Pediatricians and Global Health: Opportunities and Considerations for Meaningful Engagement

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Pediatric practitioners whose expertise is primarily focused on the care of children within health settings in the United States are increasingly engaged in global child health (GCH). The wide spectrum of this involvement may include incorporating short-term or longer-term GCH commitments in clinical care, teaching and training, mentoring, collaborative research, health policy, and advocacy into a pediatric career. We provide an overview of routes of engagement, identify resources, and describe important considerations for and challenges to better equipping US pediatric practitioners to participate in meaningful GCH experiences. This article is part of a series on GCH describing critical issues relevant to caring for children from an international perspective.

Pediatric practitioners are often drawn to child health by a desire to care for the most vulnerable. In treating childhood health conditions, pediatricians bear witness to social disparities, serving in dual roles of health practitioner and health advocate. Given this, it is not surprising that many pediatric practitioners from high-income countries feel a calling to improve the health of all children regardless of the child’s geographic location.1,2

Global health is defined as a collaborative transnational action for promoting health for all,3 with those engaged in global child health (GCH) commonly attending to health disparities in resource-limited countries in an effort to provide all children the opportunity to achieve their health potential. There is an overwhelming and unmet need for pediatric health care worldwide, with much of the morbidity and mortality being due to preventable and treatable conditions, including malnutrition, diarrhea, pneumonia, perinatal and neonatal complications, and injuries.4–6

Traditionally, US-based practitioners have responded to GCH needs by providing direct patient care; however, the practice of GCH has expanded to capacity building and system strengthening, including medical education, skill transfer in primary care and subspecialty medicine, health systems improvement, building research capacity, and advocating for access to health services.7–12

This review is focused on pediatric practitioners whose professional experience is based in US health settings and who wish to improve the health of children in resource-limited countries outside the United States, who are collectively referred to here as US GCH practitioners. We also examine the professional and personal challenges inherent in GCH and identify resources for those engaged in GCH.

METHODS

This review was prepared by an expert panel of pediatric practitioners with clinical, research,
and program development experience in GCH. Three authors from the American Board of Pediatrics (ABP) Global Health Task Force conceptualized the framework for the review and invited coauthors with recognized expertise as US pediatric practitioners and diverse routes of engagement in GCH. All the authors reviewed the GCH literature and literature on routes of engagement and ethical practice in global health, including articles published in medical journals, book chapters, and governmental and nongovernmental organization (NGO) reports. The collective experience of the coauthors was used throughout this review to emphasize the principles of sustainability, accountability, and cultural humility that are essential to the ethical practice of GCH. Given the continual growth of resources to support the field of GCH, examples of organizations and resources have been provided as illustrative models that are based on the authors’ collective experiences and vetted by all the authors, but this is not intended to be an exhaustive summary of all available resources for GCH engagement.

**ROUTES OF ENGAGEMENT**

US practitioners engage in GCH in resource-limited countries through short-term experiences that supplement a US-based career, longer GCH assignments of months to years, or full dedication to a career in GCH. A broadened definition of GCH (discussed later in this review) also includes the care of resource-limited and other vulnerable populations within the United States as having GCH needs. In Fig 1, we provide a visual representation of the spectrum of GCH engagement, recognizing GCH work internationally and acknowledging GCH activities within the United States.

US GCH practitioners may engage in GCH on a short-term basis, generally defined as commitments of <8 weeks in duration. Short-term engagement often involves the US GCH practitioner providing clinical care, providing surgical services, teaching, or assisting with public health campaigns. Such engagement may be coordinated by the individual practitioner or organized through existing programs at academic or nonacademic medical centers, faith-based and community groups, or NGOs. Although the engagement by the US GCH practitioner may be short-term, nesting such engagement within well-structured partnerships with local health systems, existing NGOs, and/or transnational commitments increases the ability of short-term visitors to meet the health needs of the community.

