational trauma. Although there are many salient historical events that I did not discuss above, I hope that what I did share gives you an understanding of why many health disparities arose and have persisted among native people.

Overall, the life expectancy of American Indians/Alaska Natives is 5.5 years shorter than that of the U.S. population as a whole. While this discrepancy has been narrowing over time, there are wide variances depending on region or tribe, and there is some speculation that data might not be accurate due to self-reporting of native heritage. What we do know is that the AI/AN community has higher mortality rates in many categories including: heart disease, with a mortality rate 1.1 times as high as the all-race average; unintentional injury, 2.5 times as high; diabetes, 3.2 times as high; chronic liver disease, 4.6 times as high; influenza/pneumonia, 1.8 times as high; and suicide, 1.7 times as high (Indian Health Services, 2018, https://www.ihs.gov/newsroom/factsheets/disparities).

The Indian Health Services system was created after many decades in which responsibility for the health care of American Indians was shifted among different agencies of the U.S. govern-

The American Indian/ Alaska Native community suffers a mortality rate from diabetes that is 3.2 times as high as the U.S. average, and a mortality rate from chronic liver disease that is 4.6 times as high as the average.

ment. The health care of AI/AN is a responsibility based on treaties and the federal government's unique historical relationship with tribes. In essence, "federal health services to maintain and improve the health of Indians is consonant with and required by the federal government", according to the Indian Healthcare Improvement Act.

Integrating Western and Traditional Medicine

Programs like AIHFS and other clinics throughout the Indian Health Services network are a big reason why there has been a modest increase in life expectancy among native people.

In addition to providing what is considered "western medicine", the clinics are also integrating traditional and cultural services. Among those services organized by AIHFS are these:

- community sweat lodges
- an annual local Pow Wow & Health Fair
- The Men's Society, a weekly gathering that provides a safe haven for men to share and discuss life's challenges and joys
- The Women's Society, a weekly gathering of caring and compassionate women who support each other and engage in craft making, exercise activities and Talking Circles to relieve stress and find inner peace with their spirit sisters

continued on next page

American Indians

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- Sacred Roots, a program working to revitalize First Nations foodways via community and commercial gardens, orchards, and kitchens, heritage seed banks, etc.

Culture plays an integral role in health because it is a protective factor. In essence, culture is prevention.

"Integrated care" is a big buzz-word in medical and behavioral health care— these days, it seems as if every provider wants to do integration. In reality, native communities have been practicing integration since before it was even a thought in mainstream healthcare. These early integration practices are based on the *medicine wheel*, an outlook through which our communities recognized the intersection of mental, spiritual, emotional, and physical health. The medicine wheel is one of the guiding concepts in a lot of the work that we do at AIHFS. Visually, it replaces the generic treatment plans in our behavioral health department. You will often see a treatment plan that includes participating in culture activities and ceremonies, as well as daily exercise along with mental health activities.

While integration of services has been happening for a long time in our communities, we are still perfecting the practice and learning more each day on how to integrate into the Western medicine model of care, which includes strict reliance on documentation. We struggle to fund traditional services, in part because they are not easily replicated and are therefore not considered evidenced-based programs. Fortunately, some of the work that we are doing is showing great success and has led us to being a leader in improvement.

Culture plays an integral role in health because it is a protective factor. In essence, culture is prevention.

One of these successes is our Special Diabetes Program for Indians, which is a federal grant program through Indian Health Services. It was established by Congress in 1997 to address the high rates of diabetes on our reservations and in our urban communities. Over time, we have seen many great successes including the reduction of diabetic eye diseases by 50%; a 54%

American Indian Health and Family Services organizes cultural services, such as an annual Pow Wow, because of the important role that traditional culture plays in physical and mental wellness.

decrease in kidney disease; and diabetes rates that have not increased in more than 10 years for youth and since 2011 for adults (Indian Health Service, 2017). This program is one of the most successful grant-funded programs that have changed the course of diabetes in the AI/AN population.

A continuing challenge is the lack of adequate funding. Some estimates show that current funding levels satisfy less than 50% of need. This is especially discouraging when you look at national health expenditures. In 2012, the per capita expenditures by the Medicare ($10,829) and Medicaid ($8,915) programs greatly exceeded that by the Indian Health Services program ($2,741). In fact, even the per capita expenditures for health in federal prisons ($4,817) exceeds that of Indian Health Services (Centers for Medicare and Medicaid, 2013; National Tribal Budget Formulation Workgroup, 2013; Sebelius, 2013).

Despite the complications of historical trauma and the ongoing underfunding of a health care system that is rooted in the historical and legal obligations of the federal government, Indian Health Services continues to make improvements in the health status of American Indians and Alaska Natives. I won't pretend that the system is perfect or that things could not be better, but that is a discussion for another day.

If you would like to learn more about American Indian Health and Family Services, visit us online at www.aihfs.org or on Facebook. In addition, we are always interested in volunteers or interns who would like to spend time working with us. The website also includes a list of items that we need for donation. •

Maternal Health in Ghana *continued from p. 19*

GHEI also aims to improve the quality of the care and treatments that community members receive. Compared to other African states, Ghana's health care system is much more developed— but it's not there yet.

In many rural areas like Humjibre, girls and young women face especially daunting odds in overcoming the challenges of everyday life. They face cultural, social, political, and economic obstacles that make their pathway out of poverty and into empowerment all the more difficult. Services in education and health are poorly designed, funded, and distributed and are marked by a severe gender gap. Therefore, since 2016 GHEI has specified that 60% of students in our Early Childhood Literacy (ECL) and Youth Education Program (YEP) shall be female. In Oct. 2018, we launched HERS (Health and Educational Resources for Success), a special endeavor to focus on girls' and women's empowerment. Through many of our existing and proven education and health programs— ECL, YEP, Mother Mentors, Sexual Education and Reproductive Health (SEaRcH), and Girls Empowerment Camp— we aim to ensure that girls and young women have the same opportunities as boys and young men.

If you would like to learn more or to help GHEI in its efforts, please visit our website at http://www.ghei.org.

Our Children's Vision *continued from page 17*

health and education officials, and still others are performing the basic research that will enable successful programs. Our partners have worked with the national governments of Cambodia, Tanzania, Uganda, and Zimbabwe, as well as state and provincial governments in France and the U.S., to have vision health included in school health programs.

Our Children's Vision has helped develop comprehensive guidelines for school health programs in low- and middle-income countries. Further, it successfully advocated for a School Eye Health Working Group within the International Agency for the Prevention of Blindness. In collaboration with the Global Partnership for Education and with the World Bank, we also completed two in-depth reports on child eye health in 43 countries and children's access to eye care services in low- and middle-income countries.

Reaching Wider Circles

Alongside training, new technology also plays an important role in making screening and other services accessible to millions of people. For example, the London-based group Peek Vision, an Our Children's Vision partner, has developed the Portable Eye Examination Kit (PEEK), a retinal camera attachment for smartphones (see photo on p. 17). The Peek system makes detailed vision checks in rural and remote locations affordable and highly effective. It was described by Dr. Andrew Bastawrous, co-founder and CEO of Peek Vision:

> In Kenya, our trial showed that our smartphone eye health system nearly trebled the number of school children receiving eye health services, compared to conventional screening. We also demonstrated the huge potential for scale with nearly 21,000 children being screened in nine days by just 25 teachers. We're now working with partners— many of them also Our Children's Vision member organizations— in multiple countries to bring these systems to even more children.

Behind the training and the technology, there are thousands of dedicated professionals who have made the progress of Our Children's Vision so rapid. Schools are the foundation of our strategy, but not all children make it to class. "It isn't just children in schools who are in need of eye care" explained Sue Chiles, Managing Director of the World Council of Optometry. "Sadly, there are millions of children who are not enrolled in a school system. We all work to ensure those children do not fall through the cracks, that they are not left behind."

It is through the insight and assistance of all of our partners that we have been able to progress so far so quickly, but the hardest part is yet to come. There are schools farther out, children living more remotely; there are regions, countries and districts that our partners have not yet reached and that we need to reach if we are to hit our target by 2020.

Anyone who would like to know more can visit our website, www.ourchildrensvision.org. Join us. Partner with us, or support us however you can. Be part of this important mission to change the lives of 50 million children by 2020, and the countless more who will come after them.

Mental Health Attitudes: Global and Collaborative Research

by Colleen Pilgrim (SC Psychology Dept.)

For a year now I have been carrying out a project to explore attitudes among U.S. and Indonesian college students toward individuals with mental health problems. An aim of the study is to better understand the obstacles that play a role in delaying or avoiding mental health treatment options.

The project has been supported by a 2018-19 Fellowship from the American Institute for Indonesian Studies (AIFIS), which I was awarded to initiate and conduct the research in Jakarta, Indonesia. The primary goals of AIFIS (https://www.aifis.org) are to "foster scholarly exchange between Indonesian and U.S. scholars, to promote educational and research efforts by U.S. scholars in Indonesia, and to facilitate visits by Indonesian scholars to the United States". My fellowship involves close collaboration with Theresia Indira Shanti and Nani Nurrachman, who are psychology professors at Atma Jaya Catholic University in Jakarta; Nancy H. Wrobel, a psychology professor at the University of Michigan-Dearborn; and two UM-Dearborn graduate students, Sarah Kesler and Devon Kardel.

From right, Drs. Nani Nurrachman, Theresia Indira Shanti, and Colleen Pilgrim during their tour of a mental health hospital in Jakarta, Indonesia.

To what extent are attitudes toward mental illness shaped by a reluctance to embrace science and medicine in general, and to what extent are they shaped by specific attitudes toward mental illness itself? To tease this apart is one goal of a questionnaire that we developed. In addition, we are examining factors such as guilt and shame, religiosity, and prior experience with persons suffering from mental health problems.

In Aug. 2018, I traveled to Atma Jaya Univ. to meet with my colleagues there and to oversee the data collection phase for the Indonesian sample. The survey respondents there were about evenly split between Muslim and Catholic. In addition, I was invited to give several lectures to students and members of the community. My presentation for about 150 incoming Psychology majors at Freshman Orientation focused on "Mental Health Issues for College Students" and was followed by a question and answer segment. I gave another talk, "Drug Addiction: Prevention and Treatment", to Master-level clinical psychology students, and a talk on "The Stigma of Mental Health Issues on College Campuses" to Ph.D. students.

A highlight of the visit was a collaborative round table with leaders of the Indonesian Network for Psychosocial Rehabilitation, which is an organization of mental health professionals dealing with stress and trauma among the Indonesian population. Along with Drs. Nurrachman and Shanti, I also visited a mental health facility for individuals suffering

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Dr. Pilgrim (at center) surrounded by clinical psychology MA students from Atma Jaya Univ., who were gathered to hear her lecture on prevention and treatment of drug addiction.

"Throw All the Labels Away": Asperger and the Invention of Autism

by Faye Schuett, SC Emeritus Prof. of English

Edith Sheffer,
Asperger's Children: The Origins of Autism in Nazi Vienna
New York: W. W. Norton, 2018

Gemüt, a person's capacity for sociability, is an important concept in Edith Sheffer's *Asperger's Children* as well as a central principle driving the murderous history that the book reveals.

Gemüt, "one of the German language's famously untranslatable" concepts, writes Sheffer, was developed by the young pediatrician, Hans Asperger, and his "senior colleagues" Paul Schroder and Hans Heinze as a diagnostic tool to identify a child's ability to fit in and be valuable to society (pp. 19, 67-9, 73, 239). Within "Nazi child psychology", Sheffer says, *Gemüt* came to mean "metaphysical capacity for social connectedness" (p. 19) upon which a child's life was balanced.

