Haiti Earthquake Disaster
Through your support, the AAFP Foundation has raised over $70,000 to aid relief efforts in Haiti. The Foundation will continue to take donations to help our partner relief agencies, Heart to Heart International and International Medical Corps. Both organizations are mobilized in this devastated area. Read more on p. 2.

WONCA Scholarships
The AAFP Foundation recently awarded five travel scholarships for young American family physicians and Family Medicine residents to attend the 2010 World Organization of Family Doctors (Wonca) World Conference in Cancun, Mexico. Read more on pp. 4-5.
George is an engaging 23 year-old man whose life was unfolding well. Orphaned at a young age, he was attending college and owned a tailor shop in Leogane where he lived with his grandmother and several cousins, commuting by motorcycle. On January 12, 2010 everything changed. In less than 90 seconds, he lost his home, his business, his college and his motorcycle. During my recent trip to Haiti with Heart to Heart International, George, who now works as a medical translator, shared his experience with me. Today, he sleeps in a tent in the front yard of his damaged home, hoping to somehow rebuild his beloved country.

Always a poor nation, Haiti has become a shattered desperate place. Tent villages are scattered on the hillsides, have sprung up on medians along the remaining passable roads and cover every available space in the urban regions. Nearly 1,000,000 Haitians remain homeless after the earthquake. An estimated one in ten Haitians was killed. Young families and orphaned children live in deplorable conditions, usually without water or electricity. In the months since “the event”, as the earthquake is called by the Haitians, school has finally resumed in large tents. Most buildings have been reduced to rubble; those remaining are precarious. Beyond the structural damage is the extensive psychological damage, especially for the children of Haiti. They refuse to go inside.

In the daylight hours, life is slowly returning to this area. Vendors have set up stands with brightly colored umbrellas to protect their wares from the intense heat. When darkness falls, though, the damage to the social structure of this stricken country becomes apparent. Singing can be heard throughout the night as people take shifts staying awake to protect their families and what little remains of their possessions. As outsiders, we are cautioned to not leave protected areas in the day and are forbidden to venture out after dark.

The Bel Aire clinic in Port-au-Prince operates six days a week from the upper levels of the Nazarene church. Much of the help is through local volunteers and paid translators and each morning hundreds of people travel to be seen. As they arrive, the patients are given numbers and often must wait for hours with little to no food or water. Everyone is suffering loss of a family member, neighbor or friend. While most of Haiti is unemployed, their days are occupied with finding water, food and shelter. Many have walked miles to arrive at the clinic after having spent the night sleeping on the ground. Some sleep on towels, and if they’re lucky, they have two towels.

In Leogane, the epicenter of the earthquake, nearly 95% of the buildings have been destroyed. Rubble remains because of the logistic impossibility for movement. Our clinics are more mobile here, each day traveling to a different community in the region. Even without advance notice of our arrival, our days are full with nearly a hundred patients of all ages. We treat malnutrition, hypertension and diabetes, malaria, dengue fever and leishmaniasis. As in Port-au-Prince, many of the concerns are related to post-traumatic stress disorder. Sometimes, we can only listen. As a family physician, I’m grateful for the comprehensiveness of my training and experience. Our supplies and resources are limited, but empathy can be a universal balm.

The acute phase of disaster recovery has finished, although we continue to see multiple traumas each day. Infected wounds, badly healing fractures residual from the event several months ago, new injuries because of the difficult living conditions are common.

One evening as we were finishing clinic, a young man appeared with a blood-soaked rag on his hand. He’d been working outside and dropped a 55-gallon oil drum on his hand, severing three fingers. We loaded him on our tap-tap for a trip to the Doctors Without Borders field hospital.

New medical needs, as well as care for chronic conditions, arise daily. One patient walked to the clinic for miles to ask the American doctors why he woke up screaming every night. When asked, “How are you?” Haitians commonly respond, “No worse than before.”
The Road to Need
...continued from page 2

Because of the absent infrastructure, the disruption of families and support systems and the chaos of daily living, it is difficult to see a better future.

