Dear fellow Section members;

It is fitting that the introduction to this edition of our newsletter should be a tribute to one of our ilk who has been a truly remarkable leader and inspiration globally. It is touching and humbling to see the outpouring of comments and memories that have circulated on various listservs, recognizing the influence and “touch” that one person can have.

Professor David Morley died from a heart attack on July 2nd, 2009 while on holiday at the age of 87 years young.

Quoting from David Chandler and Neil Pakenham-Walsh: “David Morley was Founder and President of Teaching-aids At Low Cost (TALC), a remarkable UK-based charity that has provided reference and learning materials for health workers and communities in developing countries since 1963. David was also Professor Emeritus at the Institute of Child Health, London. He had practiced in Nigeria, East Africa, and India, and had also travelled in the Middle East, China and South America.

After retirement he dedicated himself to a number of causes, most notably the challenge of meeting the information and learning needs of primary and district-level health workers. In recent years, David championed the production and distribution of e-TALC CD-ROMs containing high-quality content for health workers, and has distributed tens of thousands of these worldwide, 

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especially to hospitals and health facilities in Africa which have poor internet connectivity.”

Professor Morley was influential on a global scale before the advent of the internet, primarily through his work in various countries, his later travels and courses, and his insightful books.

I pulled my old copy of “My Name Is Today” off my shelf and re-read it. I should do this periodically. It is a remarkable compilation of wisdom imparted in lucid prose and vivid images that I seem to understand more as time goes on. Chapter 4 on “The changing role of health workers” resonated most on this read-through because of where I think we are in considering how to expand access to care to meet the Millennium Development Goals.

On July 9th I got a lovely reply from David – or those helping to clear what I would imagine to be an enormous e-mail load. We had been communicating with the intent of putting something together for our SOICH listserv and newsletter on the story and mission of TALC and its myriad resources, particularly the CDs but also the books. I will put that piece on our listserv.

May we all be inspired by the lifelong energy and spirit of David Morley to continue, with renewed vigor, our own work for children locally and globally.

Peace,
Cliff O’Callahan, MD, PhD, FAAP
Chairperson, SOICH
Dear friends:

7 July, 2009

David Morley’s death reminds us that truly creative minds almost always die too soon at no matter what age.

Doctor Tony Waterston, his colleague, cited some of the uniquely useful ideas that kept springing forth from his ever curious cerebrum. Here are a few comments on those that he cited and on others that he didn’t:

1. The growth chart: it was far more than that. He sometimes called it the “under fives card” or the “road to health” chart because, as used by his colleague and co-conspirator, nurse midwife Margaret Woodland, at the original “under fives” clinic at Imesi Ile, Nigeria. It incorporated a brief family history, at-risk factors for that child (tbc, sickle cell, etc), immunizations, breast feeding duration, inter current illnesses like measles (written next to the growth curve so that family and staff could see and come to understand its often fatal impact on growth!), and family planning reminders for the mother. David realized that the mothers were far less likely to lose the chart than the clinic or hospital and that it could serve as an integrative tool for the mother, the family, and health personnel to view and treat the child as a whole rather than as a disease or statistic.

2. Teaching Aids at Low Cost: Like all his innovations “TALC” operated non profit so that the materials, translated into multiple languages, could be available and accessible to those in greatest need. Many of the staff were local St Albans folk, so inspired by David’s generosity of time and effort that they worked as volunteers or for almost no wages. Sometimes his altruism had a paradoxical reverse effect. By refusing any royalties on his (and Hermione Lovel’s) seminal work, His Name Is Today, written in 1986 with the prize money he won from the King Faisal Award in 1982 and insisting that it be published in paper back at low cost, book stores realized little incentive to stock it, so that it soon became widely unavailable! But this and many of his other books remain classics in tropical child health to this day.

3. “Child to Child” education curricula: David wanted school age children to learn about health by teaching, so he developed materials from which children could learn in school but also take home to their siblings (and perhaps parents). At first he envisaged the siblings as younger, but later realized that often they were older, (perhaps because girls drop out sooner?), after which he changed the name to Child to Child. This program worked so well in disparate cultures all over the world that it won a UNICEF Maurice Pate award in 1991.

4. David spent years working on a simple low cost, tough scale, such that any community health worker anywhere could carry it along on outlying village or home visits. He also wanted it designed to involve the mother in the growth monitoring of her child. The TALC scale depended on a spring calibrated so that 1 kilo of weight translated into 1 centimeter on the growth chart. A hole in the pointer allowed the mother to affix the weight directly on her child’s chart. The scale itself was made of plastic, with the instructions imprinted on the back, and so tough that, as he used to boast, a truck could drive over it without detriment, unlike the usual the UNICEF “Salter” model or later battery or solar powered types. Like the Salter, it was made to hang from a door jam or tree branch, but cost 1/5th as much. The only problem was that the growth charts had to be exact replicas of the TALC chart which was made of resistant (to both tearing & urine) plasticized paper and calibrated to fit exactly onto the scale itself. David realized that for growth monitoring to be effective, it had to be made as simple as possible and extended to entire target populations, and not just offered to those who turn up at clinics or health centers.

5. Though having started in Nigeria, where it’s mostly warm, he realized in his travels that newborns were widely suffering from hypothermia and espoused the widespread distribution of small low cost disposable skin thermometers for primary prevention: another TALC product.

6. Even cheaper was his pebble & (calibrated) string pendulum for the watch-less village health worker to use in screening for tachypnea indicative of pneumonia... so simple... but he thought of it!

Continued on Page 4
7. Perhaps David’s most remarkable achievement came early on when he went out to work at the Wesley Guild Hospital in Nigeria. Having trained under Donald Court at Newcastle on Tyne, David knew the value of longitudinal prospective research. Before undertaking the design of his seminal “Under Fives Clinic” at Imesi Ile, he set up and, with Margaret Woodland, carried out a five year study of the lives, morbidity and deaths of all babies born in that village. As the study was progressing services were designed to meet the observed needs:

Home visits and highly accessible (“twenty four seven”) primary Maternal and Child Health care by locally recruited and trained semi professional (“grade 2”) midwives ensured 95% compliance. Mothers were encouraged to bring all their children on every visit. Good weaning nutrition was built in via prolonged breast feeding and home grown chick peas & beans, careful growth monitoring and supervised feeding for those who “faltered” (failed to gain weight for 2-3 months). Immunizations were available daily & coverage was over 90%! Measles deaths dropped precipitously after every child got the new vaccine (David was friendly with Krugman and so Imesi was the first village in the world to be protected!) Basic medications and supplies were always available thanks to weekly restocking by the Wesley Guild.