Examples of opportunities for US GCH practitioners to engage in GCH on a short-term basis while providing direct patient care and supporting local health systems are offered by organizations such as Save a Child’s Heart, an Israeli-based pediatric cardiac care NGO, and Operation Smile, an NGO that treats children with cleft lip and cleft palate deformities worldwide. Both organizations have evolved since their inception from embarking on international missions to a model of training medical practitioners from resource-limited countries and building health infrastructure in those countries. Operation Smile has developed comprehensive cleft care centers in resource-limited countries where local health practitioners provide care year round, with medical volunteers from the United States and other high-resource environments staying for days to weeks to provide education, skill training, and mentorship. Another NGO, Project Medishare, partnered with the Haitian government to rebuild the trauma and critical care center, Hospital Bernard Mevs, with US GCH practitioners contributing through a train-the-trainer model in patient care teaching, subspecialty skill transfer, and mentorship for Haitian health care leaders.

Additional examples of short-term engagements that meet an expressed need to strengthen capacity are in training and skills transfer, such as through the Helping Babies Survive curriculum, which allows trained practitioners to transfer skills in newborn resuscitation during a daylong educational session, and Health Volunteers Overseas, an organization that matches volunteers...
to resource-limited educational settings to provide clinical mentorship to provide clinical mentorship, often for 1- to 2-month assignments. Many US faith-based and community groups as well as academic and nonacademic medical centers have longstanding international relationships with resource-limited communities. Faith-based organizations, in particular, may be well integrated into resource-limited communities and have commitments to service in rural and otherwise inaccessible communities. For practitioners with limited GCH experience or without existing partnerships, several US-based and international NGOs offer opportunities to engage in GCH that range from weekslong service-learning experiences to multiyear encounters.

A subtype of short-term GCH engagement is disaster response, with nearly 200 million children affected by disasters each year. Earthquakes, floods, environmental changes, famine, and conflict all alter how children receive routine and emergency medical care. Children in disaster settings may experience trauma, disease outbreaks, psychological or behavioral disturbances caused by separation from their families, and exploitation. Such overtly high-need situations attract volunteers whose efforts, if not coordinated, can be duplicative, fragmented, and burdensome. For instance, in response to the 2010 earthquake in Haiti, practitioners with no previous experience in Haiti, humanitarian relief, or resource-limited settings provided no-cost care outside the Haitian health infrastructure, resulting in a temporary loss of work for many Haitian practitioners and a burden on the local health system that was left to provide follow-up care. An influx of volunteers presents an added burden on infrastructure with visitor needs of housing, water, food, sanitation, safety, and other logistic support.

To minimize harm, emergency responses should be coordinated, involve local existing resources, and ensure follow-up and long-term support. During the Ebola epidemic in West Africa, the disease spread in underresourced and understaffed health centers. As the epidemic grew, international NGOs, including Doctors Without Borders and Partners in Health, were among the first international responders in Sierra Leone, working in coordination with district hospitals, community clinics, and local NGOs to reopen health centers, identify infections, provide clinical care, and stop disease transmission. The National Ebola Response Center, chaired by the president of Sierra Leone and including officials from the Ministry of Health and Sanitation and the Ministry of Defense and National Security, was found to improve coordination between donors and implementing partners, mobilize available financial and human resources, and involve Ministry of Health national- and district-level staff to facilitate the transition from emergency response to long-term health system strengthening.

For those who can engage in prolonged GCH experiences, the benefits to the US GCH practitioner, patients, community, and health system include time to learn the needs of patients and the community and the opportunity to evaluate interventions. Long-term engagement of months- to years-long assignments may occur within existing organizational GCH commitments, such as assignments with humanitarian NGOs (including Doctors Without Borders, the International Committee of the Red Cross, and the International Medical Corps) or with faith-based organizations (such as Catholic Relief Services). These highly recognized organizations are among the many with existing programs delivering patient care, training and capacity building, and public health initiatives. Additionally, US government organizations, such as the US Agency for International Development, the US Centers for Disease Control and Prevention, and other governmental development agencies directly fund health system—strengthening efforts, including models to enhance medical education and research training.

