August 2014 Newsletter

Section on

International Child Health

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Sectional News: The articles in this issue are a compilation of news and writings by members of the Section. (Sectional News issues alternate with Abstract issues.) The authors write to inform you of the international activities they, like you, wanted to do and then something stirred them to do it. They write how they got involved and how they were able to fit international health into their busy schedules. The aim is to stimulate you to prioritize your time and propel you to get involved. The world is waiting.

On page 4 **Primary care and advocacy for immigrants/refugees:** Welcome to Katherine Yun from The Children's Hospital of Philadelphia to the SOICH Exec. Com. In this issue, she discusses experiences and challenges related to providing primary care to immigrant and refugee families where she focuses her research on health literacy and child development. She incorporates these concepts into her discussion of the Sustainable Development Goals 2015

On page 5 **Newborn screening for sickle cell disease:** Please also welcome Pat McGann, Cincinnati Children's Hospital MC to the SOICH Exec. Com. He discusses his collaborative experiences in Angola to develop a newborn screening program and clinic for sickle cell disease. His current research is in the use of hydroxyurea among patients in Africa, and he mentors for an I-CATCH grant emphasizing education for adolescents on sickle cell anemia.

On pages 6 **Unaccompanied minors from Central America:** Increasing numbers of children from Central America continue the long dangerous journey to the United States. In this issue, Marsha Griffin, Ryan Van Ramshorst, Michael Seifert, and Elizabeth Kennedy cover this humanitarian crisis and the factors precipitating this migration. They discuss the environments for these children in both CA and the US – and ways that we can advocate for these kids.

On page 8 **Implementation of newest standards of care:** Steve Kairys – the Medical Director for the AAP's Quality Improvement Innovation Network (QuIIN) discusses collaborative networks and how they can be used to address the difficulties in implementing the newest evidence-based medicine. He outlines the steps involved to develop these networks.

On page 10 **Poverty and justice:** Leila Srour reviews "The Locust Effect: Why the End of Poverty Requires the End of Violence" by Gary Haugen and Victor Boutros. She discusses the book's emphasis on how those in the developing world are vulnerable when corrupt or dysfunctional law enforcement and legal systems exist. http://www.thelocusteffect.com.

In this Issue:

"We are guilty of many errors and many faults, but our worst crime is abandoning the children, neglecting the fountain of life. Many of the things we need can wait. The Child cannot. Right now is the time his bones are being formed, his blood is being made and his senses are being developed. To him we cannot answer, 'Tomorrow'. His name is 'Today'."

Gabriela Mistral
Nobel Prize-winning
Poet from Chile

HIS NAME IS 'TODAY'

Get Connected

Two easy ways to find others with like interests in your favorite country

1. "The Section's International Child Health Network is a free and open service designed to establish connections that foster cooperation on a variety of health projects including relief and development work, humanitarian service, equipment/supply donation, education, research, fund raising, and visitor exchange."

Go to the Section's web site and "search the ICHN independently to identify colleagues who have specific interests and expertise. Alternatively, you can find partners and opportunities by contacting Country Coordinators –designated advocates (one for each country worldwide) who facilitate correspondence and activities between Fellows of the AAP, colleagues living and working abroad, and other individuals or groups concerned with promoting child health. Using the ICHN is easy! After a brief registration process you will immediately be able to search the network on your own or communicate with Country Coordinators."

2. The list serves for CHILD2015 and HIFA2015 now have over 7000 registered participants representing 167 countries worldwide. This list serve continues to be very active and informative with topics of general interest discussed from those on the ground; those in the trenches. There are frequently reports and articles that would be of interest to many of you. If you have not joined, go to their website and sign in.

We have recently extracted those registrants who have given permission to publicize their contact information. That data is available in an Excel file and contains the names, positions, country, and interests or expertise of more than 300 child health professionals representing over 60 different countries. Find a person who shares your interests and a country would like to work in and make a connection.

Go to the Section's web site: working opportunities

The Chair's Column

Linda Arnold, MD, FAAP

One of my relatives often forwards emails – ostensibly written by "insiders" of various sorts – that alert readers to the many scams, boondoggles and governmental programs that threaten to jeopardize the health, financial security and lifestyles of American taxpayers. I am a pediatrician and former Peace Corps volunteer; she is an octogenarian who hires undocumented workers to do landscaping and other odd jobs, but bristles at the notion of allowing their children to receive healthcare or attend public schools in her town. Our beliefs and our politics are so different that I suspect she sends these emails to provoke me. Sometimes I take the bait, but more often, I delete whatever she sends without reading it.

Several weeks ago, however, she sent something I couldn't ignore. As many of us were just learning – and feeling outraged – about the thousands of children being held and "processed" in overcrowded U.S. detention centers, this email was intended to incite outrage of a different sort. Claiming to be a nurse at one of the military bases, the author detailed appalling conditions and dire circumstances: suicidal teens given bus tickets, rather than psychiatric care, and rampant infestations of lice and scabies. Her reason for sounding the alarm, however, was not out of concern for the well-being of the children, but born of a fear that she and other "innocent" U.S. citizens might "catch something" from "them." "Them," to be clear, being unaccompanied child refugees, many of them victims of physical abuse, gang violence or human trafficking, who risked everything to escape conditions of extreme poverty, constant fear and senseless violence. Close to 60,000 unaccompanied children have completed the long and difficult journey from Central America to the U.S. since last fall; a number equivalent to the entire membership of the AAP, the largest pediatric professional association in the world. Now detained far from home, feet bloody from the journey, these children are more vulnerable than ever, still afraid, still powerless, voiceless, and often denied due process.

