It has happened before; kids head back to school, fall schedules get hectic, and cooler weather sets in. With all that’s been going on, you’ve spread yourself thin. Before you know it, dreaded achiness and exhaustion are on the scene. “Perhaps I just need some hot tea and a good night’s sleep,” you tell yourself. The morning comes and confirms your fear; it’s flu season.

In the United States and across the northern hemisphere, there is a fairly routine circulation of influenza virus in the fall and winter months. This is one reason why, come August and September there tend to be many more flu vaccination campaigns.

Even your local grocery store has the vaccine on hand. It is a common-enough illness that we often don’t think twice about it until the symptoms have onset, and we miserably acknowledge that our old foe, the flu, has struck again.

Wayne Sullender, M.D., F.A.A.P., Visiting Professor of Pediatrics, Section of Pediatric Infectious Disease at the University of Colorado School of Medicine and Senior Investigator at the Center for Global Health at the Colorado School of Public Health urges us to remember that the influenza virus is a big deal.

Since most of his work with influenza vaccines takes place abroad, he is all too familiar with child mortality as a result of influenza infection and subsequent pneumonia.

Pneumonia, an infectious process occurring in the tissues of the lungs, can emerge from a number of pre-existing conditions, influenza being one of them.

The number of influenza-related deaths among children in resource-limited settings is shocking; 90 million cases of influenza in children under the age of five cause between 28,000-111,500 deaths from influenza annually in that demographic.

This large range is a result of the fluctuating virulence of flu strains that emerge each season. Furthermore, two million children die each year from pneumonia. Pneumonia kills more children than any other illness—more than AIDS, malaria, and measles combined. Ninety nine percent of child deaths from pneumonia and influenza occur in the developing world. Recognizing the significance of this illness, UNICEF has dubbed pneumonia “The Forgotten Killer of Children.”

(Continued on page 3)
In 2006, Calvin Wilson, M.D., Associate Professor, Department of Family Medicine at the University of Colorado School of Medicine received a three-year grant from the United States Agency for International Development (USAID) to work with the National University of Rwanda (NUR) located in the city of Kigali, Rwanda in East Africa.

The grant was designed to initiate the rebuilding of medical infrastructure through the sustainable development of all of their residency programs, which had been suspended because of the 1994 genocide. This also included the development of a new post-graduate residency program in family medicine. The first group of residents began in 2008 and six of them just graduated from the 4 year program in 2012.

The key activities of the USAID Rwanda Medical Training Initiative (RMTI) included the provision of critical curricular components, faculty training, and support for the creation and implementation of family medicine as a specialty.

In 2009, when the USAID grant was finished, the project was taken up by Tulane University, under the auspices of Centers for Disease Control and Prevention. Dr. Wilson remained the principal investigator for the second phase of the project, in collaboration with University of Colorado School of Medicine physicians Michael Miller, D.O., and Louise King, M.D. both Assistant Professors in the Department of Family Medicine.

Having worked closely with the FAMCO residents in a teaching capacity, Dr. Michael Miller offers his insights about the program, from its beginnings, to its current state, and he theorizes about the future of Family Medicine in Rwanda.

**Global Health Link (GHL): Can you start by speaking to the identity and role of Family Medicine in Rwanda?**

Michael Miller (MM): Because Family Medicine is a new specialty in Rwanda and fairly new in East Africa, its identity and role are still in the process of being formed.

We are training our residents to have the skills and the knowledge to handle many of the common problems that present at the district level, but also teaching them concepts that to this point haven’t been integrated into the medical culture, such as preventive medicine, chronic care, and continuity of care.

Right now, the new Family Physicians will be based in the rural inpatient setting, but we are hoping that as the profession grows, they will be more active in the Community Health Centers and the outpatient setting where their skills are most needed and will really set them apart.

**GHL: I know there is a dearth of doctors in Rwanda, especially among primary care givers. Why do you think that is? Do you think the attitude toward generalists is shifting?**

MM: The medical community, like the rest of the country, was devastated by the genocide in 1994. Most of the doctors here at that time either were killed or fled the country.

