

Section on Global Health (SOGH) Newsletter

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Section on Global Health

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A Note from AAP Leadership



By: Janna Patterson, MD, MPH, FAAP

Senior Vice President, Global Child Health and Life Support, AAP

I am pleased to introduce Dr. Maimunat (may MOON uh) Alex-Adeomi MBBS, MBA, our recent hire on the Global Child Health and Life Support Team as the Director of Global Training and Implementation.

In this new role, she oversees the global newborn health and training programs portfolio at the American Academy of Pediatrics (AAP) including the manager (Naji Hattar) of the Section on Global Health.

Maimunat is a primary care physician and health systems expert whose journey in global health began several years ago while working as the only physician serving a population of about 45,000 people in a small town in the south-western part of Nigeria. She shared this story: “I was called to the health center around 3am to attend to a woman who had just given birth but had a retained placenta. Getting to the center, everywhere was dark except for the delivery room where a midwife and her assistant had just taken delivery of the baby with a lantern as the only source of light. There was no ambulance to transport the patient to the next level of health care and the relatives did not have a means of transport either. With no electricity, blood bank or a functional theatre, I was handed non-surgical gloves and a tray with limited instruments to manage the situation...” She shared additional details from her experience in this [LinkedIn article](#).



Dr. Maimunat Alex-Adeomi, MBBS, MBA

According to the Constitution of the World Health Organization, “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition”. This has shaped Dr. Alex-Adeomi’s ethos, and she has dedicated her career to designing and implementing novel and fit-for-context service delivery, management, and workforce training programs focused on healthcare needs in resource limited settings. She works closely with

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local partners, technical experts, and network contacts to advance specific organizational objectives and deliver positive impact for people and health systems.

Maimunat is eager to leverage her 15 plus years of experience in medicine and global health with organizations such as Operation Smile Inc.,

Sanford World Clinics Ghana, Afrikids Ghana and Partners in Health, to support the mission of the American Academy of Pediatrics, to attain optimal physical, mental, and social health and well-being for ALL infants, children, adolescents, and young adults.

Wealth of Opportunities to Help



By: Karen Skjei, MD

Much attention this past year has been justly focused on disparities in health, safety and other rights and resources here in the U.S. While these inequities must be addressed, it is important to remember that even greater inequities exist between high income and middle and low-income countries. These disparities are wide reaching, touching nearly every aspect of life from educational opportunities to human rights and the ability to raise a safe and healthy family. While the enormity of the problem can be overwhelming, these disparities provide us with a wealth of opportunities to get involved and make a difference in people's lives, and to grow as human beings in the process. Global work can take many forms – from volunteering at an international clinic to speaking in local medical conferences to helping erect a schoolhouse or potable water aqueduct. Consider turning your yearly vacation from a personal get-away into something that contributes. Or better yet, find a way to combine them!

If obligations at home prevent you from traveling, consider collaborating with an international academic medical institution to exchange experience and expertise, or hosting an international traveler at your house or institution. Simply donating money to reputable organizations that have the capability to impact lives, like Medecins Sans Frontieres (Doctors without Borders) can affect change. If you are not sure where to start, educate and inspire yourself by watching documentaries that reveal life as it is beyond our bubble of air conditioning, clean water and free Wi-Fi.

The magnitude of injustices can be intimidating, but don't let them prevent you from taking action. I challenge each of you to find a way to positively touch one person or family's life from other locations around the globe. I think you will find, as I have, that you will get back much more than you give.

Pediatric Emergency Care in Ecuador – A Couple of Vignettes

By: Monica Larson, Case Western Reserve University School of Medicine, Medical Student

On embracing our role as trusted care providers:

I was walking down a main street in Quito, Ecuador with the four others who were interning with me in a pediatric ER. We were coming home from work after a long, emotionally stressful day and were still dressed in our hospital scrubs. Suddenly, I heard a desperate cry for help, “Doctoras, doctoras, ayuda por favor”. I looked towards the voice and saw a small crowd of people gathered around a man lying on the ground, unconscious and without a pulse. We were visitors in this city, pre-medical students trained only in CPR, and not so well versed in Spanish that we could comprehend everything being said in that stressful situation, but no matter how out of place we felt, our responsibility as healthcare providers transcended our discomforts and insecurities and so we stopped and did what we could. Even now, I find myself remembering that moment and mentally preparing to apply my skills should I be called unexpectedly into action again, whether at home or abroad. Now, as a third year medical student, with immeasurably more medical knowledge and a few more skills, I am even more aware of the confidence and preparedness needed to respond to medical emergencies.



Monica Larson in Ecuador

On the universal expression of sorrow:

It was the most silent and challenging twenty minutes since I began my internship at the pediatric ER in Quito, Ecuador. I watched the EEG as it frantically traced our patient's brain waves. He was an eleven-year-old boy who had been admitted with multiple seizures the day before and had been in critical condition since then. Although as a pre-medical student I could not understand the machine's reading, when I looked at the paramedic next to me holding back tears and observed the somber look on the technician's face, I realized the prognosis was

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not hopeful. We sat there in solemn silence and I thought about the boy's father waiting just outside, whose son might never wake up. While the EEG continued to record, I began to process the tragic cases of child abuse, infant death, rape, severe infection, and trauma I had seen during my time at Baca Ortiz. Even now, as a medical student, I think back on that moment as the first time I was had to sit with the heaviness of a medical career, and think of all the tragic moments I have participated in since then. During that sum-

mer internship in Ecuador, I had the opportunity to observe, reflect, and be changed by what I saw. When I return after medical school, I look forward to working with the medical team and have the privilege to prevent, intervene in, and treat patients like him.

An Update from the Department of Federal Advocacy



By: Mandy Slutsker, MPH; Director, Global Child Health Advocacy, AAP

Following the passage of the Global Child Thrive Act on January 1, 2021, the AAP received grants from the Bainum Family Foundation and Children's Policy and Funding Initiative to focus on successful implementation of the law. With support from these foundations, the AAP created a new role of Global Child Health Policy Assistant and hired Elisabeth Piper for this role.