As a pediatrician, I assumed that everyone would feel empathy towards these children, and the many others throughout the world trapped in unimaginably difficult situations. Surely, reason and compassion would prevail over politics and xenophobia in the face of this major humanitarian crisis. I was wrong. From the mobs of demonstrators blocking buses to the scores of anonymous hate-filled blog posts, it is clear that there are many who vilify these young victims of circumstance, characterizing them as enemies, as less than human, as "things" we need to protect ourselves from. People like Ann Coulter, born into a life of privilege, highly educated, and savvy enough to exploit a media culture that provides a ready platform for the controversial views of beautiful, incredibly wealthy people. Ann Coulter, who suggested a simple solution to this epic human tragedy: infecting these displaced children with the Ebola virus, then deporting them, as a means of discouraging illegal migration once and for all.

While the 1st amendment protects people's right to say detestable things, we also have the right – and a responsibility – to publically challenge those who foment hatred or engage in fear-mongering for personal or political gain. Messages like these should serve as a call to action, as bleak reminders that not all people, organizations or governments will do what is ethical, and just, when left to their own devices. As pediatricians, we need to demonstrate and foster empathy for vulnerable children, to work together to put a face on these and other young victims of socioeconomic and political instability, to challenge characterizations that liken them to dehumanized carriers of disease. We need to redirect discussions to focus on our personal, national and global responsibility for ensuring that children everywhere are safe, and their physical and mental health needs are met. Individually and collectively, we need to make it clear that people must stop blaming the victims, and start doing what is right.

This is one of those times that we need to join forces in order to "be the change", and to advocate for the rights and needs of all children – in other parts of the world, and here in our own backyard, as well.

Meet one of your new Executive Committee Members

D Katherine Yun, MD MHS

I am honored to join the Executive Committee of the Section on International Child Health. I originally joined the Section because of its role building connections between pediatricians inside and outside of the United States. These connections facilitate the exchange of knowledge and ideas, enrich our practice, and make us better clinicians, educators, and advocates. This has never been so important. One in four American children have at least one immigrant parent (or are immigrants themselves), including over 200,000 children who have resettled in the United States in the past decade as refugees. Although the vast majority of these children are healthy, some require treatment for conditions that are less common in the U.S., such as malnutrition or neglected tropical diseases. For these children, the expertise developed by pediatricians in low-income settings has informed practice in the U.S. and improved our approaches to diagnosis and treatment. Similarly, caring for children across cultures and languages has become integral to pediatric practice in the U.S., and many of the leaders in cross-cultural pediatrics are also leaders in international child health.

Immigrant and international child health priorities are also converging. Next year the United Nations will reach the target date for the eight Millennium Development Goals and transition into the "post-2015" sustainable development agenda. The prevention of under-5 mortality will remain a key part of the global child health agenda, but there are also signs of a renewed focus on child abuse and neglect, environmental health, and non-communicable diseases, including early childhood development. In addition, there is likely to be sustained attention to gender equity, a key social determinant of health for children everywhere.

Like many members of the Section, I have an interest in both immigrant and international health. I grew up in Asia and served in Uzbekistan as a Peace Corps Volunteer prior to attending medical school in the U.S. Following residency, I completed postdoctoral training with the Robert Wood Johnson Foundation Clinical Scholars Program at Yale University, where I focused on refugee health and U.S. health policy. I now work at The Children's Hospital of Philadelphia. I provide new-arrival and ongoing primary care for immigrant children through the hospital's Refugee Health Program and a nonprofit serving families from Mexico and Central America. I also study the promotion of health system literacy among new immigrants. In essence, this means that I study the skills people need in order to obtain healthcare for themselves and their families. I also evaluate interventions intended to teach new immigrants these skills, work in which I have been fortunate to partner with leaders from the city's Bhutanese refugee community.

I am excited to work with the Section. I hope to contribute to ongoing efforts to strengthen the connections between immigrant and international child health specialists, as well as the Section's growing advocacy and policy portfolio. And I am excited to learn more about the incredible work done by Section members. I hope to meet more of you at this year's AAP National Conference & Exhibition, on my next trip overseas, or perhaps even at "Namaste Market" in South Philadelphia.

Meet another of your new Executive Committee Members

Patrick T. McGann, MD MS

I am an academic pediatric hematologist/oncologist at Cincinnati Children's Hospital Medical Center. My research interests are focused on improving the diagnosis, clinical care, and outcomes for children with sickle cell anemia (SCA) living in Africa. During my fellowship under the mentorship of Dr. Russell Ware, I was provided the opportunity to develop a sickle cell program in the Republic of Angola. The goals of the pilot program were to develop and implement a newborn screening program for SCA in the capital city of Luanda. Although there are more than 10,000 infants born each year with SCA in Angola and hundreds of thousands more born across sub-Saharan Africa, newborn screening (NBS) is not routinely performed. Without early diagnosis and care, a majority of these infants will die in the first years of life. Our program aimed to demonstrate that NBS and closely linked follow-up care are feasible and effective even in the limited resource setting of Angola. I spent four months in Angola during the first year of the program and lived there permanently for most of 2012 and 2013. I learned the Portuguese language and developed many connections with Angolan healthcare workers. We were faced with many challenges, but were able to screen nearly 40,000 babies in the first two years of the program. The NBS program found that 1 in 66 infants born in Luanda are affected by SCA (compared to 1 in 600 infants born to African American parents in the US) and 20% have sickle cell trait! We also developed an infant sickle cell clinic, where we provided sickle cell education for parents, penicillin prophylaxis, insecticide-treated mosquito nets, and pneumococcal immunizations. Throughout this pilot program, we were able to train many doctors, nurses, and laboratory technicians in the diagnosis and care for infants with SCA. Our role was mostly supervisory and in coordinating this complicated program, but the work on the ground was performed primarily by Angolans. Although not without ongoing challenges, this "proof of principle" pilot study was important and proved that newborn screening is both possible and effective even in a place with limited health resources.

