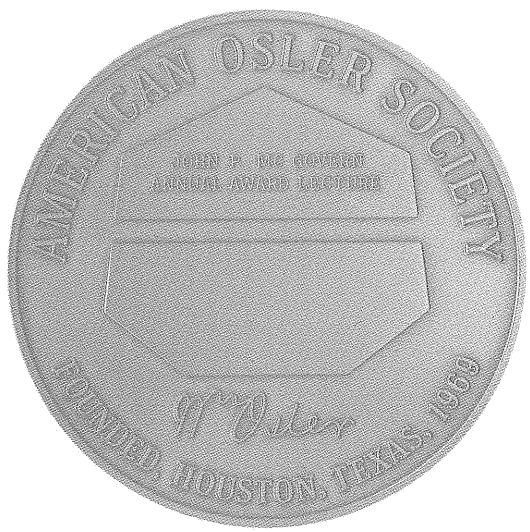
American Osler Society, Inc. John P. McGovern Award Lectureship

Just Call Us Children: The Impact of Tsunamis, AIDS and Conflict on Children

Karen Hein, MD



John P. McGovern Award Lectureships

1. *Our Lords, The Sick* presented by Albert R. Jonsen, Ph.D., April 12, 1986, in San Francisco, California.

2. *To Humane Medicine: Back Door or Front Door?* presented by Edward J. Huth, M.D., April 29, 1987, in Philadelphia, Pennsylvania.

3. *Medicine and the Comic Spirit* presented by Joanne Trautmann Banks, May 3, 1988, in New Orleans, Louisiana.

4. *The 'Open Arms' Reviving: Can We Rekindle the Osler Flame?* presented by Lord Walton, April 26, 1989, in Birmingham, Alabama.

5. *Rx: Hope* presented by E. A. Vastyan, May 8, 1990 in Baltimore, Maryland.

6. *Osler's Gamble and Ours: The Meanings of Contemporary History* presented by Daniel M. Fox, April 10, 1991, in New Orleans, Louisiana.

7. *From Doctor to Nurse with Love In a Molecular Age* presented by William C. Beck, March 26, 1992, in San Diego, California.

8. *The Heroic Physician In Literature: Can The Tradition Continue?* presented by Anne Hudson Jones, May 12, 1993, in Louisville, Kentucky.

9. *'The Leaven of Science': Osler and Medical Research* presented by David Hamilton, May 10, 1994, in London, England.

10. *A Body of Knowledge: Knowledge of the Body* presented by Sherwin B. Nuland, May 10, 1995, in Pittsburgh, Pennsylvania.

11. *Other People's Bodies: Human Experimentation on the 50th Anniversary of the Nuremberg Code* presented by David J. Rothman, April 25, 1996, in San Francisco, California.

12. *The Coming of Compassion* presented by Roger J. Bulger, April 3, 1997, in Williamsburg, Virginia.

13. *Why We Go Back to Hippocrates* presented by Paul Potter, May 6, 1998, in Toronto, Ontario

Cover — Obverse and reverse sides of John P. McGovern Award Lectureship commemorative medal which is presented to each annual lecturer.

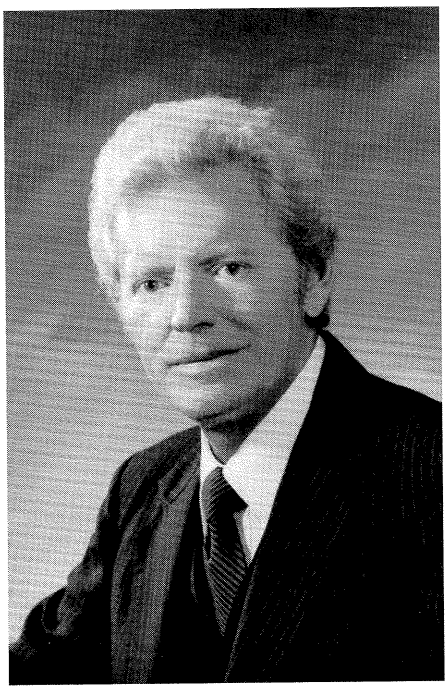
The Twentieth John P. McGovern Award Lecture

"Just Call Us Children"
The Impact of Tsunamis, AIDS and Conflict on Children

by

Karen Hein MD

Delivered April 2005
at the Thirty-Fifth Meeting of the American Osler Society



John P. McGovern

JOHN P. McGOVERN AWARD LECTURESHIP

Through the generosity of the John P. McGovern Foundation to the American Osler Society, the John P. McGovern Award Lectureship was established in 1986. The lectureship makes possible an annual presentation of a paper dedicated to the general areas of Sir William Osler's interests in the interface between the humanities and the sciences—in particular, medicine, literature, philosophy, and history. The lectureship is awarded to a leader of wide reputation who is selected by a special committee of the Society and is especially significant in that it also stands as a commemoration of Doctor McGovern's own long-standing interest in and contributions to Osleriana.