Elisabeth has previous experience working as a Coordinator for Federal Advocacy at the AAP and is using her skills to help guide the AAP's engagement with Congress and USAID around implementation of the Global Child Thrive Act, which directs USAID to integrate early childhood development (ECD) interventions into current foreign assistance programs. The AAP's advocacy on ECD is done primarily through its leadership role on the Thrive Coalition, a community of 42 organizations dedicated to building U.S. government support for global ECD. The Thrive Coalition, under the AAP's leadership, has urged the creation of implementation guidance by USAID and continues to work closely with the bill's lead sponsors, including coordination around a House Foreign Affairs subcommittee oversight hearing on July 27 on implementation of the law.



Elisabeth Piper,
Global Child Health
Policy Assistant

In addition to advocacy around implementation of the Global Child Thrive Act, the AAP continues to be heavily involved in the annual appropriations process, advocating for increases in United States foreign assistance funding for maternal and child health, nutrition, vulnerable children, and childhood immunization programs. Additionally, the AAP endorsed two additional pieces of global child health legislation – the Reach Every Mother and Child Act and the Support UNFPA Funding Act. The Reach Every Mother and Child Act, which was introduced in the Senate in April, would enact key reforms that would maximize the effectiveness and impact of USAID's investments in maternal and child health, including requiring USAID to have a coordinated U.S. government strategy on ending preventable maternal and child deaths. The Support UNFPA Funding Act, which was introduced in the House in June, would authorize the U.S. government to appropriate funds for UNFPA regardless of which political party is in power, directing funding for programs that aim to end preventable maternal deaths, end the unmet need for contraceptives,

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end gender-based violence, end harmful practices including child marriage and female genital mutilation, and deliver health care and protective services in humanitarian settings. Representative Chrissy Houlahan, the lead sponsor of the bill, included a quote from the AAP's President Dr. Lee Beers in the press release about the Sup-

port UNPFA Funding Act.

To learn more about global child health happenings in Federal Advocacy, join the SOGH webinar coming soon!

Founding a Novel Pediatric Eating Disorders Program in the State of Qatar



Madeeha Kamal, Alanoud Al-Ansaria, Schahla Al-Shiblib, Marian Adanb, Aisha Al Naamaa, Athba Al Safib, Dionne Searsa, Nehal Kamundara, Alyaa Al Dosaria , Malissa Alia

a Sidra Medicine, b Hamad Medical Corporation

Eating disorders are complex illnesses that affect adolescents with increasing frequency and have the highest rate of mortality within mental illness. They rank as the third most common chronic illness in adolescent females, with an incidence of up to 5%. Physically, no organ system is spared the effects of eating disorders (Canadian Paediatric Society Clinical Practice Guideline)

Background

The goal of the program was to establish a comprehensive dedicated service for adolescents with an eating disorder which was multidisciplinary in approach, targeted at the specific needs of this client group and in line with international best practices. Adolescent Medicine is currently the only service dedicated to treating eating disorders in Qatar between the ages of 10-18 years old. The program was also established due to a response to the increasing population of children and in particular those within the

15-17 year old age bracket, where the population in Qatar is set to grow by 22% between 2014 and 2030 (HMC Strategic Planning Dept.). The types of eating disorders treated by Adolescent Medicine include: Anorexia Nervosa, Bulimia Nervosa, Avoidant/ Restrictive Food Intake Disorder, and other Specified Feeding or Eating Disorders.

Objectives

1. To establish a multidisciplinary eating disorders program in the State of Qatar to diagnose and treat those with an eating disorder
2. Increase awareness among physicians and nurses about the existence of eating disorders within our population by establishing a teaching program (Family physicians, Pediatric residents, fellows, medical students and nursing staff)
3. Creation of a 'one stop shop' to provide accessible and affordable care

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Method

The program consists of an Outpatient and Inpatient service. The multidisciplinary team consists of consultant pediatricians, a psychologist, social worker, nurse and a dietician. Once referred, patients are screened via phone triage and attend the clinic within the week.

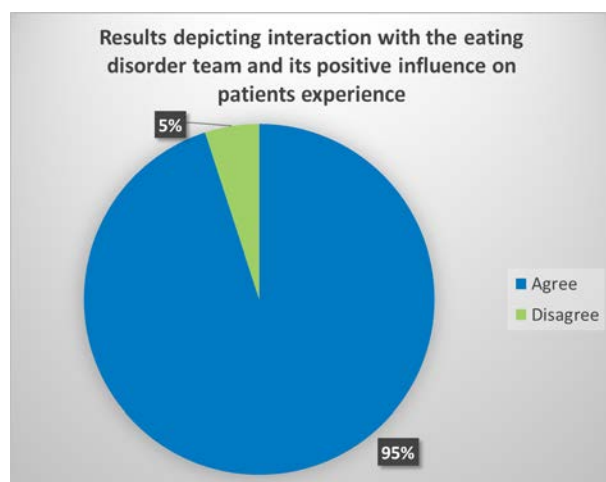
Patients are seen weekly initially until they are medically stable, unless they need an admission. Patients rotate through the clinic and see all professions on the same day.

Patients were asked to fill out a patient satisfaction survey after attending regular appointments with the service. The survey measured care quality and gave an insight into effectiveness of care within an outpatient and an inpatient setting.

Conclusion

This is the first eating disorder service in the State of Qatar with successful patient outcomes and positive patient feedback. Due to the increasing demands, the service aims to expand awareness and intervention across multiple sites.

Service statistics	%
Female patients	95
Male patients	5
Diagnosis: Anorexia Nervosa	80
Diagnosis: Bulimia Nervosa	20
Inpatient admission rate	50
Inpatient readmission rate	7
Patients on SSRI/Antipsychotics	30



Results as shown in the table and chart above.

