Surgeons and bureaucrats: an interactive research experience at the World Health Organization

Introduction

During a recent internship at a general hospital in my hometown of Dallas, I could occasionally be found lurking around the main surgical unit. I wanted to be surrounded by the atmosphere of saving lives by manipulating the tiniest capillaries, the most sensitive nerves, the most essential organs. The idea of racing against the clock to save a life, yet having to work with the utmost care is one that is unsettling and enthralling to me all at once. Surgery is infinitely intricate, exceedingly precise, and beautifully complex. And quite simply, it fascinates me.

At the same time, I am very involved with public health issues. My major at Brandeis, "Health: Science, Society, and Policy," is a perfect description of how I view the health sector. I champion – and probably overuse – terms like "multi-sectoral" and "collaborative efforts." To me, collaboration is everything. Medical science plus social and political science *is* public health, and I am happy to work between the three to try to find answers to the world's most pressing public health questions.

Given my interests in surgery and public health, I was delighted to find a brochure at the World Health Organization (WHO) library in September entitled, "Emergency and Essential Surgical Care" ("EESC"). I immediately picked one up and began reading the enclosed journal article on surgery as a public health issue and the information on an ongoing WHO project on emergency and essential surgical care (EESC) in developing countries. After writing a paper on the EESC project and its initiatives and tasks, it seemed the next logical step to pursue an internship at the WHO in this particular area for

my Independent Research Project. I had exhausted the sources of information on EESC outside of the organization; it was time to see what I could learn as an insider.

Finding an internship

To begin the process of finding an internship, I contacted Dr. Meena N. Cherian, who works at the WHO in the Department of Essential Health Technologies (EHT) as a part of the Clinical Procedures Unit. I explained to her my interest in the EESC project and asked if she could meet with me to talk about both the project in more depth as well as any internship opportunities within her department. After discussing Dr. Cherian's background in anesthesia and surgery and the evolution of the EESC project within the WHO, she explained that she would be happy to allow me to work on the project over the next month.[1] She expressed a sentiment that I encountered frequently during my time at the WHO: always too much work, never enough people to do it or space to do it in. Thus, if I did not mind cramped office space, I could certainly be a useful addition to her team, if only for a few weeks.

Before beginning my work at the WHO, I defined some goals for my time there. The simple fact of being able to experience daily life at such an organization would have satisfied me, but I wanted to be able to measure my progress in order to effectively evaluate my experience. In general, I aimed to become more familiar with the inner workings of an international public health bureaucracy like the WHO. I wanted to better understand how an endeavor like the EESC project works: what kinds of tasks it entails, who it involves, how it can be made realistic.

[1] See section "Discussion and Meeting Write-ups": Meeting with IRP advisor, Dr. Meena Cherian on 22 Oct 2008.

In a more research-oriented sense, I wanted to become more familiar with the data available on the state of surgical care in developing countries; if possible, I intended to find some patterns in this data in order to better explain real-world situations and the relationship between surgery and public health to others. I also looked forward to having access to further resources – both literary and human – with information on the ongoing EESC project in India, a topic I touched on in my first paper on EESC.

Finally, I anticipated learning from professionals, and especially surgeons, who knew public health either from the organizational perspective, from the strictly medical perspective, or both. I felt that these discussions would have the potential to help me form my own opinions about the two perspectives and perhaps give me a better idea of where I wanted to focus my studies and future career path.

Surgery is a public health issue

¨Beyond treatment, surgery provides primary and secondary prevention strategies for avoidable mortality, morbidity, and disability.¨

The Global Initiative for Emergency & Essential Surgical Care, WHO 2006

In order to understand the EESC project in more detail, as well as my own tasks and experiences during my time at the WHO, it is important to understand how surgery is an important public health issue. Unfortunately, the significant relationship between surgical care in developing countries and public health efforts is often either underestimated or completely overlooked. Until relatively recently, with the founding of the WHO EESC project, the issues surrounding essential surgical care were unrecognized within the public health domain.

Two important factors contributing greatly to global mortality rates – road traffic injuries and pregnancy-related complications – are often treatable with surgical procedures. In developed countries, it is a non-issue to obtain surgical care for such problems, but developing countries present a different picture.

First-referral level health care facilities (that is, district or rural facilities) in developing countries often lack the basic infrastructure, sufficient supplies, and adequately trained personnel necessary to carry out life-saving surgical procedures. Such services are frequently only available at tertiary level medical centers in urban areas, which can be too far away for patients to reach in time. Due to the inability to perform essential surgeries at the local level, the poorest one-third of the world's population undergo only 3.5% of the surgical procedures performed worldwide, according to a study conducted by the Harvard School of Public Health.

As a result, the burden of disease from surgically treatable conditions in developing countries is estimated to be disturbingly high. It is costing the world not only in human lives, but in an economic sense as well. Nearly half of all traffic-related fatalities involve young adults, the most economically productive population group; in low-income countries, patients with injuries resulting from traffic accidents occupy one-quarter of all hospital beds. The world's progress towards achieving the Millennium Development Goals (MDGs) is also hindered by the surgical burden of disease. Improving EESC could help accomplish at least three MDGs: reducing child mortality, improving maternal health, and combating HIV/AIDS.[2]

[2] Lust, Hannah. "Improving essential surgical care in first-referral level healthcare facilities: evaluating training programs implemented by the World Health Organization." SIT Switzerland: Development and Public Health Studies, 2008: 1-3.

One aspect of the EESC project is advocacy and promoting surgical care as a means to achieve major public health goals. During a meeting with Dr. Cherian and others working on the project, Dr. Cherian explained that in developing countries, surgeons are rarely considered by ministries of health to be important to advancing the quality of the countries' healthcare systems. Many governments and ministers of health do not make the connection between surgery and public health initiatives related to the MDGs, such as improving maternal health, which invariably involves emergency Cesarean sections and obstetric fistula repair, for example.[3] To improve this situation and make stakeholders aware of the importance of quality EESC, Dr. Cherian spends a lot of time traveling to developing countries and contacting Ministers of Health and WHO country offices. Once people become conscious of the significance of surgical care, the training aspect of the EESC project can be implemented.

To improve the quality of surgical care in developing countries by training professionals, the WHO created the Integrated Management of Emergency and Essential Surgical Care (IMEESC) toolkit. The IMEESC toolkit is a training tool comprised of management guidelines for surgery and emergency care, CD-ROMs with teaching slides, and a manual called *Surgical Care at the District Hospital*. Dr. Cherian has traveled to countries all over the world to conduct surgical training workshops for healthcare workers in conjunction with local Ministries of Health and non-governmental organizations (NGO). The training workshops also include interactive, hands-on teaching, where participants can practice skills such as suturing and resuscitation techniques. At this point in time, the workshop has been performed in 22 countries. The

[3] See section "Discussion and Meeting Write-ups": Meeting with Dr. Meena Cherian, Dr. Sandro Contini, and Dr. Lawrence Sherman on 21 Nov 2008.

