From the Chair

Welcome to the winter 2014 issue of *PopFam Quarterly*, a newsletter designed to keep students, faculty and alumni informed about the latest developments in the Department.

In the aftermath of the devastating typhoon in the Philippines and newspaper articles sharing the plight of refugees from Syria, it seems fitting that this issue focuses on PopFam’s efforts to promote public health in emergency settings.

Our feature article describes the critical work that is being conducted by four PopFam faculty who are part of our Department’s Program on Forced Migration and Health (PFMH): Professors Les Roberts, Alastair Ager, Mike Wessells, and Lindsay Stark. Founded in 1994 in the aftermath of the Rwandan genocide, this program is working to professionalize the field of humanitarian assistance so that the best intentions also produce the best results.

In addition to two practicum spotlights highlighting work by PopFam students, we are reprinting a student blog by Dr. Tim Tan, an emergency physician who recently traveled to the Philippines to deliver medical care in rural villages. Dr. Tan is slated to earn his MPH at PopFam in 2014 and is a Columbia University International Emergency Medicine Fellow. Established by our Department and run in partnership with New York Presbyterian Hospital, this fellowship program prepares physicians for leadership roles in global health and humanitarian assistance.

Our faculty spotlight is on Professor Lindsay Stark, who earned both her MPH and PhD at Columbia University. In addition to teaching advanced research methods, Professor Stark is working to bring measurement to the global problem of children living outside of family care. This issue is central to a major new global action plan for addressing the needs of children living in adversity, which was recently spearheaded by Neil Boothby during his two-year post with the U.S. government. We are delighted to welcome Dr. Boothby back to the Department this spring;
you can read about his work in Washington in this issue as well.

On the domestic front, we are pleased to share information about Getting Ready for School, an innovative program enhancing Head Start programming.

Finally, our alumni profile features Syeda Ayesha Ali, MPH ’10, who is working on sexual and reproductive health and rights in her native Pakistan.

As you can see, we have a lot to share in this issue. I hope you enjoy it.

Sincerely,

John S. Santelli, MD MPH
Harriet and Robert H. Heilbrunn Professor & Chair

---

**Feature Article**

**Health in Crisis Settings:** Bringing Data to Humanitarian and Health Emergencies

It is hard to imagine a greater challenge than safeguarding the health and well-being of individuals recovering from natural disaster or war. But ensuring that such populations have access not only to food, water, and shelter but to psychological, educational, and logistical support is the mission of PopFam’s Program on Forced Migration and Health (PFMH). Each year, through applied research projects and technical partnerships, this program works to “professionalize the field of humanitarian response.”

Established in 1998 to train future generations of refugee and humanitarian response workers, the PFMH has grown into one of the world’s leading centers on humanitarian research and teaching. Students earn a Master of Public Health degree along with a Certificate in Public Health and Humanitarian Assistance (PHHA). In addition to coursework, students complete a practicum in a humanitarian setting, often working on projects developed by their PopFam professors.

PopFam Quarterly spoke with four PFMH professors to learn more about their projects and the role of data and measurement in addressing humanitarian crises.

---

**Effective Action Requires Accurate Information**

PopFam Professor Les Roberts knows a thing or two about bringing assessment skills to natural and man-made emergencies. During his two-decade-plus career, he has led over 50 surveys in 17 countries, becoming one of the world’s foremost experts in measuring mortality in times of war. In recent years, his work has taken him to the Democratic Republic of the Congo, Iraq, Zimbabwe, and the Central African Republic. He is currently working to document the incidence of human rights violations.

According to Dr. Roberts, one cannot properly respond to a humanitarian crisis without first understanding its variation and magnitude. He cited an example of a population-based survey he led in 2010 that set out to measure grave violations committed against children during a period of armed conflict in the Democratic Republic of the Congo. The United Nations had passed a resolution calling for an end to such violations and was also monitoring them in a group of countries that included the Congo.

Dr. Roberts and his colleagues conducted their study in the Congo’s South Kivu Province, an area that had been especially hard hit by conflict and where the national army was taking steps toward peace. Working at the request of UNICEF and in partnership with a local NGO, Dr. Roberts’ team gathered data from individual households on four kinds of grave violations against children: military recruitment; abduction; killing and maiming; and attacks against education. The researchers also conducted interviews with traditional leaders and other stakeholders in the targeted areas.
Their findings indicated that grave violations were occurring at rates that were far higher than those indicated by the U.N.’s monitoring of these problems. The household survey estimated that 44,898 incidents of the four targeted violations had been perpetrated in South Kivu Province, compared to 54 events that had been recorded by the U.N. system for same period.

“The U.N. monitoring system is not really interested in how many violations are occurring,” Dr. Roberts explained. “They are interested in identifying a few violations and having U.N. peacekeepers verify that these violations really happened so that they have the evidence that will stand up in a court of law.” While also critically important, the U.N. agenda is entirely different from a public health agenda, Dr. Roberts said. “I want to understand the nature and the magnitude and the U.N. wants well documented examples so that they can hold political and legal processes accountable.”

Professor Roberts explained that his researchers have the advantage of collecting data that will be kept entirely confidential, which makes it more likely and safer for individuals to share information. But only by understanding the full magnitude of the grave violations that occurred is it possible to develop an effective programmatic response.

**Entering a Major Humanitarian Crisis with a Calculator**

Playing a technical role in a humanitarian emergency can be difficult, Dr. Roberts said. He recounted working on a terrible cholera crisis in Zaire. “Approximately 60,000 people died in a three-week window and my job was keeping track of how many new cases had arrived and how many people died each day.” Dr. Roberts spent his days on motorcycle taxis visiting clinics, asking NGOs how many people had died, information he shared in evening conference calls.

“At the time, I felt quite ashamed that I wasn’t doing more for people,” he said. “I could see people with IV bags that were hanging below the wrist and which weren’t going to work and instead of finding sticks and branches to (raise these up), I was just chasing data.”

About a year later, he recalled, he was teaching for the Red Cross and presenting information about the cholera outbreak in Zaire and there was a doctor in the training who had also been there during this crisis. He remembered receiving the epidemiological data on the outbreak on a daily basis. “He said that at first he thought ‘somewhere out there some bleeding academic is producing this data when there is work to be done,’ but later he told me, ‘You were the eyes for all of us,’” Dr. Roberts recalled.

Today, Dr. Roberts says he can look back on this work and see that “so many of the policies we made came from this monitoring and the fact that we knew when this cholera outbreak had peaked. All of these decisions came from data. And this was very affirming. But it is only when you have perspective that the act of going into highly disorganized, near-anarchy settings and doing something that only produces data can make sense.”