UP TO SPEED WITH ICATCH:

Preventing burn injuries among young children in Mongolia's Ger Districts

By: Manuel Vides-Rosales, MD, MS

ICATCH Communication & Outreach Working Group

Director Ms. Tungalag Namsrai, Co-Director Dr. Galbadrakh Erdenetsetseg, with the lead social worker Ariunbolor Davaatsogt have been working on this outstanding project since 2018, entitled "Preventing burn injuries among young children in Mongolia Ger district". Their goal has been to train social workers and health care workers on burn prevention and treatment in order to improve healthcare support for Ulaanbaatar's most vulnerable families in Mongolia. More than 60% of Ulaanbaatar's residents live in "gers" or yurts, traditional nomadic herding style housing, with limited water and sanitation, facing daily important public health problems. According to the Mongolian National Trauma Orthopedic Research Center (NTORC) databases, in 2018, 8 out of 10 pediatric deaths in patients under 5 years of age were related to burn accidents. A prior analysis of the pediatric burn victims being assisted in the Burn Injury Department of the NTORC estimated that 66% of the patients suffered their injury around the cooking area in their household and due to scarce health services



"Gers" or yurts, traditional nomadic herding style housing in Mongolia

and education, initial emergency treatment of burns involved the use of home remedies that negatively impacted the patient's outcome.

The project's objective involved training social workers and health care workers in burn prevention and basic treatment. This training will be shared with their colleagues and within the community with the goals of teaching appropriate preventive actions, emergency treatment

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and recognition of the severity of burns and prompt referral of cases that require NTORC intervention.

The goal of this project also moves beyond the initial care of injured children and empowers social workers and health care workers as key resources for families and translates the impact of their work into improved psychological, social, and cognitive outcomes for burn children and families.

This project, now in the final months of its third year, has achieved the development of a training manual for social workers and health care workers, the distribution of information sheets among parents in the community, and the display of education material in public buildings, public areas and educative institutions. Social workers conducted training meetings within the community and with community leaders. After the first year of project implementation, a total of 1,300 community members had attended the training. Within the first year (2018-2019), 22 social workers were trained, and during the second year an additional 22 health care workers and social workers were trained. Due to the COVID-19 pandemic, the Government of Mongolia's quarantine started on January 20, 2020 and community trainings were unable to be organized. However, materials were distributed in targeted areas and health care workers and social workers were available for consultations. Even with these limitations, a decrease in cases of burn patients were documented, and the Public Health Institute and the NTORC started funding similar trainings in other districts of Ulaanbaatar.

This excellent ICATCH 2018-2021 project on “Preventing burn injuries among young children in Mongolia Ger district” demonstrates the value of strong and invested partnerships—in this case between the Burn Injury Unit at NTORC, Holt International Children's Service Mongolia Office, The Public Health Institute, and the Governor's Office of the Songinokhairkhan District, to help the distribution of preventive health information. This included information boards in 11 khoroo buildings, 1,000 copies of “Preventing children from household accidents and burn injuries” published and distributed to parents with minor children, and 500 posters on burn prevention first aid distributed to schools, kindergartens, public areas, and Family Health Centers.

The Public Health Institute, affiliated with the Ministry of Health, was so impressed with this project that they are implementing the same project in collaboration with the Burn Unit of NTORC in the Chingeltei district of Ulaanbaatar city, and Holt International plans to expand this project further to two other provinces in Mongolia.

As members of the ICATCH committee, we are so proud of what Ms. Tungalag Namsrai, Dr. Galbadrakh Erdenetsetseg and Ms. Ariunbolor Davaatsogt have accomplished so far with their project and are eagerly waiting for their final third year report.

Working Remotely: What the Pandemic Taught Us About Global Health Collaborations

Kara Montbleau^{1,2}, Barnabas Atwiine³

Dr. Barnabas Atwiine, my friend and mentor, leads a hematology/oncology clinic that serves 300 children suffering from a variety of cancers and blood disorders. He is one of only nine pediatric hematologist/oncologists in Uganda, with a mission to expand access to subspecialty care across the country. Having worked with Dr. Atwiine during my fourth year of medical school, I spent the start of residency eager to return to Uganda to begin a project targeting sickle cell disease.

With the COVID-19 pandemic, however, the nature of global health collaborations has changed dramatically in light of travel restrictions designed to curtail global spread and mitigate suffering. As a result, trainees hoping to either initiate or continue existing projects have cancelled their plans and shifted focus to creative ways of getting involved from home. For Dr. Atwiine and I, the pandemic forced us to re-examine the goals of our collaboration and offered lessons about sustainable global health partnerships that we believe will apply even after travel bans are lifted.



First, working remotely raises an opportunity to conduct a virtual needs assessment that can make our work on the ground better aligned with existing community needs. These assessments require intentional discussions with community and hospital leadership that outline shared goals prior to field work. Adapting to a virtual model of project initiation, once partnerships have been established, can strengthen pre-departure communication, provide direction while in the field, and enhance scheduling flexibility for both trainees and global partners.

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² Boston Medical Center, Department of Pediatrics, 801 Albany St., Boston, MA

³ Mbarara University of Science and Technology, Department of Paediatrics and Child Health, Mbarara, Uganda

Second, once needs are defined, trainees can optimize remote work by identifying specific, tangible skills outside of direct clinical care that can be offered to collaborators at the partner site. Skills such as project planning, grant writing, the development of IRB proposals, budget formation, and building educational tools or curricula can all be accomplished remotely and apply across research, advocacy, and implementation projects. As resident trainees, we are uniquely endowed with dedicated scholarly time to take on these tasks, a luxury not afforded to many of our international colleagues.

Certainly there are many aspects of global health work, including relationship-building, clinical care and program monitoring and evaluation, that only physical presence in the local context can achieve. But initiating and advancing

projects remotely offers a third lesson and one possible solution to the dilemma that many trainees face when returning home from field work: how to stay engaged long-term. When we define both our short and long-term goals with our global collaborators and leverage remote work to support endeavors on the ground, we remain connected with our partner site beyond a one to two month in-country elective. This, in turn, has a mutually beneficial effect for both trainees and partnering institutions that promotes sustainable global health partnerships. In our experience, the ability to continue projects remotely has, most importantly, catalyzed our effort to help expand access to sickle cell care for children in Uganda.

Orthopedics in Bolivia

By: Ricki Sheldon

This year I had the privilege of shadowing Dr. Callisperris, a pediatric orthopedic surgeon in La Paz, Bolivia. As a US medical student, orthopedics brings to mind a high-paying specialty with highly specialized experts in advanced treatments, often supported by the most up-to-date technology - a specialty for the elite. However, the importance of universal quality orthopedic care should be emphasized, as misfortune does not discern between the privileged and underprivileged - accidents and congenital conditions can happen to anyone. Untreated pediatric orthopedic conditions cause increased incidence of adults unable to care for themselves, increasing extreme poverty, joblessness and homelessness.