One such initiative, the Global Health Service Partnership, places US faculty educators in international medical training institutions for 1- to 2-year assignments with the aim of transferring knowledge and skills, developing health systems leadership, and improving opportunities for health professionals worldwide. US GCH practitioners may also seek positions with clinics or hospitals or be contracted through the country’s Ministry of Health to work in health centers or government hospitals or consult in public health or training.

CONSIDERATIONS TO ENSURE MEANINGFUL GCH ENGAGEMENT

Meaningful Engagement

With the growth of global health as an academic field of study, there has been increasing attention paid to ethical practice. US practitioners, who are often drawn to GCH by a desire to be of service, must consider not only their intentions but also the impacts of their GCH engagement. A model proposed by Wilson et al and shown in Fig 2 depicts 4 principles to consider in an assessment of whether GCH engagement is meaningful to patients and communities: service, professionalism, safety, and sustainability. Given that US GCH practitioners work in health settings with limited infrastructure and oversight, practitioners must understand regional- and institution-specific practices, self-assess competency and preparedness, and approach existing health
infrastructures with respect and humility in partnership to minimize further burdening the resource-limited community they intend to serve.

Discernment

Understanding one’s personal motivations for pursuing GCH involvement, including social justice, altruistic intentions, professional growth, and/or clinical or research interests, are important in guiding the selection of GCH involvement. The literature is replete with concerns of global health efforts plagued by “medical voluntourism” and “parachute medicine,” terms that describe global health engagement as satisfying a need of the practitioner but not meeting the needs of patients and communities. The desire to “do good” may result in harm when US GCH practitioners do not understand local needs, epidemiology, cultural contexts, and existing resources and/or do not secure a sustainable transition of their interventions. The practice principles described in Fig 2 provide US GCH practitioners with a means by which to monitor ethical engagement in GCH.

Professionalism

US GCH practitioners working in resource-limited environments confront unfamiliar physical and mental health needs in their patients as well as system limitations that complicate the diagnosis and treatment of health conditions. Table 1 provides resources that are related to preparation, knowledge strengthening, and skill building and compiled from literature review and collective author experience as useful tools for US GCH practitioners.

To engage in GCH activities internationally, US GCH practitioners must consider permissions that may be required before GCH engagement. Licensing requirements, institutional and/or governmental permissions, and malpractice coverage may be arranged for US GCH practitioners working or volunteering with NGOs, the US government, or other transnational organizations or may need to be independently secured by US GCH practitioners engaging in GCH outside such programs.

Respect for Partner Perspective

It has been recognized that within global health, there is an inherent power inequity wherein a practitioner from a resource-rich setting has assets that are needed by the resource-limited partner, which leaves patients, health systems, and communities vulnerable to the demands and directives of the resource-rich partner. It is also important to note that US GCH practitioners who travel outside the United States to provide care represent a fraction of those providing health care to vulnerable children worldwide. In-country practitioners, including doctors, nurses, community health workers, skilled midwives, and others, attend to the near entirety of GCH. Although US GCH practitioners offer collaborative clinical support, knowledge, tools, and relief work, they should do so while being mindful of not displacing local colleagues and existing health systems.