Upon my return to the US and Cincinnati in 2014, I remain closely involved in Angola and several other African countries. The most involved current project is a prospective clinical trial called REACH (Realizing Effectiveness Across Continents with Hydroxyurea), which aims to determine whether hydroxyurea therapy for children with SCA in Africa is feasible, safe, and effective. Although there is extensive experience with hydroxyurea in the US and Europe, there is little to no experience in Africa, where children are more likely to be malnourished and have a number of unique infectious exposures (malaria, TB, HIV, dengue, etc.) that are not routinely encountered in the US or Europe. This study has just begun in July 2014 and will be performed in the Democratic Republic of Congo, Angola, and Kenya. I also am a mentor for an ICATCH project run by my Angolan friend and colleague Vysolela de Oliveira. This project aims to educate adolescents about the basics of SCA and why it is important to understand your "sickle status." Monthly educational sessions will be provided for groups of Angolan adolescents and will include sickle cell testing for each participant. We hope that if these adolescents become aware that they are carriers of the sickle cell trait, they will make informed decisions about future partners and children, as this is the only way to truly reduce the burden of disease.

I am honored and excited to have been elected to the SOICH Executive Committee and look forward to representing my fellow SOICH members. I think that my skillset and experiences will be particularly useful in expanding and improving the role of SOICH in global health education, advocacy, and research. SOICH is a powerful group of intelligent, passionate and resourceful pediatricians. As a member of the Executive Committee, I hope to encourage more AAP members to become involved in SOICH and for the current SOICH members to take more of an active role in improving the health of children across the world.

Central American Refugee Children

Marsha Griffin, MD, Pediatrician Brownsville, Texas, Ryan Van Ramshorst, MD, Pediatrician San Antonio, Texas, Michael Seifert, Rio Grande Valley Equal Voice Network Coordinator Elizabeth G. Kennedy, MSc, Fulbright Scholar to El Salvador

The authors of this article include two pediatricians working with Central American refugee children on the Texas/Mexico border, a community leader who has met with refugees and politicians coming to South Texas, and a Fulbright scholar based in Central America who has interviewed 500+ children trying to reach the United States. We feel that collectively, we offer an on the ground perspective. One of us has been with the children as they leave their home countries. The others of us are receiving them. We share our stories, perceptions and recommendations for the members of the AAP Section on International Child Health.

Catholic Charities, along with other churches and Save the Children, have established shelters near bus stations in the Rio Grande Valley to care for refugee families released by Customs and Border Protection (CBP). Families must provide their own bus fare north. Volunteers meet them at the bus stations to offer food, clothes, a shower, and a cot. The young mothers initially watch us with wary eyes, but many burst into tears as they realize we truly want to help. Not a surprise after spending days in a CBP holding cell. We watch their children, so they can rest for the first time in days. Doctors and nurses offer medical care. The diseases we see are the same seen in Los Angeles, Boston or Dallas: colds, scabies, lice. They are healthy. They are also war refugees fleeing for their lives.

These families are arriving to the Rio Grande Valley alongside an influx of children from El Salvador, Guatemala and Honduras (57,000 since October 2013) so large that President Obama declared it an "urgent humanitarian situation." Indeed, these children and families are seeking the safety that their own crime- and corruption-ridden nations do not provide.

In El Salvador, child after child and family after family has reported that within their communities, they cannot trust anyone. They say: "you never know who is who" and "the walls have ears." They are afraid to report crimes when they occur, because many believe gangs, cartels, police and military work together. Most know someone who reported a crime and ended up dead in retaliation. More people are dying in El Salvador and Guatemala than during their countries' civil wars; more people die in Honduras than anywhere else except Syria. Children and families say they are desperate. There is no place to hide in their countries.

When talking to families in Central America, many report being unable to eat or sleep. Thirty-three of 322 children in a study this year are afraid to leave their home at day or night; those who are religious have stopped attending church. Three have gone to the emergency room amidst a psychological breakdown. The doctors told their parents to get them out of the country as soon as possible. Without blinking, others recount seeing scores of murders. One youth coldly described finding his father dead on a soccer field only days after they were deported from Mexico. He fears that he and his mom are next.

The politicians have come and gone to our region over the past four weeks. Only a handful have shown the courage and compassion to defend the victims of a kind of violence that requires a new vocabulary (for example, "cook" refers to the person charged with dismemberment and placing bodies in acid baths).We have been unnerved that this sort of violence is visited upon children—and that some political leaders are scheming to quickly send these children back to war-torn states under the name of a HUMANE bill that is anything but. We must insist that they not be returned to their deaths.

This crisis requires a political movement raised by the professions of medicine, law and education. Children's lives depend on us. Insist that the William Wilberforce Trafficking Victims Protection Reauthorization Act of 2008 continue to protect Central American children and be extended to those Mexican children who experience the same terror.