Dr. Callisperris's clinic is a one-stop shop for musculo-skeletal issues, including a specialist in orthopedic devices and a physical therapist. She has earned a name for herself, drawing clients from communities and cities outside of the greater metropolitan region of La Paz. In 2018, the metropolitan area of La Paz, Bolivia has a population of roughly 1,700,000 people with 19.1% of the population lies below the extreme poverty line¹.

While many patients come from social classes that have the means to pay for treatments, others come as a last resort after having received less



La Paz, Bolivia

than optimal treatment at the hospitals in the public health system. For some of these patients, seeking treatment in the private setting is risky since it may mean emptying their life savings or getting friends and family to lend them their life savings for just the primary consultation. Fol-

¹ <https://www.ine.gob.bo/index.php/estadisticas-economicas/encuestas-de-hogares/>

low-up attention, surgery and orthopedic devices would all be additional cost burdens.

The most common issues are hip dysplasia, flat feet, talus valgus and hallux valgus, however they also see conditions such as talipes equinovarus (club feet), osteomyelitis, cerebral palsy, neurofibromatosis and congenital knee displacement. I recall a 10-year-old girl with cerebral palsy, the second youngest of 8 children. Due to the lack of resources and the complexity of her medical conditions, she has been essentially abandoned. When she came in for consultation at the clinic, she was brought in by her grandmother, who could not pay for her treatment but was desperate to see a better life for her granddaughter.

When faced with such patients, this clinic offers reduced or free consultation and treatment to try to help families access much needed healthcare.

To help provide quality care for a minimal price, they even make their own orthopedic devices in-house. This is really beautiful, because it reduces costs and increases availability for custom orthopedics. In this clinic, they offer everything including: boots, insoles, adapted hip dysplasia and thorax braces, walkers for cerebral palsy, and toe trainers. Their devices are easy to maintain and operate by even those patients without a good education. They have all showed significant treatment success.

I love what this clinic has done by putting the patient first, and it has really showed me the importance of orthopedics in the long term development of a child and the importance of access to early quality orthopedic care, even in the underserved communities.

Evolution of Cultural Relativism in Global Health during Covid-19 Pandemic

By: Olubunmi Bakare, MD, MPH; Neonatologist, Children's Healthcare of Atlanta; Assistant Professor of Pediatrics, Division of Neonatology, Emory University School of Medicine; Fellow, Global Collaborating Center in Reproductive Health (GCC/RH)

It has been well established in literature, field work experience and with in-country global health experts the impact that cultural relativism, its understanding, and implementation has on the success of any global health project.

Cultural relativism is the principle that the beliefs and activities of a community must be understood in terms of that community's own culture. It is further defined as the view that moral or ethical systems, which vary from culture to culture, are all equally valid and no one system is inherently “better” than any other.

Over recent decades we have seen cultural relativism successes evident during beginning of HIV outbreak in Senegal in the 1980s, and failures such as during the attempted eradication of polio which met resistance in Northern Nigeria.

Cultural relativism becomes even more crucial not only in the inception of a project but especially in its implementation. It is important to recognize early the influential bodies or figures in that community. It could be religious leaders, political figures, or local leaders. Building capac-



ity with these people goes a long way to having recommendations and interventions received, incorporated, and practiced.

The one unspoken but understood element of cultural relativism is the “relativism”. There is the automatic assumption we relate to those we see,

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can potentially touch or commune with; at least in the field of global health. The key element of cultural relativism is human interaction - learning, identifying community leaders, observing interactions in local communities, and gathering understanding of a culture by engaging those who are in the community.

The COVID-19 pandemic, coupled with travel restrictions and variable community impacts of the pandemic, rocked the bedrock of global health projects, interventions and implementations. We have had to think “outside the box” to truly understand how we engage the communities we are working with while losing all the essential tools that enable us to connect and relate.

Success in the field of global health is heavily dependent on the comprehensive evaluation of the location and a detailed understanding and respect of the culture while setting personal biases and experiences aside. Being successful in

the era of COVID-19 requires a major emphasis on research and understanding of the culture, using internet and video calls with in-country collaborators. In addition, connecting with other global health experts who have worked in that region becomes even more important. Learning about their successes and failures, especially their failures as it relates to cultural relativism and its impact on their project. Having a team member in the diaspora from that region becomes even more important. The presence of a liaison that can serve as a bridge between two worlds becomes a priceless resource. Our role as a “servant-leader” becomes even more crucial, the local/in-country partners driving the project becomes imperative.

COVID-19 has made our global health work, projects and research drastically more difficult, but not impossible.



Addressing International Disparities for Pediatric Heart Disease

By: Faraz Alizadeh, MD; Pediatric Hospitalist and Incoming Pediatric Cardiology Fellow at Boston Children's Hospital

Despite pediatric heart disease causing over 35 million disability adjusted life years (DALYs) per year, children with heart disease often are an overlooked group^{1,2}. Every year, one million children are born with congenital heart disease (CHD) and another 300,000 will acquire rheumatic heart disease (RHD)^{3,4}. Unfortunately, only 10% of children worldwide with CHD have access to life saving cardiac care⁵ and over 280,000 individuals a year will die from RHD⁶. While the international community has seen remarkable success in improving under-5 mortality by 59% since 1990⁷, mortality from pediatric heart disease in LMICs has shown little change⁸. As described by Children's Heart Link, children with heart disease are the “invisible child” as pediatric heart disease is a prevalent but generally neglected disease, and many of these children will die without a diagnosis².

One challenge to achieving universal cardiac care is that treatment of pediatric heart disease is complex. Often, moderate to severe CHD and RHD require medical and surgical management, but only 7% of the world's population has access

to safe and affordable surgical care⁹. While strategic plans to combat rheumatic heart disease must include prevention, including adequate diagnosis and treatment for the preceding streptococcal pharyngitis infection, this is not enough - access to life saving surgical treatment is a human right for all. A common argument against universal access to cardiac surgical care is that costs are too high and sustainable programs are unrealistic, similar to arguments made decades ago against expanding access for HIV treatment in LMICs. However, numerous studies have shown that building cardiac surgical centers of excellence is cost effective¹⁰. Furthermore, many LMICs and organizations such as Children's Heart Link have demonstrated that sustainable cardiac surgical programs are not only possible but contribute to the strengthening of the entire health system. These countries have demonstrated that programs for children with heart disease require sustainable health systems, not just advanced technology and medical expertise.

