Hit the streets of Baltimore with the Back on My Feet running club. Sample injury prevention past and future. Learn what it’s like for a grandfather, a son and a grandson to write a book on saving the world. And more in online extras.

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THREATENED BY AN INVADEr like the flu virus, the human body marshals an inflammatory response. It’s a vital defense mechanism, but scientists now link inflammation to cancer, COPD and other diseases. More about our foe/friend in the Fall 2012 edition.
Our students can’t see the future—but they will create it. Scholarship programs like the Sommers Scholars and Brown Scholars bring the world’s best students to the Bloomberg School. With the knowledge and experience gained here, they will apply creative, world-changing solutions to the great health problems of today and tomorrow. In the lab, the field and the halls of government, our graduates will make discoveries, lead programs and forge policies whose impact will be measured in lives saved and the improved health of millions. Join us in creating the future.
Our Search for Answers

Wendy cried. I drove. Sarah sat in her car seat, confused by Mommy’s tears.

Sarah and my wife, Wendy, had just spent the afternoon with a child psychiatrist. Because there were not enough seats in the room, I had been exiled to the waiting room … to wait. In the car, Wendy told me that the psychiatrist had spent a long hour talking to her while 5-year-old Sarah squirmed in the chair next to her. When he was ready for Sarah, she had long since lost any inclination to pay attention or interact. At the end of the interview, his judgment was brief and to the point: Sarah was autistic. The sobbing started when Wendy got to that part of the story.

Being an academic, I went to the medical literature to understand the causes and the implications of the diagnosis. What I found was a paucity of well-designed studies about autism, at least by my standards as an epidemiologist. And there was an absolute lack of investigation into the risk of autism associated with environmental and lifestyle factors. That was 16 years ago. Since then the situation has improved. Sarah was on the leading edge of an explosion in the incidence of autism. More children will be diagnosed with autism this year than diagnosed with diabetes, HIV and cancer combined. That explosion inspired philanthropic and government funding that has fueled a concomitant increase in research.

Wendy and I soon learned that the word autism was always accompanied by the descriptor “an incurable disease.” We never accepted the implication that all was hopeless, and Sarah has always surpassed the expectations of naysayers. We also learned that the label of autism is much more nuanced than when Leo Kanner, the Hopkins psychiatrist, first described the condition. Clinicians and scientists now recognize that there is a spectrum of autism-associated disorders. Since Sarah’s initial diagnosis, many more labels followed, a veritable alphabet soup of abbreviations and eponyms. There is no biopsy, no digital readout to diagnose autism—a challenge for parents trying to cope as well as for researchers and clinicians studying the disease, predicting outcomes and designing treatment programs.

From that initial foray into the literature, I was convinced that autism research needed an infusion of epidemiology and biostatistics. My background was not in child development, but I did what I could, most notably by welcoming faculty and postdoctoral fellows who study these issues into my summer course in clinical research.

Wendy died in 2006, and the only easy thing about that tragedy was deciding how to memorialize her. We created the Wendy Klag Fund to support PhD students who are studying developmental disabilities in children. Through the generous contributions of family, friends and the Hopkins community, we have been able to support graduate students who have undertaken challenges ranging from the prevention of bullying of children with developmental disabilities in Maryland schools to assessing the prevalence of childhood disabilities in southern Nepal.

This is the first time that I have written about Sarah and the challenges she faces. It’s hard for me to write about such a personal issue, but it is time. As I was finishing this column, an email popped up from the CDC with the latest data: One in 88 U.S. children has an autism spectrum disorder, a 78 percent increase from 2002 to 2008. These data were generated in part by Li-Ching Li from our Department of Epidemiology and Rebecca Landa from the Kennedy Krieger Institute, and are an incredibly powerful affirmation of the public health impact of this condition. It’s not just a U.S. issue, of course. Soon after World Autism Awareness Day (April 2), I attended a UN panel discussion, sponsored by Autism Speaks and the governments of Bangladesh and Qatar, on the importance of international collaborations in unraveling the autism puzzle.

Even though our journey with Sarah had a very bleak beginning, it has been one long opportunity to show Sarah how much we love her, and vice versa. Sarah recently celebrated her 21st birthday with her first (very small!) drink of sake, is taking her first college-level course and looks forward to the future. She is at the forefront of adults with autistic spectrum disorders who will need services and support throughout their lives.