Still, each interaction brings us hope. The Haitians are a remarkable, resilient population, relying on their faith in God and their determination. The children laugh and play with us, the young men and women believe that life will improve. Each one of us leaves knowing that for someone, we made a difference in Haiti. Our work there, we hope was like a pebble tossed in the vast ocean of need, ringing out effects beyond our individual impact. Much remains unfinished, though.

Global Health Book Club

Stephen Schultz, MD, FAAFP, Director of the University of Rochester Family Medicine Residency Program

The University of Rochester Family Medicine Residency program has had a Global Health book club for over 5 years, meeting 5-6 times per year, depending on the length of the books selected. We rotate between fiction and non-fiction, with the participants of the book club determining what we read for the next month. In an era of carefully documented learning objectives, evaluations, and competencies, it is a refreshing change, a group of residents and faculty who gather as motivated adults to share our impressions of literature and how it relates to each of us, without the burden of documentation.

At our last meeting discussing Cutting for Stone, by Abraham Varghese, the conversation started with an intern reflecting that so many of the people she greatly admires for their dedication to global health seemed to have sacrificed their personal lives to meet the demands. This led to a discussion of the balance of personal and professional life, as well as how hard it can be to keep that balance in underserved settings in developing countries where the needs are so great. Faculty who have worked in such settings shared their successes and failures in keeping a balance and not feeling overwhelmed by the needs. We went on to discuss some of the principal character’s motivations, the meaning of the title and aspects of the book we were unclear on. This was all accomplished in one hour. As I do after every book club, I left feeling energized by the stimulating discussion, and grateful for my colleagues.

Our website contains a list of the titles we have read over the years; check http://www.urmc.rochester.edu/fammed/iht. Non-fiction titles include Guns, Germs and Steel; Confessions of an Economic Hit Man; and Don’t Be Afraid, Gringo. Fiction titles include Acts of Faith; White Man’s Grave; and The Kite Runner.

Our book clubs are required by residents who are in the global health track; it is one of the mandatory meetings that residents must attend to have the program pay for their travel expenses to Honduras. We recognize that not everyone will have had a chance to read the entire book, but we also recognize that the discussions are rich and thoughtful even if folks have not been able to finish.

I highly recommend a book club for residencies with a global health track as a way to explore the myriad of tangible and intangible issues that are part of a commitment to global health. So many of these issues defy didactic teaching, and yet lend themselves well to exploration through book discussions.
Medical Service Trip to Dominican Republic, November 2009
Sarah Fellers, DO, Georgetown University/Providence Hospital Family Medicine Residency.

Nothing could’ve prepared me for my first international medical service trip. As I walked into a small village, Esfuerzo, in the Dominican Republic, I was pleasantly greeted by a swarm of local kids eager for attention from the American doctor and, less to my liking, a huge muddy hog with its trail of baby piglets. I was taken back by the small, concrete, poorly ventilated homes with no electricity or indoor plumbing. I soon realized I was not home in Washington, DC anymore and was about to experience a new kind of medicine.

Our group -- attendings, residents, and students from the Virginia/DC area -- worked primarily at an elementary school in the local community, Paraiso, located about 45 minutes from the capital Santo Domingo. We saw about 100 patients a day at our make shift clinic, but also ventured out to the village, where we made home visits, offering medical care to those who were too ill, or physically unable to make it to the clinic. We also conducted door-to-door health surveys to gather information about the root causes of poor health in this neighborhood.

At the clinic, we saw many adults with untreated or inadequately treated chronic medical problems, including hypertension, diabetes and asthma. We also diagnosed and treated many dermatological as well as dental conditions in the pediatric population.

The burden of infectious diseases, including parasitic infections, is heavy. Therefore, we provided all eligible patients with anti-parasite medications, offering some protection for approximately 6 months.

Despite our best efforts, it became clear that a lack of access to consistent medical care, combined with poor basic infrastructure, were larger problems than we could address in our two weeks.

This was my first international medical experience and I found it to be very exciting, educational and rewarding. It certainly left me with a taste for more. I plan to pursue other global health projects once I complete my residency in June 2011.