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On this path towards pediatric health equity, we would be amiss to overlook the historical context of colonization and neo-liberalism that has caused much of the international inequities that exist in the world today¹¹. Therefore, we must reflect on the current power imbalances that remain after generations of harm and acknowledge that the solution to this global problem will not come from “experts” from the global north. There are numerous examples of “south-south” collaborations that are flourishing and building sustainable programs through local expertise. However, I do believe that American institutions still have an important role to play.

The fight for health equity will require global partnerships, but those where the agenda is set by local leadership and funding is equitably distributed. We can use our resources in the global

north to assist with training of subspecialists and provide support for quality improvement initiatives, as seen through organizations like the International Quality Improvement Initiative (IQIC). We need to ensure equal representation in leadership of international health organizations and advocate for inclusion of pediatric cardiac disease in global child health indicators. Furthermore, we must work to close the data gap on RHD and CHD in LMICs by funding its research. We must ensure equitable access to publication by removing publication fees and addressing the implicit bias against medical research done by researchers in LMICs. Perhaps most importantly, we must listen to our colleagues in the global south on how we can best support this movement and achieve health equity for children with heart disease.

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Monitoring and addressing iron deficiency anemia in the pediatric population of rural Honduras

Authors: Keri Worthierly, B.A., B.S., Ronald Lott III, B.S., Annaya Morrison, Maria Badino, B.S., Laken Johnson, B.S., Nicole Cheung, PharmD, BCPS, Charles Fleischer, MD

Iron plays a vital role in many important processes in the body such as oxygen transport, immune function, and oxidative phosphorylation, during which the body's nutrients are converted to energy. A portion of circulating iron is naturally stored in the body in the form of ferritin. These stores provide a supply of iron that can be accessed as needed by the body. Iron levels can become low in the body due to various reasons such as blood loss, pregnancy, insufficient dietary intake of iron, and intestinal malabsorption. When the amount of circulating iron in hemoglobin is normal but the body is unable to store adequate amounts of iron, this is labeled as iron depletion - this stage is usually asymptomatic. An individual is deemed as having iron deficiency (ID) once their levels of circulating iron and stored iron are low. This stage may manifest with symptoms of tiredness. A serious consequence of untreated ID is iron deficiency anemia (IDA) in which there is not enough iron to produce an adequate amount of hemoglobin or red blood cells, leading to the body not receiving the

amount of oxygen it needs to function properly.

IDA is prevalent in developing countries like Honduras where many individuals face food scarcity and inadequate sanitation systems, leading to inconsistent iron intake and nutrient malabsorption due to chronic diarrhea. Untreated IDA can cause serious long-term health consequences such as reduced immune function and cardiovascular complications. Pharmacological treatments initiated in the past in Honduras, such as iron fortification and supplementation, had questionable span of reach. Additionally, too much reliance on pharmacological treatment may lead to iron overload. A well-rounded approach that is not limited to solely pharmacological interventions should be considered.

After characterizing the prevalence of IDA in children in the rural village of Gracias a Dios, Honduras, we plan to utilize a multidisciplinary approach employing both pharmacological and

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non-pharmacological treatments. Non-pharmacological treatments will include culturally sensitive dietary education that emphasizes the importance of consuming iron-rich and vitamin C-rich foods to assist with absorption of the micronutrient, the control of chronic diarrhea via continued latrine construction and water filtration, and the implementation of cast-iron cookware use to promote the introduction of iron into the diet. This approach considers both the issues of iron intake and iron loss/malabsorption. Follow up iron levels will be closely monitored

using complete blood counts with iron studies and reticulocyte counts to gauge the effectiveness of the interventions as well as prevent iron overload. We aim to implement these interventions with the permission and close collaboration of village health leaders in Gracias a Dios. With the support of these interventions, we can contribute to the reduction of the prevalence of IDA in developing nations and the prevention of its potentially disastrous sequelae in the pediatric population.

The Long Wait for a COVID-19 Vaccine: The Already But Not Yet

By: **Kalie R.J. Hosaka**

John A. Burns School of Medicine, University of Hawaii at Manoa

On December 15, 2020, the first COVID-19 vaccines were given to Hawaii's frontline healthcare workers¹. I remember feeling a sense that the pandemic's end was finally near. I knew I needed to wait my turn to be vaccinated; after all, I was healthy and not actively taking care of COVID-positive patients, and hospital staff needed to be vaccinated prior to rotating medical students. But I did not know how long the wait would be.

By that time, I had been looking forward to my global health research year in Tanzania for several months. I was thrilled to have received an NIH Fogarty fellowship award—one that would allow me to work with youth living with HIV and better understand mental health and HIV outcomes—only to discover that my research year would be delayed due to the COVID-19 pandemic's uncertainty. I completed the first half of my fourth year of medical school, and my travel to Tanzania was approved. My flights were booked: a Christmas redeye flight to Seattle to visit my wife's family and a mid-January departure to Kilimanjaro.

I soon realized I would not get a COVID-19 vaccine unless I further delayed travel to Tanzania. When I asked my medical school's Director of Medical Education about the possibility of get-

ting a COVID-19 vaccine, she politely responded, “Sorry. Most [students] will get [first doses] in January.” The director of my Fogarty consortium also informed me that the U.S. vaccine rollout is “state-based, so unfortunately . . . [Fogarty cannot] influence vaccination policies at other institutions.”

We moved to Tanzania in the midst of widespread COVID transmission and deaths of senior government officials². Tanzania's position on the COVID-19 pandemic has been well-documented: Tanzania was declared COVID-free after a brief lockdown period, there were no recorded cases between April 2020 and June 2021^{3,4}, and there were no plans to receive COVID-19 vaccines^{2,4,5}. To a degree, Tanzania's strategy makes sense: a second major lockdown could have restricted healthcare access for patients living with diseases like HIV and pushed vulnerable families further into poverty⁵. Despite these challenges and limited resources, I have been inspired by mentors and colleagues' resilience and engagement with public health. Living here has given me insights into disparities in vaccine availability. Although I know that large-scale structural and

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preventive measures internationally are most important in ending the pandemic, I still find myself longing for the day I will get my vaccine.