In-country practitioners have perceived that to provide benefit, visiting GCH practitioners must

![Four Fundamental Best-Practice Principles to Guide Global Health Engagement](image)

**FIGURE 2**

Four fundamental practice principles to guide global health engagement.
<table>
<thead>
<tr>
<th>Resource</th>
<th>Available at</th>
<th>Description of Resource</th>
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<tbody>
<tr>
<td><strong>Domestic</strong></td>
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</tr>
<tr>
<td>EthnoMed</td>
<td><a href="https://ethnomed.org/">https://ethnomed.org/</a></td>
<td>An AAP committee established to advocate for the needs of American Indian and Alaskan Native children and provide expertise and educational resources on issues facing Native American children.</td>
</tr>
<tr>
<td>Health Reach: Refugee Health Information Network</td>
<td><a href="https://healthreach.nlm.nih.gov">https://healthreach.nlm.nih.gov</a></td>
<td>EthnoMed is a joint program of the University of Washington Health Sciences Libraries and Harborview Medical Center’s Interpreter Services Department and Community House Calls Program and is a Web site containing medical and cultural information about immigrant and refugee groups.</td>
</tr>
<tr>
<td>National Child Traumatic Stress Network</td>
<td><a href="https://www.nctsn.org/">https://www.nctsn.org/</a></td>
<td>Resources on refugee trauma and core stressors to improve access to care, treatment, and services for traumatized children and adolescents.</td>
</tr>
<tr>
<td><strong>International</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AAP SOICH</td>
<td><a href="https://www.aap.org/en-us/about-the-aap/Sections/Section-on-International-Child-Health/Pages/SOICH.aspx">https://www.aap.org/en-us/about-the-aap/Sections/Section-on-International-Child-Health/Pages/SOICH.aspx</a></td>
<td>Resources and toolkit for developing global health curricula, listing of GCH trainings and opportunities for advocacy and policy engagement.</td>
</tr>
<tr>
<td>Awakening Hippocrates: A Primer on Health, Poverty, and Global Service</td>
<td>Book by Edward O’Neil Jr</td>
<td>Examines the state of global health and global health disparities and suggests how health professionals can participate in affecting global change.</td>
</tr>
<tr>
<td>Hesperian Health Guides</td>
<td><a href="http://hesperian.org/">http://hesperian.org/</a></td>
<td>Webinars providing introduction to a wide variety of GH topics (career development, GH ethics, human trafficking, etc).</td>
</tr>
<tr>
<td>Integrated Management of Childhood Illness</td>
<td><a href="http://www.who.int/maternal_child_adolescent/topics/child/imm/en/">http://www.who.int/maternal_child_adolescent/topics/child/imm/en/</a></td>
<td>Translated into &gt;80 languages, these guides, such as Where There Is No Doctor, include useful clinical guidelines for low-resource settings. Also, with resources to strengthen public health efforts and train community health workers (Helping Health Workers Learn).</td>
</tr>
<tr>
<td>International Children’s Palliative Care Network</td>
<td><a href="http://www.icp.cn">http://www.icp.cn</a></td>
<td>Handbooks with guidance on symptom management, communication, support, and self-care in children’s palliative care; links to palliative programs globally.</td>
</tr>
<tr>
<td>Médecins Sans Frontières</td>
<td><a href="http://www.refbooks.msf.org">http://www.refbooks.msf.org</a></td>
<td>Reference books, including clinical guidelines for common and acute conditions, essential obstetric and newborn care, refugee health, and essential drug formularies.</td>
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</table>
ensure that proposed health activities reflect both the population’s needs and preferences, understand cultural contexts, formulate collaborative and sustainable relationships, and maintain professionalism based on mutual respect. Concepts considered to be useful in guiding GCH priorities include cultural humility, which is characterized by self-reflection and deference to background and experience, and cultural safety, in which the power to define the quality of health care rests with the patients and/or community according to their ethnic, cultural, and individual norms.

An example of respect for partner perspective involves collaboration with NGOs in the resource-limited country wherein the in-country NGO shares the understanding of needs and existing health infrastructure and informs US GCH practitioners of the specific resources needed to support patients, the community, and the health system. At institutional and governmental levels, international NGOs and transnational efforts often collaborate with medical centers and Ministries of Health to place US GCH practitioners with skills that are deemed by the partnering institution to be of benefit to their health system, and programs and interventions are introduced at the invitation of the partnering institution or the Ministry of Health.

