Improving Child Health in India: Great Endeavors, yet Still Work to be Done

By Tracy Marko

India ranks 45th among countries with the highest infant mortality rates, but with a population of 1.3 billion people, it accounts for the greatest number of newborn and child deaths in the world. Over the past decade Indian infant and child mortality rates have steadily decreased by 1-2/1,000 and 2-3/1,000 live births each year, respectively. Despite this decline, India did not reach the fourth Millennium Development Goal established by the United Nations, which aimed to reduce under-five and infant mortality by two thirds between the years 1990 and 2015. Infant and child mortality in India is often concentrated in specific states and in rural communities, with a national average currently at 48/1,000 for infants and 38/1,000 for children under-five. While stronger interventions are needed to address the high incidence of child deaths in India, recent efforts that have sought to reduce these numbers and to improve child health overall should not be overlooked.

In 1992, India began conducting the National Family Health Survey (NFHS) to obtain information on its population, health, and nutritional status. NFHS-4 was recently completed for the years 2014 to 2015; state statistics are now available, but a nation-wide evaluation has not yet been released. Sixty-nine percent of...
India’s population lives in rural communities, and all NFHSs have demonstrated significant discrepancies between rural and urban populations. In the third survey, which took place from 2005 to 2006, information was collected from 124,385 women ages 15-49 and 74,369 men ages 15-54. According to this survey, 28 percent of the rural population was in the lowest wealth quintile compared to 3 percent of the urban population. Mothers in rural areas were less educated and more likely to be in socially discriminated castes and tribes. Not surprisingly, infant mortality in rural areas was 50 percent higher than in urban areas, and a greater proportion of children were undernourished and less likely to receive all childhood vaccinations. To address these discrepancies, India introduced the National Rural Health Mission in 2005.

One of the greatest achievements from the National Rural Health Mission was creating a link between the community and health system through the Accredited Social Health Activist (ASHA) program. As part of this program, each village selects one female who will undergo training to become an ASHA for her community, with a focus on women and child health. The ASHA receives resources and education on minor curative care and learns to counsel women on birth preparedness and childhood health.

ASHAs are paid a minimal base-wage each month and make the rest of their earnings through performance-based incentives such as universal immunization promotion, referral and escort service provision for reproductive and child health, and household toilet construction to improve community sanitation. ASHAs regularly visit every household in their community and keep records of antenatal care and immunizations. They are a key connection between village women and the local public health centers.

Malnutrition is a severe problem in both rural and urban populations. Almost half of Indian children under five are stunted, or too short for their age, which indicates a chronic state...
Twenty percent are wasted, or too thin for their height, indicating an acute state of malnutrition. Forty-three percent are underweight, accounting for both chronic and acute undernutrition. India has initiated a number of programs to address these striking statistics. In 2004, the Midday Meal Scheme was launched to supply free lunches on working days to children in primary and upper primary classes in government schools. In 2012, the Indian government revitalized the Integrated Child Development Services program that was started in 1975 and provides a meal, primary healthcare, and preschool education to children under 6 years of age and their mothers. In 2013, the government passed the National Food Security Act, also called the Right to Food Act, which made the established food programs legal entitlements and reformed the Public Distribution System. Through the Public Distribution System, two-thirds of the population, which includes 75 percent of the rural dwellers and 50 percent of urban dwellers, are entitled to 11 lbs per person of cereals at fixed prices.

Since results of the third National Family Health Survey were released, India has made efforts to improve child health. It has restructured its public health system to include ASHA workers and initiated extensive food programs to address the health and wellness needs of its populous, especially in rural communities. The upcoming release of the NFHS-4 national statistics will be a testament to whether the new programs are making a positive impact on health measures, such as child immunization, nutritional status, and infant and under-five mortality. Although the Indian government has received much criticism, as there is continued need for progress in child health, their current efforts should be recognized and applauded.

References:

Tracy Marko is an MD/PhD student at the University of Minnesota Medical School graduating with the class of 2018.
Disease Spotlight: Keeping up with Zika Virus

By Katelyn Cusmano

2015 was the year of Ebola. While this disease is still a concern, 2016 is quickly becoming the year of the Zika virus. News of Zika seemed to spring out of nowhere in January 2015, and since that time it’s as if the frequency, implications, and recommendations for the disease are changing daily. Soccer stars are threatening to forego the Olympics, and the health implications of the disease are affecting those both at home and abroad. In fact, the World Health Organization declared a public health emergency on 2/1/16 in relation to Zika Virus.