**Better Methods, Better Information**

PopFam professor Lindsay Stark is also acutely aware of the role that measurement can play in understanding public health problems. Professor Stark, in collaboration with other PFMM faculty and students, developed and piloted an innovative methodology—known as the Neighborhood Method—for measuring gender-based violence in Internally Displaced Persons (IDP) camps in northern Uganda. Although anecdotal evidence had suggested that gender-based violence, including rape, was endemic in these camps, there was little or no concrete data on the scope of the problem.

Recognizing that people in IDP camps were living very close together, Professor Stark and her colleagues knew that a woman in one household would be likely to know what was occurring in her neighbor’s home. Relying on this insight, they developed the Neighborhood Method, in which local interviewers ask female heads of household about their own experience and their neighbors’ experiences of gender-based violence. The method proved effective and has been used to gather data in four countries—Uganda, Liberia, Ethiopia, and Sri Lanka.

Findings from studies using this methodology have turned conventional wisdom about gender-based violence on its head. This research showed that, in all of the settings that
were examined, a woman was much more likely to be raped or beaten in her own home by someone she knew than she was to be raped by a stranger. This finding was contrary to what people thought was true from official or formal record keeping. “These findings really challenged common assumptions and have major implications for policy and programmatic responses,” Dr. Stark said.

More recently, Dr. Stark has been working to bring new understanding to an under-addressed issue in the field of child protection—the global problem of children who are “living outside of family care.” Despite wide-ranging research showing that one of the most significant threats to children’s well-being is the lack of a permanently engaged parent or caregiver, there is no systematic assessment of the scale of the problem.

“The truth is that nobody really knows how many children are living outside permanent parental care,” said Professor Stark. “And the estimates which do exist tend to count the children who have been placed in institutions and to overlook those who are living on the streets or have become involved in trafficking.”

There is also little understanding of the mechanisms through which children end up outside of family care. There is evidence that many of the children in developing and middle-income countries who end up in institutional care as “orphans” actually have a parent who has relinquished their care in the face of extreme poverty or other stressors. But in the absence of national surveillance systems, it is impossible for countries to address this problem strategically or to know if they are doing so effectively.

**Defining Standards to Drive Better Methods Worldwide**

Fortunately, there is new momentum for improving the quality of data around this issue, Dr. Stark explained, in no small part as a result of the new U.S. Government Action Plan on Children in Adversity. “The U.S. government is currently working with a few priority countries on this issue,” she said, “and hopes to be able to show measurable reductions in the numbers of children living outside of family care.”

In fact, the second objective of the government’s three-part strategy is to reduce the incidence of children living outside of families and promote protective and permanent family care. These reductions will be measured at the national level and the U.S. government, in collaboration with other actors, will support the capacity of governments and local organizations in priority countries to measure them.

To facilitate reaching this goal, Dr. Stark led a small team in developing a set of guidelines for national governments to enumerate children outside of family care. By using these guidelines to conduct national surveillance in and across countries around the world, the researchers aim to collect data that is comparable year to year and that can measure progress over time.

In 2014, Dr. Stark and her colleagues will work with ministries and operational partners in a few priority countries, beginning with Cambodia, to conduct the first systematic enumerations of children outside of family care under the new guidelines. Dr. Stark hopes that big improvements in child well-being will come from these early steps to improve the evidence base. *(Learn more about Dr. Stark in the Faculty Spotlight on page 10.)*

**Questioning Long-standing Practices**

In some cases, the role of the Program on Forced Migration and Health is to rethink whether long-standing humanitarian assistance practices are actually effective. A number of practices have been scrutinized carefully for evidence of effectiveness, but many others continue simply because no one has bothered to examine them empirically.

One of the most common responses to protecting children during humanitarian crises has been to swiftly create a “community-based child protection group.” Also known as child protection committees and child welfare committees, these groups typically consist of some 15 community members who come together to assess the needs of children recovering from humanitarian crisis. Their charge is to support children and families and to refer individuals to services available through formal child-protection systems.

For some two decades, community-based child protection groups have been implemented at the frontlines of international child protection efforts. The only trouble is, no one really knows how much good they do.

For PopFam Professor Michael Wessells, this absence of data was troubling. “The lack of systematic evidence for the effectiveness of these groups makes it very difficult to
define effective practices or to give appropriate guidance to practitioners,” he said.

In response, Dr. Wessells and a group of 10 national and international child agencies and donors formed an interagency learning initiative in 2009. They aimed to develop evidence on the impact of community-based child protection groups that could inform global standards for practice. The group began by conducting a global desk review of existing evidence on community-based child protection groups.

The review found that many of these groups were not achieving their goals. In too many cases, Dr. Wessells said, external NGOs had established these entities through a didactic, top-down approach. Without a real understanding of the child-protection priorities of the communities served or significant buy-in from its members, these programs did little good and in some cases they even did harm.

Fortunately, the review also identified success stories. “The number one factor in whether a group was effective was whether there was genuine community ownership of the work they were doing,” Dr. Wessells said. When groups were formed by local stakeholders who were deeply invested in the work, they could make a real difference in children’s well-being.

**From Desk Review to Grounded Learning**

Armed with this knowledge, Dr. Wessells and his interagency colleagues developed a multi-year grounded learning initiative. This first stage of this research, which is currently underway in Sierra Leone and Kenya, focused on learning what community members saw as the greatest threats to their children and the usual responses to such threats.

In each country, these assessments were conducted by indigenous researchers who spoke the local language. Using strong observational skills and a range of ethnographic research tools, the researchers worked with parents, local chiefs, members of existing community-based child protection committees and NGO child-protection workers, focusing both on perceptions of the sources of harm to children and the mechanisms that community members could turn to for support.

In Sierra Leone, this ethnographic research revealed a deep chasm between the perceptions of parents and other community members and those of law enforcement and other representatives of the government’s formal child-protection system.

For example, Dr. Wessells noted, family members almost never contacted formal authorities to report cases of child abuse. “For more than 90 percent of the harms that people identified for children, parents told us that they relied on their own communities, whether their local chief or extended family, for help and support,” Dr. Wessells said. “They did not go to the government or to the police, even when there was a statutory crime that could have been reported.”

The research also revealed that many local people had a very negative view of the concept of child rights. Although the national government of Sierra Leone has been working to promote children’s rights and enacted a ground-breaking child rights law in 2007, these efforts appeared to be backfiring.

“Among the top harms people spontaneously identified for children was child rights,” Dr. Wessells said. “Local people objected to workers coming into their communities and teaching their children that they had rights without also teaching them that they have responsibilities.” Parents felt that these programs undermined their ability to discipline their children.

“Although other studies have indicated that a variety of logistical and economic issues prevent people from accessing formal support systems, this ethnographic research showed that cultural factors are also involved,” Dr. Wessells said. “People are telling us, ‘Our village is a family and we don’t talk to outsiders.’ So it is not surprising, he said, that people would not respond to externally driven community-based child-protection mechanisms and formal government support structures that they felt were being imposed from the outside.
Bringing Research to Practice

"We don’t want this to be a research project but a process of learning that is used to strengthen policy and practice," Dr. Wessells said.