The main innovation was success. How many simple low cost primary care services actually work... in the sense that 0-5 mortality is demonstrably and significantly lowered? Imesi worked but why? Besides the above features,

- the small maternity/clinic (but with a large covered waiting area against sun & rain) was built by the locals,
- Most of the mothers were delivered there by the midwives,
- Margaret Woodland stayed around and learned Yoruba,
- The services (curative and preventive) met community needs and reached every child, and mainly because
- The trust needed to engage the entire population was established by the integration of all services under the same roof, by the same personnel and at the same time!

Zero to five mortality dropped in ten years from over two hundred to under fifty per thousand at a cost of less than $5 per child per year! I doubt that this achievement has ever been duplicated!

David was also an inspired teacher. Despite working for years in rather traditional academic environs, and with varying degrees of support, he maintained an active role, an optimistic attitude and the unbridled energy that fueled his countless forays leading teams of students out in the field to study nutrition and demonstrate how it underlies so much of health and disease in the tropics.

I am but one of many whose whole careers were directly inspired by his mentoring. Many of these mentees presented highly innovative work at the London festschrift in his honor in 2003.

Two memories characterize David Morley for me:

- His labeling of (supernumerary) hospitals in developing societies as “disease palaces”, and
- His cartoon (in My Name Is Today) of carrots unhappily planted too close together and contentedly spaced, as a metaphor for the benefits of spacing child births!

Respectfully and reverentially,

Nicholas Cunningham MD, Dr PH,
Emeritus Professor of Clinical Pediatrics & Clinical Public Health,
Columbia University
In the past year, one of the major tasks the Office of International Affairs (OIA) of the American Academy of Pediatrics (AAP) has undertaken was to conduct an assessment on the Academy’s international operations and to develop a business plan. In order to accomplish this goal, the OIA invested a large amount of its limited staff time, worked with 6 major departments and divisions within the Academy that conduct international activities, collected and analyzed data from the last 5 years, incorporated key components from the Strategic Plan which involved the SOICH, and developed a draft of the Academy’s very first international business plan.

The business plan makes the argument that the Academy must not only continue to improve child health internationally which is in full compliance with our organizational mission statement, but it must also develop clear business objectives and strategies and achieve margin in our global operations. It must strategically position itself in the global market, identify priority regions, build country-specific assessments, strengthen relationships with local governments, pediatric societies, and individual pediatricians, and create need-based and revenue-generating business models. Such an approach will not only achieve margin in the business operations, but will also establish a strong financial support for activities that are mission-oriented. In past years, most of the Academy's international activities have been externally grant-funded.

The business plan also makes the statement that while International remains a small portion (5%) in the Academy's overall revenue portfolio, its growth rate has been very high (approximately 20% annually) and maintains a solid margin. The business plan also points out that while the Academy's international activities are categorized as reactive, decentralized and inadequately funded; the potential for future growth is significant. Major areas for international growth include membership, networking opportunities between colleagues in every part of the world, relationship building, books, journals, conferences, training opportunities, and improved funding. The 2008 NCE attracted a record high of 831 international attendants.

Mission
To attain optimal physical, mental, and social health and well being for all children throughout the world.
To accomplish this mission, the Academy will, through its Office of International Affairs (OIA), support the professional needs and interests of its membership to work internationally, identify organizations that can further the international mission of the AAP and collaborate with them efficiently.

Vision
By 2015, the AAP will be recognized as an exemplary partner in improving child health worldwide.

Strategic Priorities
A. Advance Child Health Globally
   1. Assess Child Health Priorities and National Capacity in Target Markets
      • Build profile of target markets using needs (e.g. national child morbidity and mortality rates, malnutrition, environment, disasters, etc.) blended with other criteria (e.g. relations with AAP, society strengthen & structure, resources availability, child care system, linkage to MOH, WHO, UNICEF, etc.)
      • Map FRAME criteria to each region (Funding, Reputation and Relationship, Advocacy, Membership, Education)
   2. Leverage Existing Turn-key Programs (e.g. NRP, PEDS, I-CATCH, Networking, Friends of the Section)
B. Provide High Value to our International Members

Continued on Page 6
Office of International Affairs Business Plan  Continued from Page 5

1. Establish Strategic Alliances with Pediatric Societies  
   • Pilot new group membership models  
2. Develop Customized Membership benefits Portfolio  
   • Build international community of AAP members  
3. Create an AAP International Portal (online gateway to various resources)  
   • Provide an online resource center for members  

C. Grow Revenue Efficiently  
1. Grow Revenues to 10% of AAP Portfolio by 2015  
   • Develop functional growth plans by business unit  
2. Build AAP Brand  
   • Increase “Real Estate” for international activities (e.g. Web site, AAP News, NCE programming)  

D. Improve Operational Efficiency  
1. Build Integrated Data and Report System  
   • Leverage net: FORUM (database system) capacity  
2. Generate Monthly Financial Reports  

E. Increase Staff/Volunteer Collaboration  
1. Establish (Institutionalize) an International Business Unit Team  
2. Improve Administrative Support for SOICH  
3. Provide the AAP Executive Committee with Regular Updates  

Priority Countries or Regions (FY 2008-2009)  
Mexico (Maintenance Market)  
China (Growth Market)  
India (Growth Market)  
Egypt/Middle East (Strategic Market)  

In the coming year, the OIA will continue to work with various business units within the Academy to: explore a new membership model with Egypt/Middle East, create publishing opportunities in China, increase overall NCE attendance, complete the Pediatric Education in Disasters training course in 4 countries, support NRP training and other educational programs in south Asia and Africa, build an online international portal, design a system that could track international sales timely and accurately, maintain a high AAP presence at major international conferences, and help pediatric societies establish self-sustainable projects and programs that can benefit pediatrics and children in the communities.  