What is all of the hype about?

The Zika virus is not a new development. There have been outbreaks reported since 2007, with the most recent outbreak starting in Brazil in 2015. It is a single stranded RNA flavivirus that is similar in nature to Dengue Fever, Yellow Fever, and West Nile Virus. The virus is initially transmitted by the Aedes mosquito, and additional modes of transmission are still being discovered. There have been reports of transmission via maternal to fetal spread, sexual contact, blood transfusion, and lab exposure. The disease itself is relatively mild. Most patients are asymptomatic, but if patients do become ill, symptoms usually present with two days to one week of low grade fever, skin rash, muscle and joint aches, headaches, and conjunctivitis. There are few severe complications, and most who develop the illness recover without treatment.

Then why all of the concern? Reports suggest that Zika virus could be leading to the development of Guillain-Barré Syndrome in patients with the disease and microcephaly in infants if a pregnant mother develops the disease. Recently, a direct link between Zika virus and microcephaly has been established. Therefore, the condition can have a drastic impact on a child’s health, as in many cases microcephaly can lead to problems with development, movement, hearing and vision, and seizures.

On a global health level addressing the spread of Zika virus increases the need for mosquito control. Mosquito control has been emphasized by health organizations for years in order to prevent mosquito borne illnesses such as malaria.

Mosquito prevention should continue to be promoted to prevent the spread of the Zika virus. These steps can include reducing the number of mosquitoes via insecticide spraying, wearing long clothing, using insect repellent, and providing mosquito nets.

The Zika virus also presents with significant ethical issues related to reproductive health rights. Brazil has recommended that women avoid becoming pregnant, and other countries like Columbia and Jamaica have made recommendations that define a period of time in which a woman should avoid becoming pregnant. However, this presents a problem when one considers that many of the countries making these suggestions have very strict abortion laws and little access to contraception. There is the fear by public health figures that this could lead to an increase in illegal abortions internationally, or an increase in unsafe abortions at home.

Screening guidelines for pregnant
women are rapidly changing. A reverse transcriptase polymerase chain reaction can be used to diagnose the disease approximately one week after symptoms begin. However, this test does not effectively distinguish differences between Zika Virus and the other flaviviruses, and the tests are currently only being conducted at the CDC Arbovirus Diagnostic Laboratory and some state health departments. If a pregnant patient is not symptomatic but has recently been in areas where the Zika virus has been found, the CDC is currently recommending testing within two weeks to three months following return from these areas. If the test is positive, the patient should receive multiple ultrasounds to assess for changes in brain structure as well as possible amniocentesis for the presence of Zika virus. In addition, if the patient receives a negative PCR test, ultrasounds at 18-20 weeks should be done with focus on brain structure including microcephaly and calcifications. These guidelines could and probably will change in the future, which requires physicians, residents, and medical students to stay up to date with the current protocols regarding testing pregnant women.

How can a busy medical student or resident keep up with the current recommendations? Dr. Kevin Dieckhaus, head of Infectious Disease at the University of Connecticut School of Medicine, suggests that for the most up to date recommendations the best resources are the CDC and each state’s Department of Health. These resources will provide the most accurate implications for the disease as well as information necessary to counsel and treat patients in your area.

References


“How can medical students become involved in Global Health?”

This is a great question. Increasing numbers of students are interested in pursuing global health training opportunities during medical school, residency, or both. Fortunately, as demand has increased, so have the opportunities.

There are many ways to get involved in global health opportunities. What you choose to do really depends on your interests and career plans. Some opportunities are institution specific and others are available to all students through an application process. Some require a four year commitment and others are only four weeks. What you choose to do depends on what your goals are.

Global health tracks are increasingly common among four-year medical schools. These tracks may require special coursework and lectures during the pre-clinical years, and often (but not always) require an international elective. While most programs start in the first year, it is worth exploring whether it is possible to join later. This is a great option if you are interested in a career in global health.