Karen Hein MD

Karen Hein MD is a Professor of Epidemiology & Population Health and Clinical Pediatrics at Albert Einstein College of Medicine. Ms. Hein is a former President of the William T. Grant Foundation (1998-2003) and was the Executive Officer of The Institute of Medicine (1994-1998) and is Professor of Epidemiology and Population Health and(Clinical) Pediatrics, Albert Einstein College of Medicine, New York. She currently is a member of a dozen boards of non-profit organizations, including CCF, RAND Health, Consumers' Union, The National Board of Medical Examiners and is Board Chair of The Center for Health Care Strategies.

What if William Osler were giving the McGovern lecture this year? As we meet in April 2005, post-tsunami relief work continues 100 days after the worst earthquake in the region in 100 years, 21,000 people are dying each day of AIDS in Africa and we are engaged in a war in Iraq that has killed over 1500 American soldiers, but also over 100,000 Iraqis. The world is smaller by virtue of the rate of spread of news....and viruses, but what would Osler say about the relationship of doctors to human suffering and human development in 2005? Undoubtedly, he would speak to the role of physicians in ameliorating suffering, and would be keenly aware of the impact of man made disasters, namely war, on his own suffering, having lost his only son, Revere, on the Western front in 1917, the greatest tragedy in his life.

William Osler was referred to as "a doctor without borders"[1] long before Medicins Sans Frontieres won the Nobel Peace Prize. But he would have had more to say, I believe, about the role of physicians beyond ameliorating suffering, also our role in preventing deadly conflict and minimizing the impact of natural and complex disasters on not just his child, or our children, but all children.

I am honored to be giving the McGovern Lecture at this auspicious moment in the history of our country and the world. At a time when our nation is wielding its strength in ways that cause us to be the focus of world attention in both admiration and distain, I want to focus on how and why we might be involved in situations literally on the other side of the earth.

"Nationalism has been the great curse of humanity. In no

other shape has the Demon of Ignorance assumed more hideous proportions; to no other obsession do we yield ourselves more readily...it runs riot in the race, and rages today as of yore in spite of the precepts of religion and the practice of democracy. Nor is there any hope of change; the pulpit is dumb, the press fans the flames, literature panders to it and the people love to have it so."[2]

Osler was correct in identifying national boundaries as a barrier to the delivery of care. As an example consider the impact of disasters by income and year for high, middle, and low income countries. Note that the number of disasters is inversely related to income. The number has been relatively stable in Western industrialized nations over the past decade, but has risen substantially in developing and least developed nations.[3] Also the types of disasters vary as well, with the least developed nations having the greatest percentage of disasters in the form of epidemics, whereas areas like the former Soviet Union have droughts and related disasters as the predominate type.

Humanism and Medicine 2005

A Google search on Humanism and Medicine yielded 260,000 items, mostly prizes. Thus it seems that humanism is worthy of a prize instead of being a characteristic that we should all possess. This leads me to a quite literal definition: by "Human" I will be referring to membership in humanity. We are one of the only species that exhibits altruism...but we are also one of the few that kills its young. I will use "Humanitarianism" to mean acting virtuously towards those in need, a definition taken from a pivotal conference on Rights, Dignity and Inequality held in October 2003 led by Professor Amartya Sen, then Master of Trinity College, Cambridge, UK with presented papers subsequently published in *The Lancet* in September 2004. In these papers, the

ethical underpinnings of humanitarian relief work were described as being motivated by 4 considerations: (1) Humanitarianism: Acting virtuously towards those in need; based upon compassion, empathy, or altruism; (2) Utilitarianism: Maximizing aggregate subjective happiness; (3) Equity: Achieving a fairer distribution of health capabilities and (4) Rights: Fulfilling our obligations so others are dignified (encouraging "voice" and participation and self-determination).

During the past few years the UN and the US have launched several global health initiatives. The UN project, "3X5" promises to enroll 3 million people by 2005 in programs that will provide antiretroviral medications to people living with AIDS. The Millennium Development Goals have lofty expectations of vastly reducing poverty and health disparities. MDG spurred some industrialized country governments to commit to providing development assistance equivalent to 0.7% of their gross national income. Currently the US spends less than 0.1% of GDP on development assistance. The Millennium Challenge Account and PEPFAR are American initiatives addressing leading causes of death and disability in least developed countries. The philosophy behind these efforts was analyzed as part of the 2004 *Lancet* series on humanitarian relief. For example, President Bush's PEPFAR and MCA efforts might be viewed as examples of acting virtuously towards those in need. The emphasis on "mercy," although admirable, puts the emphasis on the giver, thereby creating the view of the recipient as dependent or as a victim. The "equity" approach underlies the WHO "3x5" initiative. Providing antiretroviral medications to the poorest nations helps equalize access to medically necessary treatments, regardless of circumstance. And the "rights" approach underlies the Convention on the Rights of the Child which underlies the series of programs focusing on

children that I will describe. This approach gives agency and voice to participants and encourages self-determination.