To provide oversight and ensure a common coordinated effort that addresses community-identified health priorities, some resource-limited countries and communities are developing community-driven strategies to connect local health systems with outside practitioners and organizations. Health Community Partnerships provide an example of existing community infrastructure providing oversight of global health volunteers by including community members, local health care systems, and global health organizations in common efforts toward addressing health priorities as identified by the community.

**Benefit to Patients, Communities, and Health Infrastructure**

US GCH practitioners and organizations should strive to ensure continuity of care, professionalism, and accountability and incorporate feedback from GCH partners to validate practices and identify areas for improvement. Published guidelines exist to help individuals and programs consider the impact of their GCH efforts. A framework developed by O’Callahan and described in Table 2 includes 7 essential principles in the assessment of global health intentions.

**Personal Factors**

Although often overlooked, it is important to reflect on personal factors when considering GCH involvement. Such factors include financial and professional impact, personal health, effect on the family, and cultural environment.

**Financial and Professional**

Incorporation of GCH work into practice may be limited by financial obligations. Student debt, mortgages, and dependents at home may compound the problem of missed earnings during time spent abroad. Most short-term positions require voluntary service or offer nominal living or travel stipends, and long-term positions provide a salary that may be only a fraction of what can be earned in US practice. Programs such as Doctors Without Borders and Global Health Service Partnership offer student loan deferment or public service loan forgiveness, which offset some of the financial barriers to GCH participation.

Professional obligations, opportunities to advance one’s

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**TABLE 1 Continued**

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<thead>
<tr>
<th>Resource</th>
<th>Available at</th>
<th>Description of Resource</th>
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<tbody>
<tr>
<td>Simulation Use for Global Away Rotations</td>
<td><a href="http://www.sugarprep.org/">Website</a></td>
<td>Simulation-based curriculum on common practical and emotional challenges in global health. Ethical challenges in short-term global health training: series of cases to illustrate ethical challenges that may arise during short-term international research and clinical experiences.</td>
</tr>
<tr>
<td>Stanford University Center for Global Health and the Johns Hopkins University Berman Institute of Bioethics</td>
<td><a href="http://ethicsandglobalhealth.org">Website</a></td>
<td>Global health education and career development webinars. The global ambassadors for patient safety toolkit offers educational tools to support safe and ethical global health experiences. A student module online workshop is focused on ethical challenges encountered when participating in health-related activities abroad.</td>
</tr>
<tr>
<td>Unite for Sight University of Minnesota</td>
<td><a href="http://www.uniteforsight.org/webinars">Website</a></td>
<td>Global health education and career development webinars. The global ambassadors for patient safety toolkit offers educational tools to support safe and ethical global health experiences. A student module online workshop is focused on ethical challenges encountered when participating in health-related activities abroad.</td>
</tr>
<tr>
<td>Working in International Child Health WHO: Hospital care for children</td>
<td>Book by the AAP SOICH, edited by Caroline Dueger and Cliff O’Callahan</td>
<td>A practical guide on challenges and advice for working or volunteering in international child health. Clinical guidelines for the management of common illnesses and the major causes of childhood and neonatal mortality in resource-constrained settings.</td>
</tr>
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</table>

Gt, global health
Career, and limited leave time also restrict engagement in GCH.\textsuperscript{77,83}

Time away may be considered uncompensated personal time, with practitioners maintaining a US based practice, working part-time, or consolidating vacation to engage in part-time GCH work. Hospitalists, emergency and intensive care practitioners, and some subspecialists may be able to schedule blocks of time away, whereas other practitioners may lack such flexibility. Innovations to overcome barriers include private practice groups (in which the partners rotate an away block), job sharing of a single position, and seasonal contract work.