These children need our voices now. Call your representatives. Write letters to the editor. Form alliances within your own communities to prepare for these children.

Imagine living in a village in Honduras. Imagine having to wonder if your child will be raped, will be assassinated – or will be forced to become an assassin. Those are, in effect, the only options for these families. Would you stay? Or, would you take your child, and set out on what is at once the most dangerous journey of your life and the only one that can save you?

References

1. The Rio Grande Valley is a four county region bounded by the Gulf of Mexico, the Rio Grande (Rio Bravo) River, and the Wild Horse Desert (which forms a natural barrier between the communities in the Valley and the rest of the USA). It is the closest land route between Central America and the US, and, for this reason, has traditionally been a favored crossing route for immigrants.
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SOICH
Section on International Child Health

Dear Creative SOICH Members,

We are excited to announce a new SOICH program –
The Pediatric Overseas Projects (POP) Initiative. It has always been through the creativity, ingenuity, and support of our members that SOICH has enjoyed such success in improving healthcare of children around the world. With the POP Initiative, we are again inviting you to contribute your ideas about a new project that you believe SOICH should support.

If you have a great idea, please fill out this brief survey describing your idea, a plan for implementation and sustainability, and an estimated budget. Initially, we are looking for innovative and impactful ideas with a maximum budget of $2,000 per year. We encourage you to send your ideas by September 15.

The Implementation Gap

Steven William Kairys MD MPH FAAP

One of the problems with the growth of new guidelines and new research in child health care is the growing gap between the new knowledge and standards of care and the current practice approach. Many health care researchers call this the implementation gap. As an example, there are now over 800,000 publications a year in medical journals. Also the average time of a well developed evidence based standard of care becoming part of the regular culture of health care is estimated to be over 18 years. This is especially true in countries with less developed child health care systems.

Many solutions have been put forth to address this growing implementation gap. The most basic is to mentor and support individual child health care providers to become more reflective and evidence based in key parts of their work. This is the basic concept behind quality improvement: to step back from the day to day frenetic pace of work and to focus on one or two parts of the work for a specific period of time. This could be as simple as looking, for example, at the process of giving immunizations or looking at how to better screen for mental health issues. The doctor and the health care team collect some data for a day or two about a current process of care. They could do this by looking at what is documented in the charts, or by asking the team or the patients themselves to complete a brief questionnaire. At the same time, the project leader will also do a little research to find other evidence based approaches. Then the team plans a new approach and pilots the new approach, perhaps just with one doctor or perhaps just with one patient or one afternoon of patients. The approach could be a new screening tool or a new way of using the team to care manage or to teach the patients. The team then meets briefly to review the data collected. The team studies the good and the bad outcomes of the changes, and makes adaptations based on this review- and then tries a newer approach. The cycle PDSA- the P (plan), D (do or pilot) S (study and review) and A (act or try again) can be repeated until the team is pleased with the outcomes and works to spread those changes to the rest of the practice, and also works to sustain the changes.

A structured model that has shown its usefulness at reducing the implementation gap at the local or regional level is the collaborative improvement network approach. This approach is not complicated and can be very effective long term at making positive changes in child health. The network can be a group of practices associated with a particular hospital, a group of pediatricians in one town, or a group of child health care providers in a region or country. Carole Lannon and Laura Peterson in the article Pediatric Collaborative Improvement Networks: Background and Overview (Pediatrics 2013;131;S189) detail the infrastructure necessary to develop and maintain such a network. The most important component is a passion to do the work and an individual willing to take on the burden of organizing the network. The network is often populated by early adopters, health care providers who enjoy looking for new ideas and methods. This cadre of motivated health care providers needs to be managed. This can start with internal support from the individual practices , or by seeking support from the local hospital or the regional department of health. The support needs to include communication processes, ways to collect the data, data management, and data analysis. As the system matures over time there needs to also develop a governance structure for the team, decision making strategies, and specific workgroups working on different topics or working on the data and research components of the network.

The network can begin with one project. Often a face to face meeting to kick off a new project is an important way to develop camaraderie and enthusiasm. The network can then meet by phone monthly to review results and learn from each other processes to avoid or innovative ideas that seem to work. Each team can adapt what it is doing based on the real time learning from other partners in the

collaborative. After three to six months, a wrap up meeting can be a formal way of presenting results and having each team focus once again on its new process.

As the network continues more than one project can be started in parallel. The projects can be spread throughout the practices involved in the original work. The network can continue to collect data periodically on finished projects. The network can publish its results or make presentations to other regions or other hospitals. Students and residents can be part of the projects.

At some point funding becomes a concern for any ongoing system and this is true for a collaborative network. Again, the amount of support can be as small as support for one administrative, data person to a more formal structure with research, data, and administrative personnel. These can be supported at the national or local level either by project specific grants or by a contract that supports the general infrastructure necessary for the network to flourish.

The collaborative network concept at its basics is reflective learning by a group of doctors or health care workers interested in using a structured data backed approach to improve the work that they do. It demands a desire to be better and an understanding that health care is continually changing and that many of these changes need an organized process if they are to be adapted to the local health care culture. The approach is an important concept in reducing the ever increasing implementation gap in health care.