Even if you are not interested in a global health track, there are plenty of other ways to become involved in global health. The most common times for students to travel abroad for electives are during the summer after the first year of medical school and at the end the fourth year. Most medical schools will offer opportunities during these times. It is important to identify an opportunity that aligns with your interests and goals. If you enjoy research (for example, in areas like infectious disease), you may be able to collaborate with a research mentor who already does international work, allowing you to participate in existing research. For ideas specific to your own school, attend your local Global Health Interest Group meetings. You are sure to find resources there and you might meet faculty and other students who share your interests or who can provide you with unique opportunities. It’s also important to visit your dean’s office, someone there is likely to know what opportunities exist and can direct you accordingly.

If your school does not have an opportunity that suits your interests or needs, there are many additional resources out there. The Association of American Medical Colleges (AAMC) Global Health Learning Opportunities (GHLO) Collaborative links participating medical schools from around the world to provide opportunities for students to rotate internationally. They have a wealth of resources and an online application.

The American Medical Student Association (AMSA) has resources to prepare you for choosing an elective and for funding your trip. Finally, for those of you desiring an emphasis on global health in residency, the AAP Section on International Child Health (SOICH) has resources from a variety of residency training programs.

When choosing a global health training opportunity, it is very important to consider the lasting impact of your trip. Look for well established programs with long term commitments to the people and place you’ll be visiting. Consider your goals—do you hope to improve your language skills? Or improve your understanding of tropical diseases? Whatever your goals, make sure you choose opportunities that enhance your education and in which you can serve others.

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“Mission work” has existed since the 15th century’s European conquest of land from the Native people of America and exists today as a vehicle for reaching victims of health inequality around the world. While this is a noble cause, Mississippi has its own populace of people not equally affected by disease because of political and socioeconomic disadvantage. As a first-year medical student in Mississippi, I have heard the desensitizing numbers repetitively; Mississippi leads the nation in infant mortality, obesity, diabetes, cardiovascular disease, and the list goes on. It goes without saying that in a state with such prevalent health disparity, Mississippi is a prime example of why global health truly starts at home.

Both the accomplishments and failures of the state need to be acknowledged so progress can continue. One major achievement has been Mississippi’s high vaccination rate, which leads the nation. However, even this reputation was almost compromised by recent attempts to move forward HB 938 Immunization Bill, which would have removed the Mississippi Health State Department of Health from overseeing immunizations. This would allow any physician in the country to give exemption to a school district on behalf of a child’s family. The topic is controversial in the state, in which much of the healthcare community of Mississippi fought on behalf of childhood immunizations for the safety of the elderly and exposed. Take an issue like this, and compare it to the world; vaccination against deadly diseases has been a global mission that has saved millions of lives, yet there was a local attempt to dismantle a system that has eradicated polio, measles, rubella, and other diseases throughout the world.

This is only one example of a dynamic healthcare system in Mississippi. Instead of remaining isolated and uninformed, active research is being done and systems that have worked for others are being implemented. As the first African-American pediatric resident at the University of Mississippi Medical Center in 1965, Dr. Aaron Shirley decided to bring a global healthcare system to his home. Before his death in 2014, he took the initiative to travel to Iran to observe and adapt a plan modeled on the Iranian Community Health Houses for the Mississippi Delta in 2010. This system allowed Iran to
reduce child mortality rates by 70% and increase contraception rates by 90% in rural areas since the program’s creation in 1980—all through preventive medicine and increased primary care.

The wisest words one can give to a person born and raised in Mississippi are “bloom where you are planted.” Yes, there is work to be done abroad, but it is important not to lose sight of what is going on locally, as Mississippi is lacking in Primary Care Physicians itself. The Civil Rights Movement came and went, but the health disparities that plagued people of different ethnicities and backgrounds remains. In the Mississippi Gulf Coast, there are about 8,500 Vietnamese-Americans living in Biloxi, and one out of seven of Vietnamese-Americans have chronic hepatitis B. The state has recognized this and is using education and screening methods individualized to treat this population. Despite advancements, there remain barriers beyond cultural understanding.