EESC team aims to expand the scope of the project and increase the number of training workshops through the Global Initiative for Emergency and Essential Surgical Care (GIEESC), the first collaborative, coordinated global effort to address the lack of surgical capacity and equipment in developing countries.[4]

Where I worked

The EESC project exists within the Clinical Procedures Unit (CPU) in the Department of Essential Health Technologies, which is a part of the Health Systems & Services division, all encompassed by the WHO Headquarters in Geneva. As one might imagine, the WHO is a sprawling bureaucracy in every sense of the word. There are departments upon departments; enough teams, divisions, and units to frustrate even the most diplomatic of employees; committees and taskforces as far as the eye can see.

The intended division of labor is incredible, and justifiably so. The tasks the WHO sets before its employees to accomplish are seemingly never-ending. Before being immersed in the organization itself, I never gave a second thought to the amount of work it faces. But after only my first three days on the job, I came to a seemingly obvious conclusion as to why a WHO employee's work is never done: the WHO aims to bring health and healthcare equity to all. I am not a pessimistic person, but with this goal in mind, how can one ever go home at the end of the day saying, "There, I have accomplished all I can, and my work is done"?

As a result, I never had to ask for work to do at the WHO. In past internships, there were days when I begged for something to do, either because the organization only trusted their interns with a certain level and amount of work, or because the work simply

[4] Lust 3-5

was not there to be done. Over the course of three weeks at the WHO, people were eager to have help with their daily mountain of work. I was constantly offering assistance wherever it was needed, even though I already had things to do. Thus, I never lacked a task, and I consistently felt productive and useful, and as though I were actually contributing something to the imposing task of improving EESC in developing countries.

Such a constant flow of work throughout the organization lends itself to a busy, often hectic atmosphere. I can imagine that spending longer than three weeks in such an environment could become extremely stressful, as I myself experienced a healthy amount of stress due to deadlines and sheer amount of work. However, I thoroughly enjoyed the feeling that something was constantly happening, whether it was a meeting, a conference call, or a simple discussion between colleagues. Although people rarely seemed to be satisfied with their work, it put me a little more at ease about the state of global public health to know that so many hundreds of people are endeavoring so diligently to improve it.

Surgeons and bureaucrats

¨I have two different hats here. I wear my clinician hat when I'm with my fellow surgeons, and I can relax more. When I wear my bureaucrat hat, I have to be very proper and not cut in line.¨

Dr. Meena N. Cherian

Knowing the bureaucratic nature of the WHO, I began to wonder how employees who have been clinicians all their lives make the transition to working in an organization like the WHO, and what they think about the new environment. I spoke with Dr. Sandro Contini, a surgeon who began working on the EESC project only a few months ago. Dr. Contini has been practicing surgery for 40 years, first in his home country of Italy, and

then with a small Italian NGO in Sierra Leone and Afghanistan. After discussing some of his experiences with surgical care in developing countries, I asked him how he feels about working at the WHO. I wanted to know if he experiences a conflict between the desire in surgery to solve problems directly, immediately, and manually and the need at the WHO to collect data, write reports, and inevitably wait long periods of time to see results.

Dr. Contini explained that it has certainly been difficult for him to make the transition from procedures to papers, and that it is not always easy to learn the protocol of an organization, especially at one as vast as the WHO. But he said that while it is sometimes challenging or frustrating, that does not make one approach to health more important than another. He expressed a need for balance between the clinical and the organizational methods, between the "doing and saying." A great surgeon can perform impressive procedures and save hundreds of lives, but without organizations and health journals, no one will hear about his work and be able to learn from it. Similarly, Dr. Contini commented on the indispensible importance of field workers and clinicians on the ground, but without organizations like the WHO to collect and disseminate data from these places, no one save the field workers themselves will ever know the reality of the situation.

He also explained to me the importance of having experience with attacking public health problems from both angles, clinically and organizationally. This gives one the opportunity to profit from two different skill sets. Working at the WHO, Dr. Contini

is better learning how to present the information he already knows in order to garner the attention of politicians and the general public.[5]

I agree with Dr. Contini wholeheartedly. I often see people typecasting clinicians and public health workers in two opposite categories, similar to the ¨doing and seeing¨ that Dr. Contini mentioned. It is unfortunate that clinicians are often described as only seeing the small picture or as only solving one individual case at a time; at the same time, public health workers are sometimes accused of trying to change policy on too grand a scale without knowing the medicine behind the problems they are attempting to solve. In spite of whatever faults the WHO may have, it is a magnificent place to change these stereotypes. Many of the people I worked with were current or former clinicians, like Dr. Contini and Dr. Cherian, who bring to the table a vast working knowledge of practical medicine. The WHO serves as the forum to bring together expert physicians and expert policy-makers. Although things may move slowly through the WHO due to its enormity, this collaboration is essential. There is no other way to achieve progress in global public health.

Situational analysis and critique

One of my ongoing tasks for the EESC project was compiling data on the state of surgical care in healthcare facilities in EESC target countries. Forms called the "Tool for Situational Analysis to Assess Emergency and Essential Surgical Care" are sent to hospitals in countries in Africa, Asia, and the Middle East to be completed and returned to the WHO Headquarters. The situational analysis form (see Appendix A) includes questions about patient load, basic infrastructure (such as access to running water and

[5] See section "Discussion and Meeting Write-ups": Discussion with Dr. Sandro Contini on 18 Nov 2008.

electricity), human resources, physical medical resources (such as surgical instruments or equipment to measure blood pressure), and availability of selected surgical procedures. Once the forms are returned to the WHO, they must be entered into a global database so the information can be used to publish reports on surgical care and advance the EESC project.

During my three weeks at the WHO, I compiled data from hospitals in Sao Tome and Principe, Sierra Leone, Nigeria, Liberia, Uganda, China, Mongolia, India, Kenya, Tanzania, Afghanistan, Pakistan, Papua New Guinea, and Sri Lanka. I also had access to hundreds of photos from Dr. Cherian's trips to many of the facilities for which I was entering data. Since I did not have the opportunity to visit the countries myself, I consider it a very valuable experience that I was able to see the situations as close to first-hand as possible. My discussions with Dr. Contini about his experiences in hospitals in Afghanistan and Sierra Leone also helped me to understand the reality of surgical care in developing countries.[6]

The first day I began reading through the situational analysis forms and entering the data, I was taken aback by the dire situations, and I continued to be surprised and alarmed nearly every time I picked up a new form. Certainly, I have learned about the lack of access to clean water and about the poor quality of primary healthcare in general in several developing countries. However, I do not believe that many people think beyond the immediate consequences of such problems, such as water-borne diseases and an inability to treat epidemics. I was shocked the first time I read a form from a facility that had marked "not available" on the questions regarding access to running water and electricity.

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[6] See section "Discussion and Meeting Write-ups": Discussion with Dr. Sandro Contini on 18 Nov 2008.