There are big questions about autism that need to be answered. Among others, we need to know whether the incidence of autism is truly increasing or if other conditions are being relabeled; what environmental factors contribute to the increasing prevalence; are there gene-environment interactions that increase risk; and, what policies should guide entitlement programs. To advise me on how best to resolve these questions, I convened a group of faculty from our School, the School of Medicine and the Kennedy Krieger Institute. Their advice is to take a multidisciplinary approach, examine the problem from every angle, create infrastructure to share resources and facilitate collaboration, and give them the resources to tackle this issue.

It is time to do just that. Children—and now young adults—can’t wait.

Sarah Klag, at age 3 (Photo: Michael J. Klag)
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Xiaobin Wang’s bank of biospecimens collected from mother-infant pairs have helped her pioneer the genetic study of preterm birth and persuade naysayers that adult diseases like hypertension and diabetes have roots in utero and in early childhood. (Photo: Chris Hartlove, March 27, 2012)

Cover illustration by Dung Hoang

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A child’s life is like a piece of paper on which every person leaves a mark.
—Chinese Proverb

Xiaobin Wang’s bank of biospecimens collected from mother-infant pairs have helped her pioneer the genetic study of preterm birth and persuade naysayers that adult diseases like hypertension and diabetes have roots in utero and in early childhood. (Photo: Chris Hartlove, March 27, 2012)
Feverish and often near death, malaria’s most obvious victims have long been the concern of physicians and scientists. William Moss, MD, MPH, and colleagues in Macha, Zambia, recently approached the disease from a different perspective. They focused on people infected with malaria who don’t get sick.

For every fatal case of malaria, there are perhaps 300 cases that are not. In areas of high transmission, where much of the population is repeatedly infected each year, many adults develop immunity to clinical disease. While these asymptomatic carriers do not have symptoms, their blood still harbors parasites and thus provides a hidden reservoir for sustaining the epidemic.

The interest in asymptomatic carriers is a sign, in some sense, of the recent success in controlling the disease. “When this research site [in Macha] was originally established, this wasn’t on people’s minds,” recalls Moss, an associate professor of Epidemiology. When he first arrived in Macha in 2002, the parasite was the second highest cause of mortality in the country. Since then, because of the widespread distribution of insecticide-treated bednets and the highly effective artemisinin combination therapy, as well as other factors that are not well understood, the incidence of malaria in the area has fallen precipitously. In the year he arrived in Macha, Moss estimates that the hospital had more than 1,000 pediatric hospitalizations for malaria. This year, they have had four.

Moss’ research interests reflect the new conditions. Previously, the driving concern had been to reduce symptomatic disease and prevent children from dying. “The whole focus—at least in these areas where transmission has gone down—has changed to, How do we actually eliminate malaria?” says Moss.

In addition to precipitous declines in the local malaria rates, a renaissance of interest in the possibility of globally eradicating the disease that still causes more than 700,000 deaths each year has elevated this research. “Testing and treating asymptomatic individuals really
only makes sense if elimination is a goal,” explains Moss, “because otherwise it’s a lot of effort and resources to target people who aren’t sick.”

In their Feb. 3 *PLoS ONE* article, Moss and his colleagues measured the effect on overall rates of transmission when households were proactively screened for malaria—and if necessary, offered treatment. Field teams went house-to-house using rapid diagnostic tests to identify infected individuals, whether symptomatic or asymptomatic, and offering artemisinin-combination therapy to those who tested positive. In areas with high rates of malaria, households visited by a field team every other month for one year had half the risk of infection as those visited only once. In an area of low transmission, the incidence of disease in targeted households fell even further, by more than 80 percent over two years.

While the research offers evidence that treating asymptomatic carriers can reduce population-wide transmission, there is still some uncertainty about the most efficient way to do so. The broadest approach is simply to treat the whole population with antimalarials, but this strategy is very expensive and may foster drug resistance in the pathogen. Reactive case detection, in which health care workers who diagnose cases of malaria subsequently test and treat the patient’s family and neighbors, is a more focused approach. But Moss points out that only a fraction of individuals have clinical illness and seek care in the health system, so many cases would surely be missed. The numerous home visits required might also prove onerous for local clinics, short-staffed as they already are. Moss says his vision falls somewhere in between: using a spatial risk map to test-and-treat those areas that need it most.