To move into a position to influence multiple agencies, the project has from the outset established partnerships with the government of Sierra Leone and various international and national child protection agencies. “This way, when the results are fed back to the agencies, they will likely experience a sense of ownership that will inspire them to incorporate new approaches and methods in their practice,” Dr. Wessells said. Already, he noted, the government is using the research to guide a new national child welfare policy.

The project is also enabling community-driven action and careful linkages with the national government to address teenage pregnancy, which the ethnography had identified as one of the top three harms to children. An important feature of this work has been to facilitate an inclusive community process.

“Too often, communities are sites of discrimination against women, young people and the disadvantaged,” Dr. Wessells said. Through slow, locally driven processes, youth and adults are working in creative ways to reduce teenage pregnancy. "I have done action research for a long time but have seldom seen this depth of community ownership,” Dr. Wessells said.

Taking a public health approach, the community intervention is being evaluated over two years using population-based outcome measures and a comparison group. While it is too early to see the full results of this work, Dr. Wessells reports that the research is “moving the community back to center and helping the community and the government to interact in ways that will help to strengthen the national child protection system.”

Understanding the Elements of a Successful Intervention

For PopFam Professor Alastair Ager, the use of a humanitarian response known as Child Friendly Spaces raised similar questions. Dating back to the Yugoslav Wars, when humanitarian aid workers began providing children with safe areas to play, these programs operate on the notion that the chance to participate in even a small amount of normal activity can be restorative for a child facing a humanitarian emergency.

Ranging in the size and scope of their offerings, Child Friendly Spaces (CFS) are now a common programmatic response for children in communities recovering from war, natural disaster and other kinds of humanitarian crisis. These programs aim to promote children’s psychosocial well-being and education while also serving as a bridge to more established support systems for vulnerable children.

Like community-based child protection groups, however, these programs have proliferated without a solid body of research demonstrating their efficacy.

“It makes sense that when children are uprooted from their homes and are taken—fleeing—into refugee camps, that it would benefit them to provide a safe space where they could play and where teachers and volunteers could provide singing, games and other activities, but you also need to ask if this is going to make a real difference in the lives of children facing so many challenges and having experienced so much trauma and loss,” said Professor Ager.

To fill this gap in understanding, Dr. Ager and World Vision International have embarked on a series of action learning studies. The goal is to document the impact of CFSs on children and families and to identify best practices in the design, implementation and monitoring and evaluation of such interventions.

The first evaluation was conducted in Ethiopia in a community populated with Somali refugees. This study found that the CFS was more effective in reaching boys than girls, particularly when it came to increasing literacy, results that pointed to the need to consider new strategies for addressing the needs of girls. The study also found that caregivers with children who had access to the CFS reported less stress and frustration about camp conditions.

The second study evaluated CFS programs designed for Congolese refugees living in a camp in Western Uganda. This research found that the CFSs were well used and were
providing clear benefits for children who attended frequently.

Most notably, children who attended the CFS were able to sustain their psychosocial well-being over time, while children who didn’t demonstrated a marked deterioration. The study also showed clear benefits for parents of children who had access to CFS; these caregivers reported feeling less stress about how their children were doing and more awareness of support structures that were available to families within the resettlement area.

In addition to providing overall findings on impact, however, this study provided concrete data on the importance of program quality in achieving real change in children’s lives.

“This research is showing us that it is not enough to put up a fence and to provide a place for children to be,” Dr. Ager said. The CFS must be designed and implemented strategically.

“We found that by using a simple quality checklist—looking at things like whether kids’ artwork was displayed on the wall, whether there was a timetable for activities—we could predict whether one of these interventions would make a real difference in the lives of the children served,” Dr. Ager said. “These things may not be hugely significant in themselves, but they are indicators of a meaningful engagement with children that seems crucial to success.”

This kind of learning, Dr. Ager said, will ultimately help develop evidence-based guidelines and standards of best practices that can ensure that these well-intentioned and increasingly prevalent interventions for children in crisis have greater impact.

Practicum Spotlight

Report from the Field: Katherine Arnold, MPH ’14

After graduating from college, Katherine Arnold joined the Peace Corps, spending two years in Mali as a water and sanitation extension agent. While there, Katherine conducted a needs assessment survey and helped fundraise for and install several water pumps to replace shallow wells. She also secured training to help two villagers become pump repairmen and worked with local officials to develop a local funding mechanism to finance future repairs.

Her experience working for Peace Corps sparked her interest in public health and was rewarding in many ways, but Katherine also left Mali frustrated by something that she had observed: in too many cases, the organizations she worked with weren’t measuring the real health impact of their work.

“It’s easy to report the number of wells or latrines that have been built—you know what the result is going to be and it is guaranteed to make you feel good,” Katherine explained. “If you ask instead whether these wells and latrines have actually improved health—your ultimate goal—your results might not show what you want. And I think people are afraid of that.” Addressing this gap in results reporting “sort of became my crusade,” Katherine said, explaining that she ultimately met with her boss and their major funder to discuss improving their water/sanitation reporting indicators.
It was the Program on Forced Migration and Health’s focus on measuring and evaluating the direct impact of programs and interventions that attracted Katherine to the Mailman School and to PopFam. Now in the second year of her MPH, Katherine has taken nine of the 13 courses designed for students pursuing a Certificate in Public Health and Humanitarian Assistance. “I have gotten exactly what I wanted, which is the methodological and statistical skill set needed to evaluate humanitarian programs and hold us, the aid community, accountable to the communities we impact,” she said.

Katherine had the opportunity to put these skills to use during her practicum, when she spent three months living and working in the Democratic Republic of the Congo. Working with Dr. Les Roberts and Mailman colleagues Taylor Warren and Ryan Burbach, Katherine co-led a study that sought to measure trends in occurrence of four grave violations against children—military recruitment, abduction, killing and maiming, and attacks against education—in the population in South Kivu over time. The survey was a follow up to a 2010 survey conducted by Columbia, a local NGO called Rebuild Hope for Africa (RHA), and UNICEF.

Katherine and her Columbia colleagues worked with RHA on the survey methodology and implementation and with six local Congolese who conducted 700 household interviews. The findings were dramatic: since the 2010 survey, reported grave violations have decreased by approximately 83%.

“It has been really exciting to see these results, but now we are trying to understand the reasons for this drastic decrease,” Katherine said, noting that researchers need to conduct qualitative research to understand the findings. The reduction may be resulting in part from the 2012 Action Plan that the government signed with the U.N., which outlined measures to end the recruitment and sexual abuse of children by government forces, she said.