Much of the situational analysis form would seem absurd to surgeons in developed countries. They would not dream of performing operations in a facility without running water, sterilizer for surgical tools, or sterile gloves. A hospital that serves a population of one million people but only has one functional operating theater would be a surgeon's worst nightmare. I found myself constantly entering "0" for the number of trained surgeons or general practitioners performing surgery; "absent" for suction pumps, sterile gloves, and face masks; "not available" for X-ray machines, anesthesia machines, and oxygen cylinder supply.

Yet, despite the lack of essential resources or trained professionals, healthcare facilities are still attempting to perform surgical procedures. Patient outcomes after surgeries performed in such bleak environments can rarely be good. Complications from incorrectly performed or unsafe procedures are numerous, debilitating, and frequently deadly. For example, fractures that are poorly set due to inadequate supplies of splints or a lack of knowledge about how to treat fractures can result in permanent deformities and disabilities. Surgeries performed with incorrect tools or in unsterile environments often cause life-threatening infections. With these ideas in mind, it is no longer difficult to understand the high morbidity and mortality rates due to road-traffic injuries and pregnancy complications.

Equally as frustrating and problematic is the situation in some countries in which healthcare professionals are forced to refer patients for certain surgical procedures not due to lack of skills, but rather due to lack of supplies or functioning equipment. This means that there are trained general practitioners and surgeons who have the potential to save lives at district-level facilities but are hindered by scarce resources. During a

meeting with Dr. Cherian, Dr. Contini, and Dr. Sherman about the state of the EESC project, we discussed how this problem is a major factor in the "brain drain" phenomenon. Dr. Cherian expressed frustration with the tendency to emphasize only the impact that low salaries have on the decisions of physicians who choose to leave developing countries in order to practice in developed countries. It is just as important, if not more so, to recognize the influence of decreased job satisfaction on the movement of health professionals. If surgeons cannot practice the skills they spent immense amounts of time and effort learning because they do not have access to the proper equipment, there is little reason for them to stay in such an environment. Developed countries offer a better opportunity to perform a wide range of surgeries, allowing surgeons both to improve patients' lives and further their own knowledge and training.[7]

This gap between capability and infrastructure strongly emphasizes the need for technology transfer and cooperation among developed and developing countries. While some resource scarcities, such as access to uninterrupted running water, cannot be remedied with technology-sharing, other scarcities, such as diagnostic and imaging tools, require this approach. Medical technology in the developed world continues to advance at an astounding pace, achieving remarkable new heights every year. Yet while this occurs, low-income countries are left to make do with either a complete lack of basic technology or an abundance of worthless, outdated machines. Physical exams and hands-on diagnoses are important; in fact, it is dangerous to become too reliant on CT-scans or MRI's to diagnose simple pathologies. But it is ridiculous to expect healthcare facilities

[7] See section "Discussion and Meeting Write-ups": Meeting with Dr. Meena Cherian, Dr. Sandro Contini, and Dr. Lawrence Sherman on 21 Nov 2008.

in developing countries to perform safe surgical procedures without so much as a functioning X-ray machine.

I also found that there is a large gap in capacity and availability of resources between government hospitals and health centers and private hospitals owned by NGOs or missions. NGO- and mission-sponsored hospitals in general have a decent supply of renewable supplies and access to resources, such as running water, because they receive supplies from an outside source. On the other hand, government-sponsored hospitals often lack even basic supplies, either because the healthcare budget is improperly managed or grossly insufficient. To me, this contrast emphasizes the importance of collaboration between the WHO and ministries of health. In this case, the GIEESC, an alliance encouraging global cooperation between governments, NGOs, research facilities, and scientific societies, has the potential to be a very useful tool.

In addition to gaining more in-depth knowledge about the state of surgical care in developing countries, entering the data from the situational analysis forms allowed me to better understand another aspect of global public health. The task of data compilation was interesting to me due to the contents of the data, but extremely tedious. It took over two-and-a-half hours my first day at work to enter data from six forms. Doing this job has helped me to understand in part why progress in global health seems to move so slowly. Some of the most basic tasks, not to mention policy-making, can take a long time, but they are tasks that are essential to any further steps in improving public health. Without knowing the hard facts of the situations, appropriate policy cannot be implemented.

Application and acquisition of skills

Visual and written communication skills

During my second week of work at the WHO, from 17 to 19 November, Dr. Cherian attended the 2008 Global Ministerial Forum on Research for Health in Bamako, Mali. The conference constituted the first meeting of its kind with the mindset that various kinds of research could improve health and health systems globally.[8] Part of the conference included a poster session at which several researchers presented their findings on various healthcare problems in an attempt to raise awareness about specific issues and gain the attention of government ministers and other potential participants or donors. Before leaving for Bamako, Dr. Cherian explained the need for a poster on the EESC project entitled "Can we evaluate equitable access to basic emergency & surgical care?" The poster would present up-to-date findings on the state of surgical care in eight countries. Dr. Cherian had a wealth of information about surgical care in PowerPoint slides, but the information needed to be cut down, edited, and arranged to be eye-catching and visually appealing. I set myself to the task of creating a rough draft of the poster.

After two versions had been examined and critiqued by myself, Dr. Cherian, Dr. Contini, and Dr. Sherman, I printed out what I thought might be a final copy. We presented the poster to Dr. Luc Noel, who has attended many poster sessions of a similar format, and suddenly the poster was again a work-in-progress. He explained to me that we were trying to sell our material to governments and researchers, and it was crucial to organize only the essential information in a way that was easy to read and understand in only a few minutes. Dr. Noel helped me to understand that anything not at eye level was

[8] WHO. "Ministerial forum on research for health begins Monday." 14 Nov 2008. <http://www.who.int/mediacentre/news/notes/2008/np12/en.html> (Accessed 18 Nov 2008).

likely to be ignored; we examined all of the information available and decided on the most important pieces of information, and I went back to the computer to make further changes.

Two drafts later, my work elicited the comment, “Now *this* is starting to look like an official poster!” Though Dr. Cherian and I were beginning to be pressed for time, I knew the poster could be important to the future of the EESC project, and I wanted to make it as effective as possible. Finally, some time after 17:00 on a Friday, I stood in Dr. Cherian’s office with Dr. Contini, Dr. Sherman, and Dr. Noel, staring at the poster I had taped to the back of the office door. It was finished, we decided. The poster was informative, effective, and attractive. After spending three days running back and forth between the computer and the printer and arranging, re-arranging, and editing the contents of the poster, I was relieved to hear, “Good work!” and “I don’t know what we would do without you!” from a room full of surgeons and anesthesiologists. We rolled it up, and it was ready to be packed with Dr. Cherian’s bags.

When Dr. Cherian returned from the conference a week later, she was very excited about her experience in Bamako. She assured me that the poster was successful, and that in fact, our EESC poster was the only one promoting research on surgical care, which most likely helped it gain further attention from stakeholders. Although it was slightly frustrating at times to constantly have to reword and reformat the poster, I consider it a very valuable experience. The process allowed me the chance to improve my presentation and visual communication skills. I learned about the most effective ways to present information and how to identify and eliminate non-essential information. I often become far too attached to data I’ve collected or material I’ve written, sometimes

making it difficult for me to be concise and make necessary cuts during the editing process. Creating the poster for the conference in Bamako forced me to critically examine the information from an outsider's point of view in order to determine what did and did not need to be conveyed.