Professional challenges, especially for practitioners who are engaged in longer-term GCH commitments and removed from resource-rich, technology-intensive environments, include maintaining up-to-date knowledge and skills. Online educational resources, including those used for continuing medical education and maintenance of certification, may be useful for maintaining knowledge, and practitioners can stay updated on the latest clinical and research literature through HighWire Press\textsuperscript{84} and Hinari Access to Research for Health,\textsuperscript{85} the latter being a collaboration of the World Health Organization (WHO) and publishers of major scientific journals to provide practitioners in low- and middle-income countries with open access to health literature.

Professional societies, including the American Academy of Pediatrics (AAP) Section on International Child Health (SOICH), the Academic Pediatric Association Global Health Special Interest Group, and the Association of Pediatric Program Directors Global Health Learning Community, offer resources to guide preparation and recommendations on GCH clinical knowledge and skill strengthening. Pediatric subspecialties, including hospitalist medicine, infectious disease, emergency medicine, hospice and palliative medicine, and hematology and oncology, offer GCH content at national conferences. Professional associations with a focus on global health include the International Pediatric Association as well as international pediatric subspecialty associations.

Health and Lifestyle Related

US GCH practitioners may encounter challenges when providing health care in an unfamiliar environment, such as linguistic and sociocultural isolation and/or the absence of supportive social networks.\textsuperscript{58,86}

Practitioners also may experience challenges to personal health, including occupational hazards and lack of access to health services.\textsuperscript{87,88}

Maintaining family and social connections are also challenges if the global health work places the practitioner at a geographic distance from those networks.\textsuperscript{58,89}

Practitioners relocating with family may have additional considerations of safety, child care, education, and professional opportunities for family members.

Practitioners may become overwhelmed by the depth and breadth of problems they encounter among vulnerable populations, including morbidity and mortality from preventable diseases, advanced stages of illness presentation, or the lack of resources to provide needed care. There is increasing literature focused on addressing emotional

### TABLE 2 Framework for the Assessment of GCH Intentions

<table>
<thead>
<tr>
<th>Intention</th>
<th>Framework</th>
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<tbody>
<tr>
<td>Discernment of self</td>
<td>Before every engagement in GCH, reflect on the impetus to participate and explicitly clarify goals to self and GCH partners. Consider goals of altruism, adventure, compassion, proselytizing, guilt, learning, professional advancement, research, or other personal gain.</td>
</tr>
<tr>
<td>Expressed need by receiving patient population</td>
<td>Allow the space, time, and commitment to engage the community in an assessment of needs and project planning. Acknowledge that people know their own needs. The role of the US GCH practitioner is not to presume needs but to help meet the needs identified by the community.</td>
</tr>
<tr>
<td>Cultural humility and linguistic competency</td>
<td>Language and cultural humility, including through use of language and cultural interpreters, is an essential expectation when working with vulnerable populations. US GCH practitioners bear the responsibility of acquiring such skills or identifying interpreter services that would not further burden the resource-limited global health partner.</td>
</tr>
<tr>
<td>Benefit to host community</td>
<td>Ensure that GCH efforts are of benefit to the community by examining the long-term impacts of interventions on patients, the existing health system, and future programs. Working in conjunction with existing health systems can allow for sustainable contributions to medical education and health system strengthening.</td>
</tr>
<tr>
<td>Benefit to self</td>
<td>Identify resources and support for preparation, reflection, and debriefing to maximize the benefits of working in a different health setting.</td>
</tr>
<tr>
<td>Ethically acceptable material benefits</td>
<td>Donations of medical equipment, technology, and educational materials must be done in conjunction with the expressed needs of the global health partner. Expired medications, nonformulary medications, and equipment that requires expensive maintenance or is not desired by the receiving health center can result in a negative clinical and ethical impact. The receiving GCH partner should be engaged in the determination of utility of donated materials and identification of needed resources.</td>
</tr>
<tr>
<td>Ethical relationship</td>
<td>Global health relationships must have a foundation of mutual respect and shared goals. Such relationships may require time to develop. Engaging with partners in program development, ensuring follow-up, evaluating outcomes, and sustaining communication are important to the short-term and long-term goals of GCH collaborations.</td>
</tr>
</tbody>
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challenges before, during, and after global health experiences. In recognition of such challenges, global health NGOs increasingly offer peer support and professional mental health services.