The OIA will continue to work with the SOICH providing administrative support on activities such as: SOICH meetings and conference calls, I-CATCH, resident travel grants, newsletters, educational programs and speakers, Web sites, fund raising, budget management, elections, etc.  

With very limited staff resources (currently at 2 FTE), it has been a challenge for the OIA, in addition to its administrative responsibilities, to carry out all the activities above. We will continue to search for creative ways to generate resources, both human and financial, to support our international mission. We will continue to rely on the most valuable resources we have, volunteer members like you, to guide and lead our work in advancing child health worldwide.
[Washington, DC – April 7, 2009] Health Volunteers Overseas (HVO) is pleased to announce that Dr. Caroline Dueger is a recipient of the fourth annual HVO Golden Apple Award. As part of its World Health Day observances, HVO created this award to recognize the extraordinary educational contributions of volunteers to international program sites. Each volunteer honored with this award has demonstrated a strong commitment to HVO’s educational mission by working on curriculum development, teacher training, didactic or clinical training, or the enhancement of educational resources.

Dr. Dueger volunteered with the HVO pediatrics program for many years at Cambodia’s Angkor Hospital for Children, providing both clinical and didactic teaching, and working on the development of the faculty in this teaching hospital. She organized a “Child Protection Workshop”, addressing such issues as ethics, rights of the child, and child abuse which has significantly improved the assessment and treatment skills of the staff in handling these difficult issues. Within a month after the workshop, the staff was inspired to develop and implement a child sexual abuse protocol at the hospital.

Dr. Dueger served as the program director for the HVO pediatrics program in Cambodia from 1999 to 2009, coordinating the volunteer efforts and ensuring that volunteers were well prepared for their service. She is a member of the HVO Pediatrics Steering Committee.

Dr. Dueger is currently retired from her general pediatric practice in Concord, NH. She serves on the Executive Committee of the American Academy of Pediatrics Section on International Child Health. She has been an active member of HVO since 1996.

According to recent reports from the World Health Organization, the global shortage of health care workers is estimated to be 4.3 million with the greatest shortages occurring in the poorest countries. The WHO’s Global Health Workforce Alliance has stated, “The global community has clearly recognized that the health workforce is the very heart of functioning health systems, and that without greater quantity and quality of motivated, equally distributed health workers, progress toward health and development goals will not be possible.”

“I am delighted that Dr. Dueger’s contributions to HVO’s pediatrics program are being recognized with this award,” said Nancy Kelly, HVO Executive Director. “By highlighting the accomplishments of volunteers like Dr. Dueger, we hope to raise awareness of global health issues and of the role that individuals can have in making a difference.”

World Health Day is celebrated annually by the World Health Organization and the international community. Since 1950, it has been held each year on April 7th and focuses on a relevant global health issue. This year’s theme is “Save lives. Make hospitals safe in emergencies.” It focuses on the need for building secure health care facilities that can withstand hazards and serve as a safe haven for treatment. For more information about World Health Day 2009, visit (http://www.who.int/world-health-day/en/index.html).
Health Volunteers Overseas – Pediatric Volunteers Needed!

Health Volunteers Overseas is a private, non-profit membership organization that was founded in 1986 to improve global health through education. HVO designs and implements clinical education programs in child health, primary care, trauma and rehabilitation, essential surgical care, oral health, hematology, infectious disease, nursing education, burn management and wound care. In more than 25 resource-poor nations, volunteers train, mentor and provide critical professional support to health care providers who care for the neediest populations in the most difficult of circumstances.

Currently, we have pediatric programs in Malawi, St. Lucia, and Kampala, Uganda. HVO is also exploring the possibility of pediatrics programs in Nicaragua and Bhutan!

Previous HVO volunteers have found their experiences overseas to be one of the most rewarding experiences in their professional career. Please don't let 2010 pass by without pursing this amazing opportunity to make a difference.

For more information about HVO or volunteering, please contact April Pinner, a.pinner@hvousa.org, in the HVO Program Department at (202) 296-0928 or visit the web site at www.hvousa.org. You can also visit HVO at their booth at the annual AAP meeting this year in Washington, DC.

I-CATCH Program Continues to Grow

Anna Mandalakas MD, MS, AAP
Chairperson I-CATCH Program

Seven diverse and innovative I-CATCH projects were funded during the third funding year with programs in the Dominican Republic, South Africa, Laos, China, Romania, Bosnia-Herzegovina, and Tibet.

Malnutrition is implicated in more than half of all child deaths worldwide. Poverty, low levels of education and poor health services are major contributors to childhood malnutrition. Recognizing that the nutritional status of Lao children is very poor compared to neighboring countries, Dr. Banhlieng Vorasane and her team have developed the Good Nutrition, Healthy Children project. The project aims to use Child-to-Child based health education as a method to empower children and families to better utilize the nutritional resources available to them to improve the nutrition and thus the health and development of children.

Dr. Tatiana Ciomartan and her Romanian colleagues have developed the Safe Baby Project. This primary prevention project is a hospital-based Shaken Baby Syndrome (SBS) and child maltreatment education program targeting 500 physicians and 25,000 families of newborns. A professional component of the project, consisting of a visual child maltreatment presentation, will help Romanian physicians recognize and respond to child maltreatment. A parent education component, in which trained health educators deliver SBS education to new parents prior to hospital discharge, will consist of a video, an interactive doll, a parent pledge card, and an educator led discussion to teach parents about the potentially lethal effects of SBS and how to prevent it.

The Global Strategy for Infant and Young Child Feeding endorsed by WHO and UNICEF in 2002, indicated that more than 2/3 cases of malnutrition have to do with improper feeding within the first 12 months. During infancy and early childhood, proper feeding (such as breastfeeding and proper addition of nutrients) are key to reducing the rate of malnutrition. Studies in Bangladesh, Brazil and Mexico have demonstrated the impact of counseling in communities and health services can help improve feeding practices, food intake and growth. Even Continued on Page 9
in resource poor settings, improved feeding practices can lead to improved intake of energy and nutrients, leading to an overall better nutritional status of the community. In China, although childhood nutrition has improved in the past 30 years, the gap between urban and rural areas has unfortunately widened. Hence, Dr. Guan Hongyan MD, PhD and colleagues have developed the Healthy Children, Healthy Community project. The project aims to 1) increase parent awareness of proper infant and young child feeding in a rural setting, 2) educate parents about proper infant and young child feeding, and 3) create a supportive and informed environment in the local community for infant and young child feeding, including the involvement of local health officials and community volunteers.

