Message from the Chairperson: Parmi Suchdev MD, MPH

Dear SOICH members,

The theme for our newsletter is Member Engagement, which is timely given the urgent need to better mobilize ourselves to advocate for child health and wellness home and abroad. I was overwhelmed by the amazing response from our recent member engagement poll, as 100 of you have volunteered to help with Section leadership activities. Our challenge now as an Executive committee is help channel this interest and energy into action. I first joined the Section in 2003 as a Pediatrics resident and eagerly sought out opportunities to help and learn from the many AAP global health gurus. What always impressed me about SOICH leaders was their passion, positivity, and personableness, as well as their openness to new ideas that could further the Section’s mission. As Chair, I am fortunate to be surrounded by leaders with similar qualities. Our mission remains to empower our members to make meaningful contributions to global child health through high quality education and training, effective partnerships, and staunch advocacy for the world’s children. My goals as Chair are to improve member communication and engagement, enhance existing and new partnerships, and strategically utilize resources to achieve our collective mission. Please enjoy our newsletter and give us feedback on what we can do to better serve you, our SOICH members.

Parmi Suchdev, MD, MPH
Chairperson, Section on International Child Health

A special thank you to all of you who took the time to complete the SOICH Membership Engagement Poll in March!

- 72% of respondents are interested in Education/National Conference & Exhibition activities
- 69% in Partnerships & Outreach
- 55% in Policy & Advocacy
- 18% in Membership & Communication
- 12% selected other (see below is a summary of the free text responses)
California Global Health Advocacy Track Participants with staffer from Senator Kamala Harris' office

NOTEWORTHY
The AAP and PATH sponsored an ice cream social, during the 2017 AAP Legislative Conference, during which leaders from the CDC and USAID spoke about the US commitment to maternal and child survival. There was over 50 in attendance.
Global Child Health Literature Highlight
Nia Imani Bodrick MD MPH

Ground Breaking Analysis: Trafficked Men and Boys
Labour Trafficking among Men and Boys in the Greater Mekong Subregion: A longitudinal survey of trafficked persons (N=446) who received post trafficking services in the countries of Thailand, Cambodia and Vietnam. The major findings of the study were men and boys in the fishing industry were the majority (61.7%) of labors who were trafficked. Fishermen suffered the most severe workplace violence, were the most likely not to receive health services when needed and worked the longest mean hours amongst the various types of laborers interviewed. Almost half of those who were ever injured or reported needing healthcare while trafficked did not receive medical care. Less than 1/3 of the men and boys surveyed spoke the language of their destination country.

Editor’s Summary:
There is an unmistakable void of evidence based research regarding trafficked men and boys. The purpose of the study was to explore the prevalence of violence and workplace harms amongst trafficked male labors in the Greater Mekong Region of Southeast Asia by analyzing a longitudinal survey of trafficked persons (N=446) who received post trafficking services in the countries of Thailand, Cambodia and Vietnam. The major findings of the study were men and boys in the fishing industry were the majority (61.7%) of labors who were trafficked. Fishermen suffered the most severe workplace violence, were the most likely not to receive health services when needed and worked the longest mean hours amongst the various types of laborers interviewed. Almost half of those who were ever injured or reported needing healthcare while trafficked did not receive medical care. Less than 1/3 of the men and boys surveyed spoke the language of their destination country.

Reviewer’s Commentary:
The authors conducted a thorough analysis of an under researched subset of trafficked persons-male labors. There were notable unexpected findings- for instance not having documents, not being fluent in the language of the destination country and being cheated of wages were all found to be associated with lower odds of workplace violence. This study provided a much needed foundation for further exploration of trafficked men and boys, particularly those not trafficked for sex work.

Global Child Health Literature Highlights
Matthew Stutz MD


In response to the Sustainable Development Goals (SDG) and concern that increased access to care does not always translate into high quality care Lancet Global Health Commission on High-Quality Health Systems in the SDG Era has been created. The commission plans to investigate opportunities for regionalizing service, updating medical education, integrating technology, and strengthening professional and community oversight. The commission will bring together over 30 academics, policymakers, and health systems experts from 18 countries.


Despite the presence of a vaccine, rotavirus gastroenteritis causes 37% of deaths from diarrhoea among children less than 5 years old. A large portion of which occur in sub-Saharan Africa. A randomized placebo-controlled study of 3508 infants was done in Niger to study the efficacy of a live oral rotavirus vaccine. The vaccine was given to placebo-controlled study of 3508 infants was done in Niger to study the efficacy of a live oral rotavirus vaccine. The vaccine was given to infants at 6, 10, and 14 weeks. The primary end point was the presence of laboratory confirmed rotavirus. There were significantly fewer episodes of rotavirus in the vaccine vs control group (31 vs 87) with a vaccine efficacy of 69.1%.