Online Dengue Clinical Case Management Course

Harold S. Margolis MD, FAAP, Chief, Dengue Branch, CDC, San Juan, PR

If you work in tropical or subtropical countries, you have most likely encountered dengue. Globally, million cases of dengue occur annually and 40% of the world's population lives in dengue endemic areas. In addition, pediatricians in the US often are called upon to see children with dengue because they became infected while traveling to dengue areas.

Dengue is a syndrome, which even in dengue endemic areas can be difficult to differentiate from other acute febrile illnesses such as malaria, leptospirosis, influenza, meliodosis, rickettsioses, and viral hepatitis. Advances in dengue diagnostic testing now allow an accurate diagnosis to be made using a single serum specimen obtained during the febrile phase of the illness, rather than having to obtain acute and convalescent specimens. However, because the clinical outcome can evolve dramatically over the 3-5 day period following first onset of symptoms, clinicians must recognize these changes in order to provide appropriate treatment.

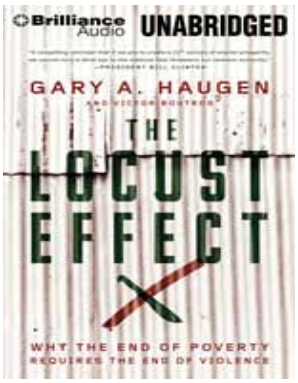
CDC has developed a postgraduate Dengue Clinical Case Management Course that is available online. The Course provides information, including case studies and reference materials, regarding dengue clinical and laboratory diagnosis, recognition of disease stages and warning signs of severe dengue, mechanisms of pathogenesis, patient monitoring and fluid management, and epidemiology and prevention. The Course has been accredited for 4 CME AMA PRA Category 1 credits for physicians and 0.4 CEU ANSI/IACET credits for non-physicians and is available at https://cdc.train.org/DesktopModules/eLearning/CourseDetails/CourseDetailsForm.aspx?courseId=1047604

The same Course is available at http://www.cdc.gov/dengue/training/cme/ccm/index.html in a non-CME version for those who do not need CME credits or want to use it for a reference.

We would be interested in feedback regarding the utility of the course and other thoughts. We anticipate having a version of the Course in Spanish in the not too distant future.

The Locust Effect: Why the End of Poverty requires the End of Violence by Gary Haugen and Victor Boutros

Leila Srour, MD, FAAP & Duke Duncan, MD, FAAP



People living in poverty, not only live without legal protection, but often they are victims of the criminal justice systems that should be protecting them. The poor are at the mercy of police who terrorize and detain them and courts where they are voiceless and without counsel. Poverty alleviation efforts are sabotaged and economic development undermined by the devastating effects of violence on poor people's lives. The epidemic of sexual violence, illegal detentions, violent land theft, police brutality and forced labor are hidden plagues on poor people, while attention may be paid to hunger, disease, homelessness, poor sanitation and illiteracy. The book, The Locust Effect: Why the End of Poverty will not occur without an End of Violence by Gary Haugen and Victor Boutros (2014 Oxford University Press) reveals the daily terror and violence affecting poor people living without protection throughout the world;.women and children are the most vulnerable.

The abduction of Nigerian school girls, the attack on Malala in Pakistan, and the 2012 gang rape of a young woman on a bus in India are dramatic, highly publicized. They are examples of the dangers young women living in poverty face when they strive to go to school and follow their dreams without protection from violence and sexual abuse. Sadly, most of the world's poor people, lacking the protection of law enforcement, are vulnerable to the "locusts of violence", which destroy efforts to improve their lives. Tragically, schools are the most common location for sexual crimes against poor young women.

Historically, law enforcement systems were designed, not to protect the most vulnerable poor, but rather to protect the privileged rulers from the common people. In many developing countries, authoritarian criminal justice systems were inherited from the colonizers. When countries become independent, without law enforcement transformation, the system continues to protect the rulers. Rather than upholding justice, the police create insecurity and prey on the poor with extortion and assault. The privileged often use the legal system to their own advantage, shielding themselves from accountability. Rather than fix the broken public system, private security systems in the developing world protect the rich, while further undermining the safety of the majority poor population, who are left without defense. The wealthy and powerful in poor communities resist efforts to develop effective law enforcement, which would threaten their exploitation of the poor. Significant economic growth may occur, while inequalities of wealth and justice increase, as growth occurs in the wealthy sectors, protected by private security and corrupt public justice systems.

The causes of violence are complex, involving culture, gender, economic inequalities, lack of education and vulnerability of the marginalized. Violence is a shameful experience, leaving the victims humiliated and terrorized. Both the perpetrators and victims may want to remain hidden.

In developing countries, the police are the most dysfunctional, suffering from poor knowledge, training, disrespect, and low wages. They cover up their ignorance with intimidation and rudeness, learn corruption and abuse and prey on the poorest. Poor people avoid the police, who require bribes for protection or defense. Innocent people are wrongfully charged and violent abusers are free to continue their crimes. Corrupt law enforcement systems, tasked with fighting corruption, instead protect wealthy interests, extort bribes from the poor and fail to protect the most vulnerable.