Difficult or anti-social children deemed to possess a potential for *Gemüt* might survive Nazi persecution by being incarcerated in curative education hospitals or juvenile protection camps where health professionals trained children to modify anti-social tendencies or serve society through labor. However, children exhibiting undesired physiological or social problems and diagnosed to have little or no capacity for *Gemüt (gemütsarm*, p. 19*)* were eliminated from society through euthanasia even though they were not terminally ill. Although the cause of death recorded for euthanized children was often pneumonia (p. 20), Sheffer documents how children, deemed unfit to live because they did not fit in, died from incremental barbiturate overdoses, lethal medical experimentation, abusive punishment, and starvation.

Hans Asperger (1906–1980) performing a psychological test on a child at the University Pediatric Clinic, Vienna. Detail from a photograph taken about 1940, around the time of Dr. Asperger's first description of autism. The photo, from the collection of Dr. Maria Asperger-Felder, appeared in Uta Frith, *Autism and Asperger Syndrome (*Cambridge Univ. Press, 1991), p. 8.

Eliminationist Ideas Before the Nazis

In the 1920s, explains Sheffer, well before Austria was overtaken by Nazi rule in the *Anschluss* (1938), Vienna and other European urban centers addressed growing welfare concerns through new social systems and eugenics. Although Sheffer does not explore the origins of eugenics in her book, a recent episode of American Experience ("The Eugenics Crusade", WGBH, aired on PBS-TV on Oct. 16, 2018) illustrates how an interest in social Darwinism and genetics led biologist Charles Benedict Davenport and educator Harry Laughlin not only to collect unscientific data on family histories to support genetic biases against immigrants and the poor, but also to campaign for sterilization and marriage-ban laws that they hoped would block defective human genetics from future generations.

Concurrently, in Vienna, Julius Tandler, "a leading city councilor" and head of the city's Public Welfare Office, talked of "forging a 'new people'" within an "orderly hygienic milieu" to improve people's health so that "the state could promote the strength of the nation through shaping the conditions of and care of its people". Tandler, a Socialist and a Jew, built "380 apartment complexes between 1923 and 1938" for about one-tenth of Vienna's population, where poor families could rent comfortable, light-filled, modern apart-

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Asperger *continued from page 29*

ments for only about 4% of their working-class incomes. Tandler's widely admired "Vienna system" also "combatted rampant disease" through "health clinics and free medical examinations in kindergartens and schools" (pp. 29-30).

However, Sheffer points out, along with these positive outcomes, socialistic or "Red Vienna" shared some "darker currents" of the "Austro-fascism of the mid-1930s that would become the Third Reich". Tandler, for example, "envisaged the forced sterilization of what he called 'the inferior'", which included some criminals as well as "people deemed to have heritable diseases, physiological or mental impairments". He also "talked about the 'extermination' of 'life unworthy of life'", evidence that "eliminationist ideas were in circulation among city leaders before the Nazis came to power" (p. 31).

Nazi Killing Centers for "Autistic Psychopathy"

Arriving in Vienna in 1931, 25-year old Hans Asperger, famous today because of his observations of autistic children and what has been called Asperger's Syndrome, had just begun his professional life as post-doctoral appointee to a clinic run by Erwin Lazar within the University of Vienna's Children's Hospital.

Lazar created the field of "curative education" (*Heilpädagogik)* that seems to have been a type of medical version of special education (p. 32). Lazar argued that his "Curative Education Clinic was 'the first attempt' to distinguish between 'the mental and physical defects of the wayward and criminal'' (qtd. on p. 36). His assessments of children were highly influential, yet psychoanalyst Helene Deutsch found his methods "a jumble of topsy-turvy testing" while other psychoanalysts found his approach a "mosaic made from countless splinters of other sciences" (qtd. on p. 40).

In 1934, two years after Lazar's sudden death, Asperger's direct superior, Franz Hamburger, a notorious anti-Semite who followed Nazi ideology and "promoted the eugenicists' vision of women as breeders and children as physical specimens" (p. 42), named his protégé, Asperger, director of the Curative Education Clinic.

Between 1934, when Asperger became director and the Nazis came to power in Germany, and 1944, when Asperger published his original thesis on what he called "autistic psychopathy", Asperger, a self-proclaimed eugenicist (p. 46) and conservative Catholic, did not join the Nazi Party. Nevertheless, by 1941, Asperger had helped Schroder and Heinze develop a child's potential for *Gemüt* into a diagnostic tool, and, "along with three of his most murderous colleagues" (p. 120) established the Vienna Society for Curative Education. The professional society "aimed to synchronize the treatment of children in Vienna, channeling child development efforts under Reich auspices" (p. 127). The cofounders, Erwin Jekelius, Franz Hamburger, Hans Asperger, and Max Gundel, used their professional positions to coordinate Vienna's municipal and medical resources into a killing system.

Erwin Jekelius, about the same age as Asperger, was the medical director of two killing centers. The first, called Steinkopf, was a sanatorium for adults. The second, called Spiegelgrund, was Vienna's Municipal Youth Welfare Institution; it was physically situated within Steinkopf and had 640 beds for infants and children. Jekelius, Sheffer says, oversaw "the deaths of around four thousand adults at Steinkopf and one hundred children at Spiegelgrund." As Vienna's Director of Welfare for Mentally Ill, Addicts, and Psychopaths, Jekelius also did not hesitate to "refer patients to the Hereditary Courts for sterilization" or to recommend that others be sent to centers like Steinkopf or Spiegelgrund for possible elimination (p. 129).

> *Children exhibiting undesired physiological or social problems and diagnosed to have little or no capacity for* Gemüt *were eliminated from society through euthanasia.*

Unlike Jekelius, says Sheffer, who promoted euthanasia so publicly that he inspired public protests in Vienna, Hamburger worked behind the scenes to strengthen the "infrastructure of murder" (p. 132). For example, as director of Children's Hospital, Hamburger organized Motorized Mother Advising tours to examine "infants and children up to age 14" in and outside of Vienna (p. 88). Each car sent to various neighborhoods had a nurse, a Reich welfare worker, and a Children's Hospital doctor to help families register any child with an inherited illness or infectious disease with Public Health Offices. In one "inspection of 1,137 children in 1940", for example, "62 percent were classified with problematic conditions that included 'severely flat feet', 'hereditary feeblemindedness', and an 'alcoholic father'" (p. 89). Of the 592 surviving medical files that Sheffer examined of children who died at Spiegelgrund, 44 (about 7%) were "dispatched" by Children's Hospital, "many of whom were transferred by Hamburger personally" (p. 134). Hamburger also encouraged lethal medical experimentation by young physicians that he mentored, carried out on infants and children sentenced to elimination in the death pavilion at Spiegelgrund.

Hans Asperger, director of the Curative Education Clinic, was also mentored by Hamburger and shared bylines with him on professional publications over 14 years (p. 132). Sheffer speculates that Asperger knew of the lethal experimentation that Hamburger supervised, yet Asperger did not seem to object. In fact, Asperger "had publically encouraged his colleagues to transfer 'difficult cases' to Spiegelgrund", writes Sheffer, and "followed his own recommendation" (p. 141).

Only 592 fragmentary medical histories were available to Sheffer in her research of the "789 children killed at Spiegelgrund", but through these and other records she documents that Asperger was personally involved in transferring at least 44 children to Spiegelgrund for elimination (p. 141). Nine children were transferred from his clinic at Children's Hospital, but only two from that number were killed. Asperger sat on a municipal commission to assess the educability of children at the "Guggling care facility", among other commissions, and Sheffer examined extant records of one review, where Asperger found 35 of 210 children uneducable and recommended them for "Jekelius action", or elimination at Spiegelgrund (p. 142). All of those 35 were killed (p. 147).

Asperger also recommended transfers to Spiegelgrund when he worked for the Vienna Public Health Office directed by Max Gundel. Sheffer is not sure how many children Asperger's opinions might have sent to Spiegelgrund, but his recommendations were "scattered through case histories" and seemed to matter to the public health facilitators. For example, when Asperger identified "Friedrich K. and Karl Sp. 'incapable of education'", their reform school transferred them to Spiegelgrund immediately (p. 142). Consequently, since Asperger worked as a consultant for "numerous city offices", the "total of children Asperger" sent to Spielgelgrund for elimination is probably higher than 44.

After the war, most of the Spiegelgrund staff escaped punishment, although Nazi Party members were "disqualified from leadership positions in the immediate postwar period" writes Sheffer. Asperger himself, "cleared of any wrongdoing", might even have "benefited from the vacuum his colleagues' disqualifications created" suggests Sheffer: he was appointed "interim director of the University of Vienna's Children's Hospital from 1946-1949" (pp. 227-228). He ended his studies of autistic psychopathy but enjoyed a medical career treating cognitively impaired children. He even published a textbook, *Heilpädagogik* (1952), that had many editions through 1968 (p. 238).

The Rise of "Autism Spectrum Disorder"

Hans Asperger might not have gained international attention, suggests Sheffer, without the interest of British psychiatrist Lorna Wing who, in the late 1970s, tracked down his 1944 thesis and formulated the concept of an autism spectrum (p. 241).

Wing had begun to specialize in child psychiatry after her daughter Susie was diagnosed with autism. She came to believe that not all of the autistic children with whom she worked fit Leo Kanner's founding definition/description of infantile autism published in 1943 (pp. 14, 241). Kanner, an Austrian-born psychiatrist, was working at Johns Hopkins Univ. in 1941. During the same year in which Asperger began his career in Vienna, Kanner defined "autistic" children as "socially and emotionally withdrawn, and preoccupied with objects rituals." Kanner also found that these children possessed little or no speech and exhibited "severe cognitive impairment" (p. 14). In contrast, the children, all boys, whom Asperger identified "as autistic psychopaths" during his years at the Curative Education Clinic, although similarly socially and emotionally withdrawn, exhibited "a broader variety of behaviors", including advanced cognitive abilities (pp. 14, 241). As Wing saw it, Kanner and Asperger were describing "different aspects of the same condition, their work fitting together in an autism 'spectrum'" (p. 241). Interestingly, in the late 1970s, when Asperger met with Wing over tea at Maudsley Hospital in London, he did not agree (p. 241).

After 1968, notes Sheffer, Asperger's articles were "much less critical of the children he diagnosed with autistic psychopathy" during the Third Reich, and stressed the "children's special abilities" (p. 239). Asperger argued that the children he had studied were superior to the children whom Kanner had diagnosed with "early infantile autism" (qtd. on p. 240). In his post-1968 articles Asperger argued, as Sheffer puts it, that "'Kanner's early infantile autism is a near psychotic or even psychotic state' whereas his own "typical cases are very intelligent children with extraordinary originality of thought and spontaneity of activity'" (p. 240).

The idea of an autistic spectrum expanded "the criteria physicians used, and rates of diagnosis shot up" (p. 243). Currently, various children diagnosed with autism might "bear little resemblance to each other", says Sheffer, except for what the Fifth Edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V) says are "deficits" in social communications and interactions, as well as "restricted, repetitive patterns of behavior, interests, or activities" (p. 243). Ironically, "these broad criteria" focus on Asperger's concept of "not fitting into a social community" (p. 243), i.e., a lack of *Gemüt.*

Before Lorna Wing's death in 2014, she acknowledged regret about bringing Asperger's ideas to the English-speaking world: "I wish I hadn't done it. I would like to throw all the labels away today, including Asperger's syndrome, and move towards the dimensional approach. Labels don't mean anything, because you get such a wide variety of profiles" (qtd. on p. 243-4).