The entire medical infrastructure, from the medical school on up, had to be rebuilt. Right now, most of the doctors practicing in government hospitals are generalists, but even then many are from neighboring countries because Rwanda pays their doctors at a higher rate.

Over the past few years, there has been increasing attention paid to training more doctors and improving the education they receive. There is now a one year internship requirement for new medical school graduates, a national continuing medical education program has been established, and a focus on improving post graduate residencies.

But with the increasing attention paid to specialty training, we want to be sure that it doesn’t come at the expense of continued improvement in primary care. That is a message we are trying to bring, and we hope that as the new Family Medicine graduates become leaders in the medical community, it is one they can continue to emphasize.
Dr. Sullender points out, “The elderly are a well-recognized risk group for influenza, but the very young, say children in the first year of life, can have hospitalization rates that are just as high as the elderly.” Data on influenza disease burden from most developing countries is limited, and therefore influenza is often not a high priority disease for countries in the developing world.

There are a number of reasons for this. One such reason is that flu is a virus, which is treated with antivirals; however, as Dr. Sullender states, “The benefits of antivirals tend to be much more predicated on how early in the infection you start [using antivirals], and the benefits are often described more in terms of shortening the illness. The degree of benefit provided by antivirals is not as dramatic as the use of antibiotics for bacterial causes of pneumonia.”

This reality shapes expectations of health care providers and patients, and often results in less insistence on diagnosis and treatment from both parties. Even if antivirals had a more dramatic effect in treatment, vaccines would still be preferable for reducing the occurrence of infection, rather than treating an established infection.

A second and related problem is that flu vaccines are administered annually, which is expensive and cumbersome. “If you’re a health authority in a resource-limited setting, you might be doing all you can to get those basic EPI vaccines out.” EPI stands for Expanded Program for Immunization, and it is the World Health Organization’s recommended schedule of vaccines, established in 1974 to ensure that all children in all countries benefit from life-saving vaccines.

It is an unfortunate, but understandable paradox that influenza vaccine is not on this list. “It would be an incredible burden for a health care system that is already having trouble meeting the healthcare needs of the population to add a vaccine that is needed every year,” stated Dr. Sullender.

In spite of certain prohibitive factors, it is important to continue researching influenza vaccine, even in resource-limited settings. Influenza has received more attention globally due to the pandemic of 2009.

The 2009 H1N1 pandemic caught the attention of health authorities in India, where Dr. Sullender is currently conducting a large flu vaccine study. “It heightened awareness and increased sensitivity to the potential risk of influenza virus infections; it also led the Indian government to stimulate their biotechnology industry so that they could develop and produce their own influenza virus vaccines.” Up until recently, no Indian manufacturers were producing influenza vaccine.

Dr. Sullender’s study, “Influenza Immunization in Children in India,” is being conducted in collaboration with the All Indian Institute for Medical Sciences (AIIMS), and also the University of Alabama, Birmingham. Their funding is coming from the Centers for Disease Control and Prevention (CDC) in a cooperative agreement, which means that all parties are very much involved in the management of this large study.

The study has two main parts; a three-year fall season immunization protocol, and a two-year spring season immunization protocol, each vaccinating approximately 3,600 children between the ages of 6 months and 10 years.

The study population is located in three rural villages that are proximal to each other and to Delhi in the state of Haryana in northern India. It is a prospective, controlled trial that is randomized by household.

The test population is receiving an inactivated trivalent influenza vaccine (TIV), and the control group is receiving inactivated polio vaccine (IPV). Outcomes will be measured with real-time polymerase chain reaction (RT-PCR) lab assays to confirm the presence of influenza infections in vaccine recipients and households.

Possible influenza infection will be assessed by means of self-reported fever, and confirmation of any symptoms of respiratory infection. This surveillance is being conducted weekly by field workers, which generates much data, and requires significant personnel-power.