Even before the results of the research were published, the Zambian government began implementing test-and-treat in two southern districts, and Moss says they have treated more than 50,000 individuals there, most of whom were asymptomatic. The work conducted by Moss and his colleagues to estimate the effectiveness of test-and-treat is important because this large-scale program does not have a control group for measuring the change in malaria caused by the intervention.

For now, though, Moss believes that eliminating malaria from Zambia is “still a little bit of a pipe dream” because of its resurgence in neighboring countries, particularly Zimbabwe and the Democratic Republic of Congo. Even if the malaria parasite were eliminated from Zambia, the mosquito vector that carries it would not be. A worst case scenario would be for Zambians to lose their immunity and then for malaria to be reintroduced from outside. It would likely spread through the now-naïve population causing disease in most infected individuals. That could “really be a disaster,” says Moss.

Coordinating efforts across the region—and across the African continent as a whole—is thus of enormous importance, he says.

—Ted Alcorn, MHS ’10

**Blowin’ in the Wind**

Quinine, chloroquine, artemisinin, DDT and pyrethroids. Over the past century, humans have targeted malaria and the mosquitoes that carry it with an arsenal of chemicals but have yet to fully control the disease. Professor David Smith is taking aim with a different weapon: math.

Smith, PhD, who began his academic career in mathematics and ecology but ended up a professor of Epidemiology, says he is interested in getting into mosquitoes’ heads, or in his words, their “search algorithm”: the basic hardwiring that tells the insect how to move from the pool in which it was born to the house of its human prey and then back to the pool to reproduce. This demands a close reading of the mosquitoes’ behaviors, and the latest factor to catch his attention is the wind.

In a Feb. 14 *Nature Communications* article, Smith and his co-authors show that wind direction helps predict the homes that mosquitoes are most likely to target, and therefore the children at greatest risk for contracting malaria. During the rainy season when the study was conducted, in nighttime hours when the mosquitoes are biting, the wind was consistently in a southerly direction. This had a significant influence on the spatial distribution of malaria incidence in the study area in Kenya.

The finding may help control the vector in order to curb the disease, but more importantly, it is another small step toward a more complete understanding of the mosquito mind. “The bigger message is that there is a research agenda to try and understand how mosquitoes find humans,” says Smith. “If we can understand those algorithms across species, then we can do a much better job at predicting where humans are at risk, and therefore at doing malaria control.”

—Ted Alcorn, MHS ’10
At a dentist appointment last year, obesity researcher Sara Bleich had an epiphany.

“I noticed that [the dentist] had really bad teeth,” recalls Bleich, PhD, an assistant professor in Health Policy and Management, “and I thought to myself, How can this dentist possibly take care of my teeth if his teeth are so bad?”

The thought triggered another question that led to a novel research study: Can heavy doctors provide appropriate care for overweight and obese patients?

Bleich’s leap from a dentist’s teeth to doctors’ weight is the kind of original thinking that drives her research. She’s also examined how race affects obese patients’ care and sought new ways to steer teens away from sugar-laden drinks.

For Bleich, who describes herself as “very practical,” obesity research provides an opportunity to develop innovative solutions to a complex problem. “Because of [the epidemic’s] reach, it’s very policy relevant,” she says, “and because it’s so complicated, there can be lots of creative solutions.” She focuses on devising environmental strategies that help people cut calories—food placement in stores, price incentives, exercise-friendly cities, for example—and improving obesity care.

Her explorations of obesity’s infrequently studied aspects stand out in a field known for dire surveillance studies and standard evaluations of diet and exercise interventions.

“We need to have studies that really are feasible, that we can actually learn from, and we need to find solutions that are practical and reach large numbers of the population,” says Mary Story, PhD, RD, a professor at the University of Minnesota School of Public Health. Story directs the Robert Wood Johnson Foundation’s Healthy Eating Research Program, which supported Bleich’s research on sugar-sweetened beverages.

The sugary drinks study, published in the December 2011 American Journal of Public Health, analyzed the impact on sales of different caloric-information messages. Bleich arranged for corner stores in Baltimore to randomly display signs with different messages: that a bottle of soda or fruit juice has about 250 calories, contains 10 percent of your daily calories or requires 50 minutes of running to work off its calories.