As of July 2021, as part of a strategy to begin mitigating community transmission of COVID-19, President Samia Hassan has planned to join COVAX⁶. Yet given widespread vaccine shortages globally, it is not clear when vaccinations will begin. In a world with limited resources, getting vaccinated is a privilege—I will be able to return to the United States as an American citizen this Fall and receive my long-awaited injection. While vaccines are big part of the solution, they are not a panacea. The COVID response of one region is inseparably tied to others, and we must work to-

wards improving systems of care and promoting global health equity.

Acknowledgments/About the Author:

Kalei R.J. Hosaka is a senior medical student at the University of Hawaii. He is a National Institutes of Health (NIH) Fogarty Global Health fellow (2020-2021) based at the Kilimanjaro Christian Medical Centre in Moshi, Tanzania, where he has the privilege of working with youth living with HIV. The content is solely the responsibility of the author's and does not represent the official views of the National Institutes of Health.

References:

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Appreciating the Environment

By: Mohsin Ali

In February 2020, as part of the global health program in my residency between Boston Children's Hospital and Boston Medical Center, I completed a four-week teaching and clinical elective in Dar es Salaam, Tanzania. Specifically, I was based in the departments of Pediatrics, Epidemiology, and Biostatistics at Muhimbili University of Health and Allied Sciences and Muhimbili National Hospital.

The teaching component of the elective aimed to support pediatrics residents with the design, analysis, and reporting of their mandatory Master's theses. Drawing on my graduate training, research experience in epidemiology, and input by local students and faculty, I designed and taught a four-lecture “refresher” series on fundamental concepts in epidemiology and biostatistics, while also providing one-to-one office hours for students' theses.

The clinical component structured the elective as an exchange - I learned by rotating through the pediatric wards, observing rounds, and attending case conferences and grand rounds. Overall, the experience not only laid down the foundations for future research and teaching-based collaborations, but was also a formative clinical experience in a relatively low-resource setting—relevant to my career interests in global health, infectious diseases, and epidemiology.

I learned in seemingly all environments: during



Dar es Salaam, Tanzania

rounds, in the classroom, and outside the gates of the school–hospital complex. Clinically, I was struck by the number of resources available at Muhimbili, including advanced imaging (e.g., CT, MRI, Echo), a brand-new PICU and CICU, as well as a robust pediatric oncology program. Yet interestingly, I found that one area of potential improvement—one I had taken for granted at Boston Children's and BMC—was standardization of care. At Boston Children's, for example, we have hospital-wide, easily accessible evidence-based guidelines (EBGs) that providers reference when providing care to patients. There are EBGs for seemingly everything, from asthma to the febrile neonate, to minor head trauma, to—in a classically Children's fashion—macrophage activation syndrome. EBGs help decrease

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inter-provider variability, and their adoption requires hospital-wide coordination and effort to enact and maintain. This point was most salient for me when a fellow resident suggested obtaining an Echo for a febrile child. When I followed up with curiosity about her reasoning, she clarified “for screening purposes”. This contrasted with my own experience at Boston Children’s where the diagnostic value of an Echo outside the oncology ward, stem-cell transplant unit, or ICU usually merits much discussion on rounds as well as authorization by—and further discussion with—the cardiology fellow.

In terms of teaching, the residents designed quite interesting research projects aimed at improving the health of their patients. As with prior experiences in teaching epidemiology at Mount Sinai in New York City, I found that, naturally, the quality of their proposals and papers varied. To their immense credit, it is difficult simultaneously learning the clinical practice of pediatrics while completing a master’s thesis that, for most students, focuses on epidemiology and biostatistics. Both fields are notoriously hard to teach to medical trainees since one can easily devolve into discussions about the underlying mathematical theory - I’ve been there. Hence, I tried in my lecture series to complement theory with real-world examples, including some of my own work. Post-class surveys showed that lectures were generally well received, and pointed out areas for improvement.

Finally, I also learned a lot simply by living on my own in Dar es Salaam. While I spent the first six years of my life in Lahore, Pakistan, and have spent time in Argentina and Guatemala as an adult, this was my first experience not only in Africa but also living by myself in a “developing”

country for an extended period as an adult. Several lessons linger from the elective, but perhaps the most relevant to medicine and public health has to do with water. Specifically, I appreciated the social and psychological impacts of viewing water as a vector for disease. In the “developed” world, we associate water with hygiene. Television ads flow with images of “fresh” water. At our grocery stores, sprinklers intermittently spray leafy greens. Yet, in an area where tap water is not potable, the effects on culture and society are interesting, if not also devastating. Time in the shower decreases. The prevalence of cooked vegetables in the local cuisine increases. Simple tasks, like washing one’s dishes, become more involved. The experience thus impressed upon me the privilege of living in a country with potable tap water and the infrastructure necessary to produce this remarkably complex public good. It is interesting too that many classic diseases discussed in introductory epidemiology courses were primarily transmitted by unsafe water and food (e.g., cholera, typhoid)—at a time when Western countries were developing their industrial infrastructure. As the history of public health illustrates, this development led to the decline in infectious diseases even before antimicrobials were discovered. Of course, the challenge remains to accomplish this goal for all people, while preserving the environment for all life, of this Earth.

Disclaimer: The viewpoints discussed above are mine alone. They do not necessarily represent those of any person or organization mentioned.

Resisting Normal



By: Zachary Tabb, MD

It appears as though the fulcrum upon which the pandemic tilts is shaped by access to vaccination. Looking around, it's easy to believe the balance is tilting toward something that resembles a pre-pandemic normal. Cases are declining. We receive regular pronouncements about further and further narrowing of mask recommendations and limitations to socializing in person with others. Movie theatres, restaurants, colleges and other large public gathering spaces that were unthinkable to consider attending even 3 months ago now seems inevitable. But if we view the current changes through a health equity lens then we can ask ourselves the real questions. Whose normal is this, and is this actually anything but normal?