The goals of the study are two-fold; first, to estimate the efficacy of TIV in children, and to estimate by extension the indirect or herd immunity effects; and second, to attempt to identify the appropriate timing of vaccine administration in northern India and other regions with similar influenza seasonality. This second question concerning appropriate timing for vaccination is based on the bimodal distribution of influenza (meaning, it occurs in both the summer and the winter).
Although it sits in the northern hemisphere, India and many other tropical and subtropical regions experience increased influenza activity during the summer monsoons, and again in cooler weather in the winter.

Sullender and his team are attempting to determine whether a flu vaccine would be more efficacious if it were distributed in the spring, before the monsoon season, as opposed to the fall, which is usually the case with countries in the northern hemisphere. He hypothesizes that influenza vaccination in late spring will confer better protection during the period of highest influenza activity.

In addition to the intricacies of India’s seasonal flu activity, there are also other generic factors that contribute to influenza, such as indoor air pollution, malnutrition and crowding.

India is a challenging setting for researchers, but it creates an opportunity to understand influenza in its most complexly layered environment. For an illness commonly thought to be so ordinary, it has many unpredictable qualities.

Learning how to make better predictions is the nature of Dr. Sullender’s work. “Our obligation as investigators is study design, collection of data, analysis of data, and producing those results in a fashion that is understandable not only to the scientific community, but to decision makers in their various forms,” he states.

Fortunately, Dr. Sullender has tremendous support from the CDC and his collaborators at AIIMS and the University of Alabama, Birmingham in accomplishing this range of tasks.

Whether the Indian government chooses to push the influenza vaccine as a public health initiative remains to be seen. The process of influenza vaccine development, production, and distribution is an expensive and lengthy research process with many variables, both at home and abroad. Despite its confundities, it is a topic well worth research and attention.

In the United States alone influenza annually generates an $87 billion economic burden, not something to take lightly.

As Margaret Chan, M.D., Director-General of the World Health Organization affirmed, “Influenza pandemics must be taken seriously, precisely because of their capacity to spread rapidly to every country in the world,” and the H1N1 influenza pandemic of 2009 reinforced this notion that a threat from anywhere can quickly become a threat everywhere.

To learn more about Dr. Sullender’s project, contact him at wayne.sullender@ucdenver.edu.

Pneumonia kills more children than any other illness—more than AIDS, malaria, and measles combined.
GHL: We know from previous issues of the *Global Health Link* that the work with the Family Medicine program began in 2006 with a three-year USAID grant. When that was completed, and the initiative was taken up by CDC/Tulane, how did the project change at that time?

MM: With the continued support of the Family Medicine program, we were able to take the next step in building the residency, which was to hire a full time faculty.

Dr. Inis Bardella worked with the program for a year in 2007, and then I moved here with my wife, Amy and three primary school boys, Malachi, David, and Jeremiah, in late 2009. This allowed for a greater presence both with the training and in the medical community.

Cal Wilson, who had been making frequent trips to coordinate, moved to Rwanda with his wife, Mimi, a year later. Since then, with the support and partnership of the CDC, through Tulane University, the program has continued to grow.

We now have the equivalent of 4 full-time faculty members and have even been able to provide the residents with in-country workshops as well as trainings in Kenya and South Africa, which wouldn’t have been possible without that support.

GHL: What has the process of Family Medicine training been like for these six graduates? Has the medical curriculum become more standardized, as Jean Bosco Gahutu, Head of Pedagogy predicted it would (in issue 13 of the *Global Health Link*)? How has the Family Medicine program evolved during their education?

The Faculty of Medicine at the National University of Rwanda, led by Dean Patrick Kyamanywa and the Head of Pedagogy, Jean Bosco Gahutu, have given a lot of tireless enthusiasm and commitment to standardizing the curriculum, both in the medical school and in the post-graduate residencies.

Using tools such as exam templates, modules, and curriculum review, they have improved the structure and accountability at all levels. We have tried in the Family Medicine teaching to take some of the experience we have from a Western teaching model and carefully adapt it to the Rwandan context, and I think that the students have really benefitted from it.

Our residents are now tested using techniques such as Objective Standardized Clinical Examinations (OSCE)* and standardized patients with objective scoring, which weren’t used at first. Though these are unique to the Family Medicine department for now, the NUR is welcoming of these ideas and are committed to continual improvement.