Violence against poor people has many different forms. Forced labor is the enslavement of poor people who are coerced to work, in conditions over which they have no control and from which they cannot escape, under threat of violence and mistreatment. Violent land theft is illegal and forced property theft, especially from women and children, who lack property rights protection. Poor women and children may be forced into prostitution. Abusive detention is imprisonment without charge or conviction, the fate of the majority of people in developing world prisons. Mortality rates in these prisons are higher than in war zones or acute disasters. The book, Nightmare in Laos by Kerry Danes reveals the true story of two Australians imprisoned for 10 months and released due to the efforts of Australian government representatives. They wrote this book to expose the tragedies of their fellow prisoners, many held without charge or representation, without any hope for release and suffering from extreme human rights violations.
Freedom from violence is necessary to allow poor people to improve their lives. Courageous local champions of justice reform need our support. Transformational projects can teach and inspire us. Investments in the criminal justice system in the developing world are necessary.

The International Justice Mission (IJM) is working in Cambodia, China, India, Burundi, Rwanda and Zimbabwe, supporting local defense centers. This mission has shown that functioning justice systems are possible even in poor developing countries where they do not currently exist. Dysfunctions of these systems are expected, just as in our own recent justice system histories. The challenge is to improve the criminal justice systems, especially where the needs are greatest. Research is needed to better understand the extent of the problems. Social services and social workers are essential to protect and support poor victims. Donor aid and diplomatic partnership should depend on willingness to make concrete commitments to build criminal justice systems and effective law enforcement for the poor.

We hope that you will read The Locust Effect, which informed and inspired us, with heartrending examples from poor people's lives, recommendations and workable solutions to provide protection for the most vulnerable from all forms of violence.

"In terms of social and economic development, high levels of crime and violence threaten to undermine the best-laid plans to reduce poverty, improve governance and relieve human misery." World Bank Report 6

Unanswerable Questions in the Warm Heart of Africa

Erin Kwolek, MD, PGY-4 clinical fellow in Pediatric Respirology, Hospital for Sick Children, Toronto.

"What are we going to do about [her]?"
She was HIV positive and suffering from pulmonary Kaposi's sarcoma and tuberculosis and I was being asked this question on a daily basis during my time at the Kamuzu Central Hospital in Lilongwe, Malawi. My time in Malawi was filled with adventures and amazingly kind, generous people. My work there, however, was filled with unanswerable questions that I asked myself silently. Why are things this way? Why can't we do more? How are these circumstances fair? What can we offer these children who are so sick?

My practice in Canada brings up some unanswerable questions as well. As a general rule, I like to ruminate on clinical scenarios and I focus on minutiae. In short, the unanswerable questions pertain very specifically to the work I do, rather than the larger scale issues. In Canada I know how to access resources, how to ask for help, how the system works, and in the third year of my general paediatrics residency I had a vague approach to many common paediatric presentations. In Malawi, everything including the language was new and at times I felt beyond lost. I simply didn't know what we were going to do for this young girl.

In April of 2014, I made my way from Calgary, Alberta, Canada to the Baylor College of Medicine - Abbott Fund Children's Clinical Centre of Excellence in Lilongwe. Malawi is in South Eastern Africa and is one of the poorest countries in the world. The average life expectancy is less than fifty-five (World Bank, 2012) mostly due to infectious diseases (HIV, malaria, cholera, TB and typhoid) and significant food insecurity. The country is called "the warm heart of Africa" largely due to the tremendous kindness of the people. Many people, including clinic staff, were also very eager to help me learn Chichewa!

I completed this elective through the Baylor College visiting scholar programme, which allows paediatric residents to complete electives in sub-Saharan Africa where Baylor has established Centers of Excellence for paediatric HIV/AIDS care. The elective is ideal for the paediatric resident hoping to learn more about HIV care. Anti-retroviral medications are covered for all patients in Malawi who qualify (based on medical status or age) and in clinic (where you spend the majority of your time) I saw patients for maintenance visits as well as sick visits and was involved/responsible for admitting very sick patients into the neighbouring public hospital. Having had limited clinical experience working with HIV positive children and having an appreciation for the global burden of disease of HIV, I was looking to learn how to care for this population. Over the course of my elective I learned a great deal about common sub-acute presentations in the context of HIV infection.

When I left for Malawi I wasn't sure if my future career goals included global health. I felt that some exposure was necessary for comprehensive paediatric resident education, but I thought it would end there. Upon arriving back in Calgary to complete a rotation in Intensive Care, I was overwhelmed by the resources available to me as a resident and to my patients. I often found myself trying to think of my Canadian patients in the context of my recent experience. While I hadn't initially thought I would return to global health work, it seemed as though I couldn't leave Malawi in my past. It is clear to me now that work in the developing world will be part of my future.

While the unanswerable questions remain, I can say with a great deal of certainty that I have gained medical expertise in caring for children with HIV, malaria, tuberculosis, and malnutrition that I would have been unable to achieve in Canada. More notably, however, I have come back so grateful for the care I am able to provide and to be able to do so in environments conducive to family-centered care. The unanswerable questions I am struggling with now seem to be "how can I incorporate global health into my future career?" and "how could I not go back to Malawi?" Of all the vocabulary words I was taught, I recently realized that no one had ever taught me how to say goodbye in Chichewa – I just learned how to say 'tionana' (see you soon).