Although the Affordable Care Act (ACA) was passed in 2010, about 20% of the state remains uninsured because of misunderstanding, political unrest, or lack of accessibility. Mississippi is conservative, extremely religious, and ranks last economically—all factors that must be taken into consideration when attempting to bridge the gap of inequality. Mississippi’s Governor Haley Barbour once claimed, “there’s nobody in Mississippi who does not have access to healthcare” at a time when one-fifth of the state lacked insurance. It is this denial that has set back much of the great work that has been done by informed healthcare professionals in Mississippi. This disconnect has perpetuated the belief that there is more work to be done in other countries than in their home state. In the Mississippi Delta, the life expectancy of men is less than that of men in countries like Brazil or Latvia, yet, of the more than 5,000 physicians in the state, a mere 10% work in Delta counties.

There are regions of Mississippi where children once suffered from bloated
stomachs caused by starvation but are now at risk of Type 2 Diabetes before a standard age of onset because of severe health risk factors. The resources for a healthy lifestyle sometimes simply are not there, and if they are, the education on how to maintain this lifestyle is not. There have been regional, state-wide, and even nationwide efforts to change this. First Lady Michelle Obama visited cities like Hernando and Jackson, Mississippi on a campaign to end childhood obesity, and the Obama administration even pledged approximately $400 million for underserved regions of the state, yet the Affordable Care Act has been met with resistance in the unhealthiest state. At the end of the day, Mississippians are the key to change in healthcare, not politics. Governor Phil Bryant recently signed HB 1523, allowing medical professions to refuse services based on the religious belief that marriage should be between a “man and woman.” This is a prime example of why Mississippi must continue training young, righteous professionals to protect its own citizens from certain unconstitutional political officials and beliefs. As Congressman Bennie G. Thompson stated, it is difficult to cultivate a supportive and understanding atmosphere within the socioeconomic dynamic of Mississippi when there is this constantly looming thought that “industries that are considering bringing jobs to our state and talented individuals considering bringing their skills to our state could decide to turn their backs on Mississippi just as the Governor and State Legislature have turned their backs on our own citizens and neighbors.”

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I see the lucky ones. That is the thought that materializes in my head after my initial intake visits with my refugee patients. As a pediatric resident actively involved in my program's refugee clinic, I am part of a group of providers that sees refugee patients within a month of their arrival. Part of the initial visit involves hearing about the situation that the family is seeking refuge from and learning more about the hardships that they have been exposed to. As I hear parents describe the state of the communities they left, the dire conditions that children were exposed to, and the fear that pervaded these families’ lives, I feel very humbled to realize that I can provide the families with some sense of security, at least when it comes to their children’s health.

Of course, "lucky" isn't the initial word that comes to mind as I hear my 11-year-old patient describe a kidnapping attempt made on her solely because of her dad's job as an interpreter with the American army. Nor is it the word I think of as my 8-year-old patient tearfully describes the harassment she faced because of her religion, nor is it my first thought when a family tells me that their young sons will still cry at loud noises and ask if their new home is about to be bombed. Nonetheless, most of these families express relief at having escaped critical problems in their home countries, so I, in turn, feel their sense of enormous relief, though we are all aware
of the ones who were not "lucky" enough to escape.

I have always been interested in global health and have tried my best to broaden my knowledge and skills through experiences abroad. However, so much of my global health experience during residency has come from my experiences here at home in the United States. Even as a resident, I have seen patients from many different countries with even more varied cultures, and I find myself being exposed to children and families from differing backgrounds. According to the most recent United Nations refugee agency (UNHCR) annual report, worldwide forcible displacement last year reached 59.5 million people, a record high. More than half of the world’s refugees are children. Recently, annual refugee arrivals to the United States have ranged between 35,000 and 70,000 persons, depending on the refugee cap, which was recently increased; one can imagine that even more refugees would be arriving if the United States permitted it. Additionally, thirty to forty percent of the refugees in the United States are children.

In her article “Narrating Medicine: How Cultural Differences Challenge Doctors,” Dr. Rosenthal discusses how difficult, and often unexpected, the divide between patient and provider can be to navigate. The examples of cultural differences creating confusion were familiar and really struck a chord with me. How many times have I had to discuss with families that they are overfeeding their child when this is the first time that they have had easy access to food, or that they cannot use eyeliner from their home country because it contains high levels of lead, or how car seats are important for safety when their standard of danger in their home country is on a completely different scale? Like Dr. Rosenthal mentions, it is easy to get frustrated, but there is often so much under the surface that we just do not think to ask about. That is why I think the biggest lesson that I have learned in residency about global health is that it is not confined to going abroad; most of the times that I have had to rely on global health skills and knowledge has been within a 10-mile radius of my very American apartment.