GHL: Dr. Wilson is previously quoted as saying “When the residency graduates its first two or three groups of well-trained specialists and they begin to train new residents, I will know it is time to step out.”

While this might not be the case quite yet, do you feel that the program has become more sustainable and self-perpetuating?

MM: We are certainly much closer to that point. The first cohort of six Family Physicians will graduate this October, and they are an outstanding group of individuals.

Even halfway through their training, they were beginning to establish themselves as competent doctors, teachers, and leaders at their training hospitals. They would even get phone calls at home from the other medical staff, asking for advice or a consultation on a patient.

**Dr. Michael Miller with his wife, Amy and three boys with new friends in Kigali, Rwanda.**

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**Michael Miller, D.O., Assistant Professor of Family Medicine at the University of Colorado School of Medicine**

Even halfway through their training, they were beginning to establish themselves as competent doctors, teachers, and leaders at their training hospitals. They would even get phone calls at home from the other medical staff, asking for advice or a consultation on a patient.
As residents, they have been instrumental in starting the Rwanda Family Medicine Association. When they graduate, the plan is that many of them will teach for the department as they continue to break ground in this new field.

Because of all this, our role here is transitioning from the primary teachers to that of faculty development. Though it is headed toward being a sustainable Rwandan program, that transition hasn’t happened yet. But it is thrilling to see these young doctors becoming capable and willing to take the reins.

GHL: Where is the future of the Family Medicine program headed? Have you observed increased interest among students? In practice, how has Family Medicine been received among Rwandan patients?

MM: For the past year, our department has been involved in teaching community medicine to both the 4th and 5th year medical students (out of the 6-year medical school training at the National University of Rwanda), and we have been introducing the medical students to ideas such as preventive medicine, continuity of care, patient-centered medicine, and community oriented primary care.

For some of these students, you can actually see a moment of epiphany and the subsequent excitement at what they are learning. We are hoping that by exposing them to these ideas early in their training they will incorporate them into their philosophy of health, even if they go into a different field.

There is definitely a slowly increasing awareness of the nature of Family Medicine. The Rwandan patients that are treated by our residents, though they don’t realize explicitly what Family Medicine is, have really been drawn to the patient-centered focus and quality of care they have been receiving.

At the recommendation of the Ministry of Health in Rwanda, we are in the process of starting a parallel 2-year post graduate diploma course in Family and Community Medicine so that we can train more of these doctors to competency at the community and district levels without them having to spend 4 years to get a Master’s degree. For the moment, that seems where the program is headed.

Family Medicine and primary care are not always the most “romantic” medical specialties, but they are essential building blocks for a functional, successful medical system. For Rwandans, the patient-centric care that they receive from FAMCO practitioners is probably a welcomed change of pace. For doctors and patients alike, there is a growing understanding that good health is often more than the sum of its parts. This breadth of perspective is the domain of the Family Practitioner.
More and more international projects at the University of Colorado are located in Spanish speaking areas of the world.

Through the work of University of Colorado faculty staff, find out how you can learn Medical Spanish and make it a part of your cultural immersion.

The Spanish language is on the rise. The numbers might surprise you. Spanish is No. 3 among the more than 5,000 languages spoken in the world today. Only the languages of China and India are spoken by more native speakers. Even English takes a back seat to Spanish with 330 million native speakers in the world, compared to 346 million for Spanish.

Interest in Spanish language and culture, for health care professionals, is expanding at the University of Colorado. Students, faculty and staff press to enhance their ability to deliver the highest quality, personalized patient care. Immersing oneself in the language and culture is one of the most effective, efficient ways to learn.

The last few issues of the Global Health Link have reported on the many significant activities in Guatemala by the University of Colorado and the Center for Global Health at the Colorado School of Public Health and these projects just begin to highlight the importance of the Spanish language for our teams.

Responding to interest in medical Spanish, the Office of International Affairs, located on the University of Colorado Denver Campus, supported an investigative visit to Guatemala to seek out top medical Spanish language programs.