Dr. Sara Tolentino Figueroa and colleagues in the Dominican Republic have developed the Improving Newborn Health in the Community Project. The goal of this program is to improve the health of newborns in two under-served communities by utilizing community health workers to 1) provide access to early postnatal care and to 2) increase families’ ability to provide optimal newborn care and recognize danger signs. To promote sustainability, this program will partner with local NGO’s providing other services for mother and infants.

Dr. Lhakpen Tsering and colleagues in the People’s Republic of China, Tibet Autonomous Region have developed a project to Pilot Test the Global Curriculum in Neonatal Resuscitation. In Lhasa Prefecture, Tibet, the leading cause for newborn mortality is failure to breathe at birth; data show that birth asphyxia accounted for 34% of newborn deaths in Medro Gonggar County near Lhasa. While most births and deaths occur in rural areas, high neonatal mortality also continues in hospital settings, at 42 deaths per 1000 live births (Yangzom, 2008). Thus, the need for a practical neonatal resuscitation training program is great, and the Tibet Health Bureau (THB) ranks teaching of NRP as a high priority for both hospital and rural health care providers. This project will disseminate neonatal resuscitation training to first-level providers in rural areas surrounding the Tibetan capital and will evaluate the success of an innovative resuscitation curriculum in reducing asphyxia and death. Although Tibet presents certain challenges, including high neonatal and infant mortality, a predominance of decentralized rural providers, and instruction in 2 languages (Mandarin Chinese and Tibetan), this project will build upon already existing grassroots collaborations that support NRP training, and extend a national initiative to an underserved area.

Autism, the most common developmental disorder in the autism spectrum disorders (ASDs) group, is characterized by impaired social interaction, problems with verbal and nonverbal communication, unusual repetitive behavior, limited activities and interests. Boys are four times more affected than girls. The genetics and environment factors play a role in etiology of the disease. Autism symptoms can improve with treatment. The ideal treatment plan coordinates therapies and interventions that target the core symptoms of autism: impaired social interaction, problems with verbal and nonverbal communication, and obsessive or repetitive routines and interests. Early diagnosis is imperative for timely early intervention. Reported rates of Autism in Bosnia and Herzegovina are exceedingly low. Although it is possible that the incidence of autism in Bosnia and Herzegovina is low, Dr. Mirjana Remetic and colleagues believe that it is most likely unrecognized and under-diagnosed due to lack of awareness of general population, child care workers and health care workers. Hence, they have developed the The Autism Education and Early Screening Project designed to improve the early detection and diagnosis of autism in 18-24 month old toddlers. The target population are children from 18-24 months of age and their parents. Parents will be educated on the signs and symptoms of autism at the 12 month well child visit. Screening tool for autism “M-CHAT” will be filled by parents, with the assistance of the project personnel at 18 or 24 months of age (routine visit for immunizations). Children detected by this screening will be referred for further evaluation and treatment. Information collected through this project will provide more accurate data on the frequency of autism in Bosnia and inform collaborative initiatives that might provide early intervention for autistic children.

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Dr. Susan Van Wyk and her South African team aim to “Turn INH Preventive Therapy into Reality”. Working in a poverty stricken community with an exceptionally high burden of Tuberculosis, this team recognizes that the WHO and the South African National TB Program guidelines recommending that children ≤ 5 years, who are in household contact with a sputum-positive TB index case, receive INH preventive treatment (IPT). But these guidelines are not routinely implemented and children continue to suffer from this preventable disease. The project will implement an educational program on IPT at 2 local health care facilities and within households of TB index cases to equip clinic staff, community health workers, members of households and the larger community with knowledge on this subject. The immediate goal of this program is to improve IPT uptake and adherence among community children; the team hopes to subsequently extend this intervention to neighboring communities in partnership with regional and national TB Program controllers.

Consistent with the mission of the I-CATCH program, our colleagues have designed programs that provide service to under-served communities and have great potential for broader implications that can be generalized to children in similar communities around the globe. We applaud the effort of our colleagues as they overcome huge challenges to make a difference in the lives of children – our best to all of them.

Special thanks are given to the ICATCH subcommittee for their commitment and hard work that make this program possible. We also thank colleagues from the AAP Section on Perinatology and from PerkinElmer Life and Analytical Sciences for the generous sponsorship that enabled us to fund seven projects in total this year.

The next cycle for I-CATCH Grant applications has begun. The deadlines for preliminary and final submissions were May 1st and August 1st, respectively. Applicants submitting a preliminary proposal will be teamed up with a member of the SOICH to offer guidance in grant writing. For more information and application materials go to: http://www.aap.org/sections/ich/I-CATCH_page.htm

If you are interested in participating in the I-CATCH program as a grant writing facilitator or grant reviewer, please contact Anna Mandalakas, I-CATCH Program Director at anna.mandalakas@case.edu.

WANT TO KNOW MORE

about your Section, I-CATCH projects, Overseas Opportunities, etc.?

Visit the SOICH Web site at:

www.aap.org/sections/ich/
New publication by SOICH members & global collaborators: 
*Atlas of Pediatrics in the Tropics and Resource-Limited Settings*

SOICH is pleased to announce the publication of the “Atlas of Pediatrics in the Tropics and Resource-Limited Settings.” The Atlas is a project developed by SOICH members which, during its 2+ years of production, evolved to become a true global collaborative effort.

This hardcover, handbook-sized textbook was borne from the idea that educational messages shared through the right visual information can facilitate a powerful process of rapid and sustained learning. The aim is to catalyze a process of improved care for children and their families living in tropical and resource-limited settings worldwide by helping to enhance healthcare workers’ understanding of child illness in these regions.