Mark Your Calendar Now!
Upcoming Global Health Conferences & Courses

Donna Staton, MD, FAAP

2014 Humanitarian Crisis Simulation
Friday, Sept. 5 – Sunday, Sept. 7, 2014
University of Minnesota, Cannon Falls, MN
The Humanitarian Crisis Simulation is a 48-hour experience that is designed to immerse participants in an environment typical of humanitarian crises. The exercise begins with interactive sessions that cover important concepts, core standards, and best practices in humanitarian aid. The simulation will equip participants with knowledge, experience and skills that will assist them in working in any humanitarian crisis. http:// Uganda www.globalhealth.umn.edu/education/humanitariansimulation/#sthash.F4x2OdGO.dpuf

UCSF Boot Camp for Global Health Care Delivery
October 2-5, 2014, UCSF, San Francisco
Many of the skills needed in Global Health are not taught in traditional health professional curricula. Though many health professionals have strong clinical skills, they lack some low-cost, low technology skills that would allow their clinical experience and knowledge to be applicable in the global setting. These topics and skills include health system design, value chain mapping, leadership training, ultrasound skills, servant leadership, and quality improvement principles in resource constrained settings. Hence, this boot camp, in the department of medicine, will use simulation, hands on training and cases to improve GH ethics and clinical practice. http://globalhealthsciences.ucsf.edu/news-events/events/ucsf-bootcamp-for-global-health-care-delivery

Intensive Update Course in Clinical Tropical Medicine and Travelers' Health
October 6-7, 2014, Philadelphia
ASTMH (American Society of Tropical Medicine & Hygiene) has developed this course as an update in the essential components of tropical medicine and travelers' health. This two-day meeting is designed for physicians and for all other health care providers working in tropical medicine or travelers' health. Speakers are internationally recognized authorities in the field.
http://www.astmh.org/Intensive_Course/5881.htm

AAP NCE, October 11-14, 2014, San Diego
SOICH has many activities at this meeting every year, from our daylong section program on global child health, to our section committee meetings and the Christopherson Plenary (always a great speaker on an important issue in global child health). This is a great time to network with your pediatric global health colleagues, and meet new colleagues who can help you with your global health work.

US-China Collaboration on School Medical Service for Children With Special Needs
Friday, Oct. 10, 2014, 8:00-11:00am
This series of US-China collaboration will explore sustainable models for providing school-based services to children with special healthcare needs, particularly developmental and behavioral health needs. This session will be presented by faculty from the US and China and is open to a broad audience of pediatricians who are interested in considering models for understanding the role of schools and communities in child health. (Note: separate ticketing required for this event)

SOICH Section Program

Sunday, Oct. 12, 2014, 9:00-5:30
Countdown to 2015: Challenges, Problems and Moving Forward
Many excellent speakers with Keynote by Dr. Hans Rosling

Christopherson Plenary
Monday, Oct. 13, 2014, 10:30-10:50
Hans Rosling, MD PhD: "Child Deaths & Money: Uneven Distribution"

Joint Program: Section on Bioethics and SOICH:
"Ethics and International Child Health: Altruism or Self-Interest? Striking A Balance"
Monday, Oct. 13, 2014, 1:00-5:00pm

International Reception (all welcome!)
Monday, Oct. 13, 2014, 7:00-8:00pm

The International Reception is a forum that welcomes leaders from pediatric societies and attendees around the world to network with AAP leadership and share its work in pediatrics.

ASTMH (American Society of Tropical Medicine and Hygiene)
November 2-6, 2014, New Orleans, http://www.astmh.org/Home.htm
Excellent pre-meeting courses (clinical and basic science) on tropical medicine updates the day before (November 1) for which you can register separately and not attend conference. http://www.astmh.org/Schedule_at_a_Glance.htm

CHOP Global Health Conference, Exploring the Health Gap: Global Gender Disparities and the Impact on Girls, Nov. 3-4, 2014, Philadelphia
http://www.chop.edu/service/international-medicine/global-health/conference/home.html

Global Health and Disaster Course, University of Colorado, Aurora, CO, annually in November
Nov. 10-14, 2014 Global Health Course
Nov. 17-20, 2014 Disaster Course
Nov. 21, 2014 Global Health Symposium
This international health course is a two-week course offered annually as part of the University of Colorado School of Medicine Global Health Track (open to others). The first week of the course is the Global Health section of the course and the second week of the course is the Children in Disasters section. The course prepares its participants for international experiences and future global health work. This is an interactive training course that incorporates readings, lectures, small-group problem based learning exercises, technical skill sessions and a disaster simulation exercise.
http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/globalhealth/education/Pages/2013-Global-Health-Disasters-Course.aspx

American Public Health Association, November 15-19, 2014, New Orleans

Many global public health offerings; for program details and registration:
http://www.apha.org/meetings/annual/

Global Health Essentials, Feb. 14-22, 2015, Cornell Medical College
This two-week CME course aimed at physicians, fellows, residents, nurses and other healthcare providers will focus on providing participants with the tools and knowledge necessary to effectively engage in high-impact interventions in a variety of global health settings with a focus on the most pressing challenges of our time: malaria, TB, HIV, trauma, non-communicable diseases and complex humanitarian emergencies.
http://globalemergencymedicine.org/GHEcourse.html

Unite for Sight: Global Health and Innovation Conference, March 28-29, 2015, Yale University, New Haven, CT
The Global Health & Innovation Conference is the world's leading and largest global health conference as well as the largest social entrepreneurship conference, with 2,200 professionals and students from all 50 states and more than 55 countries. This must-attend, thought-leading conference convenes leaders, change-makers, and participants from all sectors of global health, international development, and social entrepreneurship.
http://www.uniteforsight.org/conference/

Humanitarian Response Intensive Course (April 14-26, 2015)
http://www.humanitarianacademy.harvard.edu/humanitarian-response-intensive-course
This course is offered each year to professionals from around the world in Boston, Massachusetts. Through presentations, hands on table top exercises, and in-the-field simulations offered by faculty and guest lecturers who are experts in their topic areas, participants will gain familiarity with the primary frameworks in the humanitarian field (human rights, livelihoods, Sphere standards, international humanitarian law) and will focus on practical issues that arise in the field, such as personal and team security, rapid assessments, application of minimum standards for food security, shelter, WaSH (water, sanitation and hygiene) and operational approaches to relations with the military in humanitarian settings.