Why should we get involved? Osler's reflections expressed it magnificently: "By far the most dangerous foe we have to fight is apathy, indifference from whatever cause, not from a lack of knowledge, but from carelessness, from absorption in other pursuits, from a contempt bread of self-satisfaction."[4]

Why focus on children and youth? William Osler had a deep connection with children. "Osler loved children and in turn children loved him...Osler was the Children's Captain...on occasion he crawled on all fours, allowing warmth, affection, and concern to spill out through a screen of lively banter that bridged the gap between man and child."[5]

In the United States, most people are focusing on the rising proportion of the population that is over the age of 65 years. While the proportion of children and youth is decreasing, the absolute number continues to rise, so that currently there are millions more children and adolescents than during the Baby Boom years when attention was on the resources needed by these younger people, rather than the elderly.

In most countries affected by natural, complex disasters and deadly conflict, the pyramid is just the reverse of ours, with children and youth accounting for a growing percent of the population and in many developing nations those under age 35 years account for well over half of the population. The median age of the 10 youngest countries is about age 16 years, and all of these countries are in sub-Saharan Africa (Yemen, Nigeria, Uganda, Burkina Faso, D. Republic of the Congo, Angola, Somalia, Burundi, Zambia and Benin). Life expectancy in Japan is 82 years, more than 2 1/2 times that in Zimbabwe, where it is only 34 years. Thus, it is important to examine our view of children and youth.

Reframing our view of young people

I have entitled this presentation, "Just Call Us Children": The impact of tsunamis, AIDS and armed conflict on the young. The reason for this title is that children and youth want us to think about them as kids...not as orphans or victims or child soldiers. They want us to know them but not to brand or stereotype them by life circumstance any more than we would stereotype them by class or race. They ask that we think about ways to support their development, independence and contribution, not focus exclusively on their vulnerability, susceptibility or risk.

Media portrayals of young people often demonize and stereotype their behavior as problematic. A more positive, developmental view of young people's potential as well as their contributions under girds a new, "positive youth development" perspective. This approach has been adopted by many organizations, including the William T. Grant Foundation, viewing young people as a resource has now been incorporated into its mission. Organizations and various branches of the UN including WHO, UNICEF and PAHO have also adopted a positive youth development approach, rather than exclusive focus on problems or diseases.

It's possible to reframe our view of children and youth to incorporate this shift in thinking and action. This change in perspective means shifting from an emphasis on deficits to one emphasizing assets. Programs are geared to not simply relieving suffering or preventing problems, but rather to creating circumstances that permit young people to live up to their potential....to thrive instead of simply survive.

Osler's view of human potential is consonant with this view of positive youth development. "Linked together by the strong bonds of community of interests, the profession of medicine forms a remarkable world unit in the progressive

evolution of which there is a fuller hope for humanity than in any other direction."[6]

Aristotle wrote that society's obligation to maintain and improve health rests on the ethical principle of "human flourishing"—the ability to live a healthy and thus flourishing life. Flourishing and health are inherent to the human condition, according to Ruger. [7] How could this view of children and youth apply to the post-tsunami situation? How could we reframe the opportunities to intervene in ways that support human development and flourishing rather than only seeing deficiencies, need and remediation? I will describe our recent experiences in southern India doing post tsunami relief work and also our experiences in sub-Saharan Africa to demonstrate how children and youth do contribute to well-being and thriving, even under the most dire of circumstances.

Experiences doing post-tsunami relief work in southern India

In early 2004 I joined the board of The Christian Children's Fund (CCF), an ecumenical organization with projects in 40 countries focusing on children and youth. CCF's philosophy is based on the idea that with some support and resources, communities can identify and remedy situations that keep children from reaching their potential. They focus on poor kids, but define poverty as more than the absence of material resources. Exclusion and vulnerability are two additional factors that cause kids to fail, so CCF projects focus on ways to give dignity, voice and rights to kids and to reduce the threats to their environment that limit their ability to develop and thrive. I've experienced these projects in very personal ways. As one youngster said to me in a remote village, "CCF is a felt organization."