The same pre-pandemic health inequities that existed in our own country are still present, only compounded in LMICs. While COVID-19 was the great exacerbator of these disparities, as HICs monopolize the vaccine supply and technology, residents of many LMICs are only left with the fallout of the pandemic, and none of the hope of its abatement. While residents of some communities literally win a financial lottery by winning a birthplace lottery (read: get vaccinated in America), billions don't have that luxury. As further delays and resistance to distributing vaccines globally continue, the vaccine apartheid will further intensify the already devastating impacts on the health gains achieved over the past

three decades.

Movements toward a TRIPS waiver is critical but insufficient. COVAX has played a role but is hobbled by issues of HICs withdrawing supplies (and letting them go to waste) as well as contributions promised but as of yet, not delivered by pharmaceutical companies (the same ones fighting against intellectual property waivers and tech transfers). Discussions of vaccine passports need to happen thoughtfully to avoid dangerous ethical issues that further limit human rights and freedoms. It's not hard to imagine a world where vaccinated residents of HICs are free to roam around the globe, but residents in LMICs are restricted from movement in and out of their own countries and from access to necessary services.

I'm thrilled to have been able to get the vaccine, and I'm thrilled that adolescents can now get them as well. But I also recognize that there are people around the world at much greater risk of getting COVID-19 and of severe outcomes and need to be vaccinated as well. Those who argue it is either us or them who can get vaccinated are presenting a false choice. Unless everyone is vaccinated, all of us remain vulnerable. Rather than hoping to return to the stark global health disparities of a pre-pandemic normal, we should be striving for something better. We put astronauts on the moon - surely we can get vaccines into arms.

HVO Connect Announcement



I am pleased to announce that HVO is once again accepting applications for the Wyss Scholarship for Future Leaders in Global Health. For now, we will only consider virtual training opportunities. The scholarship, which was initiated in 2015, provides short-term professional development opportunities for health care professionals at HVO sites. Recipients of the scholarship are those who are early in their careers but have demonstrated leadership qualities. To date, 41 scholarships have been awarded.

I encourage HVO volunteers to keep prospective scholars in mind as you come across training opportunities. For our colleagues at project sites who wish to be considered for a short-term scholarship, please review the guidelines on our website. (<https://hvousa.org/get-involved/apply-for-a-fellowship/wyss-scholarship/>)

Best wishes for a pleasant, relaxing summer to those in the northern hemisphere!

Sincerely,

Nancy

Nancy A. Kelly, MHS
Executive Director

Global Health Book Review

Shaina Hecht, MD, FAAP; Daniel Guiles, MD, MPHTM, CtropMed; Bobbi Byrne, MD, FAAP; Megan McHenry, MD, MS, FAAP

Medical anthropologist Johanna Tayloe Crane provides a unique perspective on what it means to “do Global Health” in her book *Scrambling for Africa*. In particular, she focuses on the ethnographies of Ugandan healthcare workers while providing in-depth historical background and context of foreign medical interventions, from post-colonial times to the present.

Crane's book begins by offering context to global health science, especially as it relates to the evolution of the AIDS crisis. While slow reading early on, she provides essential insights required to understand critical topics in the development of global health - for example, she describes an inherent Western bias in available HIV antivirals. Crane does add considerable interest by intertwining this ethnographic study with the story of one HIV clinic in Southwest Uganda. This clinic, over decades, transitioned from helping those with AIDS die with dignity to providing lifesaving treatment with antivirals for patients afflicted with HIV, with the help of PEPFAR (President's Emergency Plan for AIDS Relief) as well as other aid dollars. However, with aid money came researchers from the Global North, eager to study the effects of antiretroviral therapy (ART) on those with HIV who had never been treated. Although these researchers were seemingly well intentioned, Crane sensitively details the

perspective of Ugandan healthcare workers and scientists as they sought to balance the opportunities provided by global health science with their own career interests and ideals. She uses the example of Dr. Jason Beale, a US-based physician scientist, as an instance of a foreign researcher who over time was able to work in partnership with their Ugandan colleagues, providing research mentorship, albeit with both positive and negative consequences to the local healthcare system and academic community.

Scrambling for Africa should be required reading for any individual involved in global health education and research, whether from the Global North or the Global South, as it forces the reader to reckon with responsible and equitable global health participation. Crane explores the concept of “partnership”, now considered an essential component of global health practice. She also challenges our understanding of the term “global health” as an idea of the resource-rich world. Through examination of what global health aspires to accomplish as well as scrutinizing “the uncomfortable mix of preventable suffering and scientific productivity that characterize global health”, this book will assist individuals in their reflection regarding responsible and ethical global health work.

Partnerships Corner – Who's Doing What?

By: Nicole St. Clair, MD, FAAP

In this section, we offer updates on what other groups and organizations are doing related to global child health, including other medical and surgical subspecialties. If you have any updates for us, please send to sogh@aap.org. For this newsletter, we are featuring the Global Health Subcommittee of the AAP Section on Hospital Medicine (SOHM). This summary was kindly provided by the Dr. Alexandra Coria, a committee co-lead.

The Global Health Subcommittee of the AAP Section on Hospital Medicine (SOHM) supports dialogue and facilitates collaboration among pediatric hospitalists interested in global health. We actively seek to bring the competencies of pediatric hospital medicine (PHM) to low-resource settings globally, promoting integration of the full spectrum of clinical and nonclinical work done within our subspecialty into global health projects.

We welcome anyone who practices hospital-based pediatrics, whether or not they are working toward boarding in PHM. This includes neonatal and ICU hospitalists, as well as individuals practicing in community or non-academic hospitals.

This year, we have defined and worked towards four major goals:

1. To grow a network of pediatric hospitalists and hospital-based practitioners with interest in global health and health equity.
2. To promote visibility of the specific role of PHM in global health within the greater AAP, global health and hospital pediatrics communities.
3. To facilitate participation of hospital-based pediatricians working in low-resource settings in AAP SOHM activities through administration of an international travel grant and follow-up network-building activities.
4. To maintain a repository of resources useful to PHM practitioners interested in global health.

Specific activities include the administration of a yearly grant to bring physicians working outside the US to the Pediatric Hospital Medicine conference, to share their work and gain exposure to our subspecialty. This year, we have been evaluating this program by surveying previous grant recipients in hopes that we can increase the value of this initiative for our partners.