While providing any calorie information significantly decreased the number of teens’ sugary-drink purchases, the sign equating one drink to nearly an hour of running reduced the odds by half.

Such interventions that resonate with teens could easily work in a variety of settings, observes Story. “This is the type of research we really need,” she says, noting that the study is the first to test a calorie-labeling intervention at point-of-purchase settings in stores.

Bleich saw another opportunity in patient care. Following previous research that had shown doctors, in general, do a poor job of diagnosing obesity and providing related care, she embarked on her doctors’ weight study. It found that physicians with normal weight are more likely than overweight doctors to diagnose obesity and discuss weight loss with patients. She is now working to determine whether having an overweight doctor affects a patient’s trust in the physician’s advice.

Another study involving race yielded striking results: Black obese patients are less likely to receive care from both white and black physicians. Bleich speculates that doctors, overall, may have negative perceptions toward black patients or feel that these patients have fewer resources for exercise and healthy eating. “I think that in the short term, physicians need better training in how to care for obese patients,” Bleich says. “They simply don’t have the skills.”

—Jackie Powder
For children, there’s no place like home. However, youngsters are injured more often in the home than anywhere else; home injuries lead to more than 4 million emergency room visits by children each year.

For the past 15 years, researchers at the Johns Hopkins Center for Injury Research and Policy (JHCIRP) have been seeking ways to make homes safe for kids. Recently, they visited more than 200 homes in East Baltimore to determine how well kids are protected and identify hazards like stairs without gates, nonworking smoke detectors or water-heater temperature settings that could cause scald burns. During their investigations, they also learned about unsafe housing conditions. “Our data collectors started telling us about broken stairs, broken windows, holes in the walls,” remembers Wendy Shields, MPH ’96. “This suggested to us that the condition of the house itself is often an overlooked injury hazard.”

The comments encouraged the team, led by JHCIRP director Andrea Gielen, ScD ’89, ScM ’79, to consider whether standards for low-income housing could be used to protect children. They reviewed the U.S. Department of Housing and Urban Development (HUD) Housing Quality Standards, a checklist used to certify homes for the Section 8 housing voucher program.

The researchers, with CDC funding, have now launched an effort to determine if children in Section 8–compliant homes have lower injury risks than those in homes that do not meet the criteria. They also want to know if additional criteria would reduce the risks even further. To that end, they have been developing the Children’s Housing Assessment for a Safer Environment (CHASE) checklist that can be combined with the HUD criteria to more fully capture child injury risks associated with the home. While HUD criteria emphasize built environment hazards like broken floors and bad wiring, CHASE adds hazards such as unsafe water temperatures, poison storage and infant sleep environments.

The idea of “breaking down silos” between the healthy housing and injury prevention communities intrigues Gielen. “These two groups should really be talking with each other,” she says.

One way to encourage interaction might be the new use of a standardized tool to help determine the houses that have a risk of injury for kids. “If [CHASE] performs well, then we’ll be ready to suggest to the folks at HUD that they use this to help ensure that federally subsidized housing is as safe as it can be for families with young children,” Gielen says.

Awareness of health and safety issues in homes has evolved rapidly in recent years. Successful campaigns to reduce brain-damaging lead compounds in house paint and yard soil, and asthma-causing indoor allergens, have given way to a broader public health push known as the “healthy housing” movement. “The problem is that most of the researchers in the healthy housing field don’t have experience in evaluating injury risks, and there’s not yet a standard, validated tool that they’re using to assess these risks,” says Shields. “They’re waiting eagerly for us to develop it.” —Jim Schnabel

**Home, Safe Home**

The Johns Hopkins Center for Injury Research and Policy is celebrating its 25th anniversary with not only a new prospectus and video about its work (magazine.jhsph.edu/extras) but also a public opinion poll about motor vehicle–related policies and a seminar series. “We are extremely pleased that this year also marks the launch of a student scholarship fund in the name of Professor Susan P. Baker, the founding director of the Injury Center,” says Center director Andrea Gielen.

**Injury Center Marks Silver Anniversary**

Wendy Shields (left) and Andrea Gielen seek to align the healthy housing and injury prevention communities to reduce risks for kids.
Sub-Saharan Africa is saddled with stubbornly high rates of infant and maternal mortality, widespread poverty and a population expected to balloon from 1 billion to as high as 3.5 billion by the end of this century, further stressing an already resource-poor continent.