When the tsunami hit, I asked CCF if I might help. They

already had programs in the affected regions of India, Sri Lanka and Indonesia before the tsunami, and have a commitment to be there not just for months or years, but for a decade or more afterwards. Hence CCF was perfectly positioned to gear up quickly in the most affected post-tsunami areas. We did our volunteer relief work in the areas around Chennai, Pondicherry and Karaikal in February 2005, just 5 weeks after the tsunami hit. Of the 270,000 deaths associated with the tsunami, more than 10,000 occurred in the state of Tamil Nadu along the southern coast of India. Half the people affected were children (Table 1).

Table 1. Children affected by the tsunami in Southern India

Number of children	0-5 years of age	6-10 yrs of age	11-18 yrs of age	TOTAL
Separated Missing	4,250 6,133	4,350 4,800	3,200 3,750	11,800 14,683
Disabled	300	200	200	700
Double Orphans	644	500	600	1,744
Single Orphans	800	400	250	1,450

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Reports of child trafficking are widespread with an estimated 6,159 children involved in trafficking or migration activities suspected as including sexual exploitation. Most of these antedated the tsunami, but risks escalated following the tsunami. Responses varied by age with youngest who were separated from parents at greatest risk of institutionalization. Adolescents seemed to be doing less well as a group than younger children.[8]

A personal account of what it looked like 5 weeks after the tsunami hit "Find a place that makes you happy....and go there". The print was clear on the bright poster of a garden, but the frame was askew and it was the only family belonging left on the only remaining wall of a house in a destroyed fishing village in South India. I stood fixated on this idyllic poster, trying to envision the family that once sat in this room together, sheltered by now shattered plaster walls. Tangled fishing nets balled up and hurled by the tsunami into the corner was the only remaining sign of their source of income and stability. People are afraid to eat the fish, because they might have consumed human remains. Now the remaining villagers don't want to be anywhere near the sea, except to mourn.

Being part of the humanitarian relief effort focusing on children and youth

After a half-day of orientation by CCF staff, we (my husband Ralph and I and our Tamil speaking staff person, Gokula) headed to the beachfront for our first experience with the reality of the tsunami...not just a TV clip or an article in the local paper...but being with dozens of people, all eager to tell their stories and to find out why we were there. At first, the beach just seemed empty. A few huge pieces of wooden boats scattered about. A few men sat on the beach, facing different ways, not facing the water. As we got closer, we nearly tripped over chunks of broken concrete. That was all that remained of this fishing village where 1,000 families

were living just 5 weeks ago. Fifty-two people were killed in this one village, and not one house remains.

As we kept walking, the rubble became more dense... pieces of driftwood, bits of plastic, random debris. Walking was difficult, since the ground was nothing more than piles of crumbled concrete. Away from the rubble people were living in makeshift lean-to's and huts, with plastic sheets partially covering upright sticks defining small spaces where a family or group of people were sheltered. There are no chairs, no beds, nowhere to sit, and no privacy. Women cook on driftwood fires. They are stuck between their past and the future.

People have to get water from a nearby water pump and use a public toilet at a community center. Each day, the government brings some rice and the women line up to get an allotment. The kids are going to a school some distance away. They are afraid to return, and since there's little for them to do where the adults are, they stay at the school all day and into the evening.

People are afraid to sleep near the water, so many just sleep on the edge of the road or in the temple-across a major road and away from the sea. At first, some older teenage boys approached us and began telling us about the situation, and then older men and women joined us and finally some kids. They took us around, introducing us to people who couldn't walk because of injuries from the tsunami. One young man had his feet bandaged and told us that he had 21 stitches in his soles to repair cuts sustained as he ran through the crumbled concrete to rescue children from the tsunami. The government gave him a few antibiotic pills, some vitamins and a pain reliever and told him not to walk. So, there he sits, in the rubble, on a mat...5 weeks so far. The government has offered the people temporary housing 20km inland, but the temporary camp is 10km from the water. They are

fishermen so they give up their livelihood if they move.

In one destroyed village, as I wandered through the rubble, I saw pages of school books sticking out of downed palm trees, and looked up at a 50-foot water tower where a boat was found suspended from the top! In the midst of this scene of utter devastation was one young man living in the shell of his old house. He had laundry hanging from a line and was sweeping the area in front of his missing door. He was silent as was I. The rest of the village had moved to new temporary tent dwellings, but he remained, rooted to some inner memory of a life or family that existed just 5 weeks ago.

The women were doing the basics of caring for the family....cooking on make-shift stoves of pots on driftwood, cleaning, even sweeping the sand with a broom in front of the tent or palm frond dwelling, washing and hanging clothes. But they wanted more. They asked about opportunities for additional training so that they wouldn't be dependent on the men for income, since fishing was unlikely to bring in money soon, or ever again. They talked in groups and planned together. They asked for training so that they could develop additional sources of income.