Cultural

Region-specific beliefs and practices may affect one’s professional and personal integration within the community. Religion, sex, sexual orientation, local laws, and customs may impact one’s ability to work with and live in a particular community. In some countries, for example, homosexuality is punishable by law; this may raise a personal and/or ethical concern for practitioners who wish to work in persecutory countries. Organizations may also have beliefs and practices that could affect one’s ability to participate in activities of the organization. For example, faith-based NGOs may incorporate religious beliefs into medical practice to varying degrees, such as proselytizing or linking healthcare to religious education. GCH practitioners should consider whether this additional mission is congruent with personal objectives.

OPPORTUNITIES AND GAPS

Mentorship

Practitioners with experience in GCH contribute to the growing demand for global health education by offering mentorship and career guidance through academic institutions and national and international associations, such as the AAP International Community Access to Child Health program and the Consortium of Universities for Global Health Program Advisory Service. These and other professional associations with GCH interest sections provide informal networking opportunities and can be a repository of lessons learned and a source of clinical and professional guidance. Specific guidance may be needed for US GCH practitioners in regard to local licensure, malpractice coverage, occupational health and postexposure prophylaxis, and evacuation insurance that protect them from professional and personal risk. Further structured mentorship and individual guidance to navigate the above professional and personal challenges and consideration of a peer-support network to address culture shock may be invaluable resources for encouraging greater engagement in GCH.

There is also a need and opportunity to identify ethically sound GCH activities. Although professional organizations and academic GCH programs often share GCH opportunities through Web site content and national conferences, to date, there is no description of a database with standardized and transparent criteria to assess GCH activities. The creation and maintenance of such a database, along with methods to evaluate and monitor GCH opportunities, could provide an essential resource for US practitioners seeking meaningful and ethical GCH engagement.

Advocacy

The AAP SOICH, the United Nations Foundation Shot@Life, and global health and faith-based NGOs engage US GCH practitioners in legislative advocacy to influence GCH priorities and draw increased attention to GCH needs. US GCH practitioners, when within the United States, serve as advocates to strengthen clinical, educational, and research capacity in resource-limited settings. For example, to build capacity and engage in equitable GCH partnerships, US GCH practitioners host learners and colleagues from resource-limited health centers in resource-rich settings for conferences, training, and skill exchange. Additionally, although underused, telemedicine and online resources can be used to offer innovative cost-saving and carbon-sparing means for consultation, education, and skill transfer.

Standards of Care

Differences in epidemiology, resources, culture and context, language, and continuity of care limit the application of experience from resource-rich settings to resource-limited settings. Guidelines for GCH, such as the WHO Integrated Management of Childhood Illness, have been shown to promote practitioner skill strengthening, health system strengthening, and health education in resource-limited settings. Additionally, the WHO considers one of its core functions to be the development of global guidelines to ensure evidence-based, region- and country-specific practice and publishes clinical and health policy guidelines on a multitude of health topics. A country’s Ministry of Health may also have protocols and published formularies to help standardize care. However, US GCH practitioners do not universally use these tools, and there remains a tendency to base global health clinical practice on anecdotal rather than evidence-based medicine.

The use of WHO, NGO, and/or national guidelines by US GCH practitioners working in resource-limited settings internationally and the resultant effect on patients, communities, and health systems has not been evaluated and described in the literature.