Many conditions described in the Atlas are inherently linked to pressing population health issues and these important relationships are explored wherever possible. The first section of the textbook specifically addresses global public health concerns, with chapters discussing: Human Rights of Children, Immunization in Developing Countries, Neglected Tropical Diseases, Neonatal Survival, Psychosocial Considerations, Traditional Health Practices, and Water and Sanitation.

The second section then describes individual pathologic states in greater detail. More than 70 chapters include conditions such as: Ascariasis, Beriberi, Burkitt Lymphoma, Carrión Disease, Chikungunya Fever, Cysticercosis, Lymphatic Filariasis, Guinea Worm, HIV, Leishmaniasis, Leprosy, Loaisis, Malaria, Malnutrition, Measles, Melioidosis, Noma, Onchocerciasis, Pellagra, Plague, Poliomyelitis, Tropical Pyomyositis, Schistosomiasis, Scurvy, Tetanus, Trachoma, Trypanosomiasis (African & American), Tuberculosis, Tungiasis, Typhoid Fever, Viral Hemorrhagic Fever, Yaws, Yellow Fever, and more.

Given the considerable burden of global child illness attributable to nutritional disease, the book also contains tools that help healthcare workers to identify and diagnose malnutrition: a mid-upper arm circumference (MUAC) band with instructions for use; and weight-for-height charts. In addition, found in the appendices is a table that lists common therapeutic regimens for diseases discussed in the book.

The Atlas could not have been developed without the hard work and dedication of a great many SOICH members (*thank you*!). Contributions from collaborators spread widely across the globe were equally invaluable – including those from friends and colleagues at the Gorgas Institute of Tropical Medicine, the Liverpool School of Tropical Medicine, the Swiss Tropical Institute, the International Trachoma Institute, The Carter Center, Doctors Without Borders / Médecins Sans Frontières, Centers for Disease Control, and the World Health Organization.

The Atlas of Pediatrics in the Tropics and Resource-Limited Settings is now available for purchase through the AAP online Bookstore (www.aap.org/bookstore). We are thrilled to report that a portion of revenues from the sale of the book will fund meaningful programs in global health sponsored by SOICH. These programs may include I-CATCH grants, the distribution of Atlases to colleagues who otherwise might not have access to the book, and other compelling projects with a common goal of improving global child health in real and sustainable ways.

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**Image 1A–1D**

Early nodular lesions in New World cutaneous leishmaniasis (CL) transition to ulceration (Image 1A). A typical lesion exhibits an ulcerated central depression with a raised and indurated border (Image 1B). Wet CL ulcers are covered by serous exudate (Image 1C). Healing during appropriate therapy is recognized by clearance of exudate and progressive defect filling by fibrin tissue (Image 1D). *Courtesy: Alexander von Humboldt Institute of Tropical Medicine Leishmaniasis Research Group, Cayetano Heredia University.*
On the left Jackeline Cano Rodriguez, a nurse in Ciudad Victoria with Dr. Daniel Harris, Chief Resident Family Practice at Georgetown (currently a family physician at Fairfax County Community Healthcare Network in Northern Virginia)

Pediatric training and practice are shifting focus: from acute to chronic conditions, from a local to a broader global health perspective, and from individual patient care to advocacy and collaborative effort on behalf of entire communities of children.4 Living among and serving children and their families from South Texas’ Lower Rio Grande Valley (LRGV) and Mexico, we realized that there were tremendous opportunities for this kind of training very close to home. We were able to tap into long-standing relationships with colleagues at Hospital Infantil de Tamaulipas, the only children’s hospital in the State of Tamaulipas, Mexico. We also had access to a robust infrastructure for medical education and public health training located at the border through the regional campus of UTHSCSA. This including programs for upper level medical students and residents and a cadre of volunteer community-based faculty. In addition, the University of Texas School of Public Health-Houston’s Brownsville campus has faculty with extraordinary expertise in international public health.

With support from the UTHSCSA Department of Pediatrics leadership and in consultation with key stakeholders, the Community for Children international electives were established. The first elective was created for the LRGV and Northern Mexico as Community for Children: At the Border and Beyond, with plans for expansion to other international sites. Community for Children’s fundamental commitment is to the vision of a world where all children have the right to enjoy the highest attainable level of health, as outlined in the U.N. Convention on the Rights of the Child; the vision of a world where communities join together in partnership to assure that all children attain their fullest potential. Our overarching goal is to prepare future physicians to provide compassionate, effective leadership in advocating for all children.

Application is open to 2nd and 3rd year residents, 4th year medical students, graduate nursing and public health students. This four-week elective is designed as a field-based rotation to help participants develop leadership skills addressing seven key areas:

- children’s rights,
- social determinants of disease and health,
- clinical care in resource-poor communities,
- the face of poverty,
- preparing for advocacy,
- cultural competency and
- fostering a culture of compassion.

The curriculum provides didactic and experiential training in advocacy, working in partnership with community-based organizations, international public health experts, promotoras, (community members who serve as liaisons between their community and health, human and social health organizations), medical anthropologists, migrant and refugee health experts, and families on both sides of the Texas/Mexico border.

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Through *Community for Children*, participants leave the familiar clinic setting to explore the sources of health, disease and healing in the LRGV and to examine models of health delivery in Mexico. One full week is spent at a main state health clinic, Centro de Salud #1/Tamaulipas, where students are oriented each day to different public health programs in Mexico. They continue each day at *Hospital Infantil* in Ciudad Victoria and surrounding rural areas doing field work through Centro de Salud/Tamaulipas, as a public health component of the curriculum. In addition, they share emergency room duties with the Mexico physicians and attend rounds with the Mexican pediatric residents in *Hospital Infantil*.

Management of the elective requires significant collaboration and investment of time and resources. Eighteen faculty from South Texas and 15 faculty from Mexico serve voluntarily as educators. Six of these faculty provide intensive mentoring throughout the rotation. Participants encounter immigrant families closely, in relationship; a crucial aspect of the elective designed to help foster a culture of compassion. They experience the frustration felt by physicians and families when health care is inaccessible for children on both sides of the border. However, through mentoring and guided reflection, participants are given the tools to process their experiences and develop capacity to continue their advocacy when they return to their training programs. Six-month follow-up interviews indicate the ripple effect of their experiences. Participants have continued their advocacy through endeavors such as lecturing on the impact of immigration policy on children's health, organizing a food bank and peer teaching on the meaning of working with the poor in any country. "I started sharing immediately after I returned. I became adamant about the need for a level of understanding of language and culture of our patients. I was so intent on the importance of asking people if they were being served." D.H.