In this bold summary the authors delineate the byzantine immigration pathway for unaccompanied minors and help physician-advocates in ways to perform trauma-informed care. They also in no uncertain terms denounce current practices of detention of immigrant and refugee children and call for improved conditions as “The Department of Homeland Security facilities do not meet the basic standards for the care of children in residential settings.”

CATCHING UP WITH ICATCH
International Community Access to Child Health (ICATCH) Grant Program

The International Community Access to Child Health (ICATCH) program was initiated in 2005 by the American Academy of Pediatrics Section on International Child Health. It provides modest funding and technical support for starting or expanding training or services to improve child health in resource-limited settings.


Pediatrics and Neurology, Boston University School of Medicine
Aaron Emmel MA, Manager, Global Health Advocacy Initiatives, AAP Department of Federal Affairs, Washington DC

Edith Clarke, MD, MPH, Assistant Professor, University of Minnesota, Department of Emergency Medicine/Hennepin County Medical Center


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Edith Clarke, MD, MPH, Assistant Professor, University of Minnesota, Department of Emergency Medicine/Hennepin County Medical Center
Getting More Children & Pregnant Mothers Under Bednets in Uganda,
Donna Staton MD, MPH & Aly Torres MD

One of our section’s 2015-2017 ICATCH Grants is supporting the impressive efforts of Project Director Edward Ntwere (Uganda) and Project Co-Director Edward O’Neill (Emergency Physician in Newton, MA) as they work to increase the number of households regularly sleeping under insecticide treated bednets (ITNs). Their success is largely the result of a partnership between the Village Health Teams (VHTs) in Uganda’s Mukono District, east of Kampala on the northern shores of Lake Victoria and Omni Med, an NGO registered in both the US and Uganda. Since 2008, Omni Med volunteers have worked closely with the VHTs in this district, who provide primary preventive care and education at the household level. Their aim is to reduce the incidence of the 3 major killers of young children there: pneumonia, diarrhea and malaria. By 2015, efforts were well underway to tackle the first 2 through their programs promoting cleaner cook stoves and protected water sources for households in the district. But Ntwere and O’Neill wanted to add in a training program for the VHTs addressing the low level of bednet use.

ICATCH began funding this proposal for the bednet component in 2015 ($2,000/year for 3 years). In the first year, they were able to construct a storage facility, purchase 200 ITNs and negotiate donation of another 80, and 7 VHTs were hired and trained (as ITN Masters) on proper use and maintenance of ITNs, household mosquito reduction strategies, and referral for treatment of suspected malaria. The key to their success was that this was NOT just another ITN distribution program. The VHTs make regular follow-up household visits to ensure nets are properly hung and in use, and to teach adults how to keep nets in good repair. They have found a 97.7% user rate at 3 months. The program is thriving, having expanded last year to another village, with the purchase of 207 more ITNs, and the hiring of an additional 6 ITN Masters. The focus for year 3 was on households with pregnant women and/or children under age 5. Initial user rates in the villages prior to the ITN distribution was 57.69% for pregnant women (N=36), and 34.53% for children under 5 (N=164). Three months later, following initiation of the distribution and monitoring program, user rates increased to 88.46% among pregnant women and 91.01% in under age five children. The number of new ITNs distributed that were found at three months to be hung properly was 99.4%. Considering that ITNs can decrease malaria rates by 50% and under-5 mortality rates by 55%, the impact of their work in these 2 village areas is not insignificant!

The VHT model will remain the program backbone in 2017 as it continues to expand, working very closely with the Ugandan Ministry of Health and the District Health Office who are enthusiastic partners. For those interested, Omni Med can always use medical volunteers from the US in this work. Partnerships have even included US students in health fields assisting with data analysis.

Dr. O’Neill: “Without ICATCH, we would not have perfected the ITN distribution piece and would not have had the resources to distribute roughly 1000 ITNs to vulnerable children in our catchment area. We greatly appreciate the support from ICATCH and hope to repay your kindness adequately!”

As always, ICATCH’s ability to help support such work is made possible thanks to YOUR SOICH membership dues and your donations to ICATCH! Click here to learn more about ICATCH.