Preparing the poster also helped me learn how to merge opinions and suggestions that differed somewhat into one final product. Since we were faced with a rapidly approaching, inflexible deadline, there was little time for four surgeons and an intern to argue about the best font color or the best placement of a particular photo. At a certain point, it was necessary to put an end to the debates and simply do what I could to compromise and make the changes I thought were most necessary.

While working in the CPU, I also had the chance to improve my editing skills, as I was asked to review and edit several country reports and workshop reports. Reports of visits to facilities in different countries or of on-site training workshops can be a useful advocacy tool, as they demonstrate the more tangible work the EESC project has accomplished. Often these reports were written by WHO staff members in Geneva, but from time to time reports of in-country training workshops were written by participants for whom English may not have been a first, second, or even third language. Reviewing these reports took extra care and time; frequently the intended meaning of a phrase was not entirely clear to me. In any case, my editing tasks also helped me learn how present information clearly, professionally, and completely in order to attract interest to a given topic or project.

Organizational events

Throughout my time at the WHO, I attended small meetings with various members of the EESC project team and the CPU as a whole. Although it was not my responsibility to write official meeting reports, I took every opportunity I could to summarize and organize both what had actually been discussed at the meeting and my own thoughts. Writing quick summaries after each meeting helped me develop a skill set I believe is important for anyone working as a member of a team. When I could clearly set out the contents of a given discussion, I could easily see where each team or group member stood, whether in regards to an opinion during a debate or progress within a group effort. This gave me a better idea of my own position among the group and made me very aware that I was not working as an individual but as part of a team.

Summarizing meetings and discussions also effectively prepared me for future conversations. It allowed me to develop questions and determine where any misunderstandings or miscommunications might lie. This skill helped me derive the maximum benefit from my time at the WHO, as I could get the most out of the resources around me by asking thoughtful questions and making important clarifications.

Learning outcomes

My internship at the WHO enhanced my learning experience in Geneva in three prominent ways. First and foremost, it provided me the chance to apply and see in action much of what I have learned about public health, here in Geneva and in my undergraduate work at Brandeis University leading up to my time in Geneva. Working at the WHO brought me into direct contact with public health policy-making, where ideas like brain drain, resource scarcity, and capacity building are not just concepts taught in a

classroom, but concrete actions taking place in countries across the globe. I heard from Dr. Cherian about trained surgeons leaving their home countries because they cannot practice their skills; I analyzed situational analysis forms from Nigeria that demonstrated a lack of running water, oxygen cylinders, and anesthesiologists; I saw photos and edited reports from workshops in China where healthcare workers were trained in basic emergency surgical care. I came to a clearer, more realistic understanding of what public health theory requires to be successfully implemented in order to attempt to solve global health problems.

Working at the WHO also gave me an incredible opportunity to learn from both physicians and public health workers about their experiences working in healthcare. Dr. Cherian explained to me several times the importance of having clinical experience before working in public health. She expressed a frustration with people in the health sector who propose and attempt to enact policies without ever experiencing first-hand the grave reality of public health in target countries. We also discussed the importance of sound clinical knowledge in creating effective policies. While I have rarely been unsure of my decision to go to medical school in the near future, this reinforced the idea that I should do so before attaining a higher degree in public health. These discussions also gave me a better idea of how I might shape my career in medicine and public health after medical school. I am still not sure how or where I would like to work within the public health sector, but after my time at the WHO I am sure that I would not be content to only practice medicine for my entire career.

However, I know that I will be practicing medicine for some time, and my exposure to the specialty of surgery while at the WHO was a valuable experience.

Unfortunately, or perhaps fortunately, I am not in any better position to decide in what area of medicine I would like to specialize, but working on the EESC project has certainly increased my interest in the field. I had remarkable opportunities to learn from incredibly knowledgeable, skilled expert surgeons like Dr. Contini and Dr. Sherman. Occasionally I would simply sit and listen to them share stories about particularly interesting cases or once-in-a-lifetime procedures they performed; when Dr. Contini showed some of his more "clinical" photos to me, I listened intently to his detailed explanations of each injury and operation. I continue to be enthralled by surgery, and after my internship at the WHO I am strongly inclined to pursue surgery as an option for specialization.

Evaluation of interactive research experience

The three short weeks I spent working at the WHO with Dr. Cherian, Dr. Contini, and Dr. Sherman are three weeks I will always remember. I worked diligently alongside experts in their fields on a project I have truly become passionate about. I gained exposure to important areas of public health – such as research, advocacy, and policy-making – that I had little or no experience with prior to my interactive research. I approached a first-hand experience as nearly as possible without being able to visit the actual project sites through photographs, personal stories, and data analysis. Dr. Cherian's constant words of "You are such a great help, I don't know what we would do without you!" significantly reinforced my feeling that the time I spent at the WHO was meaningful and worthwhile.

I believe I accomplished most, if not all, of the goals I set out for myself before starting my internship. Although I only grazed the surface of the WHO and certainly do not understand all of its inner workings and technicalities, I nonetheless have a better understanding of the structure of the bureaucracy and the flow of work within it. I also am familiar with the practicalities of a WHO project with a specific aim. I consider myself fortunate to have worked on the EESC project, since it is a project truly in its beginnings, despite having already achieved impressive research. This allowed me to witness many of the smaller obstacles such a project encounters in its lifetime.

I am satisfied that I took full advantage of the resources available to me during my interactive research. Certainly, I could always learn more about all aspects of surgery in developing countries. However I feel that I learned a substantial amount from reviewing the country data, reading documents and journal articles that were available, and speaking with others working on the EESC project. This provides me with a firm foundation to continue my research in the area and to speak about the project with others.

As I mentioned in the previous section, working at the WHO was a chance for me to put my knowledge about public health theory into action. Personal goals and accomplishments aside, I believe this is the ultimate benefit of the interactive research experience. Without it, what I have learned about vertical vs. horizontal programming, Millennium Development Goals, and health systems is nothing but words in the pages of a journal or ideas communicated by my professors. During my interactive research, I spent 8 hours a day in an organization whose work is based entirely around these ideas. These ideas, these public health theories are ingrained in every resolution the WHO passes, every project it approves, and every report it publishes. The opportunity to work

in such an organization has advanced my understanding of the concepts behind global public health in a remarkable way, and for that I am extremely grateful.

Conclusion

I am certainly motivated to continue what I started at the WHO. As one of the biggest problems facing the EESC project currently is awareness of surgery as a public health issue, I would be very interested in finding ways to bring it more to the forefront of public health. My own Brandeis University may in fact be the perfect place to begin this kind of endeavor, since it boasts an impressive science-minded pre-medical population, as well as an extremely lively social activism circuit. This combination could be very helpful in my attempts at EESC advocacy. I believe I have a good basis of information about surgery in developing countries to discuss the topic knowledgeably with peers and professors.