“We did see a drastic reduction in the percent of grave violations committed by government forces—down from 63% in 2010 to 26% in 2013,” Katherine said, adding that, “it would be incredibly useful to the international community to have an example of a policy like this impacting the situation on the ground. However, we need to explore other theories and understand whether the reduction in violence was isolated to South Kivu, or whether it happened other places in DRC as well.”

One of the most valuable aspects of the practicum for Katherine was learning from the local NGO that led the study on the ground. “Rebuild Hope for Africa initiated the study, organized all the logistics, and knew the security situation on the ground,” she said, adding that the founder and director, Gang Karume, “got us out of a couple sticky situations!”

When you work on the ground, Katherine said, you realize that local partners are everything when it comes to achieving intended goals. “Just because you have a U.S. education and different technical skills does not mean you know more than your local colleagues, because in fact the opposite is true,” Katherine said. “I learned in both Mali and Congo that a program won’t work unless it is led by a local person who is committed to what they do, because they are the ones who really know the context, language, problems, and feasible solutions. This was the case during my practicum in Congo, and I think that’s why I had such a great experience.”
Practicum Spotlight

First Person Account: Hannah Wesley, MPH ’14

After completing my first year in the PopFam department, I traveled to Jordan to conduct my practicum in the area of child protection as a part of my global certificate requirement. While I was there, I assisted with several projects, including a series of evaluations that are being conducted by Professor Alastair Ager in collaboration with World Vision International to gauge the effectiveness of Child Friendly Spaces (CFS). Developed to provide children living in emergency settings with a safe place to play and learn, CFSs are implemented around the world. However, there is a dearth of scientific studies on their impact.

The project I worked on is part of a major, three-year research collaboration and is included in the 2013-2015 Child Protection Working Group’s (CPWG) official work plan, which is effectively the United Nations blueprint for helping promote the protection of children in humanitarian emergencies. Through the evaluations that are being conducted, researchers are hoping to answer three questions: (1) How effective are CFSs in providing a protective environment for children vulnerable to abuse, exploitation or violence? (2) How effective are CFSs in providing psychosocial support to children? and (3) How effective are CFSs in mobilizing and equipping communities and caregivers to fulfill their roles to protect and care for children?

To date, evaluations of CFS programs in Ethiopia and Uganda have been completed and studies are currently being conducted in Iraq and Lebanon, focusing on CFSs for Syrian refugees in both camp settings and host communities.

I spent a good deal of time preparing for a third Middle East evaluation, which is scheduled to take place in Jordan in early 2014. My tasks included collaboratively developing the tools that will be used in the evaluations in this region, as well as working side by side with a local monitoring and evaluation officer and coordinating with other staff at the implementing organization. Additionally, I had a chance to assist in conducting a secondary analysis for the project’s Uganda dataset, which has given me a better understanding of how the data we are currently collecting will help us show results. Our hope is that the results obtained from these studies will reflect that CFSs promote children’s wellbeing and safety, as well as help communities come together to care for their children.

My previous overseas work experience had been in East Africa, so coming to Jordan was a big change. However, it didn’t take long for me to fall in love with the culture and I was lucky enough to enjoy many of the amenities of home, such as high-speed wireless, cable, and safe streets. I’ve found a place in my heart for the food and I even love the weather, which is something I never thought I’d say about the Middle East. My return to the U.S., where I don’t hear the call to prayer five times a day, has certainly taken some adjustment!

Professionally, I’ve had the opportunity to work with some preeminent child protection specialists, and I have learned a great deal about my chosen specialty. I now understand firsthand how unpredictable humanitarian work can be and how being able to adjust to setbacks and changes are just a part of the job description. For example, the timeline I was given prior to leaving for Jordan ended up bearing little resemblance to what actually played out, but we were able to adapt on the ground.

While setbacks can be challenging, I have also gained more appreciation for the importance and complexity of the work that emergency response teams are providing. The number of stakeholders involved in a humanitarian response—from host governments, to national and international NGOs, to the hosting population—is staggering; the sheer logistics involved in
operating a complex system such as a refugee camp can be overwhelming. However, it is incredibly inspiring that, despite these challenges, these entities are able to successfully coordinate their efforts and make a positive impact in the lives of those who need it the most.

**Faculty Spotlight**

**Lindsay Stark**

Professor Lindsay Stark has more than a decade of experience leading applied research on protection of women and children in humanitarian settings. As an assistant professor of population and family health in Columbia University’s Program on Forced Migration and Health, Professor Stark’s scholarly agenda has focused on developing rigorous and culturally sensitive measurement approaches in areas where there remains a dearth of knowledge.

She has helped pioneer a number of new methodologies, including the Neighborhood Method for documenting human rights violations; a Participatory Ranking Method that has been included in a recent World Health Organization assessment toolkit; and the Child Protection Rapid Assessment in Emergencies Toolkit, which was developed for the global Child Protection Working Group.

**What is your role and range of responsibilities at the Mailman school?**

When I was hired to join the [PopFam] faculty three and a half years ago, I was based in Indonesia, where I supported the University of Indonesia, the government of Indonesia and UNICEF to set up a research and policy think tank focusing on child protection. The goal of the center is to build the capacity of faculty in Indonesia to conduct applied research and to train future leaders in the field of child protection and welfare.

Now that I am back in New York, my time is divided between teaching, research, and policy/advocacy efforts. I co-teach our Investigative Methods course and I am teaching Advanced Methods in Global Health for our doctoral students. I also direct the Child Protection in Crisis (CPC) Learning Network and co-chair the Assessment and Measurement Taskforce of the Child Protection Working Group, the global coordination body for child protection in humanitarian settings.

*The Program on Forced Migration and Health states a goal of “professionalizing the field of humanitarian response.” What does this mean?*

For a long time the field of child protection—and humanitarian operations, more broadly—has not been guided by a strong set of guidelines or standard procedures and it hasn’t been informed by robust evidence. The focus has been on the immediate—we have to go in and protect children, we have to respond—and there isn’t time to assess whether our interventions are helping. But without really taking the time to understand what works, you can’t be sure you are actually helping. Even worse, you might be doing harm.

We have seen this historically, for example, where Western models of addressing trauma or depression have been imposed without any understanding of the way a local community or culture may interpret or respond to specific events. We know we can do better. For example, in post-conflict Sierra Leone, girls who had been with armed groups during the conflict showed signs of distress—both from their wartime experiences and from the subsequent rejection by their families and communities. In seeking to learn more about how these girls viewed their distress and what practices would best support them, practitioners came to understand the importance of communal cleansing rituals, which allowed girls to rid themselves of their perceived “spiritual pollution” resulting from their wartime activities.