Similarly, in her closing paragraphs, Sheffer, who dedicates her book to her autistic son, Eric, reminds us that autism is "often a diagnosis of behavior" rather than an "underlying physiological condition". She speculates that there are probably a number of as-yet unknown physiological causes for autistic behaviors. Sheffer finds it troubling that popular and media images of autistic children are often stereotypes: solitary, white, middle-class boys "disconnected from society" who are "trapped in their own minds" (p. 248), rather than real boys and girls behind the labels.

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A Densely Woven Tale: The Water Crisis in Flint

by Rheta N. Rubenstein

Dr. Rheta Rubenstein is a mathematics education specialist who retired at the Univ. of Michigan-Dearborn in 2016. A native Detroiter, her teaching career also included stints at public schools in Detroit, at the Univ. of Windsor, and at Schoolcraft College (1996-2001). She is an avid reader and contributor for International Agenda*; her most recent previous article was "No, We Don't Want to Talk about Race, But We Must and We Must Learn How!", a review of Ijeoma Oluo's* So You Want to Talk about Race *(Winter 2018). Rheta and her husband Howard live in Ridgefield, WA.*

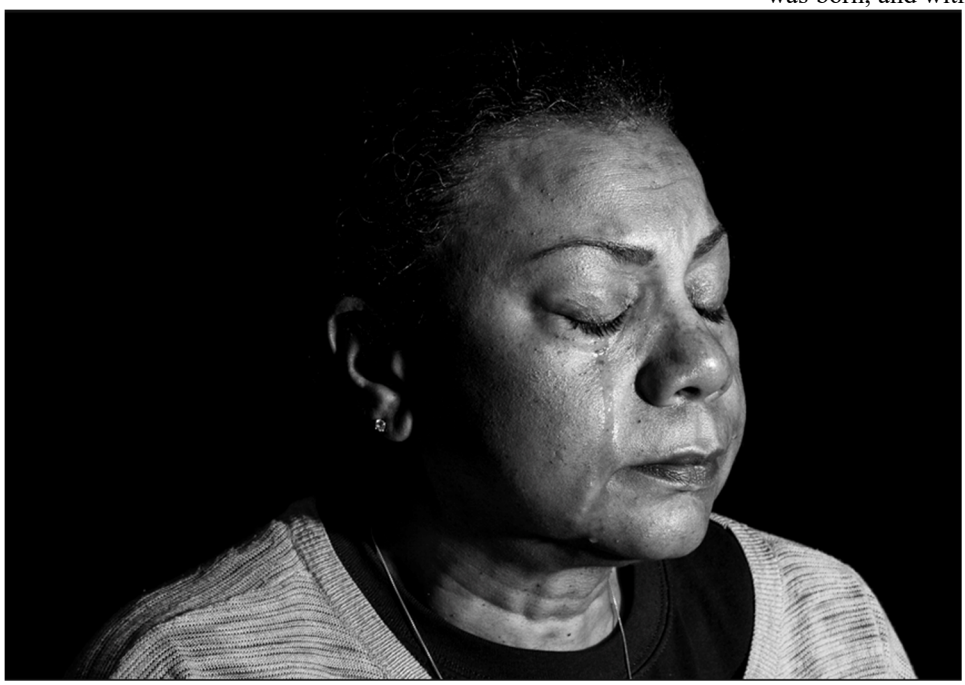
Mona Hanna-Attisha,
What the Eyes Don't See: A Story of Crisis, Resistance, and Hope in an American City
New York: One World (Random House), 2018

The very day that I started to read *What the Eyes Don't See*, my book club had talked about naming customs. But still I wondered, at first, why this book's author opened with her family's naming heritage. I learned, as the book unfolded, that it was not simply a history, as I expected, of the water crisis in Flint, Michigan (2014-2016); it was a story of much more, including the author's inheritance of a thirst for science and a hunger for social justice, where these came from and where they led her. Her explanation of how her Chaldean-Iraqi-American family members were named was just one thread that she was weaving through her densely woven tale.

Not all histories read like a mystery, pressing the reader in each chapter to move along, move forward, move quickly to learn the next incident, the next stage, the full and true story of what had happened and was happening. This one does. Mona Hanna-Attisha, 'Dr. Mona' to patients, is more than a pediatrician, more than a medical educator, more than a public health scientist, although all of these are parts of her 'day job'. As she learns about the lead-laden water in Flint— water that all of her patients, including bottle-fed infants, consume— as she voraciously reads related research, as she confronts repeated evasion by public officials, as she garners allies and data, as she and a few partners design and carry out large-scale data analyses in a matter of days, as she rides an emotional roller-coaster of successes and defeats, she discovers herself to be more: a risk-taker, a researcher, an advocate, a strong and clarion voice, and, ultimately, a public health warrior.

The history and activism of Dr. Mona's family is only one of many threads that she manages to weave into this book. Science is another of the major threads. How dangerous is lead? How does it affect growing children? What difference does the temperature of water make on blood lead levels? How could pipes that were inert with Detroit water become hazardous with water from the Flint River? What might Flint have done to avoid lead leaching into the water supply? Read this book and learn the answers.

Another thread is Flint history. We learn how General Motors was a premier local corporation but it could not withstand the power of its own workers in 1936-37 when they occupied the Fisher Body plants for 44 days. When the workers' demands were finally met, the United Auto Workers emerged as a major force. Out of such developments— wages high enough for workers to buy the cars they assembled, fair pay for overtime, and substantial benefits— the working middle class was born, and with it a big part of the American Dream. We also learn that the GM engineer and inventor, Charles Kettering, for whom Sloan-Kettering and other esteemed institutions and awards are named, was, according to Dr. Mona, a "public health villain" (p. 146). He discovered that lead, known even to the ancients as a dangerous element, when add-



Flint resident Joyce Wilson, 60, began struggling with respiratory issues and bouts of pneumonia after using tap water that originated in the Flint River. "I thought I was going to die. I had been sick but it had never been like it was in the last year or so. A lot die from things like pneumonia and respiratory infections."

Jake May, *The Flint Journal*, April 2016

ed to gasoline, would take the 'ping' out of car engines. He got gasoline manufacturers to add it to car fuel. No matter that it was bad for the environment or humans. Much later (2014), when, for financial reasons and under Emergency Management, Flint changed from the trusted Detroit water to their own system using the Flint River, GM quit using Flint water because it was corroding cars! Even then, it was only the residents, and no one in authority, who questioned whether the water was healthy for the community.

We also learn how researchers operate. Dr. Mona and her colleagues were fortunate, in a way, that their facility, the Hurley Medical Center, like other health facilities throughout the state, tests children regularly for lead. (No one dreamed that lead might be in the water, but they knew that old homes had paint chips that children sometimes ate.) It was a struggle to gain access to the data, but, once having it, there were lots of questions: Which ages of children should we examine? Which zip codes do we include? Which dates of blood testing do we use? Does it make a difference in which season of the year the blood is drawn? I particularly appreciated how well this portion could help a non-scientist get a sense of how a research study is designed and how data are analyzed productively.

I was shocked and confused to learn that a researcher for the national Environmental Protection Agency (EPA) had to leak his own data because he was kept from sharing it publicly.

Another thread is the politics— the stonewalling that Dr. Mona got from many, many agencies and officials. These included the Michigan Department of Health and Human Services and the governor's office. I was shocked and confused to learn that a researcher for the national Environmental Protection Agency (EPA) had to leak his own data because he was kept from sharing it publicly.

Finally, there is the issue of race. In the mid-20th Century, Flint was a vibrant, solidly middle-class community. As in many other northern industrialized cities, Black people, and others from around the world, had migrated to Flint for job opportunities. But federal housing policies and local racist covenants created segregated neighborhoods. After World War 2, veterans with GI loans bought homes in the suburbs. The city itself started to become African-American, a trend more fully realized today. Michael Moore noted that the Flint water crisis "was a racial crime. If it were happening in another country, we'd call it ethnic cleansing" (p. 307).

Indeed, the interweaving of so many threads is part of what builds tension in the book. You are in the middle of a sequence of shocking health information, and the next chapter interjects more personal or local history. All of this is done with clean, clear, engaging writing with dialogue, insights, passion, and compassion. Foremost, throughout the narrative you can see that Dr. Mona is driven by her deep caring for her patients, their health, and their potential. As things develop, she works to build hope— creating a pediatric health foundation aimed at bringing the strongest possible wrap-around services to the Flint community.

This is an important and inspiring book for everyone— educators, health care workers, scientists, historians, environmentalists, activists— all of us who care about our world. And for those who question the contributions of immigrants, Dr. Mona is one example of the talent, heart, insights, persistence, and courage that they contribute. •

Asperger

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Like Wing, Sheffer encourages us to throw out preconceived notions about autism and the treatment of children with or without social connection, in favor of neurodiversity:

> As appreciation of neurodiversity now grows, we might begin to see the perils of a totalizing label based on varying traits, since labels affect the treatment of individuals, and treatment affects their lives. The history of Asperger and autism should underscore the ethics of respecting every child's mind, and treating those minds with care— showing how a society can shape a diagnosis (p. 248).

In his own contribution to *Asperger's Children,* Eric Sheffer, age 13 at the time of publication, also wants to "put an end to the label of autism" (p. 251). People diagnosed with autism, he argues, should be treated like everyone else, lest the label isolates them further. "Parents of all children", he suggests wisely, "whether or not they are autistic, should think of their children's perspective and help their children based on their perspective" (qtd. on p. 251).

Asperger's Children: The Origin of Autism in Nazi Vienna is a meticulous social history of one era's perspectives and treatment of socially disconnected children. As Sheffer constructs the Nazi-era case on Asperger and his colleagues, she also weaves into the story numerous anecdotes from fragmentary medical histories that she examined of children who were killed at or managed to escape from Spiegelgrund. Sample intake photos, drawings and letters by children, as well as grisly details about the treatment and medical experiments that the children suffered, bring the reality of curative education and euthanasia into sharp focus. *Asperger's Children*— a searing cautionary tale for professionals and parents who hope to practice a perspective about the children they assist— remains, steadfastly, both respectful and label-free.

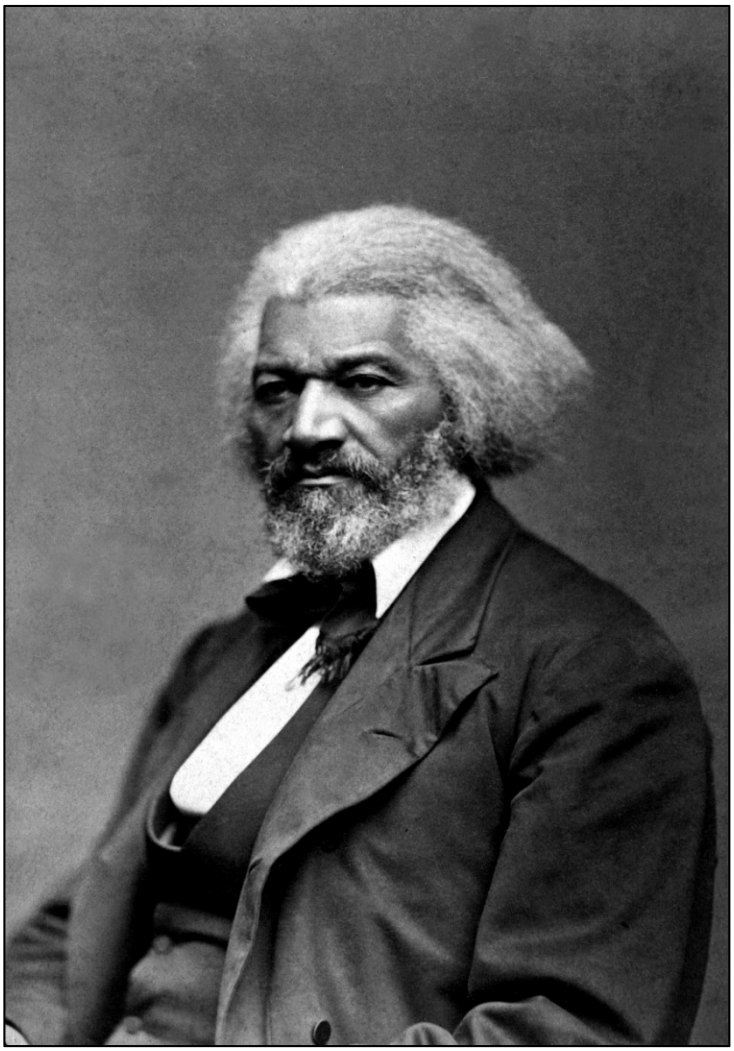
Frederick Douglass

by Robert Hayden

When it is finally ours, this freedom, this liberty, this beautiful
and terrible thing, needful to man as air,
usable as earth; when it belongs at last to all,
when it is truly instinct, brain matter, diastole, systole,
reflex action; when it is finally won; when it is more
than the gaudy mumbo jumbo of politicians:
this man, this Douglass, this former slave, this Negro
beaten to his knees, exiled, visioning a world
where none is lonely, none hunted, alien,
this man, superb in love and logic, this man
shall be remembered. Oh, not with statues' rhetoric,
not with legends and poems and wreaths of bronze alone,
but with the lives grown out of his life, the lives
fleshing his dream of the beautiful, needful thing.