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We have also focused recently on increasing our engagement with the larger academic global health community. It is one of our primary objectives moving forward to build opportunities for pediatric hospitalists to engage in global health collaborations and partnerships.

We maintain a listserv of 200+ members where we publicize opportunities and resources in global health to pediatric hospitalists. If you are interested in joining, please email AAPSOHM-Subcommittee@aap.org with a request to join the SOHMGlobaI listserv!

Our annual business meeting will be held on Tuesday, August 3, 2021, in conjunction with the

annual PHM meeting. We are always interested in hearing from hospitalists who want to design and implement global health projects, educational initiatives, and scholarly work. If you are a hospital medicine practitioner with an interest in global health and an idea of how we can serve you better as a subcommittee, please don't hesitate to get in touch by contacting:

Alexandra Coria: ACoria@maimonidesmed.org

Sean Ervin: servin@wakehealth.edu

Sarah White: sawhite@chla.usc.edu

Global Health Literature

Adnan Mesiwala , Shahzmah Suleman, Radhika Sundararajan, Rachel Kowalsky, Kathleen Morton, Vincent Uy, Shari Platt, Michael J Alfonzo

Recognition and Management of Pediatric Sepsis in a Resource-Limited Emergency Department in Mwanza, Tanzania: A Qualitative Study

Pediatr Emerg Care.

doi: [10.1097/PEC.0000000000002471](https://doi.org/10.1097/PEC.0000000000002471)

A Suryawan, M Y Jalaludin, B K Poh, R Sanusi, V M H Tan, J M Geurts, L Muhardi

Malnutrition in early life and its neurodevelopmental and cognitive consequences: A scoping review

Nutr Res Rev.

doi: [10.1017/S0954422421000159](https://doi.org/10.1017/S0954422421000159)

Denise Naniche, Peter Hotez, Maria Elena Bottazzi , Onder Ergonul, J Peter Figueroa, Sarah Gilbert, Mayda Gursel, Mazen Hassanain, Gagandeep Kang, David Kaslow, Jerome H Kim, Bhavna Lall, Heidi Larson, Timothy Sheahan, Shmuel Shoham, Annelies Wilder-Smith, Samba O Sow, Nathalie Strub-Wourgaft , Prashant Yadav, Carolina Batista

Beyond the jab: A need for global coordination of pharmacovigilance for COVID-19 vaccine deployment

EClinicalMedicine.

doi: <https://doi.org/10.1016/j.eclinm.2021.100925>

Nicholas Paul Oliphant, Nicolas Ray, Khaled Bensaid, Adama Ouedraogo, Asma Yaroh Gali, Oumarou Habi, Ibrahim Maazou, Rocco Panciera, Maria Muñiz, Zeynabou Sy, Samuel Manda, Debra Jackson, Tanya Doherty

Optimising geographical accessibility to primary health care: a geospatial analysis of community health posts and community health workers in Niger

BMJ Glob Health.

doi: [10.1136/bmjgh-2021-005238](https://doi.org/10.1136/bmjgh-2021-005238)

Britt Nakstad, Thato Kaang, Alemayehu Mekonnen Gezmu, Jonathan Stryko

Nosocomial SARS-CoV-2 transmission in a neonatal unit in Botswana: chronic overcrowding meets a novel pathogen

BMJ Case Rep.

doi: [10.1136/bcr-2021-242421](https://doi.org/10.1136/bcr-2021-242421)

Global Health News

[No health worries for children born to mothers given seasonal flu vaccine in pregnancy](#)

EurekAlert!

June 8, 2020

[American Academy of Pediatrics releases the Neonatal Resuscitation Program, 8th Edition to elevate neonatal resuscitation, education and training in U.S. hospitals](#)

RQI Partners

June 8, 2021

[Why Physical Education Can't Be a Casualty of the Pandemic](#)

US News

June 7, 2021

[Kavi Global Announces Research Partnership with Ann & Robert H. Lurie Children's Hosp](#)

ENPresswire

June 8, 2021

[In youth, COVID-19 causes more complications than flu; fatality is rare](#)

EurekAlert!

June 7, 2021

Pediatric Global Health Events

AAP National Conference & Exhibition

When: October 8 - 12

Where: Philadelphia



SOGH and the Section on International Medical Graduates (SOIMG) will be hosting an H-program at this event. It will take place

virtually on Sunday, October 10, from 8 AM - 12PM EDT. During this H-program, we will highlight lessons pediatricians in the U.S. can learn from partners in low- and middle-income countries by exploring innovations and adaptations that emerged during the pandemic in settings of resource limitations. The program will also include the Section on Global Health oral abstract presentations and awards.

13th Annual CHOP Pediatric Global Health Conference - Making Up for Lost Time: Addressing Children's Needs Post-Pandemic

When: Friday, October 29, 2021, 4:00 PM - Saturday, October 30, 2021, 5:00 PM

Where: Arthur H. Rubenstein Auditorium, Smilow Center for Translational Research Perelman School of Medicine at the University of Pennsylvania, Philadelphia, PA

IPA Congress 2021 Postponed

As per the decision of the IPA Standing Committee which met virtually on 26-27 September 2020, keeping in view of the ongoing SARS-CoV2 pandemic, IPA will not hold its 30th International Pediatric Congress (IPA2021) which was scheduled to be held on 22-26 August 2021 in Glasgow.

New dates for the congress will be announced soon.

Acknowledgements

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If you are NOT a current Section on Global Health Member, you may follow one of two options to become one:

① Call AAP's Customer Service at +1.866.843.2271, available Mon – Fri from 7:30am – 5pm (CST)

② Go online and sign up on your own by following the five steps below:

Step 1: Confirm you are a member of the section by logging into your account by visiting this [link](#). If you are a section member you should see it listed on the My Membership home-screen.

Step 2: If you do not see the Section on Global Health listed, click on the Join Now link, which you can find in the textbox containing information on Section/Council Membership.

Step 3: Clicking on Join Now will take you to the section / chapter / council membership registration pages. (Please note: access to this page requires login. This page displays the list of all sections. Global Child Health will be in the 2nd column.)

Step 4: Select Global Child Health and proceed with the application instructions

Step 5: Email sgf@aap.org to let us know that your membership has been updated.