I am also very interested in continuing my research in the area of basic surgical care in developing countries, both in the current situations and possibilities for improvement, such as information and technology transfer. This will be more difficult without direct access to important materials like I had at the WHO, but journal articles are always within reach. I also plan on keeping up-to-date with the progress of the EESC project. Having put my own time and effort into advancing the project and having formed relationships with the people who work most closely with it, I have become even more concerned with the project's wellbeing and success.

At the end of my interactive research experience, I am compelled to continue in medicine and public health now more than ever. The passion Dr. Cherian, Dr. Contini, and Dr. Sherman have for their work inspires me to work as tirelessly as I can to do my small part to pull our world out of the public health crisis it currently faces. I have witnessed the all-important collaboration between medical, social, and political science at its best, and I am ready to continue that work in my education, research, and eventual career.

Research Location

Project: Emergency and Essential Surgical Care
Clinical Procedures Unit
Department of Essential Health Technologies
Health Systems and Services
World Health Organization Headquarters, Geneva, Switzerland
www.who.int

Chronology of IRP Research

22 September 2008 – brief advising session with Dr. Earl Noelte and Anne on general ISP ideas – 30 min

Discussed various topic options, including cardiovascular health, obesity, nutrition and physical activity, and surgery as a public health issue.; decided to focus more closely on the GIEESC and surgery

25 September 2008 – review of GIEESC, basic notes on the initiative – 1 hour

28 September 2008 – brief advising session with Dr. Earl Noelte on literature review and ISP ideas – 30 min

Further discussed the topic of surgery as a public health issue for my literature review and my possible ISP; also discussed some possible learning outcomes and how exposure to surgery could help me decide whether or not that is a field of medicine I would like to pursue

1-10 October 2008 – further review of GIEESC and current surgical training for literature review essay; writing literature review essay on GIEESC and mini-case study of the training program in Uttaranchal state, India – 15 hours

13 October 2008 – contacted Dr. Meena Cherian by email to set-up a meeting to discuss my possible involvement in the GIEESC; continued to correspond by email and phone through 21 October

22 October 2008 – meeting with Dr. Cherian to discuss progress of GIEESC, interactive research at the WHO (see Discussion and Meeting Write-Ups) – 2 hours

7 November 2008 – contacted Professor Peter Conrad (my academic advisor at Brandeis University) about WHO internship and possible future relationship between Brandeis and WHO

9 November 2008 – researched *Annals of Tropical Medicine and Public Health*, a new journal where I might be able to publish an article in conjunction with my WHO internship; defined goals and expectations for internship – 2 hours

11 November 2008 – internship (4); debriefing, summarization (1) – 5 hours

Entry of situational analysis forms for Sao Tome & Principe and Liberia

12 November 2008 – reviewed previous interactive research reports at SIT Geneva office in order to have a better idea of how to format my paper (1); internship (6); debriefing, summarization of the day (1) – 8 hours

Entry of situational analysis forms for Liberia

13 November 2008 – internship (4); debriefing, summarization of the day (1) – 5 hours
Created, formatted, reviewed poster for upcoming Global Ministerial Forum on Research for Health in Bamako, Mali; reviewed article on state of EESC in 6 LIMCs (still in writing and publishing process)

14 November 2008 – internship – 8.5 hours
Reviewed and made changes to Mali poster, final product

15 November 2008 – entry of situational analysis forms for Nigeria – 1 hour

16 November 2008 – debriefing of experience on Friday – 1 hour

17 November 2008 – internship (7); meeting with Earl to discuss structure of interactive research report (30 min) – 7.5 hours
Entry of situational analysis forms in database for Nigeria; reviewed "Surgical Care at the District Hospital" manual to research tools and procedures I'm not familiar with

18 November 2008 – internship (8); begin paper-writing (2) – 10 hours
Discussion with Dr. Sandro Contini about his experience with working as a surgeon and with the WHO (see Discussion and Meeting Write-ups); entry of situational analysis forms for Mongolia

19 November 2008 – internship (8); debriefing and continue paper-writing (2) – 10 hours
Discussion with Dr. Contini while viewing his photos from previous missions as a surgeon; entry of situational analysis forms for Sri Lanka, China, Mongolia, Liberia

20 November 2008 – internship (3.5); debriefing and continue paper-writing (2) – 5.5 hours
Review of Global Ministerial Conference on Health Research (draft of call to action, goals, tasks) and articles on state of health research in Africa

21 November 2008 – internship (8); continue paper-writing (2) – 10 hours
Meeting with EESC team (see Discussion and Meeting Write-ups); entry of situational analysis forms for Afghanistan and Nigeria; review of Bamako conference

23 November 2008 – debriefing of Friday's activities and continue paper-writing – 3 hours

24 November 2008 – meeting with Earl to discuss draft of IRP (30 min); internship (10); dinner at Dr. Cherian's house (3.5) – 14 hours
Discussion with Dr. Sandro Contini and Dr. Meena Cherian about surgery in the public eye (see Discussion and Meeting Write-ups); research on MEAK

organization; at dinner discussed experiences in public health and medicine with Dr. Cherian, Dr. Contini, Dr. Sherman, and Dr. Cherian's husband (a pediatrician)

25 November 2008 – internship (8); debriefing and continue paper-writing (2) – 10 hours
Meeting with Clinical Procedures Unit (see Discussion and Meeting Write-ups); research on Bill and Melinda Gates Foundation; entry of situational analysis forms for Tanzania, Uganda, and Kenya

26 November 2008 – internship (8); debriefing and continue paper-writing (2) – 10 hours
Entry of situational analysis forms for Tanzania and Mongolia

27 November 2008 – internship – 3.5 hours
Entry of situational analysis forms for Mongolia; organization of entered forms; review of China Training of Trainer's IMEESC workshop report

28 November 2008 – internship (8); debriefing and continue paper-writing (4) – 12 hours
Editing of China workshop report; meeting with IT; wrap-up discussion with Dr. Cherian, Dr. Contini, and Dr. Sherman

29 November 2008 – continue paper-writing – 4 hours

30 November 2008 – finish paper-writing; compile Human Resources, Discussion Write-Ups, and Research Locations sections; final editing changes – 4 hours

1 December 2008 – print IRP and assemble – 1 hour

2 December 2008 – turn in IRP at SIT Geneva office

TOTAL: 152 hours

Discussion and Meeting Write-ups

Meeting with IRP advisor, Dr. Meena Cherian
22 October 2008, 1 hour
Purpose of meeting: to further explore GIEESC, to orientate myself with current progress of the initiative, to explore internship possibilities and opportunities for involvement with the initiative at the WHO

I first contacted Dr. Meena Cherian on 13 October, 2008, to try to organize a meeting with her to discuss the Global Initiative for Essential and Emergency Surgery (GIEESC). I found her contact information in the brochure I picked up at the WHO on the GIEESC; she is the director of the Emergency and Essential Surgical Care project within the Clinical Procedures Unit and Department of Essential Health Technologies at the WHO in Geneva.