Frederick Douglass (1818-1895) escaped his enslavement in Baltimore at the age of 20 and fled to Massachusetts, where he became an internationally famous journalist, abolitionist, and statesman, a great fighter for the liberation of oppressed women and men. Marking the bicentennial of his birth is David W. Blight's acclaimed biography, *Frederick Douglass: Prophet of Freedom* (New York: Simon & Schuster, 2018).

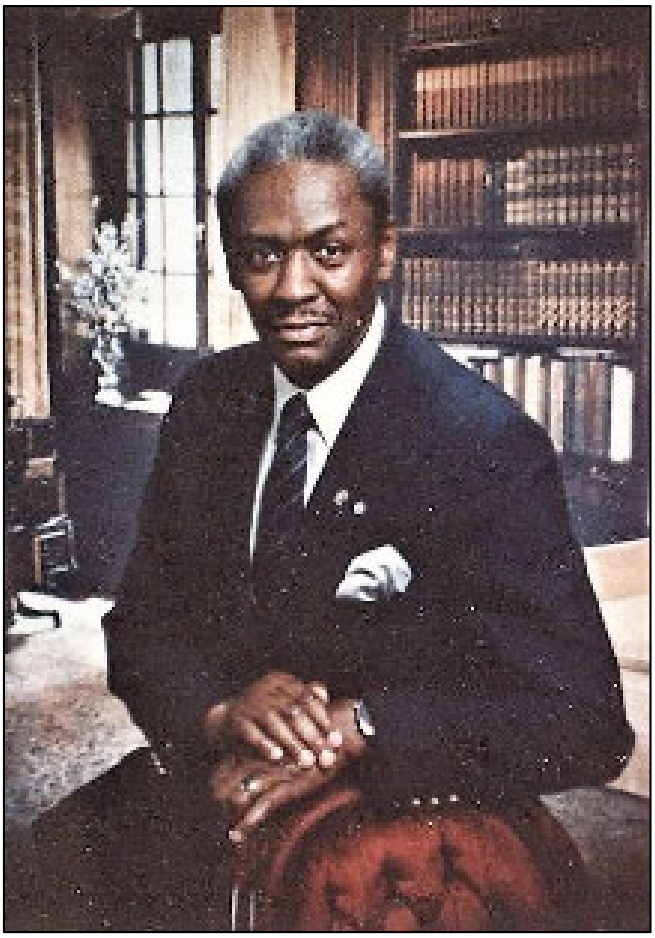
Robert Hayden (1913-1980), a writer born and raised in Detroit, was the first African-American to be appointed as Consultant in Poetry to the Library of Congress, a position later renamed U.S. Poet Laureate. He was an English professor at Fisk Univ. (1946-69) and at the Univ. of Michigan (1969-75). The above poem, written while Hayden was an undergraduate student at UM, is reprinted from his *Collected Poems*, ed. Frederick Glaysher (New York: Liveright Publishing Corp., 1985).



Photograph of Douglass by George Kendall Warren, ca. 1879. National Archives, identifier 558770

E Pluribus Unum: My America

by Frank M. Rasbury



Lt. Colonel Frank Rasbury, 90, and his wife Naida live in Ocala, FL. Late last Summer, Marianne Brandt, a member of this magazine's Editorial Committee, met the couple and their daughter during a cruise to Alaska, and Lt. Col. Rasbury kindly accepted her invitation to write about his life experiences as a Black person in the U.S. and with the U.S. Army abroad.

I open by stating, unequivocally, that there is NO black "monolith" in the United States of America. There is no "standard" appearance or speech pattern. There is no common religion, nor political stance. In short, one can never say one knows how all or most black Americans feel or think, because among black Americans there are many different attitudes relative to almost everything. Black Americans can be found in almost every sector of American society, albeit underrepresented in some and overrepresented in others.

I have been asked to write about my experiences as a black person who has lived both in the U.S. and abroad. I should point out that my experiences are uniquely mine, and should not be viewed as reflective of anything or anyone else's circumstances. Let's start with the fact that I am and always have been totally integrated into American culture. From kindergarten on up through the primary grades, high school, and college, I was always part of mainstream America, so it's no surprise that my attitudes reflect that.

An Early Habit of Self-Assessment

When I was growing up in Buffalo, NY, I remember that my parents, especially my mother, constantly pointed out good examples that were thought worthy of my emulation— a neighbor's older kid, or the example of a successful adult who was highly regarded in our community. I paid close attention to these suggestions and tried to internalize them as guidelines for future reference. As I got older, I began to scrutinize almost everyone's accomplishments and behavior in search of examples that I could assimilate when the time came. Happily, I found many "good" examples worthy of my attention and embrace. I also learned a lot of what NOT to do and how NOT to act, and promised myself that I wouldn't do THAT under any circumstances.

As I matured into my mid-teens, I developed the habit of critiquing almost every action that I took or things that I said, trying to evaluate how well or poorly I had done them. My "scores" weren't always high. Sometimes I wanted to kick myself and ask, "How could you have done (or said) something like that?" But more and more, my scores got better and my critiques resulted in "good job" and "attaboy" and other expressions of self-congratulations. Along the way, I also began to nurture an appreciation of excellence, disdaining "average" as "mediocre", which was not good enough. Honesty compels me to admit that I also got lazy sometimes and failed to fully live up to the standards that I had set for myself.

But in all of that time I never, ever thought of myself as a "role model" for anyone to emulate or follow.

The Army and the Curse of Low Expectations

In truth, despite my confidence I was NOT always readily accepted and was sometimes "sidelined" or put in less important positions to preserve the "status quo". This was especially true during the first half of a military career that spanned more than 20 years (1951-71). I entered the U.S. Army as a "private soldier", earned a commission, and ultimately achieved the rank of Lt. Colonel before retiring.

The backdrop of my poor treatment was the Army's slow emergence from segregation into full integration. Pres. Truman had ordered the desegregation of the military in 1948; however, it would be some time before desegregation became a reality. When the United States entered the Korean War in 1950, military units were still segregated. But as the military struggled with heavy losses, desegregation became necessary to maintain fully manned units. The desegregation of the military abroad was a catalyst for desegregation back home.

The war in Korea was in full tilt when I joined the Army as a private soldier in Jan. 1951. After Basic Combat Training and then Advanced Individual Training (Infantry), I attended Leader-

continued on next page

My America *continued from page 35*

ship School, an 8-week course intended to develop young soldiers into junior leaders. My embrace of excellence paid off here and I graduated #2 in my class (always thought I should have been #1). I was promoted to corporal and applied for officer candidate school (OCS). Before my processing could be completed, however, I was shipped overseas to Okinawa, Japan, located in the Ryukyu Islands and nicknamed "The Rock". It was there that I first encountered something that my cousin, William Raspberry (a Pulitzer Prize-winning columnist for the *Washington Post*), would later describe as the "curse of low expectations". This is when it is predetermined that you probably can't do well, so no one expects you to— but worse, you are not fairly "permitted" to do well due to racial stigma. This was a phenomenon that I only discerned while reviewing my experiences many years later.

The unit that I joined in Okinawa had only recently been integrated, and there existed some residual discomfort and resentment by some. I learned that the Army, in publishing orders for the assignment of soldiers from one unit to the next, routinely identified negro soldiers with the notation "Neg" by their names so that the gaining organization knew in advance that the soldier(s) being assigned to them were negroes and had the opportunity to place them where their predetermined lack of capability would have minimum negative impact. To be fair, some commanders were more welcoming and gave soldiers a chance to show their skills and advance, but many were not.

My high level of self-confidence sometimes didn't serve me well because some viewed it as "arrogance" and reacted negatively. My saving grace was that I was a good, well-grounded soldier whose skills couldn't be denied, even if unappreciated. I was given an opportunity for growth (communication school), and during field exercises I became the company commander's radio operator. My Platoon Sergeant was indifferent to me but did allow my Squad Leader to make me the Assistant Squad Leader, which could lead to promotion to sergeant after 60 days of satisfactory service in that position. I thought things were going well until, shortly before the end of the 60 days, I learned, indirectly, that I was no longer Asst. Squad Leader, so goodbye promotion! The Platoon Sergeant didn't want to see me promoted, so I was removed from that slot. No one EVER directly spoke to me about it, just quietly made the paperwork change and that was that.

I was befriended by a negro officer on the battalion staff who had discovered that we were fraternity brothers (ΚΑΨ) and urged me to re-apply for OCS. I did and was successful, and after five months on "The Rock" was ordered to Fort Benning, GA, to attend Infantry Officer Candidate School. Being driven to excellence, I did well in the intense 22-week training and graduated highly ranked in my class. I accepted a commission as a second lieutenant of infantry six months later.

After a short stint at Fort Lewis, WA, I received orders to Korea, again with the "Neg" notation by my name (this practice was abolished some years later). During my tour of duty there, I struggled against those who had low expectations of me, while awaiting opportunities to "shine" and to show off my skills. As a result, I was not hurt professionally as badly as I might have been had I indulged in self-pity. I just dug in and continued to work hard, ending this deployment as a Company Commander.

An Unwitting Role Model

I was subsequently re-assigned to Fort Ord, CA, an installation for training new recruits. There I had the good fortune to work for several commanders who thought highly of me and encouraged me to be my best.

But Fort Ord was also the place where I first got a taste of being a "role model", and it wasn't pleasant. One day, I had an appointment to take a special physical exam at 1:00 pm, but due to problems at my unit I was unable to report for my physical until about 1:30. I was rudely greeted when I arrived and upbraided for being late, my explanation notwithstanding. As I took my packet and retired to another room to complete the paperwork, I overheard one of the women remark about my tardiness: "They just don't have 'it', they'll never amount to much!" It was clear that I was being considered typical of a "poor" group (negroes) and that I was living proof of that low standing. I was embarrassed and angry to have brought discredit upon my race, which had enough problems without my poor showing. For the first time I vowed that I would become nothing short of the best representative of my race that I could be, and that I would work tirelessly to earn and display only the highest levels of competence and dignity from then on. A role model was born!

After graduation at Fort Benning, I proceeded to my next assignment in Augsburg, Germany, where I was promoted to captain and served for the next three years. Again, I was beset by the specter of low expectations. While I was recognized occasionally for my commendable contributions, I was not given positions of any substantial responsibility.