When *Community for Children* was implemented initially, the intent was to allow participants time to reflect on their own values, perceptions and cultural biases in further development of their role as physicians. "I now realize I need a better understanding of my patients' backgrounds in order to serve them well. I am a better physician, because I now go beyond the diagnoses of illness and include the concepts of circumstance." J.G.

The understanding that participants and faculty have more to learn from the community and families they serve than to teach remains at the core of this elective. "My experiences in Mexico proved reaffirming, yet redirecting... The gracious way I was accepted in C'd. Victoria taught me that I did not need to be less white for them. They were fine with my whiteness, my broken Spanish and my ignorance. I will learn; they will teach me.” D.O.

Faculty did not want to “use” the poor and any community's children in education of future physicians. The objective is that the community will truly benefit from the participants’ presence. Evaluation data from faculty, community-based organizations, families and participants indicate that we are adhering to this objective thus far. As one community site coordinator stated, “The advocacy projects completed by the Community for Children participants have and will continue to benefit a large number of children. The participants’ medical education and backgrounds have brought a new and important dimension to the legal services our office provides to undocumented children seeking asylum.” D.E.

*Community for Children: At the Border and Beyond* has been supported with funds and in-kind contributions from the AAP’s Community Pediatrics Training Initiative/CATCH Residency Training Grant, UTHSCSA Department of Pediatrics and Regional Academic Health Center, the University of Texas Health Science Center-Houston School of Public Health at Brownsville, State of Tamaulipas Health Department, *Hospital Infantil de Tamaulipas*, Centro de Salud #1 in Tamaulipas, and numerous community-based organizations. Collaborative research efforts and information exchange among the faculty, partner organizations and participants have been fostered through these partnerships.

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Community for Children: At the Border and Beyond Continued from Page 13

Community for Children offers a structured international elective to participants at minimal cost. There is no registration fee. Housing is available and a modest travel stipend is provided. For more information, please visit http://www.communityforchildren.org. Interested students and residents should e-mail Dr. Stanley I. Fisch, Professor and Director, Community for Children, UTHSCSA Department of Pediatrics, Regional Academic Health Center at fisch@uthscsa.edu.

References

Canadian Paediatric Society
International Child Health Section
Laura J Sauvé, MD, MPH, FAAP

At the CPS annual conference, we had a session on Pediatric HIV treatment, presented by Dr. Jack Forbes and myself. We also had a fundraising dinner for the Don and Liz Hillman grant; these dinners provide a great networking opportunity for Canadian pediatricians interested in global health. Dina Kulik, one of the recent awardees, gave a presentation on her elective in Phnom Penh, Cambodia. For 2010, we are planning a session on armed conflict and its affect on children.

The Don and Liz Hillman Grant supports residents' international health electives. Over the last year grants were provided to four residents: Anita Cheng (Galmi, Niger), Kirsten Ebbert (Paarl, South Africa) will be leaving in the next few months, and Dina Kulik (Phnom Penh, Cambodia) and Julie Johnstone (Mbeya, Tanzania) completed their reports. In all of the centers there has been increasing interest amongst residents in doing international electives, and the residents who return from their experiences always report they have learned a great deal – and learned to appreciate the health care system we have here!

In her trip report, Dr Julie Johnston wrote: “In Canada, we have a health care system that helps so many people. We have become victims of our own success. It has been so long since we have seen such overwhelming and devastating disease, that we find fault in the imperfections of our system. We drive a BMW and are obsessed with its broken sun-roof. It certainly is important that we fix the sunroof in order to keep out the rain, but it is a gift to remember that regardless, we are sheltered from the storm.”

Global Health Curriculum: A group led by Drs. Tobey Audcent, Heather MacDonnell and Jenn Brenner have been working on creating four educational modules for residents. These modules are design to teach all Canadian residents what they need to know about global health even if they never leave their city. The modules on introduction to global child health, approach to new Canadians, malnutrition and fever in the returned traveler have been developed and piloted at two centers. Over the next year the modules will be translated into French and presented and formally evaluated at five centers. Several members of this curriculum group have been participating in the AAP’s global health curriculum initiative as well. In the two pilot centers, even residents without a pre-existing interest in global health before valued the sessions and learned a great deal.

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Healthy Child Uganda (HCU): Dr. Jenn Brenner (University of Calgary) and Dr. Jerome Kabakyenga (Mbarara University of Technology, Uganda) have been co-leading a successful community-based child health project that started as a CPS ICH Initiative. They have trained over 200 Community Owned Resource Persons (CORP), who work on child health interventions with the health workers in their communities. With the hard work of the CORPs volunteers, the HCU staff and trainers and their village based initiatives, have seen a decrease in mortality of 35% in children less than five years of age, since 2006. Please see their website for more information on this inspiring project: http://www.healthychilduganda.org/.

Papulopruritic Eruptions in the Pediatric HIV/AIDS Population

Deepthi Gupta, MD, Third Year Resident, University of California, San Francisco

In June 2009, I went to India and worked at the Government Hospital of Thoracic Medicine in Chennai. This hospital is a tertiary care center of excellence and dedicated to the care of individuals infected with tuberculosis and HIV/AIDS. I worked in the pediatric ward and practiced pediatric HIV/AIDS medicine and general pediatric medicine in a medical environment with limited resources. I also carried out a project involving papulopruritic eruptions (PPE) in the pediatric HIV/AIDS population.

PPE is a major cause of morbidity in AIDS patients around the world. It is a commonly occurring, intensely pruritic and stigmatising diffuse skin rash occurring in nearly 50% of patients with HIV infections, with some variation in incidence depending on geographic location. It was first described in the early 1980s.

The primary lesion for PPE is a firm, discrete, erythematous, urticarial papule or pustule. Most patients scratch the lesions because of the severe pruritus. The scratching leads to excoriated papules, marked post-inflammatory pigment changes, and eventually, prurigo-like nodules. These nodules and hyperpigmentation can be extremely disfiguring and stigmatising.

