

Section on International Child Health

Newsletter
Spring 2010

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



Notes from the Chair

Cliff Michael O'Callahan, MD, PhD, FAAP

Chairperson for the Section on International Child Health
cocallahan@midhosp.org



Dear fellow members of SOICH;



A lot has occurred since our last newsletter.



We celebrated the New Year and in the first weeks of 2010 invited Luisa Oriol, the past president of the Haitian Pediatric Society (HPS), to join us as a full member on the executive committee. Luisa is replacing our wonderful Caroline Dueger who sustained significant injuries from a horrible bike accident last year. I hope Caroline will continue to be involved, as she is able, since she has always been a thoughtful wise voice on the committee.



Luisa was no sooner an integral part of our Section than the earthquake struck Haiti. She, and so many members of the Haitian Pediatric Society (HPS) that we have worked with over the years, were struggling to find family members. We were unable to contact them for many days.



Eventually, all members of the Haitian Pediatric Society leadership were accounted for and all were safe.



This extraordinary calamity has shown how vulnerable we all are and how difficult communication can be, even in this modern age. Determining a response from the AAP/SOICH with the input from our Haitian colleagues proved to be challenging but ultimately a great benefit of fostering this long term relationship. As you can see from the following excerpts from Dr Luisa Oriol's emails, it allowed a relatively brisk tangible response that was conducted with the help of Haitian and



Continued on Page 2

In this Issue . . .

Notes from the Chair	1
Welcome to the launch of the International Child Health Network!	3
Haiti and the Aftermath	5
Want To Know More?	7
I-CATCH Update	8
• Indonesia	9
• Mexico	11
Child Abuse in Pakistan	13

Health Volunteers Overseas - Pediatric Volunteers Needed!	15
International Pediatric Association	15
New Members' Column	16
• Ted Kaplan, MD	16
• Samantha L. Wilson, Ph.D.	17
Pediatric Hero: Scott J. Cohen, MD, FAAP	19
Immunizations and Infections	20
Current state of Pediatrics in Iraq and the impact of the wars	23
SOICH Executive Committee Members	26

Notes from the Chair *Continued from Page 1*

Dominican pediatric connections and resulted in a truckload of supplies for dwindling stock.

From Luisa on Jan 24th, 2010: *Just to give you the latest news about the shipment from AAP. As you already know, it arrived yesterday from DR. I went this morning to St. Damien and double checked that it was there and separated from the other donations to the hospital. I located the boxes but it is difficult to verify that everything is there.*

I was able to contact Roanld Eveillard and we will meet Tuesday to sort the boxes and send them to Leogane, Petit-Goave and maybe general hospital where it is most needed. We will also have a mini meeting with Elsie Pothel, the SHP secretary and Guy Pierre-Louis, the VP, to see how to start organizing the work through SHP which will enable us to have a better meeting with Marlene when she comes.

From Luisa on January 26th, 2010: *Just to give you an update of the supplies received. We were able to move them from Petits Freres et Soeurs to an office in Carrefour. From there Ronald and some other pediatricians will dispatch them where they are most needed, outside of Port-au-Prince (PAP). As you probably know, most of the help is here in PAP, so we are trying to cover Leogane and Petit-Goave, 2 towns south of PAP that have been partly destroyed. Guy took some supplies for a pediatric center in Petion-Ville and Elsie took some for another center North of PAP, in Bon Repos.*

As I write this, many weeks later, there are quite a few members in Haiti working alongside Haitian and NGO partners.

We can not reverse time and erase the tragedy but we can learn from this experience and do better the next time, for it is certain that there will be others. This globe is a cozier place now and we must use our connections with fellow pediatric providers to address the ongoing misery and episodic horror that affects children and their families.

This brings me to a separate but related topic – the long-awaited launching of the **International Child Health Network**. This is the next generation of the Country of Interest website project that many might remember from years ago. I am thrilled with the new version and I think you will feel so also. We expect great linkages and otherwise unexpected collaborations to become commonplace once a great number of us from around the globe enter our data. Thanks are due to Jonathan Spector and Duke Duncan, SOICH members, and the AAP IT folk.

Peace,
Cliff O'Callahan, MD, PhD, FAAP
Chairperson, SOICH



Editorial Note: Your SOICH Executive Committee and the IT Department of the AAP has spent countless hours developing “**The International Child Health Network**”; a system that allows you to connect with people and places and to assist in matching needs with resources. The potential of this interactive database will be achieved only if YOU and a large cohort of Others who care for the World’s Children, join the Network. Those of you who want to do something outside your countries’ borders but lack the connections to do so, must join. Those of you who have done something away and want to share your experiences and expertise, must join. The more who join, the stronger and more effective it will be. Throughout history, it has not been institutions nor governments that have fought disparities; it has been a cadre of concerned dedicated people working together. Now is your time to join that cadre.

Welcome to the launch of the International Child Health Network!

The International Child Health Network (ICHN) launches in March 2010! This dynamic web-based network aims to actively support meaningful collaborations among pediatricians and others who are working to improve global child health.

What is it?

The ICHN is a free and open service designed to establish connections that foster cooperation on a variety of health projects. This includes relief and development work, humanitarian service, equipment/supply donation, education, research, fundraising, and visitor exchange. The site is managed by the American Academy of Pediatrics’ Section on International Child Health (SOICH).

What can it do for me?

The possibilities are endless. Successful collaborations developed from use of the ICHN might include:

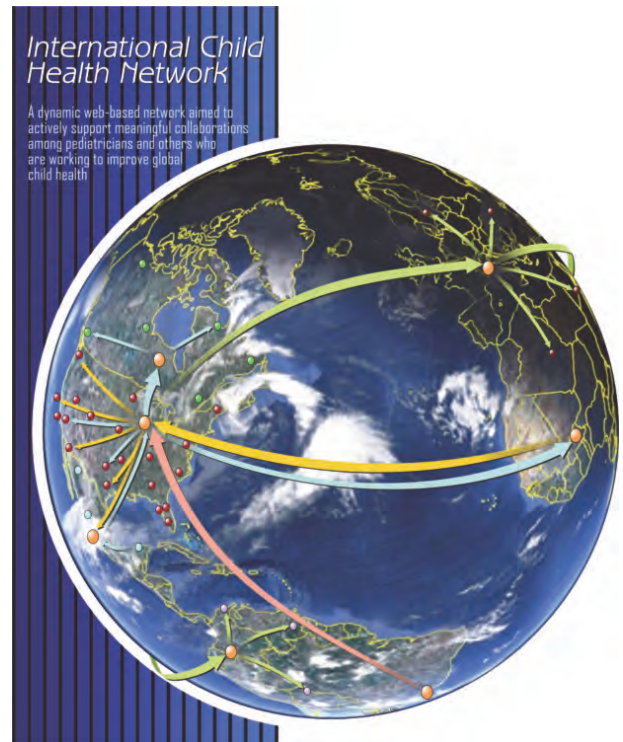
- A pediatrician in Honduras finds a pediatric practice in Texas willing to host her for a week. Six months later she returns the favor in Tegucigalpa.
- A hospital in Kampuchea receives surgical supplies from individual European and American donors contacted through the Network.
- A student in London finds a doctor in Belize to supervise him on a one month rotation in a Belmopan hospital.
- A relief agency finds 35 colleagues from 12 countries willing to work together on a tropical health education project.
- A non-governmental organization finds seven healthcare workers from three different countries for its upcoming medical relief trip to Mali.
- A disaster relief agency receives rapid situation reports and advice from local health personnel contacted through the Network.

How does it work?

Using the ICHN is simple! After a brief registration process, the network can be used in two different ways:

1. You are welcome to search the ICHN independently to identify partners who have specific interests and

Continued on Page 4



Welcome to the launch of the International Child Health Network! *Continued from Page 3*

expertise. To do so, simply log in and select “Search the Network.” You will then be asked to select characteristics of network members that are most important to you. Specifically, you can search the network for those who have a particular country of interest, language skill, and/or profession. The search engine will then quickly identify potential collaborators who meet all of your requested criteria. When the search identifies a network member who you think might be a good collaborator, feel free to email them, introduce yourself, mention that you obtained their name from the ICHN, and begin your collaboration!

2. You can identify collaborators and/or opportunities through a Country Coordinator. Each country around the world has a designated Country Coordinator who has experience living or working in that country. The Country Coordinator has meaningful knowledge and contacts that can be of use to you. To identify and contact the Country Coordinator for your country of interest, simply log in and select “Contact a Country Coordinator.” You will be presented with the list of Country Coordinators and their contact information. Once you email the Country Coordinator and introduce yourself, they will happily provide whatever assistance or guidance you require!

Country Coordinators

A number of Country Coordinators have already been identified, but Coordinator positions for many countries are still open. If you are interested in contributing to the network by volunteering to be a Country Coordinator for a specific country in which you have experience living or working, please contact Jonathan Spector at jmspector@aap.net

When can I start?

Now! The ICHN is ready to serve you. To get started, simply point your browser to www.ichn.org. The power of the ICHN will sit entirely with its members – so please join the network today!

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Home | Parenting Corner | Health Topics | Bookstore & Publications | Professional Education & Resources | Advocacy | Member Center | About AAP

News Room | Site Map | Contact Us | Search:

Welcome to the International Child Health Network

This 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, fundraising, and visitor exchange. [Click here](#) to view concrete examples of such activities.

You are welcome to 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.