Quantifying the Scope of US GCH Practitioners

Although we describe routes of engagement and identify challenges to involvement in GCH, a survey of US practitioners is needed to quantify and further describe strategies and barriers to engagement in GCH. The numbers of US practitioners engaged in short-term versus long-term GCH work, those volunteering their time and in what capacity,
remains unknown. Furthermore, it would be helpful for professional societies, in addressing the needs of their membership, to understand the barriers among US practitioners to engagement in GCH. With a more comprehensive appraisal of member needs, professional societies could offer educational opportunities to expand GCH knowledge and skills, host resources, and provide support and guidance to US GCH practitioners.

**Broadening the Definition of GCH**

In this article, GCH practitioners are defined as those attending to health disparities in resource-limited countries outside the United States in an effort to provide all children with the opportunity to achieve their health potential. However, US practitioners increasingly care for patients within the United States with medical needs that are typically seen outside the United States, including children who are legal or unauthorized immigrants, refugees, international adoptees, and returning travelers.\(^8,105,106\) Additionally, the concept of GCH is expanding to include underserved communities within the United States and within other high-income countries.\(^107,108\) The care of vulnerable children includes those living in extreme poverty; those in foster care; homeless youth; and lesbian, gay, bisexual, and transgender youth; all of whom benefit from practitioners with knowledge, skills, and attitudes that are identified as essential GCH competencies.\(^109,110\)

This broader definition of GCH is reflected in the Sustainable Development Goals described by the United Nations as applying to all countries, with the intent being to end poverty, protect the planet, and ensure prosperity for all. As an example, Sustainable Development Goal 3 to achieve “good health and well-being for all, at all ages,” is a call to expand GCH to include health care reform, environmental advocacy, and disease prevention in one’s home communities and globally.\(^111\) To deliver care that meets the sociocultural needs of all patients, it is important for pediatric practitioners working within the diverse US population to be globally aware.\(^8,112–114\)

US GCH practitioners use their experiences to influence the United States health systems in which they work. Surveys have revealed that practitioners with previous global health experience outside the United States often choose careers within the United States in which they address health disparities.\(^115–118\) Skills in community engagement and addressing social barriers can be applied to improve pediatric care in the United States.\(^110\) Although not the focus of this article, international medical graduates working within the United States bring similarly valuable knowledge, skills, and attitudes to their communities and educational institutions.

**CONCLUSIONS**

Recognizing the vulnerability and fragility of children within challenging environments draws pediatric practitioners to be change agents through advocacy, volunteerism, and careers in GCH. Although gaps exist in understanding the full spectrum of current GCH activities and the barriers to initiating or increasing engagement among US GCH practitioners, significant opportunities exist to share the resources developed by NGOs, governmental collaborations, academic institutions, and professional associations to improve how US practitioners engage in GCH. It is hoped that this will be a catalyst for further research into the activities of US GCH practitioners with the intent to improve the experience for them and the pediatric populations they serve.

**ACKNOWLEDGMENTS**

Members of the ABP Global Health Task Force include the following: Maneesh Batra, MD, MPh; Sabrina Butteris, MD; Christopher A. Cunha, MD; Chandy C. John, MD; Jonathan D. Klein, MD, MPH; David G. Nichols, MD, MBA; Cliff M. O’Callahan, MD, PhD; Michael B. Pitt, MD; Nicole E. St Clair, MD; and Andrew Steenhoff, MBBCh, DCH. The authors and the ABP Global Health Task Force acknowledge the ABP leadership for their support in initiatives or other forms of engagement into GCH. It is hoped that this will be a catalyst for further research into the activities of US GCH practitioners with the intent to improve the experience for them and the pediatric populations they serve.

**ABBREVIATIONS**

AAP: American Academy of Pediatrics
ABP: American Board of Pediatrics
GCH: global child health
NGO: nongovernmental organization
SOICH: Section on International Child Health
WHO: World Health Organization

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revised the manuscript, assisted with the literature review, provided content expertise, and edited the manuscript; the Global Health Task Force of the American Board of Pediatrics critically reviewed the manuscript; and all the authors approved the final manuscript as submitted and agreed to be accountable for all aspects of the work.
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