At the recommendation of the Center for Global Health’s Edwin Asturias, M.D., Director of the Center’s Latin America Projects and Assistant Professor in Pediatric Infectious Disease at the University of Colorado School of Medicine, Guatemala’s second largest city, Quetzaltenango, became the target site.

Quetzaltenango is popularly known as “Xela” (SHAY-la) is a beautiful and welcoming city. Xela enjoys a high concentration of higher education institutions, a reputation as an intellectual and language center and possesses a diverse local economy and relative safety. Its proximity to the Guatemala Trifinio Project program site makes Xela an ideal location for Spanish-language studies.

From May 28 through June 1, 2012, David Eckhardt, MS, PA-C, Instructor and Clinical Coordinator and Claudia Luna-Asturias, LSCW, Adjunct Faculty from the Child Health Associate/Physician Assistant (CHA/PA) program at the University of Colorado School of Medicine and John Sunnygard, Director, from the Office of Global Education at the University of Colorado Denver were tasked to visit, evaluate and recommend a course of action for a medical Spanish program for the University of Colorado Anschutz Medical Campus.

Language schools, clinical and research opportunities were considered from an inter-professional perspective, not strictly for their suitability to one particular program on campus.

Prior to the visits, Claudia and John researched language schools, medical Spanish language programs at United States medical schools and different language levels.

The team visited 10 different language schools, two in Antigua and eight in Xela. While in Guatemala, the team also visited six potential clinical placement sites (San Lucas Tolimán (1), Xela (3), and Guatemala City (2).

The team also met with one partner foundation (Fundación Rigoberta Menchú Tum), and one partner university (Universidad Francisco Marroquin) to consider best practices and development potential for clinical placements in Guatemala. The visit was a success as conversations with these other potential partners indicated many other possibilities for future development.

Guatemala offers many high-quality Spanish-language learning opportunities. Guatemalan Spanish is clear and easily understood by Spanish speakers worldwide. Xela’s strong university sector provides an abundance of well-trained instructors, as language teaching is a lucrative middle-class profession in Guatemala.

Language schools routinely offer a full course of language instruction, homestay and 3 daily meals for approximately $200 and $250 per week. Schools attract a range of different clientele, but nearly all cater to United States and European adults who seek an inexpensive path to learn Spanish in an immersive environment.

(Continued on page 8)
Immersion activities, such as homestays and “volunteer” experiences are standard attributes of nearly all the language schools visited. Schools also offer a range of recreational, cultural and adventure activities.

The University of Colorado team focused on schools with a track record of working with universities in the United States which described “Medical Spanish” programs.

The team reviewed items such as operations management, instructor qualifications, pedagogical philosophy and learning environment. They paid close attention to risk mitigation issues, such as transportation from the airport to the site, location within the city, accommodation, and student orientation.

Learning the culture that breathes life into a language is a critical reason to study in a “native” environment. Finally, they explored how schools exploit their location to take Spanish beyond grammar and vocabulary so students learn critical communicative aspects such as non-verbal expression, gender roles, interpersonal relations, beliefs, norms and customs.

Each school visited had their own approach and strengths. Two schools were most impressive: Celas Maya and Pop Wuj. These distinctive organizations presented students with a challenging language learning environment and well-structured, hands-on learning experiences for health professions students and practitioners.

Celas Maya’s innovative program is very well structured. The program manages to incorporate both United States and European language standards and add a dimension of assessment lacking in other programs. For the student who wants documentation beyond personalized one-on-one language growth, Celas Maya also applies a structured curriculum for either the DELE (Diplomas de Español como Lengua Extranjera) exam or the Instituto Cervantes Certification.

Celas Maya has established an extensive network of people and organizations to help their students meaningfully integrate into the community.

Clear protocols and screening have been established for both students and hosts to ensure that all interactions are of the highest ethical standards. This enables the students to function within the scope of their professional training. Celas Maya is located in a spacious mission-era building just off Xela’s main square.

The small student-teacher tables are neatly scattered throughout the lush courtyard gardens to offer students with a private and inspiring study environment.