PAS Meeting, April 25-28, 2015, San Diego
Annual meeting of the Pediatric Academic Societies (Academic Pediatric Association, American Academy of Pediatrics, Society for Pediatric Research and the American Pediatric Society) http://www.pas-meeting.org
Numerous workshops and sessions related to global health (GH), both clinical GH "content," as well as "how to" sessions on working and teaching in GH here in the US
Global Health Special Interest Group (GH SIG) has a great program each year
Programme for Global Paediatric Research (day-long program plus workshop); for more info email Dr. Alvin Zipursky, alvin.zipursky@sickkids.ca

CUGH (Consortium of Universities for Global Health), March 26 (all day) to March 28 (all day), 2015, Boston
http://www.cugh.org
Fabulous networking opportunity for reaching out to GH colleagues across disciplines.
http://cugh.org/events/2015-cugh-global-health-conference-boston-ma

Gorgas Course in Clinical Tropical Medicine, Feb-Mar annually, Lima, Peru.
Affiliated with several US institutions, renowned learning opportunity.
2 month certificate course, usually Feb-March. Also 2-week courses offered in August for those with some prior experience. THIS COURSE FILLS UP 18 MONTHS IN ADVANCE. Apply in October for the course starting 18 months later! http://gorgas.dom.uab.edu/

Global Health: Clinical and Community Care, University of Arizona, Tucson, July, 2015
A 3-week course offered every July (2015 dates TBA) at the University of Arizona Health Sciences Center. For medical students, residents and practicing physicians.
http://globalhealth.arizona.edu/clinical-community-care-course

INMED: Institute for International Medicine offers a variety of courses, Kansas City
Online, classroom, hybrid courses, Helping Babies Breathe (neonatal resuscitation for low resource settings are among the offerings.
http://www.inmed.us/courses-inmed/

Health Emergencies in Large Populations (H.E.L.P.) Courses
Multiple dates and locations worldwide (including Baltimore and Honolulu as US sites)
The H.E.L.P. Course is a multicultural and multidisciplinary learning experience created to enhance professionalism in humanitarian assistance programs conducted in emergency situations. The course provides the public health tools necessary for making appropriate decisions in emergency situations involving large populations. The main topics include: economic security, water and habitat, environmental health, communicable diseases and epidemiology, and other subjects.
http://www.icrc.org/eng/resources/documents/misc/help_course.htm
For 2014 dates and locations:
http://www.icrc.org/eng/assets/files/2013/help-course-calendar-2014-fees.pdf

Are you planning a global health conference or course? Get the word out to your fellow SOICH members by announcing it on our listserv! Simply send your announcement to: ichmembers@listserv.aap.org
Just be sure and send from the same email that the section has on file for you. Or, send an announcement for the next SOICH Newsletter to Melissa Moore, melissamoore@peds.arizona.edu

Selected SOICH Activities

ICATCH

- International Community Access to Child Health Grant Program
- Grants for international AAP Fellows/SOICH'ers/affiliates living & working in developing countries
- $2,000 a year x 3 years, 18 ongoing projects, 4-6 new projects annually
- Domestic SOICH'ers help mentor & partner with colleagues abroad
- Examples: HIV/AIDS Education for Public School Staff (Botswana), Parenting Education of Child Passenger Safety (China), TB Dots for Kids (Philippines), Diagnosis & Reference of Undernourished Children (El Salvador)

INTERNATIONAL CHILD HEALTH NETWORK

- Actively fosters collaborations between SOICH'ers & others focused on global child health
- Projects may include relief and development work, humanitarian service, equipment/supply donation, education, research, fund raising, and visitor exchange
- Get connected at: www.ichn.org

SECTION ANNUAL PROGRAM

- Section-sponsored education program brings global health leaders to AAP NCE each year
- Discussion & debate on pressing issues/concerns/actors in global child health (e.g. refugees in the U.S., malnutrition, indigenous communities in Latin America, neonatal warmers & Bubble CPAP)
- 2013 program included: 2nd annual abstract and poster sessions displaying ICH projects and the keynote by Zulfigar Bhutta "Beyond 2015 - priorities for Global Health

INTERNATIONAL ELECTIVE AWARD

- $1000 grants to trainees to support international electives

SECTION NEWSLETTER

- Published every other month. 3 issues each year critically review global child health articles/publications, 3 issues each year discuss Section projects and other news of interest to Section members

SECTION BOOKS

- "Working in International Child Health"
- "Atlas of Pediatrics in the Tropics and Resource-Limited Settings"
- Edited & authored by Section members, portion of revenues fund Section programs

SECTION WEBSITE & LISTSERV

- Abundant resources (field opportunities, potential funding sources, etc) at www.aap.org/sections/ich/
- Be part of an active listserve of ~1000 pediatricians with active interests in global child health

SECTION EXECUTIVE COMMITTEE

- Section membership confers eligibility to be a future leader of the Section!

... AND MUCH MORE!

Section on International Child Health Leadership (*6 Section members elected to lead SOICH)

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