Resident’s Corner

In November 2016, Dr. Eta (Obeya) Barclay, a 3rd year pediatric resident at the University of Minnesota, completed a 6-week rotation in Ogbomoso, Nigeria. Her experience was unique given that she lived in Nigeria the 1st seventeen years of her life. Her recollection of her time in Ogbomoso eloquently summarizes the challenges, hope and insight that accompany an international elective.

Ogbomoso Trip Reflection, Eta Obeya MD

The phrase “you cannot go home again” in some ways, summarizes my experience in Ogbomoso, Nigeria. I had expected to experience something different, but the magnitude of that difference surprised me. I returned with feelings of anger, sadness, motivation, wonder, and deep humility to name a few. The combination of these make a trip summary an interesting idea to explore. I was born and raised
in northern Nigeria, and lived there until I was 17 when I left to attend college in northern Wisconsin. As much of my life has been spent in Nigeria, I considered myself very accustomed to the peasant culture and overall environment of Nigeria. I attended a very helpful pre-departure orientation, and though we were taught about culture shock, I regarded the concept impersonally and academically, as I was certain it would not apply to me - I was returning home after all. The same applied to sessions that dealt with the feelings of hopelessness one encounters in a resource limited setting. I had spent some time working in clinical settings in different parts of Nigeria as a student and so I assumed, arrogantly, that I knew what I was getting into and would cope adequately. My decision to go to Ogbomoso was based primarily on two factors—my preceptor who I was travelling with had deep ties there, and it was sufficiently far away from my family and so though I was returning “home”, the environment would not be entirely familiar.

Immediately we arrived in Ogbomoso, I realized that the reality of the degree of unfamiliarity greatly surpassed my expectations. We arrived at night, and the drive to the hospital compound where we would be living was mostly until. We drove past several until houses and shacks and then arrived at what would be our home for the next few weeks. Once there, my preceptor casually announced that we would most likely only have electricity for 4 hours in the day - 2 hours in the morning and 2 hours at night, and this electricity would be supplied by the generator on the compound. She likely thought I would not be surprised at this, being Nigerian, but I was taken aback for a few seconds. I walked into the room that would be mine for the duration of our stay, and again experienced a degree of surprise when I noted my bed was four-poster bed with a mosquito net hanging over it. Ogbomoso is quite an interesting place. It is one of the oldest towns in Nigeria, and one of the first towns where foreign missionaries settled. Their influence can still be seen and felt today. The hospital and surrounding campus was a missionary institution until less than two decades ago. Across the street from the hospital campus is the campus for the Baptist Seminary. These two compounds exist in stark contrast to the rest of Ogbomoso. The residential buildings resemble those seen in colonial style mansions—well-built European styled houses with electric fixtures, bedrooms with four poster beds, and some living rooms even with fireplaces. There was running water. There were paved roads and beautiful gardens. There were even courts for badminton and tennis at the seminary compound. These contrast with the dilapidated structures around the rest of Ogbomoso. These compounds had been primarily occupied by foreigners who, it seemed, understandably tried to develop a sense of home in a rugged environment. Appreciating the difference was the beginning of my identity crisis. Though I was Nigerian, in Ogbomoso, I was clearly an outsider - I did not speak the native language, my name was difficult to pronounce. I was living in a house that resembled colonial housing, I had come from America, and I spoke in a slight accent. I was both native and foreign at the same time.

This feeling of being both an insider and outsider, extended to the hospital. I had spent countless hours over the past 2.5 years working at children’s hospitals in Minnesota where bright colors, cartoon characters, private rooms, multiple television screens, room service, and therapy dogs were the norm. When I walked into the neonatal and pediatric wards in Ogbomoso, the contrast between where I had been and where I was at that moment was almost breathtaking. Now I realize that in some ways, I had forgotten was that difference was the beginning of my identity crisis. Though I was Nigerian, in Ogbomoso, I was clearly an outsider - I did not speak the native language, my name was difficult to pronounce. I was living in a house that resembled colonial housing, I had come from America, and I spoke in a slight accent. I was both native and foreign at the same time.