[Click here for more details on how to use the ICHN](#)

Ready? [Join the Network!](#) **Already Registered?** [Sign In Here](#)

Haiti and the Aftermath

Marlene Goodfriend, MD, FAAP

SOICH has been in weekly and sometimes daily contact with the core members of the Haitian Pediatric Society (HPS) since the devastating earthquake on January 12. Your Section has been collaborating with HPS for the past six years. Our colleagues have attended as well as presented at our SOICH meetings and other pediatric meetings. They are our colleagues and have become our close friends.

Our first concern was if everyone was safe and uninjured. Dr. Jacqueline Gautier lost her husband when a building collapsed on him. She broke her foot in several places while running out of her house. She is now recuperating in south Florida at her brother's home. The other core members, including Dr. Ronald Eveillard, president of HPS, Dr. Luisa Oriol, previous president of HPS and now a member of the SOICH executive committee, Dr. Guy Pierre Louis, vice-president, Dr. Patrick Hilaire, advisor, Dr. Jessy Colimon Adrien, chief of pediatrics at the general hospital, Dr. Elsie Pothel, secretary, Dr. Jean Alouidor, vice-secretary, and treasurer, Dr. Vital Herne are alive and uninjured. However, everyone has lost relatives and friends.

On January 15, Dr. Luisa Oriol wrote:
The internet was back an hour ago. My family and I are OK. Things are not easy but both my mom and my husband who were in buildings that collapsed had been saved. I have been trying to answer to all the e-mails that I have received but I don't know how long the internet will work. So, Please let Jane, Cliff and all the others that I thank them so much for their concern. As far as the help goes, I have been trying to reach Ronald but cannot. I hope nothing is wrong with him. I spoke to Elsie very briefly but lost the communication. I know Guy is OK, you already know for Jacqueline's husband. Hopefully we will be able now to communicate. Luisa

On January 18, Dr. Jessy Colimon Adrien wrote:
It was impossible for me to communicate after the earthquake. The Pediatric building of General Hospital has been severely damaged. We will be working under the tent for a long time. It's not easy for us. Many residents (1/3) in training lost their homes and moved to the countryside. We will need a new building to continue to give care to Haitian children. I am safe and my family too. We lost many friends and loved ones. The situation is chaotic. They continue with rescuing operation. Tonight they found a two year old girl after 5 days.

Quickly the focus shifted to helping the children and the families. On January 15
Dr. Luisa Oriol wrote: "Thank you so much for your concern. Things are not easy but with all the help from the international community we hope to save as many children as possible. I have not been able to speak to Ronald nor Jessy, but I believe we will need your help mostly when things are better structured. Right now, it's pure



Pediatricians Dr. Ronald Eveillard (orange shirt) were very soon at work in the facilities near their house to help and sometimes had clinical activities in the streets because there was little attention in hospitals for sick children other than children with trauma.

Continued on Page 6

Haiti and the Aftermath *Continued from Page 5*

chaos. Shortage of food will probably be felt by next week, so milk, biscuits, whatever food which will not need to be cooked will be welcome. I believe there will also be a shortage of tetanus serum and vaccine. I will try to reach Jessie and find out what she needs at the university hospital. I will also go to the Catholic Pediatric Hospital where Jacqueline and I work to see what is the most needed. So far, I was only able to reach Hopital Canape-Vert but they had to shut down the facility because of structural damages. They will probably also need R/L, DS.33, D5, antibiotics such as ampicillin or PNC, gentamicin and ceftriaxone, intracaths or scalp veins. I will try to write tomorrow if I am able to reach the pediatric hospital and/or Jessie and Ronald. Thanks again, Luisa

On January 22, Dr. Ronald Eveillard, President of HPS wrote: On the ground, the situation is chaotic. Everything is urgent and the spreading of help is very low. I've made a round in some hospitals and in the refugee camp. There is a need for pediatricians and nurses. The problem is that everybody, even the pediatricians are involved in emergency care for injured people and this focus leaves little attention to child care. Children with trauma will have care but the others with diarrhea, meningitis, URI...have difficulties to receive appropriate care. For the moment, Hopital Saint Damiens is giving care to children, HUEH has started some activities. But, In Carrefour, Leogane, Petit-Goave, Grand-Goave children don't have access to pediatricians.

Dr. Oriol subsequently sent a list of urgent medical supplies. Hospital Petits Freres et Soeurs where she works is connected with NPH (Nuestros Pequeños Hermanos) in the Dominican Republic. It was easier to send supplies from the Dominican Republic (DR) versus flying them into Port au Prince because of the back-up of supplies at the airport. Dr. Errol Alden released \$10,000 from the Friends of Children Disaster Fund, and we were able to have supplies sent from the DR to the Petits Freres et Soeurs Hospital. This hospital became the site for dispatching supplies to other parts of Haiti including in the north and the badly hit south.

Dr. Luisa wrote on January 26 after receiving the supplies: Just to give you an update of the supplies received. We were able to move them from Petits Freres et Soeurs to an office in Carrefour. From there Ronald and some other pediatricians will dispatch them where they are most needed, outside of Port-au-Prince. As you probably know, most of the help is here in PAP, so we are trying to cover Leogane and Petit-Goave, 2 towns south of PAP that have been partly destroyed. Guy took some supplies for a pediatric center in Petion-Ville and Elsie took some for another center North of PAP, in Bon Repos.

We will probably need mostly oral medications in the future but believe we can buy them in PAP at Laboratoires 4C which seem to be standing so far. Let us hope that no aftershock will destroy it also. Guy and Ronald are trying to make a list of what will probably be needed in 2 weeks or more, when all emergencies due to the earthquake will be over. At the pediatric center where I am, Petits Freres et Soeurs, the US doctors are starting to leave which is a good sign that we are having less surgical emergencies. The Italian team is still there. We believe that in 2 or 3 weeks the hospital will be back to a completely pediatric one. I haven't look at the agenda yet, Marlene, I will write again to you as soon as I do. Jacqueline has undergone surgery in the States, she wrote to say she was doing OK with the pain killers. She is leaving the hospital today to go to a brother's house. We are learning every day of new deaths of colleagues or their families sometimes I think I am just having a bad dream. If only it were true.

Let me know if you need any more details about the shipment, Luisa

Today, January 31, 2010, the shortage of pediatricians has become more severe and acute. Dr. Luisa Oriol called me to say there is a desperate need for pediatricians. Hopital Communautaire has only 1 pediatrician and she is working around the clock. Petits Freres et Soeurs needs pediatricians, as do other areas of the country. At this moment, we are trying to arrange to send pediatricians to Haiti. Whereas many pediatricians want to do this, the main difficulty is that there is no infrastructure to support them, i.e. food, water, lodging. Dr. Oriol and I discussed that we do not want a situation where the people who go to help, then need help.

On February 1 Dr. Oriol wrote: Dr. Arty from Petits-Freres et Soeurs say that she would welcome the help of

Continued on Page 7

Haiti and the Aftermath *Continued from Page 6*

pediatricians but has no space left for tents. Dr Lerebours from la Communaute will find out if there is any place for pediatricians to set up a tent. Feeding them would be impossible. So if they cannot find an org. which will take care of them, it will be better if they wait before traveling. I know that help is needed at HUEH but this should be taken care by Jessy.

On February 2 Dr. Oriol wrote: We had a meeting this morning and tried to see how we should handle things from now on. The first thing is that the rush and the big emergency are over. We still have people coming for wounds, fractures or other traumas but it has slowed down considerably. People will start coming for infected wounds that had not been treated previously or that had not been treated correctly. They discharge patients sometimes right after the amputations. In 2 to 3 weeks we will mainly have to take care of children with infectious diseases and we should be prepared for "epidemics" or simply a lot of sick children. The lack of hygiene in the so-called camps will certainly be a factor. Malnutrition and thus TB will also be a big problem. So, we thought that we should see how to prepare centers already functioning for these events by choosing areas mostly affected: PV, Freres, Tabarre, Lillavois/Bon Repos, Carrefour, Leogane, Petit-Goave. Centers that we know of are already providing help in PV, Freres (Hopital de la Communaute), Tabarre (St. Damien), Lillavois (Dr. Blaise), The others have to be reevaluated. We will also have to provide vaccinations. We know already of 3 cases of tetanus and we are afraid we will have more and of course measles will also be a big problem. So, we will need pediatricians to rotate, pediatricians willing to go to Leogane and Petit-Goave. We will need nurses, physiotherapist and of course psychotherapists even though I am not sure how English speaking psychologists will communicate with the children. Medication: mostly antibiotics, oral salts and iv solutes for severely dehydrated children, medication against scabies. I don't know if Grace Children's Hospital will be able to provide medications against TB to all that might need them. As far as Haitian pediatricians are concerned, we already know about 3 deaths. Many pediatricians have lost a member of their family and/or their homes. Many have also lost their office space and are without a job. Unfortunately many of them have also left Haiti and we do not know for how long and thus when they will be back. We are trying to write or call all the members of the society and will then know who will be able to help in our projects. Those who are in PaP are helping wherever they can since many of them have also lost their cars and transportation is not always easy. The situation is about the same for the nurses, the national school of nursing fell killing 300 students and teachers. Well let me know what you think, meanwhile I will keep looking for space for the US pediatricians. Luisa

Presently we are working on obtaining housing for American and Canadian pediatricians to help out for 1 or 2 week rotations. There seems to be an offer of a couple of beds, i.e. mattresses, in the home of an Englishwoman who has been a tour guide in Port au Prince for many years. This could be the start of us being able to help in a hands-on way.

WANT TO KNOW MORE?

about your **Section, I-CATCH projects,**

Overseas Opportunities, etc.?