A common link for all of these problems? Insufficient access to family planning services.

In much of the world, two-thirds of married women report using contraceptives, while only one in five African women do. Their cost, disapproval of their use and superstitions about side effects have all slowed their adoption there.

But positive signs in recent years suggest that this may be changing, says Amy Tsui, PhD, MA, a professor of Population, Family and Reproductive Health (PFRH) and director of the Bill and Melinda Gates Institute for Population and Reproductive Health. In the past, only a handful of African governments were willing to commit budgetary funds to purchase contraceptive commodities, but more are now doing so. Utilization is rising rapidly in some countries, and across the continent there is increasing interest in the issue, she says.

The International Conference on Family Planning in Kampala, Uganda, in 2009—the largest conference on the topic in 15 years—attracted more than 1,200 (far more than the 350 expected). A second conference in November 2011 in Dakar, Senegal, drew more than 2,200 people. Tsui, who helped organize both events, was thrilled by the interest. “Sub-Saharan Africa has been without for so long, so it’s a very gratifying development,” she says.

Jotham Musinguzi, Africa region director for the intergovernmental organization Partners in Population and Development, says there was important symbolism in holding the conference in West Africa, an area that even relative to other parts of the continent has been slow to improve access to family planning. “This is the first time the whole world was focused on this region of greatest need, and to me that was very important,” he says. “And the message was very clear: The countries themselves are aware that they are not doing so well, but the international community showed that they were willing to be supportive and to try to sort it out.”

Several East African countries have made dramatic progress increasing access and use of family planning services, among them Rwanda, Malawi and Ethiopia, where the contraceptive prevalence has more than tripled in just 10 years.

In comparison, Musinguzi’s native Uganda has persistently lagged behind in recent decades, with one of the highest population growth rates in the world and no leadership on the issue from pro-natalist President Museveni.

“We really tried to work with him to make strong statements in support of family planning,” says Musinguzi, while acknowledging that if the president has remained aloof on the issue, neither has he openly opposed it. Notably, Uganda’s First Lady has begun advocating for improved family planning services as a means to reduce maternal mortality.

Efforts over the last five years—picking up particularly since the 2009 conference in Kampala—have begun to bear fruit. Duff Gillespie, PhD, a PFRH professor, leads the Advance Family Planning (AFP) project, which works in several countries to regularize funding for family planning and strengthen local policymakers’ commitment to the issue. In Uganda, the project has helped secure new funding for contraceptives from the World Bank, the Global Fund and the government of Uganda itself. Martin Ninsiima, a program manager at the Johns Hopkins Center for Communication Programs who works with AFP, says the 2011 Ugandan Demographic and Health Survey shows a significant increase in the use of contraceptives since 2006, from 18 percent to nearly 25 percent.

Says Musinguzi, “I think it really vindicates that our efforts have worked.”

—Ted Alcorn, MHS ’10
Mental illness takes many prisoners. Its jails hold not only the afflicted, but families, communities and even the economic health of countries.

Yet government and private funding for mental health is tragically inadequate, especially in many developing countries where mental illness carries tremendous stigma and shame. Recent news reports have described the mentally ill being restrained in cages and chains in Somalia and Indonesia. And psychiatric patients languish in prisons worldwide—in both developing and developed countries.

Mental and behavioral disorders affect more than 25 percent of all people at some point during their lives, according to the WHO. By 2020, WHO estimates that these illnesses will account for 15 percent of the total life-years lost due to all diseases and injuries.

Now, an international coalition of health experts and advocates says that it is time for the UN to highlight global mental health issues for officials at the highest levels by convening a General Assembly Special Session. The UN General Assembly has previously held only two health-related special sessions: one on HIV/AIDS in 2001 and a session on noncommunicable diseases last year.

“The call for a General Assembly Special Session is a call for the recognition of the importance of mental health,” says Judith K. Bass, PhD ’04, MPH, an assistant professor in Mental Health. Bass and colleagues made the case for the special session in a January PLoS Medicine essay. “Part of that agenda,” says Bass, “is advocating for countries to actually have mental health policies, to have humane treatment of people with mental illness, to implement treatment, all the things we know are lacking.”