We never saw children totally alone. Even when children had lost parents, we heard about who was pitching in to help out. In one village an old man held my arm and cried as he spoke about losing his wife and two daughters when they went to the beach to water trees they had planted. He took us to his home to show us her photograph. Living with him now were his two granddaughters who were in school in Bangalore learning information technology. They came home to their village to live with grandpa and help. So, he had lost his wife and two daughters, but they had lost their mother, aunt and grandmother. Their story was typical....big branches of the family tree gone...but the tree was still strong from those remaining.

We visited Pullicut Island, a very remote community of 1,000 families located on an island (a sand bar really) off the coast north of Chennai. The fresh water lake that separated the island from the mainland had been filled with fish and provided good drinking and irrigation water. The tsunami made it all brackish, so now the island, surrounded by water on all sides, has no fresh water at all. There were no health facilities or services before the tsunami as few health workers are willing to travel such a distance to supply any, so CCF is thinking of ways to both assess and provide health care along with other responses to the needs of children affected by the tsunami.

There were sporadic signs of rebuilding. Some villages had tents; others had palm frond dwellings with thatched roofs. One village had permanent brick homes being built with funds sent by a successful Indian businessman who had lived in that village 40 years ago and paid for the entire town's new homes. Other villages were just as they were the day after the tsunami...people living in the middle of empty village spaces or amidst the rubble in lean-tos or under a tarp.

Child Centered Spaces

Child centered spaces are places where children can go and be safe. They were first established by CCF in Afghanistan and were also set up in Iraq, Sierra Leone, Northern Uganda and other areas where there are displaced children. Child Centered Spaces (CCS's) are designated places, free from physical hazards, where children of all ages can spend part or all of the day. There are organized activities including recreation, education, health (physical, mental and spiritual) programs and caring adults. CCS's are staffed by "volunteers" from the community selected by the villagers. Usually they are young men or women who are 19-

25 years of age. They receive basic training in the concepts and practicalities of running a CCS, and are provided with a storage trunk containing age-specific, developmentally appropriate toys and games and a medical kit. Additional trainings include early childhood development, health assessment and psychosocial support (including crisis management and grieving assistance).

Christian Children's Fund sets up Child Centered Spaces with local Indian non-governmental organization (NGO) partners. In our case, the two local NGO partners were The Community SEVA Centre and Mass Action Network. Our Tamil speaking colleagues from each local NGO were guides for our village visits as well as translators for our health assessment training sessions.

Child Centered Spaces emerge from the rubble

Children and youth who survived the tsunami have images in their minds that include horrid visions of violent death, destruction, and loss. But now they are in the midst of rebuilding their homes, their lives and families. How can kids grow up in the midst of such disasters? What would they like us to do? To answer these questions, we spent our days and weeks with them.

We focused on CCS's set up by CCF on the east coast of Tamil Nadu in villages severely affected by the tsunami. The situations range from people still living in rubble on the sites of their destroyed villages to new temporary quarters (tents or palm/thatch dwellings) constructed farther back from the sea. The CCS is either a tent or area where children gather for various programs. In the morning, they receive supplemental food (hard-boiled eggs, bananas, chick peas), then there are various times for playing games with toys supplied by CCF (jump ropes, rubber rings, soccer balls, Indian board games) or, if no formal schooling is possible, educational ses-

sions for kids of various ages.

There are special sessions for very young (0-5 yrs), older kids (5-10 yrs), and adolescents (10-18 yrs) to help them sort through their experiences and resume some semblance of normalcy. For example, we joined a circle of young kids on the beach near the water. The CCF staff had developed a series of games and exercises to help them deal with their fear of being near the sea.

The older kids had been working on a little dramatic performance in which they acted out various aspects of the tsunami including being trees knocked over and people dying on the beach. The drama continued, showing scenes of children returning to school and a contest in which kids were able to write about and share their abilities to cope and rebuild their lives and community. The drama ended by their receiving a prize from their district leaders and having a celebration in which they all got up and danced. It was so incredible to see their energy funneled in these ways and to see how connected they were to each other...older to younger ... and adults to kids—-despite the despair and loss, the sense of togetherness and mutual help is palpable.

Child Centered Spaces: A place to make health part of well-being

The CCS's (child centered spaces) are literally and figuratively a place to promote health as a key part of well-being. The range of activities includes age and gender specific developmentally appropriate ways to engage children and youth, to allow them to mourn, but then to regularize their lives again. Christian Children's Fund quickly established 290 Child Centered Spaces in tsunami-affected areas of India, Indonesia and Sri Lanka. Each one can accommodate about 150 kids meaning that some 38,000 children from birth through 18 years of age have an opportunity not only to

restore a sense of safety and predictability but to access and improve their health status, even in the temporary setting of a post-tsunami relief camp. My husband and I, pediatricians, could easily see what needed to be done. The trick was how to integrate the health component into the child centered spaces. We chose to incorporate a health assessment training module into the overall manual written for training CCS volunteers, CCF staff and partnering NGO's.