Family Medicine: Common Language for Global Health
Notes from the 19th Wonca World Meeting in Cancun
Tasha Starks, M2, University of Arkansas for Medical Sciences College of Medicine, Little Rock, AR

As a second year medical student, I was in awe of the dedication and commitment that the leaders of the WONCA organization have made to ensure that in the future young physicians, residents, and students will have the opportunity to play a role in the decision making of the organization. It was truly inspiring to hear WONCA president, Dr. Richard Roberts, speak so passionately about wanting and needing young physicians, residents, and students to be a part of determining the goals of primary care in the new millennium. At this meeting, there was no shortage of educational opportunities for students, residents, or young physicians. Sessions ran the gamut from information about international opportunities for students to leadership development for young physicians.
Notes from Cancun. (continued from p. 4).
Moreover, the wealth of information shared through my interaction with the attendees at this conference has proven invaluable as I now have direct contact to many who live abroad. The individuals I met are eager to share information and resources; moreover, now after the WONCA conference, instead of being strangers interacting through email, we are now friends who share similar goals.

I would like to thank the AAFP Foundation for their generous support that enabled me to attend this conference. The AAFP Foundation provided a total of 5 travel awards to the WONCA World Conference. The WONCA World Conference is a perfect example of the diversity that this organization has brought and continues to bring to Family Medicine. This meeting reiterates the fact that primary care is not just a local entity, but a field that encompasses the globe focused on enhancing health care for our world.

Amy McIntyre, MD, MPH, Family Medicine Residency of Idaho, Boise, ID

The 19th WONCA World Conference in Cancun in May gathered 3000 family physicians from around the globe, with approximately 1000 young physicians, residents, and students. It was incredible to have a gathering of so many colleagues practicing in such different places - yet it was striking how many similarities we share as family physicians. Physicians from each continent talked about the importance of patient-centeredness, frustrations with health care systems moving away from prevention and primary care, difficulty recruiting physicians to rural areas, and challenges in chronic disease management. One of the most interesting examples of this was a lecture on "medically unexplained symptoms," constituting largely somatic complaints with underlying psychosocial influences, and hearing physicians from Africa, to the Netherlands, to India discussing the centrality of empathy, continuity of care, and the physician-patient relationship in care for such patients. Family medicine is truly a common language!

The theme of the conference revolved around family medicine’s contribution to the Millennium Development Goals, including an emphasis on the social determinants of health. The opening session included a keynote speaker from Belgium, Dr. Jan de Maeseneer, whose message included the importance of establishing primary care in the developing world as the core of any efforts towards diseases such as HIV and AIDS, malaria, and tuberculosis. As globally conscious residents and students, we should all visit www.15by2015.org, the website for this movement of strengthening primary care around the world. If you support this concept, sign the petition. It’s one way to keep the energy and mission of this WONCA meeting going for the benefit of communities around the world that need family medicine!

For more information about the World Organization of Family Doctors (Wonca), schedule of conferences and meetings, direct and academic membership, regional activities and initiatives, and Wonca working groups – www.worldfamilydoctor.com.
In November 2009, my colleague, Dr. Karsten Lunze, and I planned a public health mission to Northern Kurdistan in Iraq. This was a volunteer mission with the International Medical Corps. I remember telling my parents I am staying in Vienna for a couple of days on a medical mission and my father’s response “huh- did not think things were that bad in Europe” wanting to spare them the worry. After all we were going to Iraq.

The overall atmosphere in Erbil, capital of Iraqi Kurdistan did not reflect any signs of war and was among the safest cities in Iraq. However, there were subtle signs things were still not normal including heightened security in the hotel and in the airport.

In addition to the lectures, we wanted to explore barriers to preventive medicine practice among Kurdish and Arab Iraqi health professionals. All participants completed an open-ended questionnaire on problems commonly encountered in their current public health and preventive medicine practice.

Our survey identified numerous obstacles facing our Iraqi Colleagues including inadequate health services planning and insufficient resources, poor patient literacy and adherence, lack of continuity of care and incentives, and salary were identified as barriers to quality public health and preventive medicine care. In addition, after the training, providers specified management and leadership issues, insufficient health surveillance and data collection, and patient-provider communication difficulties as relevant challenges.

The work is not done and there is a substantial need to improve public health and preventive medicine resource deficiencies in the Iraqi health system and incorporate both in primary care.