I began by introducing myself in more detail and explaining my interest in the GIEESC. I explained my literature review essay on the subject and my upcoming ISP project requirement. I asked for any further information on Dr. Cherian's position, on the GIEESC, and on any internship opportunities within the Emergency and Essential Surgical Care project.

Dr. Cherian began by describing the beginnings of the surgical care project. She was originally a professor of anesthesiology who worked in a first-referral care facility in India. She explained her experiences with having to perform a wide-range of emergency surgical procedures because there was no other qualified staff available at the facility. When she began working at the WHO, there was no department or projects concerning essential surgical care, for which Dr. Cherian saw a desperate need. Soon after her arrival, the Clinical Procedures Unit saw the development of a Transplantation project and a basic surgical care project, both of which are still ongoing.

We then discussed what the most important aspects of the GIEESC are currently. Dr. Cherian explained that the next goal of the initiative is to increase the grants it is receiving in order to expand the scope of the project and to be better able to answer the needs of resource-limited countries. Dr. Cherian is trying to form more relationships with research and academic institutions, and other foundations such as the Bill and Melinda Gates Foundation.

She then explained to me that she would be happy to have me working with on the project for the next few weeks, as there was always too much work to be done and not enough people to do it. We discussed some of my possible tasks, including data compilation from situational analysis forms, review of meeting and country reports for the IMEESC workshop, and helping with project advocacy, both now and in the future. She emphasized how important it would be for me to utilize all the resources I would have access to, both human and literary. She encouraged me to use the documents available on the EESC project and country situations in order to expand my understanding of the situation. I would contact Dr. Cherian within the next week to send her my CV and to reconfirm my starting date for 11 November 2008.

Meeting with Academic Director, Dr. Earl Noelte
17 November 2008, 30 minutes
Purpose of meeting: to discuss Interactive Research Report

At this meeting I explained to Earl what kinds of things I was doing at my internship, and how I felt about it so far. We also discussed more in depth the structure and plan for the interactive research report and what was important for me to include. He stressed the importance of including my evaluation and opinion of the internship experience, and how and why I felt the way I did about it.

I think it might be difficult to find the right balance between information about the EESC project, since it's less well-known than other WHO projects, and giving my opinion. I have a lot of opinion to give, but I'm afraid of going into too much detail when I layout the setting of the interactive research.

Discussion with Dr. Sandro Contini
18 November 2008, 1 hour
Purpose of discussion: to learn more about Dr. Contini's experiences working in the surgical profession and at the WHO

This was an informal discussion that took place in Dr. Cherian's office while she was away in Bamako. She had told me repeatedly how much experience Dr. Contini had with surgery and how useful it would be for me to talk to him about his experiences. He was extremely willing to speak with me. I thought an informal discussion would be more productive and more appropriate than a formal interview complete with questions and a voice recorder, so this will be a summary of the discussion

I began simply by asking Dr. Contini to share anything he felt was important in his experiences with training, with working as a surgeon, and with working at the WHO. He began his specialty in surgery 40 years ago in Italy as a student of surgery. He has specialized in vascular surgery, but is very experienced in general surgery as well. For most of his working life, he was a professor of surgery at the University of Parma, working both in the university hospital there as a surgeon and as a professor at the medical school. About 7 years ago he began working with a small Italian NGO that focuses on emergency surgery in priority countries. They have three locations of interest currently: Sierra Leone, Afghanistan, and Cambodia, and all of their services focus explicitly on surgical care. Dr. Contini has served a number of 3 to 6 month missions in the Sierra Leone hospital and also a number of missions in Afghanistan, where there are 3 separate hospitals, the largest of which is in Kabul. Each of the NGO's hospitals employs both foreign surgeons, like Dr. Contini, and local health professionals. Each hospital generally employs a general surgeon, an orthopedic surgeon, and occasionally an obstetric/gynecological surgeon.

In Sierra Leone, Dr. Contini saw a problem with children ingesting caustic soda, which can be found in open containers around houses because it is used for making homemade soap. Children who ingested the material were clearly at great risk of suffering severe esophageal damage. The damage can be remedied by surgery, so Dr. Contini and his team in Sierra Leone worked to alleviate these problems. He expressed a

great amount of satisfaction with this project, saying that they saved over 150 children in the span of 2 years.

Dr. Contini has done his most recent work in Afghanistan. One of the hospitals there specializes in maternal care. Dr. Contini expressed a frustration with the level of care they're able to provide because in order to operate on a woman, the surgeon must have permission from the patient's husband. Dr. Contini spoke of one patient who died of post-partum hemorrhage because her husband refused to consent to the surgery. If the surgeons had gone against his wishes in order to save the woman, the local authorities would have shut down the NGO's facility for not respecting important local customs.

The hospital in Kabul mainly performs only "war surgery" (generally trauma surgery) due to the high incidence of injuries and deaths from conflict situations in this region of the country.

Dr. Contini stressed how difficult it was to study Afghanistan and the state of surgical care because it's nearly impossible to obtain data in the country. He mentioned the problem of foreign aid workers being targets of in-country violence, especially Americans. He said that he's read a few reports of the healthcare situation in Afghanistan that seem to be completely false or far too optimistic. He can say from firsthand experience that the situation is not improving, but is either stagnant (at a very poor level) or even worsening.

He also emphasized the differences between practicing surgery in a country like Italy and practicing surgery in countries like Sierra Leone or Afghanistan. In developed countries, a surgeon can specialize in an extremely narrow area of surgery and perform only those procedures for years and years. However, in developing countries, you must have a expansive, working knowledge of general surgery. Often you must perform surgery either alone or with only one assistant, so it is entirely up to you to know how to perform a surgery for a head trauma, thoracic surgery, etc. Dr. Contini mentioned that the local employees in these facilities are very helpful and eager to learn, but they have had poor education. The state of teaching materials and experiential learning is in a poor state in the medical education systems. However, in terms of serving as an educational experience for surgical students in developed countries, Dr. Contini thinks it could be an extremely valuable experience, due to the fact that one must have a wide knowledge of many different kinds of surgery. The training opportunities could be great if surgical students spent even a short amount of time in a facility like these in Sierra Leone and Afghanistan. One of the advantages of working in countries that lack a lot of diagnostic technology is that physicians are forced to do more hands on physical exams, which is a useful tool that is perhaps not used as much anymore due to the prevalence of tools like CT scans and ultrasounds.