My fortunes began to turn around after I was re-assigned to the Army Language School in Monterey, CA (across town from Fort Ord), where I undertook the study of the Russian language, again finishing in the upper level of my class. I was assigned to a Military Intelligence Battalion at Fort Hood, TX, to exploit my new linguistic ability. There, it seemed that everything I touched "turned to gold" and I rose to prominence in that unit.

This rare but welcome circumstance continued with my promotion to major and my assignment to Panama, where I was at first the brigade intelligence officer and then a battalion executive officer (second in command), both very prestigious positions, resulting in the award of the Army Commendation Medal. What a profound difference from my first 10 years of service!

Next came Viet Nam and assignment as an Intelligence Officer on a high-level general staff. My good fortune lasted about six months before I was once more working for superiors who did not care much for me. My good work ethic saved me from disaster. I was promoted to Lt. Colonel and earned a Bronze Star medal, but I still had to endure unpleasantness.

Good fortune again returned, and after I left Viet Nam I became commanding officer of an element of the Army Recruiting Command in New York City, where I finished out my 20-year career and was recognized with a prestigious Legion of Merit medal.

As the above summary shows, things in the Army were rocky for me at times, especially during my first 10 years, and the curse of low expectations showed itself repeatedly. My coping mechanisms for dealing with adverse conditions and/or indifferent/hostile commanders were (1) to look within myself for the strength to endure, and (2) to await opportunities for "redemption". Throughout my life I've been in and out of churches, but I don't consider myself to be especially religious. Yet I can and do accept certain religious tenets. When times got difficult, my default action was to turn inward, find the strength to persevere, and then press on through the storm until it abated.

Others might say that they "pray" for the needed strength. Although I try to walk a "Christian Path", the "straight & narrow", simply because it seems to be the right thing to do, I'm not pious enough to think that all strength comes from God. And I certainly reject the claims made by some people that they can just put their problems in God's hands and sit back and await a favorable outcome. I believe that I must "get off my butt" and actively DO something to achieve a desired outcome. "God helps them who help themselves" rings true to me. I am reminded of a poem by William Henley, "Invictus", whose last pair of lines read: "I am the master of my fate: I am the captain of my soul." This has been my beacon throughout my life.

I Didn't Know I Was Black and Was Supposed to Act Differently

Of course, my mirror shows me my African heritage every day, but I never took that very seriously. In growing up, I had always attended racially integrated schools, and felt totally assimilated into American culture. I assumed that all of the lessons of pride and patriotism applied to me as well. I got along very well with my classmates. I competed successfully with other students academically, athletically and, having been blessed with a pleasant personality, was well received socially. This high self-esteem gave me the confidence to approach everyone and everything with a positive attitude and expectation of full acceptance as we worked together to solve whatever problems lay before us. Thus, I always felt included— part of the "in" crowd to the extent that such a grouping existed. I was considered one of the class leaders, and I never felt any different from the others. I learned that I was as good as most, better than some, yet not as good as others. That is not to say that I never got called by a racial slur, but it was rare, and usually by the same one guy.

Later, in the military, most of my interactions were with fellow Americans from different parts of the U.S. These soldiers and officers carried with them certain biases, conscious or not, that influenced their actions and reactions. Not all of their thoughts were negative, however. In fact, as I progressed through my career, I dealt with younger people and with racial relations that, in general, were less negative. It gradually became more common that I was allowed to "show off" my skills, often with the encouragement and delight of my superiors.

In foreign lands, I did not interact much with the native populations except in Germany (1958-61), where our commanders greatly encouraged good relations with German nationals. Being a sports-car enthusiast, I joined in the formation of a German-American Sports Car Club (DASCA) in Augsburg, Bavaria, where I was stationed. We had German and American co-presidents, and I became the American President after a short time. I established some warm, and in some cases close, friendships with my German partners. It helped that I had studied German in high school. I was able to build on that and soon became fairly fluent in the language. It was common to see me in a gathering of club members speaking in German to them while they spoke in English to me, both sides polishing their linguistic skills. I was accepted as an individual based simply on my competence and personality— no more and no less. This is all that I would ask for anywhere, from anyone.

For Harmony, Not "Identity Politics"

I strongly reject the term "African-American" for several reasons. While I recognize that my heritage is African, I am just as clear that my culture is strictly American (many don't know the difference between these two words). Since I don't hear White people generally being described as European-American, my question then is why should I be hyphenated? Why identify "Asian-Americans", etc.? It seems to state that Whites in the U.S. are Americans and all others (the hyphenated ones) are some special, lesser kind of Americans.

Having said all this, I am also aware that the term "African-American" arose from within the Black community itself, from those who had accepted "victimhood" and had given up on full acceptance by and integration into mainstream America. Needing to "belong" somewhere culturally, they embraced their African heritage, proclaimed themselves "African-American", gave up on trying to fully integrate, and instead moved in the opposite direction toward "identity politics". Birthed in the Black community, popular use brought the term "African-American" into the mainstream where it might have been the model for the other hyphenated terms as well.

Calls for diversity are being heard clarion-clear, but there is little call for harmony here. It is more discord, a desire to be heard, rather than to fit in. When speaking of what diversity means to me, I usually liken it to an orchestra: there is a mixture (diversity) of instruments, each kind lending its own unique sound and playing in harmony to the same melody. Every instrument playing its OWN melody does NOT demonstrate anything other than cacophony (harsh noise). This is what is being increasingly heard today. I still believe in *E Pluribus*

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My America *continued from page 37*

Unum, "Out of many— one" (the motto found on our coins), as the foundation and promise of what our Constitution stands for. To claim the rights and privileges provided for in this hallowed document, one must accept and abide by its constraints as well.

Frederick Douglass (Feb. 14, 1818 – Feb. 20, 1895), a former slave and a leading abolitionist, writer, and orator, was the most important black American figure of the 19th Century. Even then, he was no fan of "race pride", calling it a "positive evil" and a "false foundation". He wrote, "It has long been the desire of our enemies to deepen and widen the line of separation between the white and colored people of this country." For Douglass the only relevant minority in America was the minority of one— the individual. The government of all should be partial to none. He argued for identifying with *America*— with the nation founded on "human brotherhood and the self-evident truths of liberty and equality."

This argument seems to have been lost upon those who today call for the U.S. to be or become a "multi-cultural" country, one where immigrants can bask in the wealth and comfort of this nation while still pledging loyalty to their homeland. Their goal is not assimilation but, instead, the safety to continue to be what they always were— even to the extent of flying the flags of their homelands. Pres. Theodore Roosevelt once said,

> In the first place, we should insist that if the immigrant who comes here in good faith becomes an American and assimilates himself to us, he shall be treated on an exact equality with everyone else, for it is an outrage to discriminate against any such man because of creed, or birthplace, or origin. But this is predicated upon the person's becoming in every facet an American, and nothing but an American... There can be no divided allegiance here. Any man who says he is an American, but something else also, isn't an American at all. We have room for but one flag, the American flag... We have room for but one language here, and that is the English language... and we have room for but one sole loyalty and that is a loyalty to the American people.

To this I say, **Amen!**

Role Models Outside the Military

After retirement from the military, I underwent a divorce and remarriage and set about trying to learn how to function in the civilian society. This proved to be a challenge on more than one occasion, but bit by bit I was able to deal with the lack of discipline, direction, and motivation, and applied my own experience to compensate for those appalling lacks.

The result was that I was given leadership responsibility almost everywhere that I turned. I held a series of three jobs, in top management positions in each. To be successful, I had to call upon most of the skills that I had learned in the military. Especially valuable were my abilities to manage personnel to glean their very best efforts. I had and have strong administrative capabilities, as well.

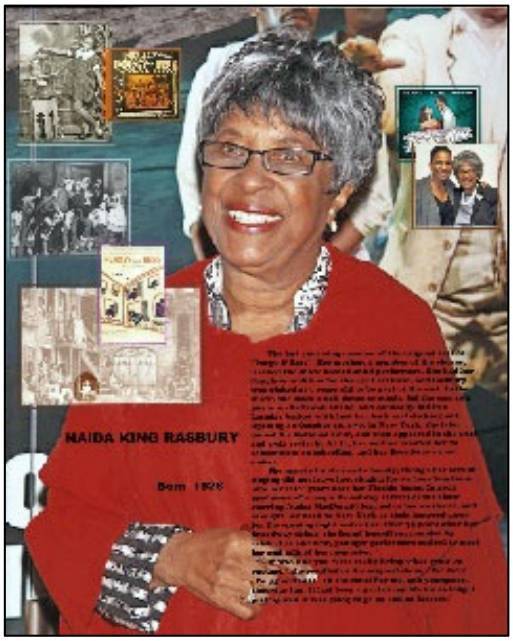
In 1975 I was invited to join Rotary International, becoming the local club's first black member and, in 1979, its President. This was followed by service on the District staff and in 1983, I became Governor of District 725. Rotary is the world's pre-eminent service organization and its 35,000 clubs are found in 200 countries and geographical regions, with a membership of more than 1.2 million business and professional men and women united by the ideal of service. After my term was over, I represented Rotary International at the United Nations in New York (1985-86), followed by several committee assignments, instructor assignments, and other avenues of service.

In 1985, Rotary clubs worldwide undertook the task and expense of eradicating polio from the face of the earth. Where there were once about 1,000 new polio cases seen each day, at the time that I write this there are only 18 known cases in the entire world, and these are limited to the countries of Afghanistan, Nigeria, and Pakistan. Total eradication is almost at hand, and the world can thank Rotary for this monumental service! After 43 years, I am still continuing my "love affair" with Rotary.

My last executive position was as Executive Director of a Red Cross Chapter in an affluent Long Island county. Its volunteer board of directors consisted primarily of the most respectable local citizens. I comported myself in my usual "take charge" fashion and proceeded to lift our chapter up from some difficult positions, to the delight of the chapter's paid staff, but not so much to some of the volunteer element who considered me to be arrogant and "uppity" and not sufficiently aware of my "proper place" in their society. I was black, but didn't realize that I was expected to act differently— deferentially. What followed was 11 years of success laced with tension, now and then, because I didn't seem to understand/accept that I was supposed to act in a more servile manner. At a meeting of the board, I finally had "enough" and announced my resignation in June 1986.

My wife, Naida, followed me into retirement in August 1987. Naida had been born into a show-business family. Blessed with a beautiful soprano voice, she made her Broadway debut at age 7 in 1935 in the George Gershwin musical "Porgy & Bess", and toured with the company across the country. When it was time for high school, she returned to New York City and graduated from Music and Art High School.

This was shortly after the end of World War 2, and Naida's mother thought it wise to send her to college to become a teacher so that she wouldn't have to rely on the vagaries of being a gifted but starving singer. She taught elementary school for a while, opened her own nursery school, traveled to Haiti and eventually visited Nigeria for its Independence Day celebration in 1960. She married and lived there for 7 years until the Biafran War forced her to leave with her two children and return to the U.S. While in Nigeria, she continued to sing and taught school as well. When I met her, we were both undergoing divorce proceedings, and we ultimately married. Naida worked as an administrator for the City of New York and was quite competent in that role.



In retirement, Naida and I moved from Long Island, NY, to Ocala, FL. We both vowed to immerse ourselves in our new, adopted community and to work as diligently as we could to make it even better. It wasn't long before we were serving simultaneously on almost two dozen boards, committees, etc. Naida and her administrative skills were widely sought after by the various groups. This was especially true when she joined the Ocala chapter of The Royal Dames for Cancer Research, which has raised millions of dollars for the treatment and hoped-for eventual cure of this dreaded disease.