Pop Wuj Spanish School is named for the sacred text of Maya-K’iche culture. This little gem has a very tight model that works extremely well. Pop Wuj has outstanding leadership focused on a strong language, culture and service program. Pop Wuj has no intention to expand beyond a maximum of 15 students per week in medical Spanish.

They have excellent teaching, adequate facilities and a good location. The school has built, equips and modestly supplies a clinic on the school’s ground floor. The clinic is staffed by a local physician who supervises the students. Three or four mornings a week, a queue of mostly women and children seeking free care weaves along the sidewalk.

This program is slowly adding a modest free dental clinic that is staffed by a local dentist. Residents, professionals and select students may work in the clinic or in other placements around Xela. The students have given their experience glowing reports.

Lauren Mehner, second year student in the University of Colorado School of Medicine. She is conducting surveys in Spanish during her recent trip to the southwest region of Guatemala.

Unlike most language schools in Guatemala that establish relationships with local organizations to offer volunteer options for their students, Pop Wuj originated as a service organization that added a language school to generate revenue to do their community work. Pop Wuj has found that balance by providing an outstanding service to all their constituents.

Many options are available to support health professional’s language learning goals. The University of Colorado’s innovative SABES (Spanish Acquisition Begets Enhanced Service) program (student created and run course in medical Spanish) and the collaboration with Common Ground International (company who works with SABES and offers a SABES II program) are excellent options on-campus and in Costa Rica.
Guatemala is a diverse, welcoming country that offers serious students the opportunity to develop their own professional skills and engage in sustained local development activities. Students who are interested in studying with either of these (or other schools) must have approval from their academic department and must register their study with the Office of Global Education.

Want to learn more about the medical Spanish programs? Contact John Sunnygard, Director of Global Education at john.sunnygard@ucdenver.edu.

To register your study, click here: https://www.ucdenver.edu/studyabroad/

To learn more about Celas Maya and their language program, click here: http://www.celasmaya.edu.gt/

To learn more about Pop Wuj and their language program, click here: http://www.pop-wuj.org/

To learn more about SABES, click here: http://www.ucdenver.edu/academics/colleges/medicalschool/administration/alumni/CUMedToday/features/Pages/SABES-Spanish-Lessons.aspx

How far are we from Lake Wobegon, Minnesota?

Join us in meeting the Center for Global Health’s first-ever global health fellow, Gretchen Domek, M.D., M.Phil, from Saint Cloud, Minnesota.

When you think of the city, Saint Cloud, Minnesota you might think cold winter weather, college town and good, wholesome people. In fact, Gretchen Domek’s home city, with a population of 66,000+, was named one of the most livable winter cities on Livability.com’s top ten list in 2011.

This is the community where Gretchen Domek grew up. She was, and still is, an Apollo High School Eagle. She competed on her varsity ski team, track team and tennis team and was her graduating senior class valedictorian.

After graduating from high school she completed an honors bachelor of science degree in biological chemistry at the University of Utah and soon headed to Oxford, England as a Rhodes Scholar. Dr. Domek graduated from Oxford University with a master of philosophy degree in medical anthropology and headed to medical school at Harvard University where she received her medical degree and graduated June 2009 cum laude et thesi propria.

Flash forward to 2012 - June 30th she completed her pediatric residency at the University of Colorado and Children’s Hospital Colorado and the first of July, Gretchen Domek, MD, MPhil started her one year Pediatric Global Health Fellowship with the Center for Global Health at the Colorado School of Public Health. Gretchen couldn’t be more suited to the center’s projects and goals, and the center is excited to welcome her as its first fellow in global health.

During the fellowship with the center, Gretchen will have the opportunity to work in a Denver-based clinical setting, teach, develop research protocols, work in data analysis and expand her international field work. This summer, she made her first trip to our Guatemala project site, bringing her expertise of childhood parasitic infections, community health and teaching, as well as disease prevalence.

She will be instrumental in the center’s work toward achieving millennium development goals 4 and 5 – MDG 4, to reduce child mortality by 2/3 between 1990 and 2015, and MDG 5, to improve the maternal mortality ratio by ¾ within the same time frame. Her expertise is vital to providing care in the later stages of the birth-to-childhood life-course.