Visit the **SOICH Web site** at:

www.aap.org/sections/ich/

I-CATCH UPDATE

The great disparities in children's access to health care are dependent on many factors. Expanding the availability of community-based services through programs designed to decrease these disparities is imperative. In 2006, your SOICH implemented a new program to motivate child healthcare providers in resource constrained settings to address these disparities in their own communities: the International Community Access to Child Health (I-CATCH). I-CATCH offers mentorship in grant preparation and project execution, and provides three-year funding to support project development and implementation. Projects are community-based initiatives that increase children's access to health care or services not otherwise available. Project initiatives aim to decrease health disparities and develop sustainable community-based child health programs that may be replicated in other communities.

In the past 3 years, I-CATCH has funded 17 innovative projects in 14 countries (Table). Grant recipients have improved access to health in infants and children affected by malnutrition, infectious disease, developmental disabilities, and neonatal conditions. Educational programs have targeted parents, teachers, health care workers, and entire communities. It has been inspirational to observe the tremendous accomplishments of our innovative and dedicated colleagues working to improve the health of the children and families in their communities.

The next cycle for I-CATCH Grant applications has begun. Applicants submitting a preliminary proposal will be teamed up with a member of the SOICH to offer guidance in grant writing. The deadline for preliminary submission is June 1st and for final submission is August 16th. More information and application materials may be found at http://www.aap.org/sections/ich/I-CATCH_page.htm. If you are interested in participating as an I-CATCH mentor or grant reviewer, please contact Anna Mandalakas, I-CATCH Program Director at anna.mandalakas@case.edu.

Name of Project	Country	Project Director	Assistant Director	Mentor
2006-2009				
Bagong Baranggay Project	Philippines	Alexis Reyes		Carmen Bonoan
The Helping Hands Project	Pakistan	Ghluam Mustafa	Imran Iqbal	Duke Duncan
The Community Education Project	El Salvador	Miraya Salazar		Bron Anders
The Kayunga Newborn Project	Uganda	Margaret Nakekeeto		Yvonne Vaucher
2007-2010				
ADHD and Mental Health Education	Mexico	Luis Lara Hernandez	Peter Dawson	Gil Handal
TB DOTs for Kids	Philippines	Elsie Baronia Locson	Sonia Timbang Madjus	Amethyst Cureg
HIV/AIDS Education for School Staff	Botswana	Mogomotsi Matshaba	Gabriel Anabwani	Elizabeth Lowenthal
Undernourished Children	El Salvador	Juan Carlos Reyes	Marthin Juarez Ramirez	Steve Berman
Parent Ed for Child Passenger Safety	China	Xiaoming Shen		Murray Katcher
Improve Understanding of GOBI FFF	Indonesia	Soemakto	Asih Tri Rachmi	Eliabeth Hillman and Donna Staton
2008-2011				
Improving Newborn Health	Dominican R.	Sara Tolentino	Kim Wilson	Alissa Rissman
INH Preventive Therapy into Reality	South Africa	Susan Van Wyck	Luzeth Smith	Anna Mandalakas
Good Nutrition	Laos	Banheng Vorasane	M. Leila Srour	Duke Duncan
Healthy Children - Health Community	China	Guan Hongyan	Fu Liping	Spencer Li
Safe Baby Project	Romania	Tatiana Ciomartan	James Crawford	Resumiye Oral
Autism Education & Screening	Bosnia-Herz.	Miriana Remetic	Vesna Dropic-Suljevic	Mirzada Kurbasic
2009-2012				
Rural Children with Diarrhea:	China	Chaomin Wan	Qin Guo	Jorge Bezerra
Dietary assessment for vitamin A	China	Ronqwang Yang	Shujiong Mao	Duke Duncan
Child Protection in Ghana	Ghana	Eben Badoe	Lili Banan	Nancy Graff
Community Awareness of Poisonings	Ghana	Ed Nignpense	Lili Banan	George Rogers
Health Evaluation & Education	Zambia	Chuck Erickson	Malvina Simulwi	Bron Anders
Asthma Project	Zambia	Somwe Wa Somwe	Emilia Jumbe-Marsden	Fernando Martinez

Improve the understanding of GOBI FFF among Suburban Community Voluntary Health Motivators (VHM's) in Malang, Indonesia (A Preliminary Report)

Soemakto

Pediatric Department Medical School Brawijaya University
Saiful Anwar Hospital Malang, Indonesia



The 1st Group participants of the VHM's training (2th, 3th June 2009)

Sitting on the front row (left to right): Dr. Anik, Dr Soemakto: The Chief of the project, DR. Dr. Budi Siswanto: Director of The Saiful Anwar Hospital, Dr. Enny Sekar: The Health Departement Malang, Dr. N Budi Santoso, DR. Dr. Mardhani, Dr. Lintang Kawuryan. Standing on back row: The Particiants.

Background: Indonesia is a relatively poor country. In 2007, it had a population of more than 200 million, an annual growth rate of 1.3%, and each year two millions new infants are born.

Administratively, Indonesia is divided into provinces, regions, municipalities, districts, villages, and sub-districts. Each district has its District Heath Centre (PUSKESMAS) and each village has its own community health activities called the Integrated Family Health Post (IFHP or Posyandu). The IFHP's are staffed and managed by Voluntary Health Motivators (VHM's or Kader Kesehatan) who are supervised by the nurses and midwives of District Health Center.

Nearly 30% of the population is between 0-14 years of age. The infant mortality, under five mortality, and maternal mortality rates are high.

To reduce children mortality and improve the lives of children, UNICEF and WHO introduced GOBI FFF; low cost, low technologies of Growth Monitoring, Oral rehydration, Breast feeding, Immunizations, Family planning, Food supplementation, and Female education. These strategies were to be promoted by the VHM's but training was necessary. This responsibility, in the face of sparse medical educational background, were the principal reasons why we applied for I-CATCH (**International Community Access to Child Health**) funds to allow us to introduce a training program. Other important reasons using VHM's were that they live with and are in direct contact with the people in their communities, are easy to reach, and with this added knowledge can encourage and motivate mothers in the implementation of the GOBI FFF. The result should be a decrease in child morbidity and mortality and an improvement in the growth and development of children.

Objective: To improve the knowledge of GOBI FFF among Suburban Community Voluntary Health Motivators (VHM's) in Malang, Indonesia.

Continued on Page 10

Improve the understanding of GOBI FFF . . . *Continued from Page 9*

Methods: To train 300 VHM's from Kedung-Kandang District, Municipality of Malang between 2008 and 2010. The training was divided into 3 phases, each with 100 VHM's.

The outline the training GOBI-FFF topics were: **G**rowth and Development, **O**ral Rehydration and Diarrhea, **B**reast Feeding, **I**mmunization and Preventable Infectious Diseases, **F**amily Planning/Spacing, **F**ood supplementation for Babies, **F**emale/Family Education: Clean and Healthy Life Behavior

Pre and Post-tests were given to all participants and consisted of ten true or false questions for each of the seven topics. Eight of ten (80%) correct responses were considered a pass.

Results: A total of 205 VHM's were trained during 2008 and 2009 and divided into 4 separate groups; 52 and 51 VHM's were trained in September of 2008 and 50 and 52 VHM's in June of 2009. (Another 100 will be trained in 2010.)

Results of the Pre-test for the four groups

Topic	Group I	Group II	Group III	Group IV	Mean
Growth and Development	6.90	6.10	6.90	6.86	6.69
Oral Rehydration and Diarrhea	8.60	6.00	8.76	8.32	7.92
Breast Feeding	8.70	8.50	8.82	8.86	8.72
Immunizations & Preventable Diseases	7.10	6.00	6.90	6.94	6.73
Family Planning/Spacing	8.90	7.60	8.30	7.30	8.02
Food Supplementation	7.90	6.90	6.85	7.88	7.38
Female education	6.90	6.90	6.77	6.79	6.84
Average score	7.80	6.80	7.61	7.56	7.44

Results of the Post-test for the four groups

Topic	Group I	Group II	Group III	Group IV	Mean
Growth and Development	7.90	8.60	8.30	7.63	8.10
Oral Rehydration and Diarrhea	9.40	7.80	9.40	9.52	9.03
Breast Feeding	9.50	9.50	9.50	9.44	9.48
Immunizations and Preventable Diseases	8.60	7.80	8.53	8.36	8.32
Family Planning/Spacing	9.50	9.60	9.50	9.51	9.52
Food Supplementation	9.30	9.20	8.36	9.67	9.13
Female education	7.90	9.30	7.52	8.96	8.42
Average score	8.90	8.80	8.73	9.00	8.85

Using the paired t-test, the mean score difference between the Pre and Post collective test results for all four groups showed a significant improvement with a p value of <0.1. The mean score difference between the Pre and Post-test results for each of the seven individual topics showed a significant difference for each of the four groups with p values between <0.1 and <0.4.

Difficulties: The training itself was not a problem, but we faced difficulties in preparation for the training.

1. This was our first training project and we had no experience in working with outside partners and in how

Continued on Page 11

Improve the understanding of GOBI FFF . . . Continued from Page 10

to reach and invite the VHM's. But with the help of the Head of the local district health centre the problems were resolved.

2. The first training venue was far away and the facility was not well equipped. So, for the second training phase we moved the venue to our teaching hospital with its better facilities and this location also eased such problems as supervision and co-ordination.
3. In 2008-09, the Pediatrics Department was very busy with accreditation as a new Pediatric Education Centre and was preparing for the Indonesian Pediatric Society Congress where the teaching staff and residents presented 38 oral papers and posters.