What we are trying to do is learn whether particular humanitarian responses and interventions are helping or hurting communities and what skills humanitarian workers need to deliver high-quality programs and services. We seek to involve students at every stage: from wrestling with
these complexities in the classroom, to applying the skills they’ve attained to real world research and practice in emergency settings.

**How did you decide to go into public health and child protection?**

After I graduated from college, I was awarded a fellowship to live in Indonesia for two years and teach at the University of Gadjah Mada in Yogyakarta. I also regularly volunteered with an institution for developmentally delayed children and adults. Residents of this institution were often bound, with no activities, stimulation, or opportunities to learn. It was a warehouse. I would plan and lead activities for the children and model this engagement for the staff. Working with these children just ignited my passion for this work.

**How would you assess the state of the child protection field from the lens of someone working to professionalize this work?**

I am excited that there is finally attention and commitment to doing this work right. For too long, child welfare professionals and policymakers have said that we can’t do what health professionals can do or what nutrition specialists can do in terms of surveillance and measurement. There are so many practices that have become standard even though we have no idea whether they are effective. We are moving forward in showing that it is possible to assess problems that are harder to measure; and as we do this more and more, programs and policies will be driven by evidence and will result in real changes for children. (See the Feature Article in this issue for details about Dr. Stark’s past and present work.)

---

**Welcome Back**

**Neil Boothby**

PopFam Professor Neil Boothby, an internationally renowned expert and advocate for children affected by war and displacement, returns to teaching in the Heilbrunn Department this month after two years in Washington, D.C., where he took on a daunting task: coordinating the considerable efforts of the U.S. government to address the needs of vulnerable children under one umbrella agency and one comprehensive action plan.

“There was really substantial work being done on behalf of vulnerable children, but it was highly fragmented,” related Dr. Boothby. In fact, U.S. government aid for children was being channeled through 30 different offices in seven departments and agencies. In addition, individual offices and agencies tended to target individual issues—i.e., children affected by HIV and AIDS, or child labor, or sex trafficking—without taking into account the overlap between them.

Seeking to develop a more coordinated and multifaceted action agenda, the U.S. government had passed a law in 2005 calling for the appointment of a special advisor to take on this work.

“Though the law was created in 2005, many people felt there had not been enough progress toward implementing a coordinated and effective strategy,” said Professor Boothby, who assumed the role of special advisor in March 2012. Under his leadership, an interagency team worked collaboratively over 10 months to develop the U.S. Government Action Plan on Children in Adversity, a document representing the first-ever whole-of-government strategic guidance for U.S. government international assistance for children.

Launched at the White House on December 19, 2012, this comprehensive plan for action has three principal objectives and three sub-objectives. While the Action Plan applies to U.S. government assistance globally, it also identifies a more targeted starting point for these efforts: to achieve three core outcomes in at least six priority countries over a span of five years.
In these countries, the plan calls for significant reductions in the number of (1) children not meeting age-appropriate growth and developmental milestones, (2) children living outside of family care, and (3) children who experience sexual violence or exploitation. The Action Plan also promotes efforts to build capacity to establish and sustain national surveillance systems to track these core results.

“Everything we have been working on is results focused,” Dr. Boothby explained, adding that in addition to establishing this framework, he has also worked over the past two years to establish a public-private partnership that is helping secure adequate funding to help children in adversity around the world. “There are currently 10 founding members including the World Bank, USAID, the U.S. Department of Labor, EIM group, Save the Children, and Wellspring Advisors,” he reported.

While Dr. Boothby is pleased with the work that has been accomplished, he is eager to return to the classroom at Columbia this month and looks forward to resuming his full slate of responsibilities at PopFam in March.

“When you have the chance to teach a course for students at Columbia, it really is a privilege,” he maintained. “For those of us who work as practitioners and academics, being able to teach is a chance to examine our own work and provides a tremendous way to deepen our understanding.”

**PopFam in the News**

Initiative increases focus on the health of boys  
*USA Today*, January 22, 2014

This article discusses new guidelines designed to help clinicians better address the health care needs of adolescent boys and young adult men. The article quotes Dr. David Bell, a PopFam Professor and medical director of the Young Men’s Clinic, on helping providers understand and engage young men.


A Tech Boost for Sex Ed and Parents: Column  
*USA Today*, December 16, 2013

In this column, PopFam Professor Leslie Kantor talks about the new digital tools that can help parents talk to their kids about sex and relationships. These include nine new tools designed by Planned Parenthood, where Ms. Kantor serves as Vice President of Education, as well as other resources.


The Philippines’ Next Challenge  
*Time*, November 11, 2013

This article examining the public health challenges of typhoon Haiyan in the Philippines quotes PopFam Professor Les Roberts on the serious impact that it has had on water, sanitation and sewage services, contributing to the spread of diarrheal diseases.

Program Spotlight

Getting Ready for School

The benefits of access to early childhood education have been well documented: children who attend preschool do significantly better in school and they tend to have better health outcomes as well. However, while access to early education has clear benefits, educators are still working to identify the specific interventions that will be most helpful to children.

A few years ago, PopFam Professor Helena Duch, a psychologist and expert in early childhood development, found herself wondering if a parent education program developed by her colleague, Professor Cassie Landers, could improve outcomes for kids attending Head Start programs in New York City.

Dr. Landers’ initiative, called “Getting Ready for School,” was developed for families in Eastern and Central Europe who had limited or no access to preschool education. The program, funded by the Open Society Foundations, provided parents with a set of home-based activities designed to promote preschoolers’ early numeracy and literacy skills.

“There were already a lot of curricula that were focusing on promoting literacy in math or language, but the vast majority of these were developed for the classroom and did not have a significant parent education piece,” Professor Duch explained. “This felt like a very big gap.”

To test her theory, Dr. Duch and her colleague, Dr. Kimberly Noble from the Department of Pediatrics, developed a pilot project adding a home-based parent education component to regular Head Start programming. The goal of the study, which also collected comparison data from Head Start classrooms that did not get the added intervention, was to learn whether the parent-led education would improve early math and literacy skills for the participating children.

The pilot study indicated that fostering parent involvement had the potential to be an effective means of supporting school readiness. However, the study also showed that parents wanted more help teaching their children how to modulate their behavior and emotions so that they could learn.

Inspired by the potential of the Getting Ready for School intervention, Dr. Duch and Dr. Noble applied for a Development and Innovation grant from the U.S. Department of Education. With these funds, they spent a year working to adapt and expand the program to ensure that it promoted both classroom and home-based learning. They also developed a significant new component intended to help children with self-regulation—the skills children need to pay attention and learn.

“It was a very collaborative process,” said Dr. Duch, noting that the team included Professor Landers and Landers’ collaborator on the original Getting Ready for School curriculum, Kathleen Hayes, as well as Herb Ginsberg, a well-known expert on early math education, and several other researchers from Columbia University, the University of Michigan, and Harvard.