Gretchen first became interested in global health work while attending the University of Utah. She conducted bioethical research with a group of philosophers; lawyers and physicians under the leadership of Dr. Margaret Battin.

She also coauthored an article in the journal Developing World Bioethics as well as a book chapter in Ethics and Infectious Diseases. This led to her work in Johannesburg, South Africa in the summer of 2004 in Pediatric HIV/AIDS.

When it comes to health and fitness, she leads by example wherever she goes, always enjoying the nature around here, whether it be in Colorado, Tanzania, or in the wintry landscape of St. Cloud.

(Continued to page 10)
Dr. Domek has tackled her fifth 14er this summer and has the blisters on her heels to prove it. She is anxious to resume skiing this winter; downhill and cross country. During her second year of residency at Children’s Hospital Colorado she got her first taste of big-mountain skiing, hitting the slopes no less than 21 times. Could be a record in the department of pediatrics.

She participated on the cross country ski team in high school and college. Minnesota is the state of ten thousand lakes (she tells me there are actually more than 10,000 lakes) but no hills. She learned to cross country ski on the lakes and in cornfields.

The University of Utah, where she attended because of the environment and beauty; (not to mention it is a ‘fine’ institution on its own, and the full ride scholarship does not hurt); has her heart when it comes to college football. Yes, she is a member of the ‘Utenation’! In her own words, she is ‘obsessed’ with college football. She has been known to wear University of Utah gear from head to toe to guilt her friends into eating dinner at a restaurant where the game will be aired. The happiest moment of her life - to date - is when she and her Dad, Bob, attended the Sugar Bowl in New Orleans at the Louisiana Superdome on January 2, 2009. The Utes whipped the Crimson Tide (Alabama) 31 to 17.

When she is not cheering on her favorite team, or climbing a 14er or skiing, she is working in underserved areas around the world such as: Chile, Ecuador, Kenya, South Africa and most recently Guatemala. While in Tanzania she climbed the tallest mountain on the African continent and the highest free-standing mountain in the world at 20,000 feet, Mount Kilimanjaro. Approximately 25,000 people attempt to summit Mt Kilimanjaro annually. Approximately two-thirds are successful. Count Gretchen in the two-thirds.

In closing on our ‘meet Dr. Gretchen Domek from Minnesota’ story, we will quote the MPR (Minnesota Public Radio) personality, Garrison Keillor, who was known for his stories on fictitious Lake Wobegon, Minnesota. The stories were based on his childhood in Anoka, Minnesota, only 49 miles from Saint Cloud., Gretchen’s home town.

As Mr. Keillor has said, “Welcome to Lake Wobegon, where all the women are strong, all the men are good-looking, and all the children are above average”.

To learn more about Dr. Domek’s work, look for upcoming articles in future issues of the Global Health Link.

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**Fall 2012 Global Health Lecture Series**

**October 24, 2012**
12 noon/ED2S, 2201
Anschutz Medical Campus

Donald Krogstad, M.D., Henderson Professor, Department of Tropical Medicine, Tulane School of Public Health and Tropical Medicine

*Challenges and Rewards in the Struggle Against Tropical Disease*

**November 14, 2012**
12 noon/Mt Oxford
Children’s Hospital Colorado
2nd floor conference center

Edwin Asturias, M.D., Assistant Professor, Department of Pediatrics, Section of Infectious Diseases at the University of Colorado School of Medicine and Assistant Professor of Epidemiology at the Colorado School of Public Health

Sheana Bull, Ph.D., Professor, Department of Community and Behavioral Health, Colorado School of Public Health

*Applying Text & Mobile Innovations to Improve Vaccine Delivery in Guatemala*

**December 5, 2012**
12 noon/ED2N, 1107
Anschutz Medical Campus

Paul Polak, M.D., founder of Colorado-based non-profit International Development enterprises (IDE), Author of the book, *Out of Poverty*

*Business Solutions to End Poverty—to improve the health and incomes of people living on less than $4 per day*
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- Katherine Reed,
Art Therapist and creator of this exhibit

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