We built our health assessment module around the stages of intervention incorporated into WHO standards divided into 3 stages

1. Immediate: safety and survival issues ; 2. Intermediate: as dwellings and communities are stabilized and people are moved to temporary or permanent places and people moved into safer, healthier temporary dwellings away from hazardous areas and debris; 3. Long term: setting up permanent links with health providers and public health infrastructure and expanding CCF sponsorship, micro enterprise/loan projects and encouraging adolescent leadership and participation.

We tested and modified the health assessment module after feedback from trainings we conducted near tsunami affected villages in the cluster offices set up by CCF and local NGO partners. We learned quickly where we were off base. The first time we set up plastic chairs for village volunteers in a circle. They removed them and sat on woven mats where they were more comfortable. After some training, the trainees broke up into groups of 4-5 to give us their ideas on "special considerations." Topics included care of women who were pregnant, people living with HIV/AIDS, ways to avoid child trafficking, how to identify those in need of further individual grief counseling and other interventions, when and how to intensify identification of potential epidemics as the rainy season got closer given the situation of

polluted water, lack of latrines and temporary housing. There's a medical kit that is part of the trunk of toys, games and equipment in each safe space. Training in the use of the kit would be provided by local health care staff as our health assessment module is incorporated into future training. These materials, now translated into Tamil, are also being used in Sri Lanka and Indonesia as CCF continues to create a total of 400 Child Centered Spaces in the tsunami affected region.

Implications for what we do for and to children and youth

Activities in post tsunami relief effort can be viewed in a broader context. Most efforts focusing on children and youth aim to reduce the risk of various bad outcomes like unintended pregnancy, STDs, HIV, school failure, delinquency...the litany of so-called youth-problems. I am proposing that we give equal or more attention to increasing supports and opportunities to children and youth. This translates into creating meaningful job training and employment, supporting young people to have relevant roles in community decisions, building safe recreation settings and defining mentoring in ways that include the potential of older kids to be mentors for younger ones and for children to be mentors to adults (as we look to them for helping us use our new electronic gizmos and technologies), and assuring that there are caring, knowledgeable, helpful adults over time in places like after-school programs and in health care.

This approach differs considerably from the usual way in which children are viewed in emergency circumstances. Children in need are often referred to as OVC's (orphans and vulnerable children). This terminology is the basis of relief organizations' activities, funding and reporting. However, it has become associated with a form of humanitarian relief

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emphasizing only the dependent, needy side of youngsters, not their ability to contribute to community or family well-being. The stereotypic photo of an "orphan" shows a child alone, without identifiable siblings, relatives or neighbors. This is far from the truth. Most children, even those who have lost one or both parents, have relatives or others who care deeply about and for them. The limitation is not in the number of caring people, but rather in the preoccupation of those adults and the limited ability to support extra children during periods of massive disruption or dislocation as experienced in the weeks and months following the tsunami in SE Asia. The term "orphans" contributes to stigmatization, and this jargon is then used to separate some children from others, causing inappropriate services being allocated that are not based upon need but upon arbitrary classification. There is a better way to think about children and youth development this new way reframes the issues form focusing on deficits to supporting the strengths and assets of young people. This model allows for activities and programs that reduce risk (of abandonment, child trafficking etc) while also encouraging activities and programs that increase supports and opportunities for children and youth.

The largest number of children that are in need is in Asia although it is estimated that as a group, these children will decrease in number as the Asian countries do better economically. However, sub-Saharan Africa continues to show a marked increase in numbers of needy children, mostly due to AIDS. Vulnerable children are those whose survival, well-being, or development is threatened (from natural, complex disaster, conflict or HIV/AIDS). In sub-Saharan Africa, some 12.3 million children under age 18 have lost one or both parents from AIDS. There are 43.4 million orphans from all causes in region, more than half of whom are adolescents. It is estimated that there are 143 million orphans in 93 countries

around the world. I spent June, 2004 on site visits in East Africa (Ethiopia, Uganda) and the first 2 weeks of November, 2004 in southern Africa (Malawi and Mozambique) with two CCF staff members. CCF will be expanding in 2005 so our team was evaluating where the expansion would occur. The programs set up by CCF have as their goal not only reducing risk, but also increasing supports and opportunities for children and youth.

What is the story of a "vulnerable child" in the current world situation?

Benson Mwaka was 11 yrs old when he was abducted from his village by the Lord's Resistance Army in Northern Uganda after witnessing the murder of both his parents. He ran away after spending a year as a child soldier. He's now 12 and is being reintegrated back into his community, living with his grandmother and younger cousin, Nancy, and baby brother.