For recreation, we joined a motorcycle riding group called the Gold Wing Road Riders Association. Naida and I were Chapter Directors in Ocala and then were offered the Directorship of Global Affairs on the national staff, which we held until 2003. Later we traded life on two wheels for one on six wheels by buying a motorhome and taking on the nomadic life of campers. We joined the Gulfstreamers organization as well as the Florida Sunshine Chapter of SMART (Special Military, Active & Retired Travel club). I was soon elected Chapter Director of SMART, where I served for two years.

By now, the reader will have noticed a pattern of leadership roles coming our way soon after our joining various organizations. Aside from our administrative and leadership abilities being recognized and embraced, it is also testament to the willingness of others to embrace us personally and include us in their activities. This kind of interaction cannot take place if one party, feeling deprived of equal treatment, strives to tout their differences instead of embracing their similarities. If you want to be treated the same, then you must act the same! It should be noted that at NO time did we EVER forego our integrity! If we thought something was wrong, we were forceful in declaring it so, but we usually also offered what we thought was a better solution. That's what won the day!

In 2012, The March of Dimes' local office honored us and our 25 years of community service during a gala celebration and fundraiser, "In Honor of Excellence". It was a touching moment when over 300 people stood and gave us extended applause, causing us to comment, "We must have done something right!" Five years later, on Valentines' Day 2017, we were similarly recognized and applauded for 30 years of service with Inter-Faith Emergency Services and its Foundation.

Today, we happily embrace the notion of being role models in our community. We fervently believe that we have made positive contributions in phil-

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Students Without Borders

The Contemporary Language of Dissent in an Era of Compelled Homogeneity

by Titas Biswas

Titas Biswas is a student working toward a bachelor's degree in sociology at Jadavpur University in Kolkata, West Bengal, India. Her previous article for this magazine was "The Crisis of Fundamentalism in India and Across Asia" (Winter 2018). She has written for several other publications as well, including the Global Daily Tribune *(Kolkata), Anarchimedia, and The Perspectives Blog.*

At the beginning of August 2018, the student population of Bangladesh rose up in fierce resistance to state terror. Massive crowds of protesters, many wearing their school uniforms, blocked streets and paralyzed Dhaka, the capital, cutting it off from the rest of the country for five days.

Prime Minister Sheikh Hasina repeatedly encouraged riot police and other forces to crack down on the students. Both tear gas and bullets were used against the demonstrators. Several armed thugs were also reported to have savagely attacked the unarmed student protesters.[1] Chhatra Parishad, which is the student wing of Hasina's governing party, the Bangladesh Awami League, was accused of rape and brutal beatings.[2]

The demonstrations had erupted after two teenage students, a boy and a girl, were struck and killed by a pair of speeding transit buses in Dhaka on July 29. The situation involving unsafe roads has already been an emergency in its own right in Bangladesh, where a minimum of 12,000 people die every year in traffic accidents frequently caused by faulty vehicles, reckless driving, or lax traffic enforcement.[3] The capital, crowded with 10 million inhabitants, is regularly snarled by road chaos. Bangladesh has the world's highest per-vehicle rate of traffic fatalities, and the accidents also cost the developing nation about 2% of its entire gross domestic product.[4]

Most of the protesting crowds consisted of adolescent, school-going children. They raised the demand for safe roads for everybody, and for measures against reckless and unlicensed drivers. Many carried posters that stated that they had no vested political interests apart from this. The government crackdown was very regressive for a modern democracy, and raised questions about the legitimacy of the political system not only in Bangladesh but also in other regions across the world.

The government crackdown was very regressive for a modern democracy, and raised questions about the legitimacy of the political system not only in Bangladesh but also in other regions across the world.

What was also quite intriguing was that students were collectively rejecting binary ideas of politics, and were instead trying to ensure a certain sense of conscience and an

A protester faces baton-wielding riot police last August in Dhaka, the capital of Bangladesh, in this photo sent out on Twitter.

inherent community feeling during the protest. Further, despite a history of Bangladeshi government bans and blockages against social media, the movement was able to appeal to and coordinate with sympathetic youths across borders. On Aug. 6, for example, students from three different universities in Kolkata, India— Jadavpur, Calcutta, and Presidency— marched in solidarity right up to the Bangladesh High Commission near the Park Circus area at the heart of the city. Bangladeshi students in Kolkata joined in, too. However, the police barricaded the march before it could reach the venue, and only a handful of representatives were allowed inside after much argument. The High Commission refused to share even the tiniest fragment of information on this issue and acted absolutely oblivious to it.

Within weeks, though, the Bangladeshi Parliament passed the Road Transport Act of 2018 to impose sentences of up to five years in jail for reckless driving resulting in death. But at the same time, the government ramped up its monitoring of social media activities, apparently frightened that Bangladesh could witness the same sort of youth-led revolts that were seen in the Chilean Students' Movement of 2011-13 and the more recent anti-austerity movements in Ireland, Portugal, Spain, Greece, and the United Kingdom.

Deeper Rumblings of Discontent

While the demand raised by the students focused on road safety, the strength of the feelings that were expressed speaks to deeper rumblings of discontent. To understand this, one needs to look with a wider lens at South Asia as a whole. The last several years have been very important ones in the history of the Indian subcontinent and its neighbor countries, especially Bangladesh and Myanmar.

In India, Prime Minister Narendra Modi styles himself as the architect of a neoliberal economic miracle and is also a leading figure in the BJP, the extreme Hindu nationalist party. Accordingly, Indians have had to witness violent fundamentalist activities carried out under the banners of both 'religion' and majoritarian politics. In addition, caste conflicts still haunt India after a 2,000-year history there. In this 21st-Century globalized world, we see the return of medieval-style atrocities, including fatal beatings and mob lynchings for the "crime" of being a Muslim.

The gradual deterioration of the Indian Muslims, both economically and politically, has slowly driven the great bulk of them toward crushing poverty. Cow's meat, widely

Bangladeshi students shout slogans as they block a road during a protest in Dhaka, Bangladesh, on Aug. 2, 2018.

AP Photo/A. M. Ahad

available and cheap in India, has been a welcome alternative protein source for those unable to afford milk, lamb, or even chicken— yet Hindu fundamentalists incite outrage against them simply for eating beef. Last Summer, when the southwestern coastal state of Kerala was hit by devastating floods that ruined many residents, Hindu commentators blamed the disaster on Muslim consumption of cow's flesh!

In Buddhist-majority Myanmar, just to the east of Bangladesh, a grotesque bout of ethnic cleansing in Aug. 2017 forced about 700,000 terrorized members of the Rohingya Muslim minority to flee their villages, journeying by foot or boat to Bangladesh and other countries. The violence was orchestrated by government, military, and paramilitary forces and encouraged by extreme Buddhist nationalists.

Essentially similar to the ethnic cleansing in Myanmar has been the treatment of the Bengali-speaking Muslim minority in Assam, a state in far northeastern India that borders Bangladesh. The Muslims there, who suffer from poverty and illiteracy, comprised 34.22% of the population of Assam in the 2011 census. Their ancestors came from East Pakistan (now Bangladesh), but they are sometimes not even considered ethnic Bengalis, and instead are labelled simply as 'Muslims', demonized as such and subjected to periodic pogroms. The BJP leaders in Assam have been encouraging such tendencies with their extremist Hindu nationalism. Further, current government schemes to update the National Register of Citizens of India (NRC) so as to identify "illegal migrants" who entered Assam after March 24, 1971 could well lead to the loss of voting rights and citizenship for the Bengali Muslims there.

The story in Bangladesh itself, with its Muslim majority, is necessarily somewhat different than in Hindu-majority India and Buddhist-majority Myanmar. The history of Bangladesh is marked by its great nationalist struggle for autonomy and independence, encompassing not only people's freedom to govern themselves but also their free-

A student protester in Bangladesh last August holds a sign saying, "We Don't Want 1 Gigabyte of Data for the Price of 9 *Taka*— We Want Safer Roads to Walk Across".

dom to speak their own native language, Bangla. Prime Minister Sheikh Hasina is herself the daughter of freedom fighter and martyr Sheikh Mujibur Rahman, popularly dubbed Bangabandhu ("friend of Bengal"); he was the central figure in the Liberation War of 1971. But under Hasina's leadership, the Awami League— the party founded by her father as a vehicle for independence— has been transformed into one that seeks to bring Bangladesh more firmly into the global capitalist orbit. With the support of India, the party's "Vision 2021" and "Digital Bangladesh" plans have sought to adopt western technology as the leading edge for the export sector, and to place mass media squarely in the service of the state. Through these means, they envision rapidly developing the country into a modern, middle-income nation.

The state goal now in all of these countries is to compel homogeneity as a pre-requisite for "national progress".

The state goal now in all of these countries is to compel homogeneity as a pre-requisite for "national progress". The goal is to *capitalize* on a certain national language, a uniform national culture and religion. Beyond that, to create a domain where human beings are just automatons with certain dominant functions and behaviors instilled and programmed into their heads. It would be silly not to notice that such policies, conglomerated together, help imperialistic powers to accomplish their own tasks. This is the most modern form of malignancy in economic, linguistic, cultural and social sectors, and it flourishes even in democratic countries— indeed, it parades around in the name of democracy. •

Endnotes

1. "Bangladesh Criticised for Student and Media Crackdown", Al Jazeera Media Network [Doha, Qatar], Aug. 7, 2018.
2. "Bangladesh Student Protests: Eyewitness Says Teens were Assaulted as Police Stood By and Filmed", *First Post* [Mumbai, India], Aug. 5, 2018.
3. Julhas Alam, "Mass Protests Over Traffic Deaths Paralyze Dhaka for Five Days", Associated Press [New York, U.S.], Aug. 4, 2018.
4. M. S. Siddiqui, "Road Accident Scenario in Bangladesh", *Daily Asian Age* [Dhaka, Bangladesh], Jan. 7, 2018.

My America

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anthropy, relations between different elements in this diverse community, and the overall health and welfare of all who reside and work here. We have succeeded in our integration into mainstream America by our own confidence, competence, and integrity. In every encounter we fully expect to be treated at least fairly, if not warmly, and because of those expectations it has been our experience that we usually are treated fairly. We heartily embrace what is good about America and, with the help of others, work diligently to correct what is not so good about our country. *E Pluribus Unum!*

Mental Health Attitudes

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from acute schizophrenia and was able to study efforts aimed at more community-based treatment and outreach. Also, jointly with Prof. Shanti I presented a weekend training on issues of adolescent development and depression for community mental health leaders and school counselors in Jakarta.

During my stay of 10-11 days, I was able to live in off-campus housing and experience Jakarta culture first-hand by traveling around the city. The huge city was gearing up to host the Asian Games, and I was able to attend the Guinness World Record Event for the "largest line dance" with over 65,000 Indonesians dancing the traditional *poco-poco*.

Currently, we are finishing the data collection phase for the U.S. sample, and plan to present initial findings at the annual conference of the Midwest Institute for International/Intercultural Education (MIIIE) this March (see sidebar, p. 44). Joint research publications will be forthcoming as the data analysis phase of the project gets underway.

The project continues to grow, as it was recently announced that Theresia Indira Shanti of Atma Jaya has received her own AIFIS fellowship. Dr. Shanti, a clinical psychologist specializing in at-risk students, will be traveling to the U.S. this April to explore mental health initiatives on college campuses in Metro Detroit and surrounding areas. Schoolcraft College will be hosting her visit and facilitating her travels and additional collaboration, including talks with our own students during her stay on campus.

"Black Superwoman"

by Marie Chantal Nyirahategekimana

My mother was the inspiration for my painting, "Black Superwoman". She was 16 when she and her family had to pack everything they could carry and leave their home due to the Rwandan genocide. My mother told me that while in the refugee camp, she often had to walk miles to get just a little bit of water. The painting is a representation of my mother, of her strength and ability to survive. Just as water saves lives, she saved her siblings with her strength and resilience.