By promoting math, literacy, and self-regulation, the new model aims to provide an integrated approach to supporting school readiness, with activities conducted both by teachers and parents.

For teachers, an important goal was to create activities that were easy for teachers to understand and to use. According to Dr. Duch, the new Getting Ready for School program is designed to address a range of topics in just thirty minutes a day, and this time need not be spent all at once.
“One of our biggest goals was to ensure that teachers could integrate the curriculum into their current schedule without having to make any major changes,” Dr. Duch explained. The curriculum often achieves this efficiency by integrating several objectives into one activity. For example, Dr. Duch said, children might be playing a math game that also has a self-regulation component.

To facilitate home-based education, parents were provided with weekly lesson plans and the opportunity to attend regular group discussions designed to help them practice new lessons and build skills. Parents could also watch videos of parents and children working together, thanks to a video library that was created for this purpose.

This expanded and enhanced Getting Ready for School intervention is currently being piloted in twelve Head Start classrooms in New York City. Dr. Duch and other researchers are assessing the program’s feasibility and fidelity both at home and in the classroom. The program is implemented in a staggered fashion, allowing time to make revisions before introducing the materials to new classrooms.

During the next academic year, Drs. Duch, Noble, and the rest of the team will conduct a small randomized control trial of this intervention to assess its preliminary efficacy. If all goes well, Dr. Duch and her colleagues should be on track to roll out the program in more Head Start programs during the 2014-15 school year and to apply for additional funding to conduct more rigorous testing of the intervention across different sites.

Student Report
Providing Emergency Medical Care in the Philippines

By Tim Tan, MD, MPH ’14

Following the devastation caused by Typhoon Haiyan/Yolanda in the Philippines, I joined a medical team deployed by NYC Medics, a disaster relief NGO based in New York City, and provided emergency medical care to hard-to-reach, small communities. The work put my Public Health and Humanitarian Assistance classwork into context in a practical fieldwork experience, from collaborating with local and NGO partners, to participating in OCHA cluster meetings, to prioritizing needs and providing care.

Our Mobile Model

True to the mission of NYC Medics, our medical team focused on providing care to remote locations through mobile units. On one of our first excursions, we worked in a village on Homonhon Island, a small island two to three hours by boat from Guiuan, which had had no contact with the rest of the country due to shattered boats and damaged phone networks. With transportation assistance from U.S. Navy helicopters, we ran a one-day clinic out of an unused hospital, seeing over 170 patients.

As expected, the team treated patients with infected wounds, infectious diseases with a high incidence of acute respiratory illness and pneumonia, and exacerbations of chronic illnesses such as asthma or hypertension. The other health issues we saw ranged widely—on one occasion, I played the role of dentist to extract a young boy’s infected
tooth. On another occasion, the diagnosis was all-too-clear when a small girl threw up an Ascaris worm (an intestinal roundworm). A patient whom we identified with life threatening conditions—renal failure and pulmonary edema—was evacuated off the island to a referral hospital run by partner NGOs.

For staffing, we had a surgical physician’s assistant, a nurse from New York-Presbyterian, several paramedics and myself, an emergency medicine physician. In addition, two nurses from the Department of Health (DoH) in Guiuan joined us and provided tetanus vaccinations to our patients. One of the DoH nurses stayed behind to provide follow-up wound care to patients that we treated.

The Navy forgot to pick us up that night, so we ended up camping overnight on the island before returning to Guiuan the following morning. The locals were more than happy to have us as our guests, however, so the impromptu stay went smoothly. It was a quick introduction to life on the ground.

**Expanding Care around Guiuan**

After that first trip out, we continued to work with the U.S. Navy and USAID to plan additional mobile medical clinics for different sections of Homonhon Island. During this first week, the NYC Medics medical team essentially split into two groups. I was the physician for the mobile team, and together with anywhere from four to seven other team members—physician assistants, registered nurses and paramedics (or EMTs, emergency medical technicians)—we made several additional trips to Homonhon Island, providing medical care to communities that had not been reached since the storm.

While one mobile medical unit served Homonhon Island, NYC Medics formed a second “land-based” mobile medical unit providing care to small communities surrounding Guiuan, treating from 130 to over 250 patients per day. Medical complaints and diagnoses were similar, with infected wounds, respiratory illness and diarrhea and untreated hypertension, diabetes, and asthma commonly encountered.

The city of Guiuan itself had its medical needs covered by a Doctors Without Borders clinic and field hospital. This field hospital served as our referral site for patients who were especially ill and needed to be evacuated from Homonhon Island for inpatient care.

**Relocating to Hernani**

During the second week of the relief mission, NYC Medics learned that several communities northward along the coastline had not received the same level of attention from relief agencies. The team thus relocated to the towns of Llorente and Hernani, where we continued to work using the same model of mobile- and land-based teams. Though the destruction in these areas was less severe, medical needs were comparable due to damaged infrastructure and limited access to personnel and resources. Since the international community had a smaller presence in this area, we mostly worked with the mayor and a local doctor to identify communities in which to work.

I continued to work with the mobile team. One of our roles was to deliver care to people on an island that was only
accessible by boat and another community that could only be reached by a mountain hike over washed-out roads. We hiked with all drugs, medical supplies, and clinic gear, rushing to beat the high tide. It showed me how out of shape I am compared to the EMTs! Around Hernani and Lorente, the patient mix included more primary-care issues, but we continued to encounter a large infectious disease burden, as one would expect post-disaster, including acute respiratory infections and diarrhea. Throughout our stay, each team saw 100 to 300 patients per day, with a final day clinic of over 550 patients (with both teams involved). In total, we treated over 2,500 patients, all in remote areas.

The Power of Partnerships
NYC Medics works with numerous partners to set up the day clinics and serve communities located outside of the NGO centers. During my time in the Philippines, the U.S. Navy provided us with transportation, USAID helped us coordinate our work with the Navy, and Doctors Without Borders was a valued referral partner in Guiuan. Many other wonderful collaborators assisted in numerous ways.

AmeriCares stands out as one of the most valuable. They provided a truckload of essential medications and supplies to our team, which enabled us to continue delivering emergency medical care. In a video that AmeriCares made during one of our trips to Homonhon Island, an AmeriCares colleague, Alex explains: “We were the first people to come to the community since the typhoon struck. The team treated more than 100 patients, including a diabetic woman who was on the verge of losing her foot from a cut she got during the storm.”

Farewell to the Philippines
I am leaving to return to New York soon, but the international response to the Typhoon is only just beginning. A lot has happened since I first landed in the Philippines. I will carry this experience back to the classroom and forward as I continue my career after graduation.

Tim Tan, MD, is earning an MPH in PopFam, with a certificate in Public Health & Humanitarian Assistance and is also a Fellow with Columbia University International Emergency Medicine.