Of course, that is not to say that experiences abroad do not have value. However, it is not the only option, and there are many avenues for medical trainees to explore global health even without traveling abroad. Whether it is through increased engagement as medical students and residents with refugee and immigrant groups, global health advocacy efforts, fundraisers to host trainees from other countries at our institutions so they can carry sustainable skills back to their home countries, attending global health workshops at the AAP National Convention and Exhibition, or op-ed writing to highlight significant global health issues, there really are many ways for trainees to get involved. As the United States’ population changes and more refugees and immigrants arrive each day, it becomes impossible for us to ignore the global communities that are developing right around us. We would benefit both ourselves as providers as well as our communities if we remember that and view our patients here within a global context.

For information on the AAP Section on International Child health (SIOCH) and for more information on Global Health in general, check out the AAP Section on International Child Health.

Swati Antala is a 2nd year resident in the Yale Pediatrics program and is the SOMSRFT Liaison to the SIOCH.

Why Should I Join SOICH (Section on International Child Health)?

SOICH already has close to 1,000 members and is one of the largest sections in the Academy. Being part of this section will allow you to partner with like-minded health professionals involved in children’s health throughout the world; find resources for global child health research, advocacy and health care delivery programs; learn about ICATCH grants that fund projects to improve the health of children in your community; be part of a diverse and lively forum for sharing ideas and information.
As a medical student, I’m no expert on global health. Nevertheless, I am deeply impacted by what happens globally. Every year, millions of children around the world die of treatable diarrheal illnesses, the number one cause of death for children globally. It’s challenging to wrap my mind around just how many children spend each day hungry or without access to clean water. The simple things many of us, including myself, take for granted are often those that are most needed by others around the world. Yet, all too often we assume that these needs exist only outside of our nation’s borders, and we forget how many people within the US struggle with global epidemic challenges.

As a native of Michigan, my heart sinks every time I see Flint, Michigan in the news. The recent tragedy in Flint has made headlines—locally, nationally, and even internationally. One of the most alarming aspects about this story of lead poisoning has been the realization that as much as we in the US would like to believe our environments are safe, we are not protected from the kind of injustices that affect people all around the world. These kind of system failures and their damaging effects on the health of children happen daily—everywhere.

As someone interested in dedicating my life to the health of children, I can’t ignore the vast health disparities that shape the lives of youth. Local and global health disparities are not happening in isolation of one another. There is a lot that we can learn, both from within our own communities as well as from those around the world, when it comes to child health. Recognizing the parallels between communities outside of our own, and understanding methods that have worked or failed elsewhere is an important first step to improving the health of children near and far.

Trisha Paul is a second year medical student at the University of Michigan Medical School.

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Places that were once off limits to visit or hard to reach are now easily accessible, allowing for the expansion of global health initiatives in medicine. However, as the world has become smaller to us, it also makes the similarities and differences across environments more stark. Admittedly many of the issues at the forefront of global health do not impact those in the US; nevertheless, other issues are more similar than we think. The trials of raising a child in poverty can happen anywhere, as can the lasting effects of malnutrition, poor access to education, and poor access to healthcare. Moreover, it is important not to lose sight of the fact that numerous dangers that surround children worldwide, from gun control to hazardous home environments to abuse, also happen in our own backyards. Though these issues may arise within different cultural contexts globally, as aspiring physicians, we need to recognize the problems children face both at home and abroad.

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Improving Interactions with Vaccine Hesitant Parents

By Shubhangi (Nonie) Arora and Arushi Arora

Recently, on a flight to Detroit, I couldn’t help but overhear a heated conversation from the seat behind me. A woman was describing to the passenger next to her that her niece had gone into a coma after being given Gardasil, the HPV vaccine. She went on to explain that the doctors didn’t think this coma was related to the vaccine, but she knew that the coma, which lasted for several weeks, was caused by it. The other passenger sounded unnerved and questioned whether she should vaccinate her own children. In that moment, I had no idea if I should say something or even what to say, so I stayed silent. However, after observing this conversation, I started to think about how we, as medical students, can engage patients and families when they mistrust the healthcare system and hesitate to vaccinate their children.