We were very happy with the VHM's sincere enthusiasm to gain health knowledge. This surprised us. The participant's questions were many and varied; a good indication of their keenness.

Conclusion: The improved Post-test over the Pre-test scores showed that the knowledge of GOBI-FFF topics was significant among the Suburban Community Voluntary Health Motivators in Malang. The difficulties in conducting the training were overcome and the results were quite successful.

Acknowledgement: We would like to thank to Elizabeth Hillman MD, Donna Staton MD (Project Implementation Advisors) and the SOICH Executive Committee that gave so much assistance and guidance enabling us to implement and conclude this project.



By Luis Lara Hernández, MD and Peter Dawson, MD, MPH

Los Niños del Mante Primero (The Children of Mante First) is a social program that emerged from the relationship between Boulder, Colorado and Ciudad Mante, Tamaulipas, México. El Mante is a municipality located in the northeast of México, close to the Gulf of Mexico.

In 2005, during a visit by colleagues from Boulder, Dr. Juan Manuel Ramirez asked Dr. Peter Dawson of Boulder for help with children with ADHD. At that time, all children with this diagnosis were referred to out-of-town expensive neurologists and medications were hard to get.

In 2007, Dr. Dawson, Dr. Patricia Carruth (psychologist) and Sonia Martinez (case manager) returned and trained our special-education staff and me in ADHD. Dr. Cesar Heredia (adult psychiatrist) joined us and I began working in the program attending children with ADHD. Initially, program activities focused on children who had been given a "probable ADHD" diagnosis made by their elementary school teachers that was followed with an evaluation by the school psychologist. The children were then sent to the Pediatrics Department of the Mante General Hospital where the information was integrated and the diagnosis was confirmed or refuted. The General Hospital serves the patients in Mante who have no insurance. Dr Ramirez, Dr. Cesar Heredia and I all work there. I also work in a private office. When parents can't afford to come to my office, I visit their homes, where I get to know them better.

Before the project, people in Mante didn't consider ADHD a priority, but it has become one. It was a big step forward when the pediatricians accepted that they didn't have to refer children with ADHD to neurologists.

Continued on Page 12

Improve the understanding of GOBI FFF ... Continued from Page 11

Before the project, we were aware of methylphenidate, but the pharmacies didn't carry it because the doctors didn't prescribe it and it wasn't covered by health insurance. We spoke to our state representative, Dr. Héctor López, himself a doctor, who was able to get methylphenidate into the formularies and it is now covered by all the health insurance programs in our state, Tamaulipas. Governmental health services in México cover many of the other children. However, some children have no coverage and parents must buy the medication. Many come from poor families with insufficient funds to purchase the drugs. With I-CATCH grant moneys we have been able to buy methylphenidate for ADHD children who otherwise would go without the medication they need.

The 15-20 children I see and the six or so seen by Dr. Heredia are monitored using an Excel spread sheet with information that includes the name of their school and the dose they are taking. Dr. Dawson has reviewed my spread sheet and has made suggestions about the use of stimulants. He thought we were doing a good job.

We frequently communicate with the schools and conduct meetings with local pediatricians, psychologists and teachers to explain ADHD and the objectives of the program. We have had meetings with parents in several of the public elementary schools to explain ADHD and its treatment and to answer their anxieties, especially concerns with medical treatment and abuse of medications. Dr. Elnora Mata, director of special education, Francis Gonzales de Ramirez, special-education supervisor, and Dr. Cesar Heredia have joined me in those talks.

The group in charge of the project includes Dr. Juan Manuel Ramirez, family physician; his wife, Francis Gonzales de Ramirez, a special-education supervisor in the schools; Dr. Cesar Heredia; and myself. We see each other around the community and the hospital, and meet every two or three months.

Glasses

Another aspect of the program is checking for visual acuity. Children from many schools in the area have been evaluated by an optometrist on referral from teachers for suspected visual deficiency. Free glasses are provided for the children who need them. Children can choose from 35 different models so we expect that they will wear them because they like them.

Summary

I think this project is going well and thank the I-CATCH program for its support. Because of this project, children with ADHD are no longer referred out of town to neurologists and health insurance now covers methylphenidate. The 40 children I have followed are much improved.



DR. CÉSAR HEREDIA, PSYCHIATRIST, IN A CONFERENCE ABOUT ADHD

Continued on Page 13



Beneficiaries of New Glasses: "I can see!!!"

Child Abuse in Pakistan

Shazia Masih was a twelve year old girl sent to work as a domestic help at the house of a lawyer, through an employment agent. Last week she was taken to a Government run hospital in coma, where she was found to have more than a dozen injuries over her body likely to be inflicted in the past few days. She died in the hospital due to infections in her body and blood (Septicemia). The parents of the child have accused the lawyer of having physically tortured the child to her death while the Lawyer claims that the girl was mentally unstable and had wounded herself. He had asked the parents to take the child home.

Whatever is the truth in the claims of either party, two facts cannot be denied. First that an underage domestic laborer was in that house sent with parental consent and second that this girl died due to extreme physical violence. This unfortunate incidence highlights on the one hand the hidden issue of children involved in domestic labour and the abuses they have to face and on the other hand the apathy on the part of the government and other agencies assigned the task of protecting the children of Pakistan.

Concerned citizens of Pakistan have taken up this issue at various levels and Pahchaan being a child protection organization feels it is its responsibility to respond appropriately and act proactively to press upon the government for effective legislation and implementation of laws against child labour and child abuse. In this regard it has prepared the following position paper to gather partners in its struggle for preventing Child Abuse and Neglect

Kind regards

Dr. Naeem Zafar
MBBS, DCH, DCHN, FCPS
President and Honorary Chief Executive, Pahchaan
(Protection and Help of Children Against Abuse and Neglect)



PAHCHAAN POSITION SUMMARY ON DOMESTIC CHILD LABORER SHAZIA ALLEGEDLY KILLED BY HER EMPLOYER IN LAHORE

PAHCHAAN (Protection And Help of Children Against Abuse and Neglect) is a registered non-profit organization based in Lahore, Pakistan. Our focus of work is child protection, especially with regard to the protection of rights of vulnerable children. Our key program streams include homeless children, abused children, child laborers, children affected by war and natural disasters, and other groups of children affected by punishment and neglect.

PAHCHAAN

PAHCHAAN has a qualified, credible, and experienced panel of experts as Advisors and governing body. Our body of work includes helping to set up the award winning first child protection unit of South Asia in Children's Hospital Lahore; Establishing the ONLY mobile kitchen for homeless kids in Pakistan; Developing need-based and localized training material for various service providers on child protection, including doctors, teachers, alternate care providers, and disaster managers; setting up child friendly spaces in Swabi and Buner for IDP children; and providing rescue and rehabilitation programs to street children of Lahore through drop in and child friendly spaces.

Pakistan has ratified the Convention on the Rights of the Child (CRC, 1989) and is legally and morally bound to bring all its laws in conformity with the Convention. However, even after 20 years, no cohesive implementation mechanisms are in place. The case of Shazia, who was allegedly tortured and killed by her employer – a lawyer – is a sordid depiction of the gap in the words we say and the deeds we do - or don't do. Whatever the future of the case turns out to be in terms of legal parlance, the death of Shazia should not be in vain. She was a face to the hundreds of thousands of children without hope, who toil at their workplaces and are abused and exploited, often hungry and sick, and never cared for or loved.

PAHCHAAN feels that the following duty bearers have failed in their duties which resulted in the circumstances leading to Shazia's death:

1. The State:

- a. Children Employment Act 1991 is silent on regulating Child Domestic Labour, Children in Agricultural sector and Children working from home. There has been no effort to include this large segment of children exploited by the employers
- b. National Policy and Plan of Action on Children, despite being approved three years ago has not been operationalized and no serious attempt has been made by the state to start its implementation
- c. The Child Protection Bill has been pending with the Government for the last 3-4 years. The fact that it has not yet been adopted reflects on how serious we are as a nation to protect our children
- d. The Child Protection and Welfare Bureau of Government of the Punjab, despite six years of its existence has yet to formulate its minimum standards for the care of street children by NGOs like PAHCHAAN, with the result that a safe night shelter is not provided to thousands of homeless children who are out on the streets by themselves. There is no rule through which NGOs who work for these children are protected.
- e. There is no separate legislation for crimes against children. The Children who are victims of Emotional, Physical, Sexual Abuse or Severe Neglect are not protected by any law and therefore even if the perpetrator is taken to the court it is extremely easy for him to avoid prosecution or force reconciliation by the poor parents.
- f. There is no regulation against parents/guardians using their children for labor in any form including all the hazardous forms



A street child of Lahore showing his cuts and bruises

2. The Employer:

According to the Employment of Children Act, it is illegal to employ a child under 14 years of age. Employing them out of sympathy for bettering their lot still makes it a crime!

3. The Employment agency:

It is illegal for individuals and organizations/agencies to deal in minors and put them to work.

4. The Parents:

It is the parent's duty NOT to use their children as a tool for income generation. The vicious cycle of poverty will not end till parents act responsibly and raise their kids to make them productive citizens instead of earning hands.

PAHCHAAN demands ZERO TOLERANCE AGAINST CHILD ABUSE! Attached please also find a few photographs of other children served by PAHCHAAN who came to us to seek help. The purpose of these photos is not to sensationalize the issue but to make all of us aware of its existence on a daily basis in our lives.

We request all of you – who are duty bearers in the media, education, policy, health and social sectors to make your voice count. In each of your circles, please create pressure on the Government to sign the Child Protection Bill so that further incidences of violence against children are minimized, reported, and taken to task.