Photo credits: NYC Medics Operations Director, Phil Suarez
This article is reprinted with permission from Columbia Public Health: Student Voices.

Alumni Update
Where Are They Now?
Syeda Ayesha Ali lives and works in her native Pakistan. Since graduating from the Mailman School and PopFam in 2010, she has worked at the Pakistan office of Rutgers WPF, a global NGO that promotes sexual and reproductive health and rights (SRHR). As program manager for sexual and reproductive health education, Ms. Ali helped create an educational curriculum that is now delivering critical information about SRHR to young people in schools in Pakistan. Prior to joining Rutgers WPF, Ms. Ali worked as a program officer focusing on global health issues for the Asia Foundation.

How did you become interested in adolescent sexual and reproductive health and rights?
I grew up in Pakistan where I did my undergraduate degree in economics and psychology and I also earned my first master’s degree in applied psychology and counseling. I ended up working at Rozan, an NGO in Islamabad that is working to address emotional and psychological health, including gender-based violence. I was a counselor on a help line, and I noticed that a lot of calls were coming from adolescents with all kinds of questions about adolescent development and puberty. We even got some calls about sexual relationships, which is a subject that is really taboo to talk about. In Pakistan, premarital sex is a punishable
crime. I realized that young people needed information and they needed outlets to ask questions.

**What do you do for Rutgers WPF in Pakistan?**
I am a program manager at Rutgers WPF in Islamabad. We have about 70 people on staff. As a program manager, I am responsible for an educational initiative that is working in local schools to give students information and education on sexual health and human rights. The goal of this program is to help adolescents make informed decisions in their lives, especially when it comes to their sexual and reproductive rights. This includes the right to protect themselves in case they face sexual harassment.

**Where is this curriculum being taught?**
It’s a pretty wide mix of schools. The English-language version of the curriculum is being taught in 49 schools, mostly private, in Islamabad, Lahore, Multan, and Quetta. The Urdu-language version has already reached 250,000 students in 10 districts across Pakistan. In all of these cases, the vast majority of students are in grades 8, 9 and 10. It’s very hard to get information to students younger than that.

**Was it hard to interest schools in this program?**
The organization I work for has been working with local NGOs in districts throughout Pakistan for almost fifteen years and these partners have the relationships that are needed to build support for a curriculum like ours on the local level. They are the ones who meet local health and education personnel and sign a memorandum of understanding to do the work. It is my job to train staff at these NGO partner organizations on the curriculum and to train the school principals and senior level teachers as well. I also use a train-the-trainer approach so that senior teachers can train the teachers in their own schools to implement the curriculum. We work this way because it is effective and it creates a far more sustainable program model.

**What other projects are you excited about in your current work?**
In Pakistan, access to information is difficult. In some places, girls literally can’t leave home and nobody teaches them [about sexuality]. Schools and libraries are ill equipped. But increasingly we have mobile phones and the internet and I am very excited about the potential for mHealth [mobile health approaches] to help young people access information. Our organization recently got funding from the Dutch government to develop mobile phone apps and internet and SMS programs that will allow people to ask questions on sexual and reproductive health and rights and get information.

**How would you describe the status of girls and women in Pakistan today?**
The dynamics for girls and women vary so much. Pakistan is a big and very diverse country. You have cities like Islamabad and Karachi where you see girls who are more independent and live by themselves and you also have areas where it is hard for girls even to go to school. If you look at our national statistics you see that early marriages are still a big issue for girls and one in four are married by the age of 18. And education remains a very big issue. Enrollment in secondary school is much lower for girls than for boys. Some of this drop has to do with poverty and some with sexual harassment [of girls who do go to school] but it also has to do with parents who don’t see the value of investing in their daughters’ education.

**How did you decide to pursue an MPH and how did you choose the Mailman School?**
In one of my jobs after college I did qualitative research with a focus on maternal and child health, HIV, female sex workers, male sex workers and other marginalized groups. I realized that I was already working in public health and that I should get a degree that would allow me to combine my training in psychology and health behavior with public health. In Pakistan—and this was five years ago—public health was still considered a domain for the medical profession and I wasn’t able to find a program focusing on sexual and reproductive health. I applied to Columbia and PopFam in 2008 and I got a scholarship to come. My first international travel was to New York and I loved it right away. It’s a place where no one feels like a foreigner.

**How did the Mailman School and PopFam prepare you for your current work?**
First, I just had such a great experience with the staff and faculty. [Director of Academic Programs] Lynne Loomis-Price wrote to me before I even got to the States to ask about what I wanted to study and to make course suggestions. My advisor, Lynn [Freedman] was incredible as were so many of the professors who were mentors to me. And I must say that I am using each and every course in my work. I use the program development course when I write proposals and develop curriculum. I use the program
evaluation course when I design and conduct evaluations, and I use the pedagogy of sexuality education course when I create curriculum. And I use what I learned about advocacy at PopFam in all of the work I do in Pakistan. Without considerable advocacy skills, you can’t do this work.

Course Spotlight

Beginning in this issue, PopFam Quarterly will shine a spotlight on selected courses offered to MPH students. In each case, the course is described in the professor’s own words.

Vaccines: From Biology to Policy

Philip LaRussa, MD

Vaccines have been heralded as one of the most important public health interventions of the 20th century but our systems for vaccine development, delivery, and acceptance remain fragile. The course I teach aims to give students the basics of how vaccines prevent illnesses and how they have improved the health of communities. We cover vaccine development and clinical trials, vaccine safety, vaccine delivery, vaccine financing, parental and provider acceptance, vaccine mandates and the anti-vaccine movement. We also examine differences between U.S. and international vaccine programs.

I like to engage the students in thinking about vaccines in the context of the epidemiological problems they are trying to solve. I ask students to think as if they were the minister of health in a country. How would they utilize vaccines as one of the tools that they have to control disease, along with medications and other public health interventions? As the minister of health, you need to think of vaccines as one of many tools that you can use in trying to accomplish your goals and you always need to consider the best use of limited resources.

Polio is a great example of present and future cost savings because the vaccine really can eliminate the disease. Malaria might be an example where there is an exciting vaccine but unless there are improvements, you will probably never eliminate the parasites that cause malaria from the environment in Africa and Asia. So in this case, if I were the minister of health, I might say that we should find the small niche where we use the present malaria vaccine, maybe in high-risk groups such as infants and pregnant women, while putting the majority of our resources into other interventions like bed nets, spraying, and draining standing water.

On the surface, first-world countries have done a very good job of controlling infectious diseases. The last case of naturally occurring polio in the United States was in 1979, and if a young mother asks me about it, she won’t have any idea of what the polio vaccine has done. Developing countries have another history, often a colonial history, with a less than optimal relationship with the first-world countries which are introducing vaccines and this complicates vaccine efforts. But skepticism about vaccines comes with the territory and it all provides for good discussion.