The World Health Organization (WHO) defines vaccine hesitancy as a delay in acceptance or refusal of vaccines.¹ Vaccine hesitancy is a complex global problem which has been implicated in direct harm during recent outbreaks of measles and pertussis.² The WHO separates the reasons for vaccine hesitancy into three main categories: contextual influences (sociocultural, health system), individual and group influences, and vaccine-specific issues.³ While the underlying reasons for hesitation differ across nations, states, counties, and communities, similar communication techniques can help us counsel parents on vaccinations.

To better understand how to communicate with vaccine hesitant parents, we investigated which influences were most prevalent in communities near Ann Arbor, MI, Novi, MI, and Durham, NC. With the help of friends and colleagues...
we circulated an informal, qualitative, and anonymous one-question survey to parents in the community asking “Do you have any concerns regarding vaccines, regardless of whether you choose to vaccinate your children?” Within two days, we received 480 responses. With guidance from Jessica Fealy, a pediatrician at the University of Michigan, we drew upon our survey replies to formulate responses to common concerns held by vaccine hesitant parents.

When counseling vaccine hesitant parents, experts advise: correcting misinformation parents have received, using evidence to address specific fears and concerns, and communicating using easily understandable language.3 Previous recommendations by Domachowske and Suryadevara (2013) support the “CASE” framework for medical professionals to speak to patients about vaccines.4 The first step, Corroborate, encourages building a relationship with the parent while acknowledging their concerns about vaccines. The next step is About you, and entails explaining to the parent what makes you knowledgeable about vaccines. After that is Science, or giving scientific evidence regarding the benefits vs. risks of vaccination. Finally, Explain calls for advising the patient on your professional medical opinion.5

With the CASE framework in mind, here are some specific reasons parents hesitate to vaccinate children and some potential responses you can provide to alleviate parents’ concerns:

“Vaccines contain substances that are harmful. The medium the vaccine is placed into for delivery has chemicals I do not want to be exposed to.”

Explain to parents that many of the strange-sounding chemicals in vaccines are actually present elsewhere in their environment. For example, have them read the ingredients in their shampoo or food products. As a medical student, you can do your own research on contents of vaccines and be prepared to explain that such ingredients in those quantities are not known to cause any harm to children. Reaffirm their desire to live as natural a life as possible, and explain that the benefits of vaccination outweigh any minor risks.

“There are so many more vaccines on the schedule than when I was a kid.”

Explain that the current vaccines are different from those given decades ago. Today’s vaccines use far fewer substances (antigens) to stimulate an immune response. You can explain that our immune system is designed to face challenges. Depending on the parent, you could even explain to them that the “Cheerio” they may have eaten off the floor today can have more antigens than the shots they will be receiving!

“I’m concerned [...] because there are no studies proving the safety of the current vaccine schedule and limited studies showing the safety of individual vaccines.”

Have a handout available with lists of CDC guidelines and examples of studies that have confirmed the effectiveness and safety of vaccines.
“My vaccination concerns have always been about side effects and who to believe about what side effects are actually linked to or related to the vaccine. I struggle with what you hear in the news about this topic.”

This concern came up in our survey repeatedly regarding Gardasil and the MMR vaccine. It is important to use scientific evidence to dispel any myths parents may have regarding vaccination. Further, it is also important to acknowledge the mild and moderate side effects which may be possible after vaccination, such as fever and soreness, so that parents and patients know what to expect! Then, if their children experience such side effects they will not frame them as negative sequelae of the vaccine, but as normal immune responses.

“No, I have many concerns stemming from a lack of trust in our pharmaceutical industry and corporations.”

We can share with parents and families that physician associations, such as the American Academy of Pediatrics, prioritize the health of children above all else when recommending vaccination. We would like to leave you with a response submitted by a parent from our survey in the hopes that it will motivate you to educate the families that you see in your clinics!

“If people learned at the doctor’s office that their child was getting vaccines A, B, and C today, which guards against these issues and WHY it’s important to get the vaccine instead of letting your kid get the disease, maybe then the next time someone was like ‘Oh, I just plan to let my kid get chicken pox, I had it and natural immunity is better you know’ at a play date a parent could say ‘Well actually, we’re choosing to get our kid vaccinated because it’s a miserable disease to have, it can cause very serious infections, especially in babies, and we don’t want to accidentally get someone else’s baby very seriously ill.’”