While the PLoS Medicine essay’s primary aim is to focus world attention on the plight of those affected by mental illness, its authors also highlight the economic costs. The article cites estimates that neuropsychiatric disorders will account for $16.1 trillion in losses over the next two decades. “If a large proportion of a population even has low levels of depression and is functionally impaired, they can’t reach their potential and are literally depressing the ability of a population to economically develop,” says Bass.

Three critical areas—access to evidence-based interventions, new research and human rights protections—need resources. Strengthening mental health research is an essential piece of improving care, says Bass, noting that more than 20 years have passed with no breakthroughs in the field. “Innovation is not focused on mental illness,” she says.

Given the paucity of psychologists and psychiatrists in developing countries, evidence-based mental health services need to be integrated into primary care and community health systems, experts say. Health care professionals need training to screen for and treat basic psychiatric disorders, and research shows that community health workers can be educated to deliver mental health services as well.

“In most parts of the world, it is simply not feasible, or affordable, for a health system to achieve coverage of mental health care through mental health specialists alone,” says Vikram Patel, MSc, PhD, a professor in International Mental Health at the London School of Hygiene and Tropical Medicine. “Use of alternative human resources [such as primary care doctors, community health workers], is not only a solution when there are no specialists, it can also, in fact, be effective in cutting costs and improving access in places that are relatively better resourced. It is important to note the key roles that mental health specialists need to play such as supervision, quality assurance and providing referral pathways.”

Patel, one of the essay’s coauthors, says that enhanced access to care, research advances and economic development won’t be realized until the human rights of the mentally ill are recognized. “I don’t think there’s any community in the world today that has seen the systematic denial of basic human rights as [have] people with mental illness, and there are very few champions speaking out for these individuals,” he says. “It’s probably the most important issue in global mental health.”

—Jackie Powder

Recognizing Humanity

For his quarter-century of advocacy on behalf of refugees worldwide, actor Sam Waterston (left) was presented with the Goodermote Humanitarian Award on May 9. Joining him at the ceremony were PhD candidate and Goodermote Humanitarian Scholarship awardee Anjalee Kohli and entrepreneur/philanthropist Dean Goodermote.
It’s quiet and dark in front of Christopher Place Employment Academy. The residential and educational program for homeless men sits between the imposing Baltimore City Jail and Scores strip club.

People in workout clothes trickle into the parking lot from the streets, and men in tracksuits emerge from Christopher Place’s brightly lit lobby.

By 5:30 a.m., two dozen people have exchanged hugs and formed a circle that’s chatty, cheerful and loud, despite the chill and the grim surroundings. They’re a mix of professionals, the unemployed, the recently homeless, graduate students and those in recovery from substance abuse.

After some announcements—Jerome got a second job, David got into medical school—the group circles arms, says the Serenity Prayer and takes off running.

Similar scenes play out in eight other cities across the U.S. several mornings each week as runners of all levels from disparate backgrounds come together through Back on My Feet (BoMF), a nonprofit that uses running as a means to build self-confidence, discipline and, most importantly, a community and support network among the homeless and other underserved populations.

“A lot of these guys haven’t felt the sense of belonging or had expectations on them to commit to something,” says Jaclyn Truncellito, a longtime runner, Bloomberg School MPH student and director of communications and corporate relations for BoMF’s Baltimore chapter.

Truncellito’s faculty advisor at the School, Kevin Frick, PhD, a professor in Health Policy and Management, runs with the Christopher Place group as one of its 60 active volunteer or nonresident members. “These guys just really want to get control of their lives, and the training and consistent goal-setting gives them a sense of control they may have never had before” he says.

George Johnson, 38, who came to Christopher Place in August 2011 after completing an alcoholism rehabilitation program, originally joined BoMF to lose weight, but found that shedding pounds wasn’t the only payoff. “I instantly loved the energy, the camaraderie,” says Johnson, who plans to apply for a BoMF grant to buy a laptop when he goes back to school, and hopes to become an X-ray technician.

Johnson, who is training for a half marathon, says that his running progress and support from his team members help him to weather the “frustrations and stresses” of job hunting.

Back on My Feet offers additional services to members with 30 days’ active participation and a 90 percent attendance record. The Next Steps phase provides help with acquiring job skills training, writing resumes, enrolling in school, preparing for job interviews and a grant of up to $1,250 to aid in the transition to independence. It might pay for tuition, a computer or a security deposit.