Studies in adults have shown that PPE is refractory to most medical therapies and linked to arthropod bites. Although, PPE has been studied in various developing countries in adults, it has yet to be studied in the pediatric population. As with most diseases, presentation and management can vary greatly between pediatric and adult populations. Our goal for this project was to determine prevalence and etiology of PPE in the pediatric population, categorize its clinical description in HIV positive children, determine efficacious therapeutic modalities, correlate the presence of the diagnosis with other findings (CD4 count, clinical presentation, etc.), and measure the impact PPE has on quality of life for children.

My daily activities at the hospital included screening - along with certified dermatologists – of all HIV infected children that came to the hospital for PPE, rounding on the pediatric ward each day with the local physician team, and attending educational conferences surrounding current practice and guidelines for HIV/AIDS treatment. This experience broadened my pediatric knowledge and taught me how to treat conditions in resource limited medical settings. I was also extremely touched by the patients and families with whom I was fortunate enough to interact.

As part of my project, I screened all the HIV infected children in the outpatient center for any dermatological conditions. If they had a pruritic rash for greater than one month, they were asked if they wanted to be enrolled in the study. If they choose to enroll in the study after informed consent, they were followed up in the clinic one month later by a staff member. During my month in India I helped establish this project with the local community and this study is now being continued by local physicians. I hope to return to India and continue to work with the pediatric HIV infected population.

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A New Perspective

Emilie Jean-St-Michel, MD, Third Year Resident at The Hospital for Sick Children, University of Toronto

I have just returned from Tanzania where a colleague and I participated in a new project between The Olive Branch for Children* and The Hospital for Sick Children of Toronto. During our stay, we were able to reach out to a segment of the Tanzanian population which, traditionally, does not have access to medical care. This provided us with a genuine opportunity to help people. Most of all, this experience has given me a new perspective of the physician's role.

I am currently in my second year of paediatric residency at the University of Toronto and this was my first experience of international medicine. I wanted to improve my understanding of the difficulties and obstacles inherent to international medical work. I believe this knowledge is necessary to be a well-rounded physician especially considering the international patient population that we encounter here in Toronto. Furthermore, to my delighted surprise, the five weeks spent in Tanzania really deepened my understanding of these issues much more than I thought would be possible in such a short time.

We worked mainly in villages around the city of Mbeya as it is difficult for the population of that district to access medical care. We traveled with boxes of supplies and medication strapped to the rear of our bicycles and we would often stay in different villages for several days. The different clinics were run with the help of Tanzanian doctors which gave us the opportunity to learn from each other. I saw a lot of very sick patients and I quickly realized how limited the treatment options were. Although I learned to work within this context, I could never fully accept it. For example, we often gave money to parents of sick children so they could transport their child to the nearest medical center when in fact we came to realize that very few actually went. Therefore, the importance of understanding the cultural background became rapidly evident. However, working in collaboration with Tanzanian doctors made adaptation gentler as we were able to share our experiences on a daily basis, and continuously improve our care.

In addition to our clinical work, we wanted to do something that would leave a lasting impact. To that effect, Dr. Kevin Chan from the Hospital for Sick Children of Toronto is currently establishing a long-term collaboration with the Olive Branch for Children. Concurrently, my colleague, Julie Johnstone, and I, wanted to facilitate the opportunity for more pediatric residents to go to Tanzania and get international work experience in an organized setting. Towards this goal, we collected data in order to answer our research question: What are the clinical skills required by medical trainees in order to work in the Mbeya region clinics? Our principal endpoints were presenting complaints. Our secondary endpoints were the ages of patients seen, the number of family members per housing, final diagnosis and the treatment given. We are planning to analyze the data in the next few weeks.

In the end, this elective was an incredible experience full of learning opportunities. Moreover, I really had the impression that I was able to help the people to an extent that is not often possible in our North American setting.

Thank you for the opportunity.

* The Olive Branch for Children operates the Orphanage Centre in the Mbeya Region of Tanzania. This region suffers from an HIV virus infection rate between 15-25%. This Region has a continually increasing number of children who are orphaned because of, or afflicted with, HIV/AIDS. On their own, these orphans have little access to medical care, education and sanitary living conditions. The Iwambi Evangelical Lutheran Orphanage Centre and The Olive Branch care for 60 HIV/AIDS orphans and provide them with nutritious food, education (primary, secondary and post-secondary), medical care, sanitary living conditions and, very importantly, a loving and supportive environment. The Olive Branch just finished constructing a new dormitory for the Orphanage Centre. That dorm will house an additional 42 children. The Olive Branch for Children is in the process of building a new kitchen and opening a new HIV/AIDS/House. The Olive Branch hosts medical clinics in small villages whose inhabitants don't have access to medicine. Deborah McCracken, who conceived The Olive Branch and is its representative in Tanzania, is also the Head of the Iwambi Evangelical Lutheran Orphanage. Her goal is to instil in the children in her care the sense that their future is bright, healthy, and they can and will flourish in their community, despite HIV.
AAP/IPA Global Pediatric Tobacco Prevention Initiative

Tobacco is the leading cause of preventable death in the world killing more than HIV/AIDS, tuberculosis and malaria combined. Five million die each year from smoking-related diseases and that number is expected to jump to 8 million by the year 2030 if the current trends persist. The AAP recognizes that tobacco use is a major public health problem and understands the need to think globally and act quickly in the development of a global tobacco control initiative, particularly to protect children. The WHO reports that disproportionally, over 80% of the world’s 1.3 billion tobacco users reside in developing countries and only a disappointing 5% of the world population live in countries that fully protect their population with any one of the key measures that reduce smoking rates.

This imbalance results in children outside of the US being more susceptible to the harms of secondhand smoke exposure. Secondhand smoke exposure is a substantial problem that causes increased rates of pneumonia, otitis media, asthma, and other short- and long-term pediatric conditions. In addition to secondhand smoke exposure, youth in developing countries are more likely to take up tobacco use themselves in forms that are more potent and harmful than cigarettes. Factors contributing to youth smoking in developing countries include cultural traditions, tobacco’s easy accessibility and moderate pricing, peer and family influences, and tobacco companies’ advertisements and promotional activities. Additionally, children may be harmed through malnutrition as parents in poor household spend money on tobacco rather than on adequate food supplies.