We also spoke about his experience working at the WHO. He only began a few months ago after meeting Dr. Cherian and discussing the possibility of his NGO participating in the EESC project. I told him about one of our speakers who had worked clinically and in the field for years and then began working at the UN; I remember this speaker expressing a level of frustration with the transition from working in a hands-on environment where one can immediately see the effects of one's efforts to working in a bureaucracy where everything takes time and one may feel like he's actually not *doing* anything. Dr. Contini said he could definitely understand that point of view. He told me about how his boss at the NGO he works for once said of the WHO that "we are doing,

and they are saying." Dr. Contini said it's difficult for a surgeon to make this transition because surgeons obviously love doing procedures and working with their hands to save lives. But he also expressed that he doesn't think it's necessarily as separate as "doing and saying." He thinks it's very important to have a balance between the two. Someone can be a great surgeon, doing great things, but without organizations like the WHO, or people with the ability to write papers, his work will never been seen by anyone else. Similarly, it's obviously extremely important to have field workers and people experiencing situations first-hand, but without organizations like the WHO, no one will ever see the reality and nothing can be done to change it. He mentioned the importance of having both experiences, working clinically and in an organization such as this, because of the different skill sets one gains. Working here, he can better learn how to present the information and knowledge he already knows so that people will take notice and take action. This is similar to what I learned last week with the poster experience!

He also mentioned showing me some pictures he has from his experiences. He said they're very "clinical," but I assured him that they would interest me. He also will hopefully put me to work in helping him with his Afghanistan dilemmas this week and next.

I think he's an incredible resource, and it was very important for me to talk to him. I agree with his perspective on having both clinical and WHO-like experiences. It goes hand in hand with all of these calls for multi-sectoral work in order to effect changes. The medical professionals have to work with the policy professionals if anything is going to get done.

Also, since I clearly can't go to any of these places where the work is actually being done (at least not at this point in my life), I think it's very helpful to hear from as many people as possible who have been there first-hand. It's the next best thing to experiencing it myself! Learning his opinion of how useful a training experience in these countries could be gives me some ideas. Maybe it should be a part of fellowships/residencies to spend time there. It could help with brain drain as well as help provide better training to our own physicians and surgeons. I think it's important though that not just anyone shows up there. A good amount of experience is necessary to be helpful at all, so residencies would probably be a good time to do it.

Meeting with Dr. Meena Cherian, Dr. Sandro Contini, and Dr. Lawrence Sherman
21 November 2008, 2 hours
Purpose of meeting: to update EESC ¨team¨ on the Bamako conference, discuss next steps in EESC project

The meeting was pretty informal. Dr. Cherian started off by saying that the ministerial conference in Bamako went very well. The EESC poster was the only one there about a surgery project, and it was well-received. The main focus of the conference was health systems and improving health systems (which goes with the primary healthcare goals). I think Dr. Cherian spent the time that she was required to at the conference, but otherwise she was busy meeting with surgeons and anesthesiologists from Mali, as well as the Minister of Health from Sierra Leone, and visiting facilities. I think this is what made it such a successful trip since she was actually able to speak with

people working in the field about the project who are very familiar with the gaps in surgical care.

She also explained some discussions she had with various people about the need to train more anesthesiologists. Surgical training is obviously important as well, but it should go hand in hand with training in anesthesiology, both adult and pediatric. You can't do major surgery without anesthesia. Apparently in Sierra Leone, there is only 1 anesthesiologist in the entire country, and when they need additional anesthesiologists or they need someone to train medical students they have to ask to ¨borrow¨ Ghana's anesthesiologists. Dr. Sherman explained the situation in Liberia, where they have mainly nurse anesthesiologists. This is a short-term solution to the lack of anesthesiologists but not a long-term solution because the nurses can't train future anesthesiologists. Dr. Cherian explained an idea for collaborative training between different countries. I think she meant that students would spend some time in one country and some time in another, maybe so that both countries would have ¨access¨ to the anesthesiologists? She emphasized again a need for well-organized anesthesiology residencies alongside surgical residencies. Once the residency is completed, a couple of the graduates would stay behind for a few years to practice and train the next class. This way the program is more sustainable and long-term. Dr. Contini reminded us that just as surgery and anesthesia go together, anesthesia and anesthesia equipment go together. This seems obvious, but I think it must be something a lot of people who aren't clinicians don't realize. People might think that if you have one type of simple anesthesia it's enough, but in reality different kinds of anesthesia last for different periods of time, work better for different procedures, etc. A functioning anesthesia machine is necessary to perform a lot of major (but essential) surgical procedures.

We also talked a little bit about specialist surgical training in addition to the ¨clinical¨ surgical training the IMEESC provides. Dr. Cherian said the training it provides is a good solution, but it's only short term and isn't as sustainable because it's only very basic skills (crucial and essential skills, but still pretty basic). In the future I think they would like to have specialist training programs, i.e. in cardiology, neurology, etc. I'm not exactly sure how that makes it more sustainable though. Perhaps because then it isn't just one surgeon performing all the procedures all the time. This sounds like a great idea, but I think it's very far in the future. I think that first the essential program should get a little further, then perhaps it can be done in conjunction with the specialist training. Right now I feel the energy should be focused on the essentials though.

The topic of evaluation of results and outcomes of the training programs was also touched on. Dr. Cherian emphasized the importance of the monitoring/evaluation tool included with the IMEESC. After the training program, are facilities actually starting to perform procedures they learned? Dr. Contini shared some experiences with not being able to evaluate outcomes in surgery as well. There are hospitals in Afghanistan that advertise a large volume of surgery (lots of surgical procedures performed) but a significant portion of them aren't performed correctly or safely, so they can hardly be considered successful outcomes.

Something I thought was interesting was Dr. Cherian's perspective on the brain drain idea. She said that everyone always talks about salary being the major factor in losing health professionals to developed countries. But one of the most important factors is job satisfaction. (I've heard this before, but the salary idea has always been more

emphasized.) If trained surgeons don't have any way to practice their skills because there aren't supplies or means to perform the procedures correctly and safely, they won't have a desire to stay in such a place. Maybe if they go to a developed country they aren't necessarily helping the public health situation in their own country, but at least they're able to do *some* good. If developing countries have the outlook that their professionals are just going to leave the country anyways to continue their training, they have no incentive to provide specialist training. Then it's just a vicious cycle! So supplies are *key*!!

Something else I didn't know was an issue: there have been problems in India and Pakistan (and other Muslim countries) with the abuse of ultrasounds. As soon as doctors can tell the sex of the baby, abortions are often performed if it's a female. Ultrasounds are such useful tools, and so important…it's awful that they're abused like this. I don't know if that ends up making donors wary of supplying ultrasounds or if they just have to take the bad with the good, knowing how helpful they can be with other conditions and with otherwise knowing the health of the fetus.

We also discussed the general problem with surgery being recognized as a public health issue. Surgeons are rarely considered by ministries of health to be of importance in achieving public health objectives. Obstetricians and pediatricians, yes, but not surgeons. People don't make the (seemingly obvious) connection between maternal health and surgery…child health and surgery…what do they think C-sections, fistula repair, etc…what do they think those entail? Dr. Cherian said that a lot of general surgeons are good friends with the ministers of health, but they're never invited to meetings. They just aren't considered to be important, when in fact they're not only important but essential to achieving a lot of public health goals.