Being born a refugee myself, I know what it is like to be a part of the most vulnerable group of people in the world. I understand that nothing brings back people's dignity like the ability to be able to help themselves on their own. All we need is opportunity. After I finish school, I will help build up Africa's infrastructure, creating schools and jobs for young refugees.

Marie Chantal Nyirahategekimana of Garden City, MI, is a Schoolcraft College student majoring in biomedical engineering and minoring in international relations. Born in a refugee camp in République Centrafricaine, she speaks three languages: French, Kiyarwanda, and English. She and her Rwandan parents and her two younger siblings lived as exiles in several different African countries before eventually settling in Portage, MI (near Kalamazoo), where Marie Chantal graduated from high school. At Schoolcraft she is a member of the Scholars Honors Program, the International Student Organization, and the Black Student Union, and serves as a staff writer for The Schoolcraft Connection *as well as a writing consultant at the Writing Support Studio. Outside of school, Marie Chantal has also worked with the Model United Nations and with Planned Parenthood.*

March MIIIE Conf. in Tennessee

The Schoolcraft College International Institute cordially invites faculty members to join us at the upcoming 26th Annual Conference of the Midwest Institute for International/ Intercultural Education (MIIIE). The conference will be held March 29-30, 2019 at Chattanooga State Community College in Chattanooga, TN. This gathering will draw educators from throughout the Midwest and beyond.

For more information, contact Helen Ditouras, our MIIIE representative, at 734-462-7263, or hditoura@schoolcraft.edu. You'll also be able to download the registration forms and other information at http://www.miiie.org.

It's a Multicultural World— Right in Our Backyard!

See also page 11 for a listing of programs in the Schoolcraft College Focus Series on global health.

Oct. 20, 2018 – Jan. 20, 2019: "Sovereign Acts", a photography exhibit exploring the history of Indigenous Peoples performing cultural dances and practices for international and colonial audiences. Art Gallery of Windsor, 401 Riverside Drive W., Windsor, ONT. For more information, see https://www.agw.ca/exhibition/479 or call 519-977-0013.

Oct. 25, 2018 – Apr. 28, 2019: "Expanded Views: Native American Art in Focus". This exhibit presents works ranging from a traditional Acoma Manta and Cherokee tipi cover to contemporary works by James Lavadour, Wendy Red Star, and Marie Watt. Gallery 29A, Toledo Museum of Art, 2445 Monroe St., Toledo. For more info, call 419-255-8000 or see http://www.toledomuseum.org.

Nov. 10, 2018 – Apr. 7, 2019: "The Far Shore: Navigating Homelands" features the work of five Arab American visual artists responding to five Arab American poets, all dealing with themes of displacement and survival. The exhibit marks the centennial of the end of WW1, a period of colonialist upheaval in the Arab World. Main Floor Gallery of the Arab American National Museum, 13624 Michigan Ave., Dearborn. For more information, call 313-582-2266 or see http://www.arabamericanmuseum.org/The-Far-Shore.

Jan. 13 – Apr. 13, 2019: "Attitudes & Actions: Where Prejudice Can Lead". A 3-part exhibit that includes (1) "Jehovah's Witnesses: Faith Under Fire", an in-depth look at ordinary people who follow their conscience in the face of tyranny, (2) "Rwanda: Personal Images", a series of striking pastel drawings about the Rwandan genocide by artist Vivian Bower, and (3) "The Tragedy of War: Japanese American Internment", bringing to life the stories and unjust confinement of 120,000 Japanese Americans during WW2. Holocaust Memorial Center, 28123 Orchard Lake Road, Farmington Hills. For more information, see http://www.holocaustcenter.org.

Jan. 19 – Apr. 14, 2019: "The Drama of Japanese Prints". This exhibit features woodblock prints by Tsukioka Kōgyo (1869–1927), from the private collections of Dr. David Weinberg and Dr. Sheldon Siegel. Each work depicts scenes and characters from Noh theatre, which combines acting, singing, dancing, and elaborate costuming to tell stories of romance, revenge, adventure, and salvation. Graphics Gallery, Flint Institute of Arts, 1120 E. Kearsley Street, Flint. For more information, call 810-234-1695 or see https://www.flintarts.org.

Jan. 27 – May 26, 2019: "Engaging African Art: Highlights from the Horn Collection". This exhibit features Western and Central African ritual and status-related artworks including masks and figures made of wood, bone, metals, clay, and beads, representing spiritual, social, and ceremonial messages. Hodge Gallery, Flint Institute of Arts, 1120 E. Kearsley Street, Flint. For more information, call 810-234-1695 or visit the website https://www.flintarts.org.

Jan. 28, 2019: Film, "The Fencer" (Estonian, 99 mins.). A champion fencer on the run from the Soviet secret service finds himself inspiring Estonian schoolchildren to take up the sport. Part of the Foreign Film Series, a free film on one Monday each month. 6:30 pm. Northville District Library. 212 West Cady St., Northville, MI. For more information, call 248-349-3020 or visit the website https://northvillelibrary.org.

Jan. 29, 2019 (see also Jan. 31 – Feb. 3, below): "Evita". With lyrics by Tim Rice and music by Andrew Lloyd Webber that combines Latin, pop, jazz, and theatrical styles, this Grammy® Award-winning musical follows the rise of Eva Perón as she becomes the iconic Argentinian First Lady. 7:30 pm. Macomb Center for the Performing Arts, 44575 Garfield Road, Clinton Twp. For information and tickets, call 586-286-2141 or visit the website http://www.macombcenter.com.

Jan. 31 – Feb. 3, 2019: "Evita" (see Jan. 29, above). Stranahan Theater, 4645 Heatherdowns Boulevard, Toledo. For information and tickets, call 419-381-8851 or e-mail info@americantheatreguild.org or visit the website http://theaterleague.com/toledo.

Feb. 2, 2019: Dhamaal 2019, Detroit's first Bollywood-Fusion dance competition, with teams from all over the nation. 5 pm. Main Stage, Music Hall Center for the Performing Arts, 350 Madison Avenue, Detroit. For info and tickets, call 313-887-8500 or see https://www.facebook.com/DetroitDhamaal or e-mail Dhamaalcomp@gmail.com.

Feb. 7-15, 2019: "Seagull". This slice-of-life drama by Anton Chekhov is set in the Russian countryside in the late 1800s and centers on the romantic and artistic conflicts of characters dissatisfied with their lives. Translated by Curt Columbus, directed by Lynnae Lehfeldt, performed by the OU School of Music, Theatre and Dance. Varner Studio Theatre, Oakland Univ., 371 Varner Drive, Rochester, MI. For information and tickets, call 248-370-2030 or e-mail smtd@oakland.edu or visit the website https://www.oakland.edu/smtd.

Feb. 8-9, 2019: "De-Centering the Global Middle Ages", a symposium exploring what the "medieval" means for scholars of various geographic regions. The aim is to facilitate a dramatic shift in our conception of medieval history and of global history more broadly. What do we gain or lose by conceiving of a more diverse Middle Ages characterized by mobility and connectedness rather than isolation and limited travel? 1014 Tisch Hall, Univ. of Michigan, Ann Arbor. For more info, see https://sites.lsa.umich.edu/globalmiddleages.

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Detroit Film Theatre

Among the films at the DFT this season, the following are set in the countries indicated. This venue is located at the John R. Street entrance to the Detroit Institute of Arts, 5200 Woodward Ave., Detroit. For details and tickets, call 313-833-4005 or visit the website https://www.dia.org/visit/detroit-film-theatre.

Jan. 25-27, 2019:
"The Guilty" (Denmark, 2018)

Mar. 1-10, 2019:
"Never Look Away" (Germany, 2018)

Mar. 23-24, 2019:
"Lila's Book" (Colombia, 2017)

Mar. 29-31, 2019:
"3 Faces" (Iran, 2018)

Apr. 3 and Apr. 26-28, 2019:
Italian Film Festival (five films)

Apr. 5, 2019:
"Lagaan" (India, 2001)

Apr. 6-7, 2019:
"The Heiresses" (Paraguay, 2018)

Apr. 7, 2019:
"Pyaasa" (India, 1957)

Feb. 9 – May 12, 2019: "Deicing/Decolonizing: Hockey Histories in Canadian Contemporary Art". Inspired by Benedict Anderson's 1983 claim that nations are social constructions that perpetuate "imagined communities", this exhibit considers hockey as a platform on which to challenge Western stereotypes. In four distinct sections— hockey jerseys, masks, cards, and equipment— the myths and metaphors that have perpetuated the talent and celebrity of the white male pro athlete become a subject of critical debate. Art Gallery of Windsor, 401 Riverside Drive W., Windsor, ONT. For more info, see https://www.agw.ca or call 519-977-0013.

Feb. 20, 2019: Concert by Ladysmith Black Mambazo, the celebrated South African *a cappella* group. The group borrows heavily from a traditional music called *isicathamiya*, which developed in the mines of South Africa. 8 pm. The Ark, 316 S. Main Street, Ann Arbor. For information and tickets, call 734-761-1800 or visit the website http://www.theark.org.

Feb. 21, 2019: "Highlighting Yemen: Short Films, Art & Activism". Featuring the films "Broken Paths" and "Waiting for Justice" (in Arabic with English subtitles), this program is a narrative journey about Yemen: its history, culture, current crisis, and the impacts of war. 7 pm. Arab American National Museum, 13624 Michigan Ave., Dearborn. For information and tickets, call 313-582-2266 or visit the website http://arabamericanmuseum.org/Arab-Film-Series.

Feb. 21-22, 2019: "Stories Never Told: Yemen's Crises & Renaissance", a traveling display curated by local Yemeni-American social entrepreneur Hanan Ali Yahya. The display visually narrates the artistic renaissance born out of Yemen's crises by featuring the art, short films, poetry, writing, and productions of Yemeni artists in Yemen and the diaspora. 6-10 pm on Feb. 21 at Arab American National Museum (13624 Michigan Ave., Dearborn) and 2-10 pm on Feb. 22 at the Univ. of Michigan International Institute (1010 Weiser Hall, 500 Church Street, Ann Arbor). For both, an RSVP is required via the website http://www.arabamericanmuseum.org/Events.

Feb. 22, 2019: "Oceans of Hope". With music, song and dance, this performance captures the essence of Irish history, a story of a people moving across oceans in hope of a better and brighter future in America, Australia, Canada, New Zealand and other nations, where they struggle for freedom, dignity and above all, family. 7:30 pm. Macomb Center for the Performing Arts, 44575 Garfield Road, Clinton Twp. For information and tickets, call 586-286-2141 or visit the website http://www.macombcenter.com.

Feb. 23-24, 2019: The Gratitude Steel Band. Bring the family to enjoy a vast array of musical styles, from Calypso to Jazz and Afro-Cuban to Motown, all united by the high-energy rhythms of Caribbean-style steel pan drums. Free. 2-4 pm. Rivera Court, Detroit Institute of Arts, 5200 Woodward Ave., Detroit. For more info, call 313-833-7900 or see https://www.dia.org.

Feb. 25, 2019: Film, "The Mafia Kills Only in Summer" (Italian, 90 mins.). Tells the story of Arturo's 20-year unrequited love for a childhood crush amid the rise of the Cosa Nostra in 1970s Sicily. Part of the Foreign Film Series, a free film one Monday each month. 6:30 pm. Northville District Library. 212 West Cady St., Northville, MI. For more info, call 248-349-3020 or see https://northvillelibrary.org.