It is estimated that there are 300,000 child soldiers involved in conflicts around the world currently. News reports have focused on these children in reports on wars including Sri Lanka (Tamil Tigers), Northern Uganda (Lord's Resistance Army), and Liberia during the past few years. Yet the impact of conflict is far greater on children and youth. Thus the effect on children is best referred to as the impact of armed conflict on all children rather than exclusive focus on child soldiers. Separation, displacement and disruption of children's lives is profound and universal in times of armed conflict. The number of civilians harmed is now estimated to be far higher than the number of soldiers killed. For example, it has been estimated that in Iraq, 1500 American soldiers have been killed, but survey research based on population based samples of Iraqis yield estimates that 100,000 Iraqis have died. Children are disproportionately affected during

armed conflict as a result of the displacement and separation as well as the direct result of the bombings and gunfight.

Seeking peace as a way for children and youth to thrive, not just survive

"Many seek peace, but few pursue it actively, and among these few we (i.e. doctors), alas! are not often to be found." [9] Creating a world that is not only safe for children, but one that contributes to their health and well-being requires a major shift in our thinking and actions. This shift is reflected in The Convention on the Rights of the Child (CRC). It was approved by the UN General Assembly in November 1989 and has now been signed by 192 countries except for Somalia and the United States! It spells out in unequivocal manner the right to which every child is entitled. Disparities within a society are viewed as a violation of human rights.

CRC reflects a new vision of the child. Children are neither the property of their parents nor are they helpless objects of charity. The child is an individual and a member of the family and community, with rights and responsibilities appropriate to his or her age and stage of development. The focus is on the whole child. States are obliged to prevent children from being separated from their families unless the separation is judged necessary for the child's best interests. Guiding principles are: (1) non-discrimination; (2) best interests of the child; (3) survival and development; and (4) participation outlined in 41 articles for children under 18 years of age (unless national laws recognize an earlier age of majority). Upper benchmarks include age 18 for capital punishment or life imprisonment; 15 for recruitment into armed forces or direct participation in hostilities (optional protocol adopted in 2000 raising it to 18 years).

The Convention on the Rights of the Child provides an entirely new approach to programs and efforts to help chil-

dren and youth in our country and around the world. In defining "children in need" the CRC expands our notion of poverty as reflected in the following new DEV (Deprivation/Exclusion/Vulnerability) model of child poverty.

Using the new framework to alleviate child poverty...the contrast between actualities and realities

Reflecting the Convention on the Rights of the Child, programs to improve the lives of children and youth should now use a much fuller set of approaches and interventions. These approaches are based on CCF's rights based definition that includes 3 components in the newly articulated Deprivation-Exclusion-Vulnerability (DEV) model:

(1) Deprivation is the lack of material conditions and services generally held to be essential to the development of children's full potential;

(2) Exclusion is the result of unjust processes through which children's dignity, voice, and rights are denied or their existence threatened;

(3) Vulnerability is the inability of society to cope with existing or probable threats to children in their environment.

"Nothing in life is more glaring than the contrast between possibilities and actualities, between the ideal and the real. By the ordinary mortal, idealists are regarded as vague dreamers, striving after the impossible; but in the history of the world how often have they gradually molded to their will."[10]

We need to know and act on "the causes of the causes."

Dr. Lee Jong-wook, WHO Director-General, in his commentary on " Public health is a social issue" puts the emphasis on this point saying that **"We Need to Know and Act on the 'Causes of the Causes'"** This is a call to focus on the importance of economic status, societal status, and personal connectedness as important factors in health and well-being.

What happens to the children and youth in the tsunami affected villages in the coming weeks and months will determine their fate. The trained volunteers now have a career trajectory as more and more training is added to the basics of how to set up a CCS. They now know about early childhood development and health. One 19 year old CCS worker said that she is healing herself as she mourns the loss of her mother by helping make younger children feel safe and learn to play again. A 15 year old village boy was selected as a youth leader because of his natural ability to motivate his peers and younger kids. He led some of the therapeutic games and singing to enable other kids to feel part of their community in the absence of school or temple as a gathering place for education or spiritual healing in these early weeks after the tsunami. He will continue his role as a peer educator with CCF's help. Babu, our Tamil colleague who is a Social Worker and heads a local NGO has become his mentor and said he will be sure that this young man gets back to school but also continues to have him as a mentor in the absence of his family members who are gone. Hopefully, many fisherfolk will resume their lives, in new safer homes with boats and motors that work hauling in fish that people will not be afraid to eat.

Children's voices arising from the rubble

Examples of children acting as healers and helpers abound. In India and Africa we saw children and youth pitching in to make their families and communities stronger even under the direst of circumstances.