7 years old abused girl reported to Pahchaan

You may send your suggestions/comments at info@pahchaan.org or pahchaan_org@yahoo.com or contact us at PAHCHAAN Main Office, House 9, Street 38, Canal Park, Gulberg 2, Lahore, Pakistan: +92-423-5762612; 5871221; 5711221

Health Volunteers Overseas- Pediatric Volunteers Needed!

HVO has opened a new pediatric training program in Managua, Nicaragua and is looking for volunteers! Participants with this program will work in two government-run hospitals in the capital city. The program will begin at Hospital Infantil Manuel Jesus Rivera (La Mascota), an exclusively pediatric hospital. La Mascota serves families from all over Nicaragua, some of whom travel 1-2 days for medical appointments. In the future, volunteers will also be placed at Hospital Fernando Velez Paiz.

Board certified physicians can serve for one month with shorter assignments considered for sub-specialists. Volunteers capable of providing training in the areas of neonatology, general pediatrics, pediatric burn management, and community outreach and public health are encouraged to apply. Gastroschesis, imperforate bowel and meningomyelocele are among the more prevalent ailments facing patients at La Mascota. Those with Spanish speaking abilities are especially well-suited for this assignment; however translators are available for those who do not speak Spanish.

Health Volunteers Overseas is a private non-profit organization dedicated to improving the availability and quality of health care in developing countries through the training and education of local health care providers. HVO designs and implements clinical education programs in child health, primary care, trauma and rehabilitation, essential surgical care, oral health, blood disorders and cancer, infectious disease, wound management and nursing education. In more than 25 resource-poor nations, volunteers train, mentor and provide critical professional support to health care providers who care for the neediest populations in the most difficult of circumstances.

If you are interested in pursuing a volunteer assignment in Nicaragua or with one of our other pediatric programs in St. Lucia or Uganda, please contact Anne MacAskill at a.macaskill@hvousa.org or call (202) 296-0928. Visit the HVO website at www.hvousa.org.

International Pediatric Association

“SIMUNYE” WE ARE ONE.

**Share your time and interests with international colleagues
AN EVENT OCCURRING ONLY ONCE EVERY THREE YEARS**

The 26th International Pediatric Association Congress of Pediatrics.

JOHANNESBURG,, SOUTH AFRICA

AUGUST 4-9, 2010

**cosponsored with South African Paediatric Association and the
African Paediatric Societies and Associations**

HUNDREDS OF TOPICS, WORKSHOPS AND SYMPOSIA

THE STATE OF GLOBAL CHILD HEALTH

DISASTERS AND TRAUMAS

ENVIRONMENTAL HEALTH

QUALITY OF CARE

CHILD HEALTH ADVOCACY

AND MUCH, MUCH MORE

For registration and information log on: <http://www.ipa-world.org/Pages/index.aspx>

New Members' Column

Ted Kaplan, MD
Altamonte Springs, Florida

NOTE: This article was written prior to the earthquake.

My name is Ted Kaplan. I am a pediatrician working in after hours urgent care in the Orlando area. I found renewed purpose as a pediatrician, and a human, in the beautiful, but struggling nation of Haiti.

I began in 2007 by traveling with my wife of, at that time, just a few months, to an isolated area in the center of the country. We went with a program developed by faculty from the University of Miami that I had been hearing about for many years, being an alumni and voluntary faculty member. My wife, an LPN, was born in Haiti, but had not been back there for 24 years. From the time of landing in Port-au-Prince, through the long bumpy ride to their compound, we were in shock at the destruction, desolation, and poverty at every turn.

Every day, doing mobile clinics working with medical students, we were inundated with never-treated conditions, most simple, a few complex, all taken to their extreme due to lack of access to any medical care except the few times a year that one of these teams is able to visit the area. Severely malnourished and growth-retarded children (and adults) were everywhere. As for fasciomas, I felt for the first time the squishy abdominal mass formed by intestinal worms. Most of all we were struck by the cheerfulness, humor, industriousness, and dignity of nearly every person we met and saw.

In addition to uncomfortable conditions and becoming very sick with vomiting, 103 fever, and diarrhea for about 24 hours, my mind began a constant search for the solution to an unsolvable puzzle with so many seemingly obvious solutions: what can we do to help these desperate people? At the same time, my heart became full with the beauty and fascinating depth of the country and people, and the massive feeling of satisfaction at being able to make a huge difference in the lives of people who lack EVERYTHING. (I'm talking no money, no source of income, no possessions, no education, no shoes, minimal donated rags of clothing, no toys or balls, no lights, no source of water, no electricity—all of the no's). We made plans to start coming back and learning more about this place.

We spent the rest of that year returning on part exploratory, part service trips in different regions of the country. We soon found that we had started at the bottom, in an area with the most uniform extreme poverty and the least infrastructure and attractions. In other regions, we discovered a number of the most beautiful and most peaceful spots that we had ever seen (yes, we have been to Hawaii). We discovered that many of the things, including many medications, which we thought we would have to bring with us in order to have, are available there, sometimes for a higher, sometimes for a lower cost than at home. The culture and society is amazing in how fascinatingly *different* it is, being so close to the US. But no matter how beautiful the scenery, no matter how profound the cultural traditions, there were still the majority of people in every region living in squalor and extreme poverty (statistics say 80% of the population). Taking advantage of the internet and email, we also discovered dozens of great organizations and their leaders doing great things in every corner of Haiti (there are more than 1000 NGOs working in Haiti). We met with and learned from many of these on our trips. Inevitably, each discovers that every community needs the complete suite of essentials (food, water, shelter, education, vocation, recreation) for which healthcare is just the tip of the iceberg. But woe be to those that really need medical care when there is none around and no money to pay for it . . .



The water's edge near Cap Haitien

Continued on Page 17

New Members' Column . . . Continued from Page 16

In 2008, we finally made it to Cap Haitien, in the north, about which we had heard much, good and bad. We were taken around by a couple key clergy contacts there that were involved in wide-ranging projects. We found Cap Haitien to be a good blend of the resources of the large city with more charm, less violence, and a much less overcrowded feel...and lots of desperately poor people not able to find or afford medical care. At first we had the impression that there were few aid organizations there, and that those giving it were not aware of each others' efforts. While we were wrong on the first score (there are at least 40-50 organizations that we now know well), we did find that there was a great need to connect the organizations to each other, as many were unaware of what, and just as importantly, *how* other groups were accomplishing various functions for their clientele.

An effort to improve communication and cooperation was undertaken, called the Cap Haitien Health Network. And it took off quickly, groups constantly being identified and gratefully joining in the effort transpiring mostly by email. Within a few months, a first live local meeting was held, which are now done 2-3 times a year, and the size of the group has mushroomed. A cooperative program was rapidly undertaken to supply some of the clinics that could not operate due to not being able to find or afford a physician. We were able to link them with underemployed Haitian physicians, and got them sponsored by NGOs that could never afford a full-time physician. The groups work together to find out how best to find and ship medications and supplies, share volunteer resources, find specialists for difficult cases, comply with governmental regulations and receive the benefits of government programs, and on and on. This networking and support project is something that I can continue to work on when I am home between visits to Haiti.

In addition to doing clinics and working with organizations through the Network in the north of the country, we also met a Haitian-American physician in our central Florida community who we work with to help provide medical care in the Haitien town he grew up in in the southwest of the country, and who provides us with the valuable perspective of one who was raised and educated in Haiti and came to and succeeded in the US.

I have started a website, called www.missionpediatrician.org, with information for pediatricians and other volunteers who would like to get involved to give them the benefit of some of the information that I have learned about going to and helping in Haiti. There are links to many of the groups that we know well that are eager for volunteers, as well as any financial and/or logistical support that an American pediatrician could provide. I am eager to bring any pediatricians that are interested on a trip with us to Haiti and/or help match them with groups that might best fit their interests and schedules. There is also a great need for subspecialists to support the few pediatricians and other generalists who gallantly provide care to children there with little resources and no subspecialists.

I look forward to learning about the experiences of others doing this kind of work in Haiti and around the world.

* * *

**International Adoption Medicine
Samantha L. Wilson, Ph.D.**

**Assistant Professor of Pediatrics, Medical College of Wisconsin
International Adoption Clinic, Child Development Center**

Jacob is a 37-month-old boy who enters your office for a well-child checkup. He is seemingly healthy without documented medical concerns. His father is primarily concerned about sleep onset/maintenance. As a pediatrician who has seen numerous families and developed myriad strategies to support sleep habits in young children, you have clear ideas of what Jacob's dad should do with regards to sleep.

Now, consider that Jacob was adopted two weeks ago from an orphanage in Romania...does that change your perspective or advice?

Continued on Page 18

New Members' Column . . . Continued from Page 17

It should.

During the course of 2010, over ten thousand children are likely to be adopted into US families from other countries. If current trends continue, those children will come predominantly from Russia, China, Guatemala, Ethiopia, and South Korea. Add these to the over 200,000 children adopted from overseas in the last 10 years and international children make up a sizable cohort within the pediatric community.

Children adopted internationally represent a diverse background of cultural experiences, risk exposure, and developmental trajectories. Specialized medical clinics have a pivotal role in supporting the optimal growth and resiliency of these children. As the psychologist within the International Adoption Clinic (IAC) at Children's Hospital of Wisconsin, I am part of an emerging group of health professionals who seek to understand the unique qualities of these children and provide specialized health care. The IAC utilizes an interdisciplinary team to assess and support children integrating into the US culture and adjusting to new families. Like many specialty clinics, it is intended to be an adjunct to primary care. While some of IAC practice is consistent with general pediatric care (e.g., discussions about medical concerns, development, and behavior), such conversations carry new meaning for a child with an undocumented (or unverified) medical history, unknown immunization status, and experience of disrupted relationships (at best) or possible neglect/abuse/trauma (at worst).