The AAP Julius B. Richmond Center of Excellence has been working with the International Pediatric Association (IPA) on a number of steps to address global pediatric tobacco control. The Richmond Center first targeted countries where children are most affected by the production, export, and use of tobacco worldwide. The IPA and AAP have partnered and launched a multiyear global tobacco initiative to raise awareness and promote involvement of child health clinicians worldwide in calling attention to children’s exposure to tobacco and secondhand smoke. Guided by the six principles laid out in the WHO MPOWER Report*, the Center is collaborating with local tobacco control advocates in these nations to develop a powerful response to the global tobacco epidemic. Planning is underway to expand the collaboration to national pediatric societies in other countries where children and youth are most adversely impacted by tobacco. The Richmond Center is supported by a grant from the Flight Attendant Medical Research Institute (FAMRI) and is dedicated to eliminating children’s exposure to secondhand smoke and tobacco.

Tobacco control funding support is also available from the Richmond Center for international visiting lectureships through the Julius B. Richmond AAP/ FAMRI Visiting Lectureship Program. The visiting lectureship grants support two- day educational programs with the goal of providing pediatric trainees, child advocates, academic and/or community pediatricians with an opportunity to interact with leading academic pediatricians on topics related to children and secondhand smoke exposure. The deadline for the four-page proposals is Friday, September 4, 2009 at 5:00pm Eastern time.

To download a copy of the application, learn about other funding opportunities; access Protecting Children from Secondhand Smoke and Tobacco: a Pediatric Curriculum Guide, and find resources for global tobacco control advocates, visit our Web site at www.aap.org/richmondcenter. To request a copy of Resources for International Pediatric Tobacco Control please send an e-mail to fkhan@aap.org.

* MPOWER. This landmark new report presents the first comprehensive worldwide analysis of tobacco use and control efforts. It provides countries with a roadmap to reverse the devastating global tobacco epidemic that could kill up to one billion people by the end of this century.

The report outlines the MPOWER package, a set of six key tobacco control measures that reflect and build on the WHO Framework Convention on Tobacco Control.
Childhood cancers (age at diagnosis: 0-14 years) comprise a variety of malignancies, with incidence varying worldwide by age, sex, ethnicity and geography. The difference in regional incidence is substantial. [1-6].

In a recent five-year study (2000-2004) in Iraq, 63,923 Iraqi patients with various types of newly diagnosed cancer were registered by the Iraqi Ministry of Health. The study included all Iraqi provinces except 3 Northern provinces (Sulaimanyia, Erbil, and Dohouk). Of the 63,923 cancers, 5,049 occurred in children under 14 years of age and accounted for approximately 8% of the total. [7] Leukemia was by far the commonest childhood cancer accounting for 33% of the childhood total.

The top 10 childhood cancers in males and females are shown in Table 1 and cancers of the liver ranked 11th accounting for less than 1% of childhood cancers [8].

The frequency of malignant neoplasms in children has been found to vary among countries. For example, in children in Canada, the United States, and Europe, the three most common cancers are leukemias, tumors of the central nervous system (CNST), and lymphomas [9,10,11], whereas in children in Latin America, the order of frequencies is: leukemias are still in first place, with lymphomas being more common than are CNST [10-14]. In other countries such as Nigeria, Malawi, and Egypt, lymphomas are the principal neoplasias [10].

The percentage of cases of each type of neoplasm in relation to the total number of cancers also differs by region. In the developed countries, the percentages for leukemias range between 30 and 37%; for CNST, between 18 and 27%; and for lymphomas, between 7 and 12% [9, 10, 11]. In Latin America, the percentages for leukemias are between 27 and 44%; of lymphomas, between 13 and 22%; and of CNST, between 10 and 19% [10-14]. In African countries, the percentages of lymphomas range between 30 and 64% [10]. In Asian countries such as Japan and China, the percentages of leukemias have been found to be between 30 and 40%; of CNST, between 12 and 20%; and of lymphomas, between 10 and 20% [10].

During the decade 1968-1977 a total of 1488 cases of neoplasms was registered in Slovakia in children aged 0-14 years. The most common malignancies were leukemias 28.2%, tumors of nervous system 23.9%, lymphomas 14.9% and Wilm's tumors of kidney 6.7%. [4].

In Poland the most frequent childhood cancers include leukemia, which accounts for 28% of cancer cases, lymphoma 14.3%, and CNS tumors 16.3%. Neoplasms of the hematopoietic system (leukemias and lymphomas) account for about 42% of all childhood cancers. Malignant lymphomas, bone tumors and germinal tumors are more frequently diagnosed in Poland, but the incidence of central nervous system tumors is lower than in other countries [6]. Figure-1 shows the pattern of childhood cancers in 4 countries.

The pattern of childhood cancer in Iraq is slightly different from the patterns in other countries with a higher frequency of leukemias than in most other countries.

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**Figure (1): The pattern of childhood countries**

![Pattern of childhood countries diagram]

**References**

Opinions expressed are those of the author and not necessarily those of the American Academy of Pediatrics. The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.
AAP NCE 2009
Section on International Child Health
annual program

Sunday, Oct 18
9am-5pm
Grand Hyatt Washington DC
Room ‘Independence A’
All are Welcome
Reception to Follow

Faculty includes

Sonia Ehrlich Sachs, Director of
Health, Millennium Village Project,
Earth Institute, Columbia Univ
Nicholas Cunningham, Emeritus Prof,
Mailman School of Public Health
Xiaoming Shen, Xin Hua Hosp &
Shanghai Children’s Med Cntr
Tido von Schoen-Angerer, Access to
Essential Medicines Campaign,
Médecins Sans Frontières /
Doctors Without Borders
Larry Schwab, International
Eye Foundation
Joy Lawn, Senior Policy & Research
Advisor, Saving Newborn Lives/
Save the Children
Nathalie Charpak, Director, Fundación
Canguro, Bogotá, Colombia
Gary Darmstadt, Head of Maternal,
Neonatal and Child Health, Global
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.. and more

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This edition of the newsletter reviews selected journal articles and other publications related to International Child Health.