We met a 16 yr. old peer educator teaching other young people and adults about HIV. We met a teacher in Mozambique that completed a shortened teacher training course after completing the 10th grade, rather than the recommended 2 year teacher training course, because so many

teachers had died of AIDS that there were none available in the district. We spent time with a 17 year old Ethiopian who had enrolled in elementary school to learn basic numeracy and literacy skills because he had devoted his earlier years to helping out on the family farm. We experienced the exuberance of young adults being taught small engine repair in Uganda as part of an apprentice program to enable him to have his own small business, a form of micro-economic project for young people who had not been in school to give them an income and to enable them to be contributing members of their societies.

When former Presidents Bush and Clinton visited Sri Lanka in early 2005, they saw a CCF Child Centered Space and witnessed first hand how CCF has created a positive environment for children in tsunami affected villages.

Following Osler's exhortation, "We are here to add, not to get what we can from life"[12], I first went to Africa in 1969 as a medical student. Now, 35 years later, I return as a volunteer board member of several non-organization. While a 4th year medical student at Columbia P+S, I took my sub-internship in Medicine at a little bush hospital in Liberia. I was imprinted at that moment about the importance of fitting health into peoples' lives and realizing that medicine was but one contribution to well-being. I learned about the privilege of being with people at their most intimate and profound moments of life. I realized the importance of each day and each action and each person. I began to understand what Gandhi meant when he said, "My life is my message."

"Let the limit of your horizon be a twenty-four-hour circle." "The future is to-day-there is no to-morrow! The day of a man's salvation is now the life of the present, of to-day, lived earnestly, intently, without a forward-looking thought, is the only insurance for the future."[13]

Child Centered Spaces don't just save lives. They give

children, youth and young adults a way to emerge from devastation to be part of the healing and rebirth of their communities. Treating injuries, assuring adequate protein and calories for growth, assuring clean, adequate water, arranging for immunizations and removing physical hazards were the obvious medical interventions we could do, but a safe space for children is the nexus for many more critically important activities that give voice, agency and opportunity for young people. Where will the energy come from for the next phase? The first wave of volunteers is returning to their homes. The energy is in the kids. As soon as we arrived in a village, the main sounds were kids' voices. The main movement was the whirr of kids' bodies running, dancing, shoving, clowning, and playing.

The kids will become the young adult safe space workers, or the construction teams or perhaps the health care workers or the next generation of government officials who have not just witnessed, but have lived through and grown up in the midst of this disaster. But meanwhile, children and youth and young adults are having experiences in Child Centered Spaces that allow them to envision a future beyond this devastation....in having found a place that makes them happy ....and a place they can go...today.

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End Notes

1. Bliss, CMJ 1998. Osler at 150

2. from Osler's Chauvinism in Medicine to the Canadian Medical Association, 1902.

3. www.UNHCR.org

4. Osler's farewell address when leaving Hopkins for Oxford in 1905.

5. From McGovern's editorial about Osler and Pediatrics also mentioning that William Osler was one of the founders of the American Pediatric Society (4th President)

6. Osler in Unity, Peace and Concord, 1905

7. Ruger. Lancet, 2004; 364:1075-80

8. Wessells, M , and Koselyny, K. Psychosocial aid to children after the tsunami. Lancet (in press) 2005

9. Osler, Unity, Peace, and Concord 1905

10. Osler, Unity, Peace, and Concord, 1905

11. Michael Marmot's reference, citing Geoffrey Rose, Lancet 365:1006, 2005.

12. Longo, L.D. Introduction. In: "Our Lords, the Sick." McGovern Lectures in the History of Medicine and Medical Humanism. 2004.

13. Osler. A Way of Life" 1913 address to students at Yale

John P. McGovern Award Lectureships

14. *Health Care in the Next Millennium* presented by John D. Stobo, M.D., May 5, 1999, in Montreal, Canada.

15. *"Writ Large": Medical History, Medical Anthropology, and Medicine and Literature* presented by Gert H. Brieger, M.D., PH.D., May 17, 2000, in Bethesda, Maryland.

16. *Reflections on American Medical Education* presented by Kenneth M. Ludmerer, M.D., April 18, 2001 in Charleston, South Carolina.

17. *John Shaw Billings as a Historian* presented by James H. Cassedy, Ph.D., April 24, 2002 in Kansas City, Kansas.

18. *The Evolution of The Controlled Trial* presented by Sir Richard Doll, May 23, 2003 in Edinburgh, Scotland.

19. *Practising on Principles: Medical Textbooks in 19th Century Britain* presented by W.F. Bynum, MD, PhD, FRCP, April 20, 2004 in Houston, Texas.

20. *Just Call Us Children: The impact of tsunamis, AIDS and conflict on children* presented by Karen Hein, MD, April 2005 in Pasadena, California.