Like Jacob's father, many new parents in our clinic are concerned about disrupted sleep. Often well-intentioned advice of "let him cry it out" has been provided by other adults (at times, including the child's pediatrician). However, in the midst of the exceptional environmental change inherent in international adoption (especially from the child's perspective), such advice fails to take into account that children regulate their emotional distress in the context of relationships. In a newly formed family, such relationships are emerging and isolating a distressed child is counter-productive. As a psychologist trained in early childhood mental health, I work with families to understand their child's cues, with consideration of his/her unique background, experiences, and stage of development. This informs my understanding of sleep issues and other parental concerns about growth, behavior regulation, and adjustment.

Children adopted internationally teach us about resiliency and risk; their experiences should shape efforts to develop international child welfare approaches that promote optimal development and healthy relationships. International Child Health has worked to augment worldwide vaccination rates and reduce child morbidity/mortality from disease, diarrhea, and malnutrition. As we focus on children's physical needs, we should remember that physical health is inextricably linked to emotional safety and connectedness....never is this more critical than during childhood. I look forward to bringing this early childhood mental health framework to discussions within the Section of International Child Health and welcome the opportunity to know others who serve children throughout the world.

For a list of providers who specialize in adoption, please visit the AAP's Section on Adoption and Foster Care: <http://www.aap.org/sections/adoption/SOAFCAAdoptionDirectory2.pdf>.

I-CATCH

Please alert your colleagues working in the "developing" world to apply for funds to help implement their creative ideas to improve the health and well-being of children and families in their communities.

June 1st is the deadline for preliminary submission of proposals.

August 16th is the deadline for final submission of proposals.

Pediatric Hero: Scott J. Cohen, MD, FAAP He belongs to us.

Editor's Note: Your Newsletter is proud. Scott Cohen, a Co-editor of the Abstract issues was one among four pediatricians chosen from the thousands of pediatricians in the U.S. as a national "Pediatric Hero". He exemplifies what many of you do in your international work and what **can** be done when one is passionate about an issue. Scott acted. "I strongly believe that every child born into this world should have the right to a high standard of health care, access to clean air and water, a well-balanced diet, unconditional love, and an environment free of violence," writes Scott. "As a pediatrician, it is my passion and responsibility to help children achieve these basic rights."

In 2002, he took the energy generated by his passion and the Global Pediatric Alliance was born. This NGO currently has community-based programs in Ecuador, Guatemala, and Mexico directed at fundamental problems that impact not just the health but the well-being of children in impoverished areas of those Latin American countries. The programs bring potable water to individual households and construct ecological toilets. Scott understands that oral rehydration salts are the treatment of diarrhea but the solution is clean water and adequate sanitation. Education is also high on his agenda as shown by the creation of "Grass root education scholarships". He emphasizes empowering women and teaches them and the health promoters how to better care for their children. Training of indigenous midwives is a large part of their work insuring that the mothers labor under watchful eyes, are skillfully delivered, are referred if necessary and that their newborns enter this world with a strong start. Scott and his team work with the community, listen to what the community sees as their most important needs, and then assists them in developing low-cost sustainable solutions without creating dependence. Then off to the next village.

Scott is a full-time pediatrician at Kaiser Permanente in San Rafael, California. He is an exemplary example of what one person can do when the passion is followed by action. Our Section has others who are also very deeply involved in international child health work and still many others who are just waiting for the right time and the right place. Scott asked: Why wait? Now is the time to follow your passion!! www.globalpediatricalliance.org.



International Child Health Network

Don't Put It Off an Other Page!

REGISTER NOW!

It's Easy Just Click On:

www.ichn.org

The More Who Join The Better It Will Be



Immunizations and Infections

By Nick Cunningham, MD

Infectious diseases have an exaggerated importance wherever, as in lesser developed areas, malnutrition, especially among children, is highly prevalent. In the US, 0-5 children rarely die or become permanently maimed by, for example, measles, pertussis or gastroenteritis. There are many reasons for this, but it's mainly because the children are almost all well nourished. By contrast, in Ethiopia, according to M.O.H. statistics, two thirds of all 0-5 children are significantly malnourished, 1/6 severely so. The latter will almost certainly die within months, while the former, though less at risk, by being far more numerous, contribute to the largest population group in that country to die every year. Almost all die of infection.

Primary care services must therefore provide for all 0-5s, both growth monitoring, including nutritional services for all those below 80% of standard weight for age (see our review in the last issue), but also, in an integrated fashion, basic immunizations to supplement and then supplant, what the mother offers trans-placentally and then via breast feeding.

Thus the first round of immunizations, provided in theory for all neonates in the form of transplacental and breast milk antibodies during pregnancy and lactation, give the infant relative immunity from a variety of infections for the first 4-6 months of life. Measles, the big killer is therefore uncommon in the first months. Equally important is tetanus neonatorum against which the infant can be passively protected if the mother has herself survived tetanus, or if as a young woman she received at least two tetanus shots. Since this fact remains usually unknown, tetanus immunization for young women, either before or during pregnancy, is considered a vital aspect of the WHO/UNICEF Expanded Program of Immunization (EPI).

The other vaccine given at or shortly after birth is BCG, the efficacy of which (being a difficult-to-standardize biological product) has been hard to quantify, but which is still considered to offer some protection against both tuberculosis and leprosy, especially in areas of high prevalence of those diseases. (In the US we also downplay its importance either because we see it as obscuring the results of our skin test screening, or because it was developed long ago by Frenchmen!)

Following the successful worldwide eradication of smallpox in 1978, there remain six major diseases against which WHO and UNICEF recommend immunization for children in developing countries: tuberculosis, diphtheria, pertussis and tetanus (DPT), poliomyelitis, and measles. The recommended schedule, after neonatal BCG, begins with three shots of DPT at bi-monthly intervals, starting at about 2 months of age, a series of three doses of polyvalent live polio, and an initial dose of measles vaccine (usually without mumps or rubella to save money), given at 8-9 months, to be repeated at 14-15 months. The first dose of measles vaccine is given early because infants in much of the developing world are carried all over by their (usually breastfeeding) mothers, starting right after birth and are thereby widely exposed at an early age. Close living conditions also make for earlier and more intense exposure, with secondary cases usually faring worse than primary.

Obviously, many other protective vaccines are in use in the "North" developed countries, but these are not yet being recommended for universal use in the "South" or less developed areas, either because of high cost (despite great need) as in the case of rotavirus, hepatitis or pneumonia, or because of (on a relative mortality basis) lower priority, e.g. rubella and mumps, or for both reasons, as with H.P.V.

What makes immunizations so crucial worldwide is the widespread exposure to infections and infestations secondary to inadequate water supplies, lack of sanitary waste disposal, overcrowding and, as mentioned above, hugely higher rates of malnutrition early in life. Especially important is the synergism between malnutrition and recurrent or severe infection. This synergism, whereby malnutrition reduces the infant and young child immune responses, and infection, whether severe as in the case of measles or recurrent as with diarrhea, leads (together with weaning problems) to malnutrition accounts for the excess mortality in children aged 0-5.

But infectious processes do not occur in a vacuum. The environment has a great deal to do with the prevalence, severity, duration, and eventual survival vs. mortality from infections of all types. It also impacts importantly on the viability of any vaccine delivery system.

Continued on Page 21

Immunizations and Infections *Continued from Page 20*

For a specific vaccine to be effective, it must be of known efficacy and safety, and be administered in an active form to an individual healthy enough to produce antibodies sufficient to provide protection. Many immunization campaign considerations concern the logistics and management required to deliver an active and effective vaccine in a location where susceptible individuals can be given the vaccine safely. Vaccines are usually manufactured in a distant location and to provide broad population coverage, must be delivered to outlying areas for administration, but, being heat sensitive, depend on being maintained at the correct temperature so as to be active at the time of administration.

This demands the creation and maintenance of a secure “cold chain” storage system, with indicators accompanying all vaccines to ensure their viability. Because of bad roads, rising waters, excess heat, decrepit vehicles and canoes, widespread corruption and variable electricity, the transit from refrigerated central supply and peripheral delivery sites can be long and fraught! And the temptation to administer ineffective immunizations to people who’ve traveled miles and now demand their “shots” can be overwhelming!

In addition, as indicated above, to achieve protective levels of immunity, some vaccines must be given twice or three times at specific intervals. This booster requirement creates huge difficulties and entails the maintenance of accurate records which is problematic even in the “North”, despite our high literacy, advanced electronics and immunization registries! Record keeping is a problem everywhere but especially when in the hands of rural dispensaries or mobile units manned by less trained or poorly supervised health workers serving semiliterate mothers who either may be suspicious of modern medicine – as in the case of the great Kano, (Nigeria) scare that polio immunizations create sterility - or equate all “shots” with magic properties.

Overemphasis on provider productivity or incentives to increase population compliance can lead to over immunization, which, when feeding into an evaluation scheme based on shots delivered, divided by target population served, may greatly exaggerate coverage estimates. I observed this phenomenon in Mali, where the population, sensitized by a long history of meningitis epidemics and emergency mass immunization campaigns, and ignorant of the concept of “completion” of a vaccination series, would deny that their children had been vaccinated in order to get the magic shot for which they’d been rounded up and came long distances to get! A local doctor called my attention to this phenomenon, but the EPI campaign team didn’t want to hear about it!