We spent some time discussing the ways the WHO works as well. Dr. Cherian kept telling me how lucky I was to be learning about policy and decision-making within organizations so early on, instead of having to wait until after my clinical training. This makes me even more inclined to do a combined MD/MPH program, so I can continue learning both at once. Anyways, all three of them emphasized the importance of the WHO regional/country offices. The people in charge of the country offices are like ¨kings and queens¨ according to Dr. Cherian because they are the key to getting a project off the ground. They have contacts with ministries of health, so instead of a program just being forgotten and left behind, people actually pay attention to it.

I think at this meeting I also discovered part of the reason there seems to be so much (too much) work in this department. (It's possible that it's like this in every department though I suppose…) Dr. Cherian said, ¨We're too nice in the CPU.¨ Whenever experts come to work on a project in the CPU, like Dr. Contini or Dr. Sherman, other departments try to use them for their expertise, and end up taking away from the time they have to work on what they were hired to work on. I think they also end up taking on too many projects. Dr. Cherian was saying that she has had to become much more firm in turning down helping with other people's projects or attending meetings in other departments. They have enough work to do on this EESC project without all of that. I'm a little afraid of what's going to happen to all of the situational analysis forms that come in after I leave and before another intern arrives…

Finally, we heard a little bit about progress with Dr. Contini's project in Afghanistan and Dr. Sherman's project in Liberia.

This was an incredibly helpful, informational meeting for me to sit in on, even if I didn't really have anything to offer. I learned a lot about the future of the EESC project and the current progress, as well as about the department and WHO in general. I enjoy being considered ¨one of the team.¨ Dr. Cherian started off the meeting by saying, ¨We just haven't had a chance to meet, all four of us, and I think it's important that we do because we're the ones working on this project.¨ They also make me feel like I'm useful even though I'm only here for three weeks. It seems so simple what I'm doing, entering data into a database, editing papers, looking at pictures, hearing about personal experiences. I'm completely happy doing it since I'm learning so much, but I never would have understood how important the data compilation is without Dr. Cherian and the others telling me at least once a day how much of a help I am and how much I know. (I know nothing compared to them, I have no idea what expertise I have to offer compared to the three of them except for maybe figuring out English wordings and editing since I'm the only one with English as a first language…)

Meeting with Dr. Meena Cherian, Dr. Lawrence Sherman, and IT
24 November 2008, 1 hour
Purpose of meeting: to discuss wider distribution of and access to Situational Analysis form

At this meeting, we met with the IT woman who had first helped the EESC team make the situational analysis form. We expressed to her a concern that had been communicated to us by several facilities filling out the form. Many facilities are reluctant to fill out the form and send it back due to printing and postage costs. They would much rather either a) a form that is editable on the computer that they could then email back to Dr. Cherian, or b) a way to access the form on the internet. (This situation of course only applies to facilities with internet access. Others will continue to fill it out in a paper format.) The link to access the form on the WHO website was changed from a PDF link to one that facilities can fill out online. I'm not sure why this change hadn't been made until now; it seemed almost like an obvious improvement. Since access to the form online requires a username and password, I think they were worried about random people having access to their data. However, it was ensured that the password used by people filling in the form would only allow them access to filling out the form and nothing else.

I think it was important for me to also see the IT aspect of the WHO, even if I didn't learn too much during the actual meeting. I'm happy to see as much of the organization as possible.

Discussion with Dr. Meena Cherian and Dr. Sandro Contini
24 November 2008, 1 hour
Purpose of discussion: to talk about ways to get essential surgery into the public eye

After reading the article in ¨L'Uomo Vogue¨ about a non-profit organization that does eye and cardiac surgery in Kenya (MEAK), Dr. Cherian was very interested in getting their EESC project (or at least essential surgery) into the public eye in some way.

We talked about how it was important for people who are not necessarily experts (like me) to write opinion articles and smaller pieces like that to be seen places other than scientific journals. According to Dr. Cherian, donors aren't reading the technical scientific journals, so the project needs to be publicized somewhere else.

She asked me what I thought about it, and I told her it was a little strange to be that people didn't care about surgery that much because, at least in the US, it's a very lucrative, ¨sexy¨ branch of medicine, thanks to ER, Grey's Anatomy, etc. After thinking about it later, I'm a little surprised that something like that hasn't been capitalized on. In a perfect world we would have a spokesperson like Noah from ER or Derek, Meredith or Christina from Grey's. I'm sure the project and the department doesn't have the money for it, but even a quick spot raising awareness about surgical care in developing countries sometime during a Grey's episode could be helpful. I'm not sure if WHO-sponsored projects are allowed to do things like that though. It's probably very unrealistic, and we should probably just stick to younger people raising awareness. I'd love to try to do that back at school, but Brandeis is drowning in social activism.

Meeting with Dr. Meena Cherian, Dr. Luc Noel, Dr. Sandro Contini, Dr. Lawrence Sherman, Transplantation project staff members, coordinator of Clinical Procedures Unit (Clinical Procedures Unit)
25 November 2008, 1 hour
Purpose of meeting: to discuss most recent updates, developments, and problems within the Clinical Procedures Unit

I didn't participate very much in this meeting; I was more there just to observe. The first part of the meeting was spent discussing budgetary issues. The CPU coordinator talked about the implications of the financial crisis for the WHO budget as a whole, which would also obviously have implications for individual CPU projects, like the EESC project. If developed countries have to pour billions of US dollars into their own economies to bail out banks, they won't have those billions to give to the UN system like most years. Apparently WHO executives have decided that no new positions can be hired until they can determine exactly where all of the budget will come from since the financial situation is somewhat precarious. This can't be good news for any department in WHO. Dr. Cherian is constantly saying how understaffed they are and how much she would like to have more people working on their project. If I could I would gladly volunteer my free time for as long as possible!

Dr. Cherian also gave her report of the Bamako conference again because neither Dr. Noel nor the CPU coordinator had heard it yet. She mentioned that one way WHO could cut back financially would be to not send so many people to one conference. There were 65 WHO staff members in Bamako, and most of them were apparently from the same cluster. They should focus more on sending only staff members like Dr. Cherian who go and not only participate in the conference but make other advances for WHO as well, like her meetings with ministers of health and her facilities visits.

Finally they discussed the next steps for the GIEESC. There was some talk about WHO legal standards and procedures that I didn't quite understand. However, I do know that they were discussing a balance of power between the initiative itself and WHO, since

it is in fact a WHO body. The CPU coordinator warned against the GIEESC having a chairperson who could become too powerful and want to "run the show" his own way.

I felt not quite so important at this meeting since I didn't understand some of what they discussed. But it was good to see other proceedings and hear about other concerns for the project, like the budget and the legal aspects of the initiative. It seems to me that simply accomplishing small goals with the EESC project is enough of a task, without having to worry about all the rest!

Resources

Human Resources

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Dr. Lawrence Sherman, MD
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Literary Resources (not an exhaustive list)

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