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Toward the end of my first week though, that excitement had begun to wane. On a particular day, we had admitted a baby with anoxic encephalopathy and resulting respiratory difficulties and septicemia. My preceptor and I had put together bubble CPAP and placed it on the baby, but she still had significantly increased work of breathing. I knew that in Minneapolis, I would proceed with intubation and then obtain a blood gas. In Ogbomoso, however, there were no ventilators, and the lab could not run blood gases. So, I stood by attendants helplessly. After about an hour, the baby seemed to have settled somewhat with a more comfortable appearing breathing pattern, with stable oxygen saturations. We left to go home to bed. The following morning when we arrived at the maternity, business seemed to be going on as usual but I could not find that baby. We were told he’d died during the night. I felt anger for the first time there. Anger, that business would just go on as usual after the baby died; anger, that not having a ventilator was a reason for death; anger, that I had not been able to even know what his blood gas was; and anger, that no one else seemed angry about all of this. In their defense, this was not an unusual occurrence, but to me it was. Again, I felt like an outsider looking in. Though in some ways, there were my people. That week, I was also able to recognize the difficult financial situation a lot of the patients as there were no staff pediatricians present that day. I felt a mixture of awe and excitement. These doctors had a level of independence that I probably would not experience throughout my residency training. My sense of excitement was slightly dampened after I realized that the hospital, a tertiary care center, had no echocardiogram to characterize the type of heart lesion the child with heart failure had; or that even if this was available, the child’s parents, both of whom were farmers would be unable to afford a reinstall; or that if were somehow miraculously able to afford the treatment, there was possibly only one in the country that only sometimes offered surgery and this was only when they had a visiting foreign surgeon. The feeling of hopelessness emanating from the child’s parents was palpable; but that day, I was buoyed by the sense of excitement that developed when I arrived at the emergency department.
creep in. Our typical day consisted of rounding in the mornings followed by research projects in the afternoons. Our research primarily centered on the management of jaundice. My preceptor, Dr. Slusher, had developed a method of treating jaundice using filtered sunlight and the randomized control trial, comparing that method to conventional phototherapy was taking place in Ogbomoso. We also had secondary projects including temperature monitoring using thermoregul sticker in babies under phototherapy, as well as assessing the knowledge, attitudes and practices of mothers and health care workers regarding jaundice. This aspect of our trip also included several difficulties - doing clinical research in an environment without constant electricity, consistent laboratory services, a language barrier and workers with different levels of education can be daunting. Also, in the case of the project which involved knowledge, attitudes and practices, administering written surveys in a setting where the primary language was not English and literacy was not uncommon certainly had its challenges.

By the end of my 6 week stay, we had seen many more babies die than I had in my 2.5 years of training in Minnesota. We had seen two babies develop kernicterus. I had seen families take their sick children home, to a fate I am still unsure of, as they were unable to afford treatment which amounted to the equivalent of $10-$20. I had sat with 15-year-old girl who needed a liver transplant, and a 4-year-old girl who needed a kidney transplant knowing that transplant surgery was only a fantasy. I had felt the deep frustration of successfully resuscitating a baby who was then stable on a nasal cannula, only to have the electricity in the hospital go off, and the oxygen thereby fail. By week 6, I was ready to leave. I felt emotionally and physically drained, and defeated. I returned not knowing how to process these feelings. My preceptor who was there with me concluded that part of what I experienced was culture shock. Shockingly, she was right. I also realized the flaws in my preparation and views about global health. Now, I see that for me, a sustainable career in global health would need to have a focus of some kind. Simply going to work in a resource limited hospital is not only overwhelming, but would also feel insufficient. I, as a singular clinical doctor, also have quite limited resources in terms of how many people I can treat effectively. Seeing Dr. Slusher's project with sunlight phototherapy, and her passion for jaundice inspired me – the use of low cost technology to provide a high impact treatment using the resources of that particular environment, the dissemination of that knowledge, and long lasting effects of teaching appears to be a much more effective approach to global health. I am challenged to think about what that would look like in the long term for me. After returning, I was also challenged to try to identify positive aspects of my trip. Now I see that with all my feelings of anger and hopelessness, I overlooked so much. I left with a deep appreciation for the doctors I worked with, especially the house officers. They bear an amazing amount of responsibility with no work hour restrictions. Their physical exam skills are admirable as they are unable to rely on diagnostic imaging or lab tests as often as I do in Minnesota. The families are incredible. They are able to endure so much hardship, and yet continue to smile. The children are tenacious. Their little bodies are so tough, and even in the most unlikely circumstances, a lot of them overcome severe diseases. My personal statement in my application for pediatric residency contained this sentence: "I want to be a pediatrician to use my role as a physician to equip caregivers for the good of their charges, to use the art and science of medicine to work with the inherent grit of children in helping them overcome illness, and in doing all of that, to fight to give children from different socioeconomic backgrounds the maximum change at a beneficial childhood". My stay in Ogbomoso challenged me in many ways, including making me question my identity, but it also helped strengthen this resolve.