Home based records based on David Morley’s Under Fives Clinic “Road to Health” cards can resolve many of these problems. Such records, kept by the mothers and brought with the child for all contacts with health care providers whether for curative or preventive care, if filled out and kept up to date, provide accurate information about all aspects of the child’s health from weight gain and weaning to immunization status. They encourage parent participation in their children’s health care and promote questions and interactions which inform both providers and family. They can also be used to promote and integrate immunizations with other service components like ORT, child spacing, basic accident prevention and wound care. Studies have demonstrated that mothers like them and rarely lose them (especially when compared to the huge retrieval problems of most clinics). This is particularly true for highly mobile pastoral groups and whenever populations are uprooted by civil unrest or war, since such family owned records are available for all contacts at the variety of health facilities to which mobile populations take their children. Finally, since the records are kept at home, they provide a target population based source of data for program evaluation, whether gathered by census or by surveys based on household sampling. Immunization coverage estimates based on such samples are likely to be far more realistic than estimates by other methods, based on numerator data.

Two important measures that serve to protect individuals of all ages from various infections are the development of a safe and copious water supply and a system of sanitary waste disposal. These two related environmental systems are often taken for granted by those living in developed countries, but their lack in both rural and peri-urban shanty towns is a major factor in the transmission of various infections and infestations, usually coincident with the weaning process. For many of these like cholera and typhoid, effective vaccines have yet to be developed. Living in crowded and often smoky conditions is another environmental factor that promotes a high prevalence of respiratory diseases, both of the upper and lower respiratory tract. The highest risk groups are infants and young children, the elderly and all those who are malnourished.

Continued on Page 22

Immunizations and Infections *Continued from Page 21*

Poverty, war, natural disasters and population displacement also play major roles in infectious disease incidence, and on preventive immunization efforts. Immunization programs work best in these situations, when started early on, focused on infants and pregnant women, integrated into broad primary health care programs, and combined with improved nutrition, safe water, sanitary waste disposal, and uncrowded hygienic living space.

On a global scale, dedicated vertical programs such as the smallpox eradication program can be effective when organized on a worldwide basis so as to eradicate a susceptible targeted disease. While this particular vaccination campaign was a success, because it was uniquely susceptible, (e.g. widely prevalent, easily identifiable, no animal hosts, an excellent vaccine, dangerous, and enjoying world wide support), it may or may not provide much of a template for how to address other infections. Nonetheless, this focused approach is now being employed to attack polio, already eliminated from the Americas. The costs are high, the rewards limited (at least in terms of 0-5 mortality reduction) and many experienced workers like Carl Taylor view this campaign as diversionary from the long range goal of integrating immunizations into long term sustainable primary care strategies. Nevertheless, they can prevent serious widespread suffering from particular conditions like guinea worm and onchocerciasis (river blindness) at quite reasonable cost.

A more generic argument against indiscriminate “top-down” focused immunization campaigns was made a few years ago by my friend and eminent colleague, the late Professor Olikoye Ransome Kuti. Having worked for years as a salaried academic paediatrician, never entered into private practice, and then spent 7 years as Nigerian Minister of Health, he needed a bit of money for his retirement and spent several years with the World Bank in Washington, D.C. After returning to Nigeria and retiring to a new house, I called him up to see how things were going. He said “badly!” I asked him to explain, and he said, “You know how I like to get up early every morning and walk to the bakery for fresh bread?” I said “Yes”, knowing that that was his habit. He then said, “Well, I can’t do it anymore!” “Why not?” “Well, the streets are unsafe; there are all these EPI boys, and they’ll attack you and take everything you have!” I asked, “What do you mean, EPI boys?” He said, “Well, you know that WHO Expanded Programme in Immunizations? Without any comparable child spacing efforts, it’s now created a glut of young men, for whom we have neither education nor jobs. Without hope, they roam the streets making life miserable for all of us!” It is my view that just going and doing something because we know how and it saves lives, without considering the larger question of its impact on a society quite different from our own, and lacking the resources to deal with such rapid change, is immoral! (cf *The Immorality of Excellence*, by my mentor, Dr Robert Wright, or the critiques of Maurice King concerning “demographic entrapment”!).

Current research into new vaccines against malaria, HIV and other dangerous viruses and infection related cancers offers hope, but is considered highly challenging and is so far under funded. Meanwhile existing vaccines effective against Hepatitis A and B and rotavirus, considered routine in the “North”, could and must be made available in the “South”.

On a broader societal scale, prevention efforts focus on interrupting transmission by a variety of containment measures, e.g.:

- health education, condoms and preventive antiviral therapy against HIV, especially mother to child transmission,
- proper sterilization of contaminated needles and syringes in the case of HIV and hepatitis,
- discouraging mosquitoes by attacking their breeding sites and use of impregnated bed nets – against malaria, yellow fever, dengue and hemorrhagic fevers, and
- Women’s education and economic support to facilitate all of the above!

Suggested readings:

Morley pages 272-283

Wallace pages 482-

Cuts J. Trop, Peds 37(4) 153, 1991.

Current state of Pediatrics in Iraq and the impact of the wars

By Professor Aamir Jalal Al Mosawi

Head of the department of pediatrics
University Hospital in Al Kadhimiya, Baghdad, Iraq

Advisor doctor, Iraqi Ministry of Health

E-mail: almosawiAJ@yahoo.com

Iraq is a country abundant in resources that has suffered unbelievable loss, destruction and misallocation of resources as a result of poor governance and successive wars followed by a long period of violence and loss of security. Iraq has become an economically disadvantaged country. Only a small fraction of the national product has been made available for health care for decades. Children have been ravaged by successive wars.¹

Iraq lies between Turkey on the north, Iran on the east, Kuwait on the south, and Saudi Arabia, Jordan, and Syria on the west with a land mass of 435052 Km.² Iraq is divided into eighteen governorates (or provinces) and in 2006 had a population estimated to be 28,506,000. The population has more than doubled during the last 25 years. In 2007, 67% of the population was living in urban regions.¹

Serious deterioration in the quality in both general medicine and pediatric is the end-result of complex and multiple factors that began with deleterious impact from several years of dictatorship, socio-economic disruption of successive wars, and to the serious repercussions from a gradual deterioration in medical education.^{1,2} (Figures 1 and 2)

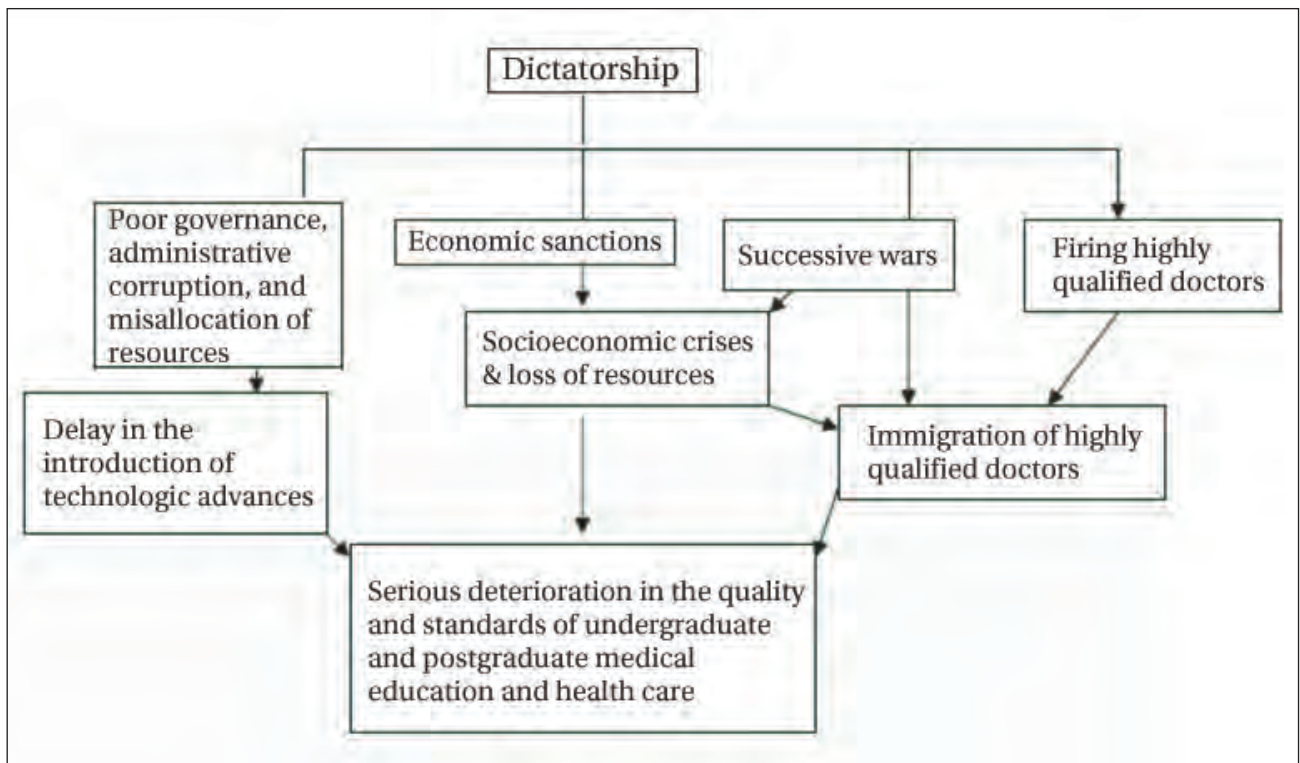


Figure 1: The impact of dictatorship and poor governance on the quality and standards of medical education and health care.