Dean Michael Harrod, who stayed in a homeless shelter before coming to Christopher Place, has a decade of experience working on cars and trucks, and hopes to become certified as a diesel mechanic. The soft-spoken team captain says that running with the team helps to build his self-confidence and discipline—and, it’s fun.

“It’s like a party once you get out there,” Harrod says.

Based on BoMF surveys, the program is a success across its chapters, in terms of improvements in self-esteem, setting goals, trusting others and other subjective assessments.

However, from a public health perspective, says Frick, such attitudinal surveys aren’t especially useful because they don’t measure long-term program outcomes. BoMF recently hired an internal evaluator to enhance the process. A fundamental question is whether BoMF members achieve better outcomes—more success finding employment and housing and furthering their education—than individuals who don’t take part in the program.

“I think an organization like this may be able to demonstrate a whole new way of thinking about integrating people into the community,” says Frick.

—Jackie Powder
The Mystery of Vif

The AIDS-causing retrovirus HIV is a marvel of insidious efficiency. With a toolkit of just 19 different proteins, it easily thwarts the defenses of its vastly more complex H. sapiens hosts by infiltrating the very immune cells that should attack it. But HIV’s simplicity also means that its secrets won’t long withstand scientific scrutiny.

“After three decades of work, we’ve learned a lot about this retrovirus,” says Xiao-Fang Yu, MD, DSc, a professor in the Bloomberg School’s W. Harry Feinstone Department of Molecular Microbiology and Immunology. Yu is the senior author of a report in Nature in January that reveals a key detail of one of HIV’s most important survival strategies—a strategy that may soon be blockable with drugs.

The new finding concerns the HIV protein Vif (viral infectivity factor), a sort of bodyguard molecule that the virus needs to thrive and spread.

A decade ago, scientists discovered that human cells normally contain antiretroviral enzymes, known as APOBEC3 enzymes, that can bind to retroviral genes and mutate them destructively—except when Vif is present. As Yu and his colleagues reported in Science in 2003, Vif shields HIV by cleverly co-opting several normal proteins within infected cells, and using them to form a ubiquitin ligase—a complex enzyme that marks APOBEC3s for destruction by the host cell’s own housekeeping systems.

In the new study, Yu and his students discovered that Vif can coordinate this counterattack only with the added assistance of a host-cell protein called CBF-. “When we blocked CBF’s interaction with Vif, we removed nearly all Vif’s ability to thwart the relevant APOBEC3 enzymes,” Yu says.

A key point for drug development purposes is that CBF uses one part of its structure for binding to its normal protein partner in cells, and a different part for binding to Vif. Thus, it should be possible to block the Vif-CBF interaction without disrupting CBF’s normal function. Drug companies are already knocking on Yu’s door.

Scientist Xiao-Fang Yu’s latest discovery involves a “bodyguard” molecule for HIV called Vif and its partner in crime, the CBF protein. Stop the pair from interacting, and you weaken HIV.

CBF normally works in cells as a transcription factor that enhances the expression of certain genes, and research in the 1990s showed that two other viruses use this basic functionality of CBF to enhance their own replication within infected cells. “It’s intriguing to see that CBF has yet another pro-viral function, this time with HIV,” says Nancy Speck, a professor of cell biology at the University of Pennsylvania who did much of that earlier CBF research.

Yu thinks it’s possible that CBF serves as HIV’s partner in crime on yet another level, since in immune cells its job as a transcription factor effectively makes it a regulator of the broad immune response. “It’s easy to imagine that HIV might be co-opting CBF in one way to combat APOBEC3s, and in another way to manipulate immune cell activity so as to benefit its own replication and survival,” he says.

Existing anti-HIV drugs can hold the virus at bay, but generally can’t remove it from the body. If Yu’s suspicion proves correct, then fully blocking Vif’s subversions of CBF might at last enable the eradication of the virus.

“It’s an interesting hypothesis, and a testable one,” says Speck.

—Jim Schnabel
Fighting for Docs in War Zones

Protecting health care workers in armed conflicts has been a veritable black hole of human rights.