Mar. 1-10, 2019: Shen Yun 2019. Reviving 5,000 years of Chinese civilization, this extravaganza includes classical, ethnic, and folk dance as well as orchestral accompaniment and soloists. Detroit Opera House, 1526 Broadway, Detroit. For information and tickets, call 844-647-4697 or visit the website http://www.ShenYun.com/detroit.

Mar. 2, 2019: The National Arab Orchestra presents a concert, "A Night of Tarab". The NAO are dedicated to preserving and performing classical and contemporary traditions of Arab music. 8 pm. Main Stage, Music Hall Center for the Performing Arts, 350 Madison Avenue, Detroit. For info and tickets, call 313-887-8500 or see http://www.musichall.org or http://www.nationalaraborchestra.org.

Mar. 2, 2019: "Rhythm of the Dance". This extravaganza of traditional dance and music relives the journey of the Irish Celts across 1000 years of history. 8 pm. Stranahan Theater, 4645 Heatherdowns Boulevard, Toledo. For more info, call 419-381-8851 or e-mail info@americantheatreguild.org or see http://theaterleague.com/toledo.

Mar. 6-8, 2019: Annual Conference of the Michigan Assn. of International Educators (MAIE). Eberhard Center, Grand Valley State Univ., Allendale, MI. For more information, see https://maie.us/conference.

Opens in mid-Mar. 2019: "Paradox of Liberty: Slavery at Jefferson's Monticello". This touring exhibit brings to life the stories of the families enslaved by Thomas Jefferson through more than 300 objects, works of art, documents, and artifacts from his plantation. Charles H. Wright Museum of African American History, 315 E. Warren Ave., Detroit. For more info, call 313-494-5800 or see http://www.chwmuseum.org.

Mar. 16 – Oct. 6, 2019: "Tillirnanngittuq: The Power Family Program for Inuit Art", an exhibit that depicts Inuit art from the Canadian Arctic from the 1950s to the present, and the story of its popularization by the Power family of Ann Arbor. Univ. of Michigan Museum of Art, 525 South State St., Ann Arbor. For more information, call 734-764-0395 or see http://www.umma.umich.edu.

Mar. 22 – Apr. 13, 2019: "Venus". This Obie Award-winning play by Suzan-Lori Parks was inspired by the true story of Saartjie Baartman, who traveled from her home in southern Africa to 19th-Century London seeking a better life, only to become the "Hottentot Venus" of the freak-show circuit. Studio Theatre at the Hilberry, Wayne State Univ., 4743 Cass Avenue, Detroit. For information and tickets, call 313-577-2972 or e-mail boxoffice@wayne.edu or visit the website https://www.theatreanddanceatwayne.com/venus.

Mar. 23, 2019: Wayne State Univ. Indian Student Association Show, celebrating Indian dance and culture. 6:30 pm. Main Stage, Music Hall Center for the Performing Arts, 350 Madison Avenue, Detroit. For information and tickets, call 313-887-8500 or see http://www.musichall.org.

Mar. 23, 2019: Chinese Spring Festival 2019, an evening of folk and classical dances performed by Metro Detroit area Chinese Schools. Features vocal soloist Shuping Ma, duets, Peking Opera, the Canton Philharmonic Choir, Michigan Chinese Choir & March Wind Choir, and instrumentalists on *pipa* and *guzheng*. Reception at 6 pm includes displays on Peking Opera; performances at 7 pm and 9:15 pm. Village Theater, 50400 Cherry Hill Road, Canton. For info and tickets ($5), call 734-394-5300 ext. 3 or see www.cantonvillagetheater.org.

Mar. 23 – Jun. 30, 2019: "The Six Senses of Buddhism". This exhibit on Japanese Buddhism engages all six senses integral to Buddhist devotion: sight, hearing, smell, touch, taste, and mind. Univ. of Michigan Museum of Art, 525 South State St., Ann Arbor. For more information, call 734-764-0395 or visit the website http://www.umma.umich.edu.

Mar. 28, 2019: 18th annual Multicultural Fair, a vibrant celebration of the international cultures on our campus. 10 am – 3 pm. DiPonio Room, VisTaTech Center, Schoolcraft College, 18600 Haggerty Road, Livonia. For more info, contact Helen Ditouras at hditoura@schoolcraft.edu.

Apr. 5, 2019: Annual Winter concert by OU's World Music Ensembles, this year featuring legendary steel pan artist Andy Narell. 8-10 pm. Varner Recital Hall, Oakland Univ., 371 Varner Drive, Rochester, MI. For information and tickets, see https://oakland.edu/smtd/events/2019/040519-world-music-concert-with-andy-narell or call 248-370-2030 or e-mail smtd@oakland.edu.

Apr. 9-14, 2019: "Les Misérables". Cameron Mackintosh presents the new production of this award-winning musical set in 19th-Century France, with staging and scenery inspired by the paintings of Victor Hugo. The story of broken dreams and unrequited love, passion, sacrifice and redemption is "a timeless testament to the survival of the human spirit." Stranahan Theater, 4645 Heatherdowns Boulevard, Toledo. For information and tickets, call 419-381-8851 or e-mail info@americantheatreguild.org or visit the website http://theaterleague.com/toledo.

Apr. 11-14, 2019: "The Battles of Coxinga". This Japanese history play was written by Chikamatsu Monzaemon (1653-1725) for puppet theatre, allowing spectacular scenes of superhuman feats and mayhem. Here, it is adapted and directed by Kerro Knox and performed by the OU School of Music, Theatre and Dance in various styles of traditional Asian theatre: Noh, Kabuki, Bunraku, shadow puppetry, and the original Joruri. Varner Lab Theatre, Oakland Univ., 371 Varner Drive, Rochester, MI. For information and tickets, call 248-370-2030 or e-mail smtd@oakland.edu or visit the website https://www.oakland.edu/smtd.

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May 2-26, 2019: "The Beauty Queen of Leenane". This Tony Award-winning, wildly funny and deeply shocking play by Martin McDonagh is set in the mountains of Connemara, Ireland. Telling the story of Maureen Foley, a plain and lonely woman in her early 40s living with her manipulative mother Mag, it "re-creates the traditional Irish family drama only to set it ablaze with a postmodern blowtorch." Produced by the Detroit Public Theatre and directed by Andrew Borba. Allesee Hall, Fisher Music Center, 3711 Woodward Ave., Detroit. For info and tickets, visit http://www.detroitpublictheatre.org or call the DSO Box Office at 313-576-5111 or e-mail info@detroitpublictheatre.org.

May 5-15, 2019: 21st annual Lenore Marwil Jewish Film Festival. Organized by the Jewish Community Center of Detroit. Berman Center for the Performing Arts, 6600 W. Maple Road, West Bloomfield. For more information, call 248-661-1900 or e-mail brobinson@jccdet.org or visit the website http://www.jccdet.org.

May 11, 2019: "Sarovar: An Evening of Carnatic Music". A grand classical concert by distinguished artists from India, who blend complex devotional compositions with intricate improvisations and virtuosic interplay between voice, *mridangam* (drum), and violin. Part of the Indo-American Festival of Performing Arts. 5 pm. Varner Recital Hall, Oakland Univ., 371 Varner Drive, Rochester, MI. For info and tickets, call 248-370-2030 or e-mail smtd@oakland.edu or visit the website https://www.oakland.edu/smtd.

Early June 2019: Cinetopia International Film Festival. Over 50 films shown at venues in Detroit and Ann Arbor. For info and tickets, call 734-668-8397 or e-mail info@cinetopiafestival.org or visit the website http://www.cinetopiafestival.org.

Jun. 23 – Oct. 13, 2019: "Humble and Human: Impressionist Era Treasures from the Albright-Knox Art Gallery [Buffalo, NY] and the Detroit Institute of Arts". A selection of more than 40 Impressionist and post-Impressionist treasures by Cézanne, Degas, van Gogh, Monet, Morisot, and others. Detroit Institute of Arts, 5200 Woodward Ave., Detroit. For more info, call 313-833-7900 or see https://www.dia.org.

Mid-July 2019: 27th annual Concert of Colors, metro Detroit's free, five-day world music festival accompanied by ethnic food and merchandise, musician-led workshops, a Forum on Community, Culture & Race, and a large children's tent. Organized by the Arab Community Center for Economic and Social Services (ACCESS) and partners. Midtown Detroit. For more info, call 313-582-2266 or see http://concertofcolors.com.

Aug. 3-16, 2019: "Cyrano De Bergerac", Edmond Rostand's romantic 1897 play about a man skilled in both sword and pen but whose enormous nose leaves him a swashbuckling lonely heart. Translated from the French by Brian Hooker, directed by Janice L. Blixt. Part of the Michigan Shakespeare Festival. Village Theater, 50400 Cherry Hill Road, Canton. For information and tickets, call 734-394-5300 ext. 3 or visit the website www.cantonvillagetheater.org. •

Spring/Summer Ethnic Festivals in Southeastern Michigan

Last weekend in March: Dance for Mother Earth PowWow. Skyline High School, Ann Arbor. http://www.umich.edu/~powwow.

April 14, 2019: Greek Independence Day Parade. Monroe Street, Greektown. http://www.greekparades.com.

Second or third weekend in April: Dance Recital of the Polish National Alliance Centennial Dancers Lodge 53, Village Theater, Canton. https://pnacentennialdancers.wordpress.com.

Memorial Day weekend: Saint Mary's Polish Country Fair. Saint Mary's Preparatory School, Orchard Lake campus. http://www.stmaryspolishcountryfair.com.

First Saturday in June: Romanian American Heritage Festival. Saints Peter & Paul Romanian Orthodox Church, Dearborn Heights. http://spproc.org/festival.

First Saturday in June: African American Downtown Festival. East Ann Street & North Fourth Avenue, Ann Arbor. http://a2festival.org.

Second weekend in June: Ya'ssoo Greek Festival. Saint Nicholas Greek Orthodox Church, Ann Arbor. http://www.annarborgreekfestival.org.

Mid-June: Dearborn Arab International Festival. Warren Avenue between Schaefer and Wyoming Avenues, Dearborn. http://www.americanarab.com.

Mid-June: Motor City Irish Fest. Greenmead Historical Park, Livonia. https://motorcityirishfeStreetcom.

Mid-June: Carrousel of the Nations multicultural festival. Riverfront Festival Plaza, downtown Windsor, Ontario. http://www.carrouselofnations.ca.

Second weekend in July: American-Polish Festival. Sterling Heights High School. http://www.americanpolishfestival.com.

Mid-July: Saline Celtic Festival. Mill Pond Park, W. Bennett Street, Saline. http://www.salineceltic.org.

Late July or early August: Arab and Chaldean Festival. Hart Plaza, downtown Detroit. http://www.arabandchaldeanfestival.com.

Late July or early August: Highland Games Scottish Festival. Greenmead Historical Park, Livonia. http://www.highlandgames.com.

Early August: Detroit Caribbean Cultural Festival. New Center Park, 2998 W. Grand Blvd., Detroit. http://www.myccco.org.

Early August: St. Andrews Society of Detroit Highland Games (Scottish Heritage Festival). Greenmead Historical Park, Livonia. http://www.highlandgames.com.

Mid-August: African World Festival. Museum of African American History, downtown Detroit. http://thewright.org/african-world-festival.

Mid-August: Assumption GreekFest. Assumption Greek Orthodox Church, St. Clair Shores. http://assumptionfestival.com.

Late August: Pow Wow and Health Fair. Romanowski Park, southwest Detroit. http://www.aihfs.org.

Early September: Hispanic Heritage Festival. WCCCD Downtown Campus, Detroit. http://www.wcccd.edu/about/hispanic%20festival.htm.

Second or third weekend in September: Ann Arbor Russian Festival, St. Vladimir Russian Orthodox Church, Dexter. http://www.annarborrussianfestival.org.