Continued on Page 24

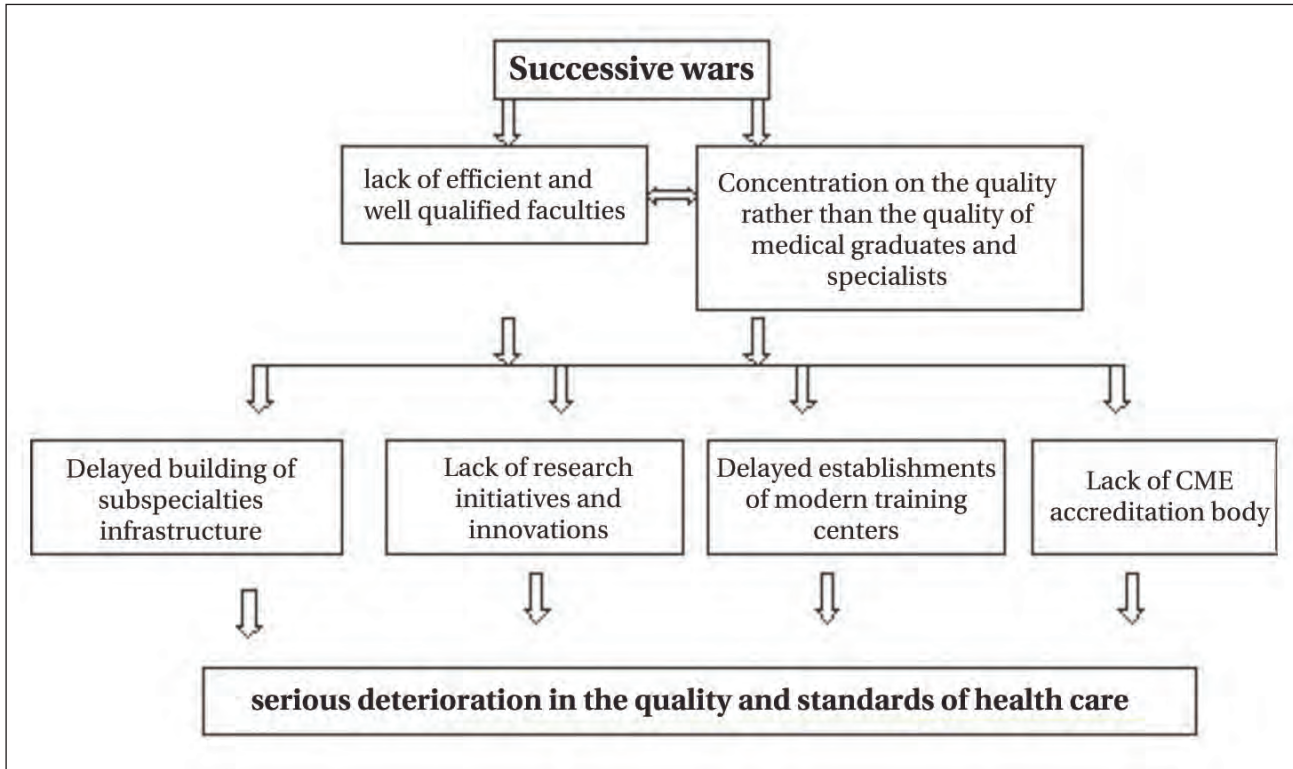


Figure 2: The impact of successive wars on the quality of health care in general.

There have been successive large-scale waves of migration from Iraq that included qualified and academic doctors that began early in the regime of Saddam and have continued. Although some expatriates returned to Iraq after the 2003 invasion, the flow had virtually stopped by 2006. In addition to approximately 2 million Iraqis who fled to neighboring countries, the Internal Displacement Monitoring Centre estimates the number of people currently displaced within the country at 1.9 million.

Impacts of wars on the practice of pediatrics and pediatric health care in Iraq

One of the most important impacts of successive wars is the lack of efficient and well qualified faculties' necessary to educate, train and graduate physicians in all specialties. For decades successive governments were concentrating on the quantity rather than the quality of medical graduates and specialists. This has led to serious deterioration in the quality and standards of health care in general and pediatric health care in particular. Primary ambulatory health care probably remained better than inpatient health care as primary health services generally require less qualified personnel for its provision. However, inappropriate treatment has been observed even in outpatient health care and in many circumstances have been attributed to deteriorated standards of medical education, pediatric education and training. Table -1 show the most common examples of inappropriate treatment in pediatric health care.

Table 1: The most common examples of “inappropriate treatment” in pediatric health care
• Treatment of gastroenteritis with nystatin because of monilia in the stool
• Treatment of non-febrile gastroenteritis with gentamicin
• Treatment of infantile gastroenteritis with antispasmodics rather than oral rehydration solution
• Treatment of neonatal colic with antihistamines resulting in exacerbation of the symptoms and constipation
• Treatment of upper respiratory tract infections with antibiotics

Continued on Page 25

Childhood morbidity, mortality and chronic disorders

During the years 2004 and 2005, the most common cause of hospitalization for patients over 5 years of age was accidents; 282770 accidents were registered from all Iraqi Provinces in 2005 and 111 cases of sexual assaults. A Road traffic accident was the single most common type of accidents accounting for 25.75% of all registered cases of accidents. During the years 2004 and 2005 the most common cause of hospitalization for patients under 5 years of age was gastroenteritis; 897,441 cases of diarrheal illnesses were registered from all Iraqi provinces in 2004 and 935,919 in 2005. During these two years the second most common cause of hospitalization was lower respiratory tract infections and disorders associated with bronchospasm including bronchial asthma. In 2004, the most common causes of death in patients under 5 years of age in order of frequency were: idiopathic respiratory distress syndrome, septicemia, accidents, pneumonia, prematurity, congenital abnormalities, malnutrition, chronic renal failure, and diarrheal illnesses. In 2005, the most common causes of death in patients under 5 years of age in order of frequency were: septicemia, pneumonia, congenital abnormalities, diarrheal illnesses, prematurity, accidents, neonatal hyperbilirubinemia, idiopathic respiratory distress syndrome, and meningitis.¹

Reference:

1. Hasnawi SM, Al khuzai A, Al Mosawi AJ. Iraq health care system: An overview. *The New Iraqi Journal of Medicine* 2009; 5 (3): 5- 13
2. Al Mosawi AJ. Medical Education and the Physician Workforce of Iraq .*Journal of Continuing Education in the Health Professions* 2008; Spring;28(2):103-5.

International Child Health Network

This is the Last Page

No Reason to Put it Off Any Longer.

REGISTER NOW!

It's Easy

Just Click On:

www.ichn.org

***The More Who Join
The Better It Will Be***



Section on International Child Health

Executive Committee

Cliff Michael O'Callahan, MD, PhD, FAAP
Chairperson
Middletown, CT
cocallahan@midhosp.org

Bronwen J. Anders, MD, FAAP
Executive Committee Member
Lakeside, CA
banders@ucsd.edu

Caroline K. Dueger, MD, MPH, FAAP
Executive Committee Liaison
Concord, NH
cdueger@pol.net

Anna Maria Mandalakas, MD, FAAP
Executive Committee Member
Kirtland, OH
anna.mandalakas@case.edu

Elizabeth Montgomery, MD, FAAP
Executive Committee Member
Program Co-Chairperson
Houston, TX
elizmont@yahoo.com

Luisa Roy Oriol, MD
Executive Committee Member
Port-au-Prince
Haiti
luisaoriol@yahoo.com

Jonathan Michael Spector, MD, MPH, FAAP
Executive Committee Member
Program Co-Chairperson
Cambridge, MA
jmspector@aap.net

Donna Marie Staton, MD, MPH, FAAP
Immediate Past Chairperson
Weston, MA
dstaton@massmed.org

Marlene Sally Goodfriend, MD, FAAP
Membership Chairperson
Jacksonville, FL
marlenegood@hotmail.com

Ann T. Behrman, MD, FAAP
Nominations Committee Chairperson
Madison, WI
atbehrma@wisc.edu

Mirzada Pasic Kurbasic, MD, FAAP
AAP Liaison
Louisville, KY
mirzada.kurbasic@louisville.edu

Elizabeth Hillman, MD, FAAP
Nominations Committee Member
Manotick, ON, Canada
hillmane@iname.com

Monica Arango, MD, FAAP
Section on Residents Liaison
Kansas City, MO
marango@kumc.edu

Deepak Kamat, MD, FAAP
Nominations Committee Member
Northville, MI
dkamat@dmc.org

Jane G Schaller, MD, FAAP
International Pediatric Association Liaison
Vancouver, BC Canada
jschaller@cw.bc.ca

Laura Sauve, MD, FAAP
Canadian Pediatric Society Liaison
Halifax, NS, Canada
LSAUVE@gmail.com

Karl Neumann, MD, FAAP
Newsletter Co-Editor
Forest Hill, NY
travhealth@aol.com

Burris R Duncan, MD, FAAP
Newsletter Co-Editor
Tucson, AZ
bduncan@peds.arizona.edu

Scott J Cohen, MD, FAAP
Newsletter Co-Editor
Oakland, CA
scott@globalpediatricalliance.org

Spencer Li, MPA
Director, Office of International Affairs
American Academy of Pediatrics
sli@aap.org

Alejandra Lule, MM
Manager, Office of International Affairs
American Academy of Pediatrics
alule@aap.org

Mark A. Krajecki
Pre-Press Production Specialist
American Academy of Pediatrics
mkrajecki@aap.org

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