MARK YOUR CALENDAR!!!

Global Health Related Sessions
AAP 2017 National Conference & Exhibition
Sept. 15-17, 2017 - Chicago, IL

C0014 Physician Wellness and Burnout: Examples and Best Practices From Around The World, Sept. 15, 8:30 -11:15 AM

Physicians face challenges related to balancing physical, mental, emotional and professional commitments. This course will discuss how these issues affect physicians and patients. Examples to promote work life balance for physicians and opportunities for engagement and interaction will be presented. A panel discussion will share best practices to promote resilience and work life balance for physicians.

Faculty:
Mary McCaffrey MD, FAAP, University of Arizona Center for Integrative Medicine, AZ
Lucky Jain MD FAAP, Emory University, Atlanta, GA
Juan Gapueto MD, PhD, Universidad de la República, Montevideo, Uruguay

P1072 Children in Immigrant Families: A Policy and Advocacy Update
Sept. 16, 2017, 11:50 AM - 12:10 PM

Nearly one in four U.S. children is an immigrant or the child of an immigrant. Among Latino and Asian communities, this number rises to 55% and 76%, respectively. In the past year, the U.S. has introduced numerous policies that directly affect the health and well-being of these children, as well as children seeking humanitarian protection or life-saving medical care. This presentation will review the impact of current federal policies on clinical care and identify opportunities for AAP members to support children in immigrant families.

Faculty:
John Linton, MD, FAAP, Wake Forest School of Medicine, Winston-Salem,NC

P3074 From Afghanistan to Zambia: 10 years of International Child Health
Sept. 16, 11:10 - 11:30 AM

The International Community Access to Child Health (ICATCH) program supports more than 60 programs in over 35 countries. This session will provide a brief overview of how and why the ICATCH program was started 10 years ago using the CATCH program in community health as a model. Several CATCH-funded innovative community health programs from Africa, Asia and Latin America (many to choose from: reducing epilepsy stigma in Uganda, providing home visits for new born moms in Liberia, first child abuse prevention program in Ghana, school gardens and nutrition education in Uganda, Hepatitis B vaccination for students in monastic/monastery schools in Myanmar (Burmese), group prenatal care for women in Afghanistan, etc. etc.) will be highlighted.

Faculty:
Charlotte Munson, MD, MPH, FAAP, Program Director
International Community Access to Child Health (ICATCH) Grant Program, Los Altos Hills, CA
I3114 - Your Global Health Career: Education and Funding for Your Passion
Sept. 18, 2:00-3:30 PM
In this interactive session, global health career options will be explored and ways in which residents and faculty can best prepare themselves for a career in global health will be discussed. An interactive panel discussion will include leaders in global health education and research and representatives from nongovernmental organizations and government agencies. Ample time will be provided for small group discussions where attendees can explore their own interests and discuss common challenges, pitfalls, and solutions through case-based discussions.

Faculty:
Patricia McQuilkin, MD, UMass Memorial Medical Center, Harvard, MA
Christiana Russ, MD, FAAP, Boston Children’s Hospital, Boston, MA

W3166 - Innovative Approaches for Life-Saving Procedures in Low-Resourced Settings (Repeats as W4039), Sept 18, 4:00 – 5:30 pm
Participants will learn about and practice evidence-based technology modifications for life-saving procedures in low- and middle-income countries. Procedures will include setting up and performing a neonatal exchange transfusion, including how to do an umbilical venous catheter placement; setting up bubble continuous positive airway pressure without “store bought” set-ups; and making spacers for all ages and sizes. In addition, faculty will discuss how to think through other procedures that might be needed to determine if low-cost, safe, and effective alternatives are available.

Faculty:
Tina Stusher, MD, FAAP, Professor of Pediatrics, University of Minnesota, Saint Paul MN
Yvonne Vaucher, MD, MPH, FAAP, Neonatologist UCSD La Jolla, CA

SECTION ON INTERNATIONAL CHILD HEALTH EXECUTIVE COMMITTEE
Parmi Suchdev MD, MPH, FAAP - Chairperson
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Swati Antala MD - Liaison, Section on Pediatric Trainees
Linda Arnold MD, FAAP - Immediate Past Chair & Nominations Committee
Coura Badiane, MA, MBA - Section Manager/Manager, International Affairs

Questions? Contact soich@aap.org

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