References


Nonie Arora is a first year medical student at the University of Michigan Medical School. Her sister Arushi Arora also assisted with this article.

Human Trafficking: A Call to Action for Medical Students!

By Angela Thelen, and Kalli Sarigiannis

Like many first year medical students we had never been exposed to the realities of human trafficking prior to matriculation. Though we had heard the term used before, most of our knowledge was based on Hollywood portrayals from movies such as Taken or television shows like Law and Order: SVU. Furthermore, we never expected that it would be something that would affect our community and future careers, or that we would have the opportunity to become advocates for victims.

In our first year of medical school, we joined the American Medical Women’s Association Chapter at our medical school where we became chairs of the Anti-Human Trafficking and Sexual Assault Committee. In this
role, we quickly learned how widespread and horrific of an issue human trafficking is in the United States and around the world - approximately 400,000 domestic minors are trafficked in America, with an additional 50,000 individuals trafficked into the country each year.\(^1,2\) Clearly, this is not just an international public health concern, but also a major domestic problem in our own backyard.

**What is human trafficking?**

Two major categories of human trafficking exist - sex and labor. The U.S. National Institute of Justice defines these two forms as: (1) “Sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age” and (2) “the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.”\(^3\)

‘Force, fraud, or coercion’ is assumed in the case of trafficking of minors. Some victims are trafficked by strangers, however many are actually trafficked by family members or friends. Traffickers often exert power over their victims using physical, sexual, or emotional violence. However, the use of intimidation, threats, and economic coercion may also be implemented.\(^4\) Major risk factors for exploitation include living in extreme poverty, identification with a marginalized/minority group, and history of physical and/or sexual abuse. In 2015, the National Center for Missing & Exploited Children estimated that one in five reported runaways were likely sex trafficking victims, with the majority in the care of social services or foster homes when they went missing.\(^5\)

**How can medical students advocate for victims of human trafficking?**

Nearly 88% of survivors of domestic sex trafficking reported at least one encounter with a healthcare professional during the time period that they were being trafficked.\(^6\) This shocking statistic seems to indicate that healthcare settings provide a critical opportunity for victim identification and intervention.

As medical students, the first step we can take to combat human trafficking is learn how to properly identify victims. Some of the more obvious indicators include: signs of physical abuse, evidence of sexual trauma, recurrent sexually transmitted infections or unwanted pregnancies, and evidence of drug abuse.\(^4\) Additional “red flags” you may see include: delayed presentation for medical care, discrepancies between stated age or history and clinical presentation, reluctance or inability to speak on one’s own behalf, and delayed physical or cognitive developmental milestones.\(^4\) However, it is important to keep in mind that actual presentations can be quite variable.

**What types of questions can medical students ask?**

The trauma experienced by victims can be a deterrent to disclosure. Moreover, because traffickers often accompany their victims, it is important to carefully and discreetly ask to speak with the patient privately. Often, victims have an emotional connection to their trafficker. They may consider them to be their “boyfriend” or “girlfriend”, and may not realize they have been endangered or harmed. The victim may also fear retaliation from their
trafficker or distrust the healthcare and legal system. Therefore, it is extremely important to establish rapport with your patient and to be kind, patient, and understanding during your interactions. Avoid direct inquiries about trafficking and trauma. Rather, ask suspected victims sensitive “probing” questions and allow them to divulge information they are comfortable with sharing. You may use a trauma-informed approach to care, which includes:

- Reduction of re-traumatization,
- Highlighting patient strengths and resilience,
- Promoting health and recovery, and
- Support of development of healthy coping mechanisms.

What should I do if I suspect a patient is being trafficked?

Laws for reporting suspected trafficking cases vary by state, so it is important to learn about state specific reporting procedures. If you encounter an adult who you believe is being trafficked, it is important to first ask if they would like assistance before taking any action. However, healthcare providers are mandated to report all cases of suspected child trafficking. Agencies to contact include:

- State Department of Health and Human Services
- Local or state law enforcement
- National Human Trafficking Resource Center Hotline (1-888-373-7888, available 24 hours), operated by Polaris Project

For further information, we encourage you to check out Polaris Project, a national organization that outlines the specific reporting details in each state.

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