The Elimination of Pediatrics AIDS: Towards a Global Approach

Stephen W. Nicholas, MD

This course addresses the history of the AIDS epidemic from the mid-1980’s until the present day. I really try to help students understand the history of the epidemic and how complex AIDS has always been as a public health issue. For many students today, the assumption is that AIDS is a heterosexual epidemic in Africa. Many of my students don’t understand the original assumptions about the disease here in the United States or why it was once considered a gay men’s disease. They lack insight into the enormous fear that people had about AIDS and how this affected decision making and funding and policy.

One of the ways that I introduce students to these issues is to have them engage in role playing. I introduce them to a particular point in the history and I assign them a point of view—it could be that of a gay man living with AIDS, or of a minority person living with AIDS, or of a caregiver or a dentist, or a conservative minister, or a person running a blood bank—and we have a
discussion. To be assigned a role that is very different from your own point of view helps you understand how complicated all of the assumptions about AIDS were and how complicated it was to develop policies.

One of my areas of primary focus is the prevention of mothers’ transmission of HIV to their babies, and my class re-enacts the huge fight that we had (in New York State) about whether there should be mandatory testing. Was this testing evil? Was it good? Behind the scenes on this debate, gay men were enormously worried about what the testing would mean for them. And you have to remember the huge amount of stigma surrounding AIDS at this time. We all knew people who were losing jobs and housing. But in the end, many of the predictions of the bad things that would happen (because of mandatory testing) did not occur.

We also cover the progress that has been made in addressing pediatric AIDS, from the height of this epidemic in children in Harlem to today, and we examine how lessons learned in Harlem and New York City apply to other low-resource settings, like the Dominican Republic and Haiti, where the struggle to eliminate pediatric HIV/AIDS continues.

Planning Child Survival Programs

M. James Eliades, MD, MPH

Over the past several decades child health programs have contributed to a steady decline in the absolute number and rate of under-five deaths worldwide. Rates remain high, however, and mortality in the first month of life—which accounts for 40-60% of under-five deaths—has not seen a decline, so there is still a great deal of work to be done.

Although my class gives an overview of the main causes of mortality for newborns and children under five, the focus is on how to best deliver known interventions and the broader systems and human resource issues that serve as barriers to implementing effective child survival programs. We explore preventive and curative service delivery mechanisms in depth, focusing on the community and primary health clinic level, and we examine the skills that are needed to plan and manage programs in challenging real-world contexts.

I try to talk to students about the things that people didn’t talk to me about during my training. For example, we talk a lot about human resources issues. What does the research show on what motivates health workers to improve their performance? Is it more effective to pay a health worker for performance or is it more effective to give a health worker higher status in their community? We also talk about how small strategies can sometimes make a big difference. Take the issue of drug expiration. Médecins Sans Frontières developed a new way of shelving drugs that loaded new drugs from the back so that the older drugs would be removed first, greatly decreasing drug wastage.

I draw on my own experiences in the field and invite guest speakers with special expertise. For instance, for the class on community case management (CCM) of childhood illnesses, representatives from Save the Children, UNICEF and the International Rescue Committee joined us for a panel discussion to speak frankly about successes, failures and challenges in efforts to develop CCM programs that resulted in a stimulating three-hour discussion with students.

Announcements

Recent Awards and Grants

Alastair K. Ager, PhD, received a grant of $40,000 from the Luce Foundation for a project, “The Engagement of Local Faith Communities in Humanitarian Response.”

Alastair K. Ager, PhD, and Helen de Pinho, MBBCh, received a grant of $283,169 from the ReBUILD Consortium for “Health Systems Resilience: A Complex Adaptive Systems Analysis.” The project is using case studies in Cote d’Ivoire, Nigeria, and the Democratic Republic of the Congo to model the capacity of health systems to continue service delivery in context of crisis.
Wendy Chavkin, MD, MPH, was honored for her work on behalf of underserved women and children by the Public Health Association of New York City at its November 2013 annual awards Ceremony. Dr. Chavkin received the inaugural award named for the late Dr. Jean Pakter, a long-time Mailman School faculty member and former head of New York City’s Bureau of Maternity Services and Family Planning.

Helena Duch, PsyD, received a Calderone Award for Junior Investigators. The $25,000 award will support her project, “The Role of Maternal Acculturation in the Development of Early Childhood Obesity in Latino Children.”

Sally Findley, PhD, received a 13-month, $399,943 award from The Robert Wood Johnson Foundation to assess patterns of participation in WIC and other community health resources. The study is a collaboration with the New York State Department of Health and Public Health Solutions and will yield the first “real world” picture of WIC enrollment over time and births.

Theresa M. McGovern, JD, received the Pandora Singleton Ally Award from SisterLove, Inc., a non-profit organization working to eradicate the adverse impact of HIV/AIDS and other reproductive health challenges for women and families around the world. This award honors a person who has worked in the field of HIV/AIDS for 20 years or more.

James Phillips received $30,000 from the Doris Duke Charitable Foundation to fund research capacity workshops in Ghana (for GEHIP) and Tanzania (for Project Connect). These workshops will address quantitative and qualitative analysis as well as writing and dissemination.

Carolyn Westhoff, MD, MSC, received the Guttmacher Award from the Association of Reproductive Health Professionals at their annual meeting in September 2013.

Recent Publications


Health Policy and Planning, 1–11.
doi:10.1093/heapol/czt086


doi:10.1093/heapol/czt091


Upcoming Events

Tuesday, February 4

5:30 pm-8:00 pm

Mailman Auditorium

Please join the Heilbrunn Department’s Health & Human Rights Film/Lecture Series for a special screening of ENDGAME: AIDS in Black America with special guest Director Renata Simone. A question & answer session will follow.

Wednesday, February 19

9:00 am–3:00 pm

Hammer Health Sciences Bldg

(Room LL103 before lunch; 8th Floor Auditorium after lunch)

The CPC Learning Network and the Global Social Service Workforce Alliance will host the second session of a three-part symposium series, Measuring the Immeasurable: Building the Evidence Necessary for Effective Child Protection and Family Welfare Policies and Programs. The symposium will bring together experts on the social service workforce to discuss recent research and foster dialogue between those working domestically and internationally. To register for the symposium, or to request further information, please email Eva Noble at evanoble.cpc@gmail.com.
Weekly Series (Mondays) 11:30 am–1:00 pm  B2 Conference Room

Also, don’t forget the weekly Department seminar series in the B2 Conference Room. February speakers will include Professors Jim Phillips, Lindsay Stark, and David Frost. (Details on speakers and topics can be found in the Student Digest, www.mailman.columbia.edu/students/student-life/student-digest)