There was no doubt in our minds this was a successful trip. We maintained contact with some of the participants. We offered moral support. We offered hope.

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**Ask the Expert**

The AAFP Center for International Health Initiatives

**Question:** What are your top recommendations for resources and books for doctors traveling abroad or planning careers in Global Health?

**Bruce Dahlman, MD**

Director,

Institute of Family Medicine

Nairobi, Kenya

Having available resources to answer clinical questions has its challenges in the majority of the world, especially when working remotely as it appears you intend to do. It is an area I have been doing some research although my findings are not fully analyzed yet. My focus has been trying to encourage use of resources at the point of care, where the answer you find can directly benefit the patient that is prompting the question.

From my research, PDA or smart phone-based resources that answer questions the best: 1) clinical databases – we tested DynaMed (www.ebscohost.com/dynamed) but Up-to-Date or another one would be useful too. DynaMed has the advantage while working “on the fly” of reducing evidence to easy-to-use bullet points rather than reading a narrative like a textbook - but each has their preference. 2) clinical handbooks – here we tested and would recommend the Oxford series that are the standard in Commonwealth countries like Uganda. Most used are Clinical Medicine, Clinical Specialties, Tropical Medicine. These can be sourced from Skyscape but we used a clinical collection called Dr. Companion available from the UK (www.medhand.com) that includes the British National Formulary (also the standard here) and Cochrane reviews (also embedded in DynaMed) and an anatomy text. British Medical Journal and EBM
Guidelines are also included but were not utilized as much by participants in our study. 3) Textbooks for your shelf at home: general texts that you have are useful, but those that are written from an African or tropical medicine demographic or perspective are, in general, more helpful. There is a number of tropical medicine focused texts, of which others might have more expertise for suggestions. Your web-based resources are likely not accessible with enough bandwidth to be useful answering questions at point of care; those questions have to be saved up to the evening to have time to wait for slow download times. Computers are not safe to bring to work either unless you have a private room to lock each time – Kenyan physicians leave them at home. CD-ROMs are a good “at home” reference, the best known for Africa use is eTALC (Teaching AIDS at Low Cost) which you can Google.

Warren Heffron, MD:
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My favorite light weight resource is a book I frequently carry with me even on residency consults. I frequently wind up making rounds or get consulted on some exotic stuff or have to put together a quick power point presentation at the last minute. It is sort of a resource poor country St. Louis manual. It is: Handbook of Medicine in Developing Countries. Third edition, by Dennis Palmer and Catherine E. Wolf.

Key health related information on a country by country basis is well done by the WHO regional organizations. For instance the one I have for the western hemisphere is the PAHO publication Health in the Americas. They update this every four years.

Obviously the younger generation is more facile with web based resources which now can be accessed from even some very remote places. Simple Google, Pubmed, MDconsult etc. might be included on such a list.

Alexis Cambanis, MD:
Director, Tropical Medicine Program
Presbyterian Intercommunity Hospital-University of California Irvine

Family Medicine Residency (PIH-UCI)

The books I would recommend for a physician/resident to take with them to ensure the best clinical practice i.e., a resource they can use to look things up and find out current therapies include:

- Oxford Handbook of Tropical Medicine -- small, light, can fit in your pocket, and is excellent for rounds, at the hospital etc.
- Manson’s Tropical Diseases (Cook and Zumla ed.) - a huge tome, but if one is serious about this field, this is the book to keep at home when you are living abroad to read at night and use as a more in-depth resource. This was, by the way, our textbook for the Masters in Tropical Medicine at the Liverpool School.
- Atlas of Tropical Medicine and Parasitology (Peters and Pasvol) -- excellent atlas full of images that teach you to recognize the visual appearance of tropical diseases

These three above I would take. Another smaller book that helps review these areas is Lecture Notes on Tropical Medicine (Gill and Beeching), but this is less critical than the first three.

All are available at Amazon in paperback.

As for planning a career in global health, any knowledgeable person in this field must read Infections and Inequalities by Paul Farmer, The Invisible Cure by Helen Epstein, and 28 by Stephanie Nolen. I also recommend Laurie Garrett’s The Coming Plague. I make my students read these.

Send your next question to Alex Ivanov – aivanov@aafp.org

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