When ambulance drivers in Gaza told Leonard Rubenstein about being delayed at checkpoints and blocked from hospitals, and when doctors in Kosovo described arrests and torture for providing care for rebels, they echoed the stories of multitudes in Mexico, Libya, Burma and beyond.

“Health workers are trying to do their jobs, consistent with their ethical responsibilities, and are vulnerable because of it,” says Rubenstein, JD, LLM, a senior scientist at the Berman Institute of Bioethics and Human Rights and associate faculty of the Johns Hopkins Center for Public Health.

His efforts are focused on a veritable black hole of human rights: the protection of health care in armed and civil conflict.

Egregious and persistent violations of medical neutrality happen all the time all over the world despite a body of international law that explicitly protects health workers and facilities. “Unlike other areas of human rights, where protection and accountability mechanisms have been developed over the past 25 years, international institutions have paid little attention to this problem,” Rubenstein says.

Syria and Bahrain, in the news with flagrant attacks on health workers and facilities, represent one extreme according to Rubenstein. Equally troubling are the lower-level unreported violations that simmer for decades in places like Burma (also called Myanmar), where targeted kidnappings, obstructions, invasions and lootings put health workers at risk.

He and colleagues have been working to develop an international system of documentation, prevention and accountability, as well as to drum up support for these efforts from WHO. At a special briefing held March 7, Rubenstein told Congress that greater leadership is needed from the U.S. government to protect physicians and health facilities.

During the week of May 21, he’ll be in Geneva, working at the World Health Assembly (the decision-making body of WHO) to promote passage of a resolution mandating the systematic collection and dissemination of documentation of attacks on health care.

On the heels of that event, he’ll travel with colleagues to Mae Sot on the Thai-Burma border. Their goal: to develop a uniform questionnaire that’s reliable, sensitive and specific enough to be used as a reporting tool by health workers and provide a baseline of evidence. They’ll be piloting the project with health workers who originate from and work inside Burma but regularly cross the porous border for retraining and resupplying. By providing emergency and basic health care to refugees fleeing poverty and ethnic fighting, these workers are at constant risk. The potential democratic opening in Burma raises the possibility of a negotiated settlement of its armed conflict with ethnic groups, with guarantees of protection of health care from interference; if so, the tool can then be used as a monitoring device, says Rubenstein, who recently received the American Public Health Association’s Sidel-Levy Award for Peace.

Rubenstein and his colleagues envisage the questionnaire as a global tool. “Say you are running a clinic in the countryside, and you’ve been trained that if a violation happens, you can fill out the form and send it to the WHO country office, which is collecting and collating data,” Rubenstein says. “In such a system, the report of the violation may generate action to pressure perpetrators to stop. That’s empowering.”

—Maryalice Yakutchik

A Tri-Generational Take on Saving the World

For a hopeful book, it had a fiery beginning. Three generations—public health legend Carl Taylor, his son Daniel and grandson Jesse Oak—fought passionate battles through more than 20 drafts of the recently published Empowerment on an Unstable Planet (Oxford University Press, 2011). Their diverse backgrounds—Carl in community health, Daniel in education and Jesse in literary theory—sparked divergent views and many fierce discussions. The book may represent a final testament to community-based solutions long advocated by Carl Taylor, the founder of the Department of International Health who died in 2010. The Taylors coalesced around a strategy for improving communities and health by relying on the people themselves and not costly development projects. “You can run projects, or you can mobilize people to take collective action,” says Daniel Taylor. “That’s the core idea of the book.”

Online: Q&A with the Taylors at magazine.jhsph.edu/extras
For many cultures, a newborn’s umbilical cord comes attached to something more than the placenta—it has deep and spiritual meanings. And with this belief follows a host of customs meant to honor the cord and ensure its sanctity, such as the application of special oils or spices.

Often forgotten is that the site of the recently cut cord is an open wound, making it an easy portal for infection. That reality contributes to astoundingly high infant mortality rates in many developing countries. Abdullah Baqui, MBBS, DrPH ’90, MPH ’85, a professor of International Health, has been studying cord care practices in Bangladesh in hopes of reducing newborn child deaths worldwide. He has found that incorporating a common antiseptic called chlorhexidine into postnatal cord care could decrease mortality by about 20 percent, findings that confirm other studies, including one conducted by Johns Hopkins researchers in Nepal.

“If you look at data from countries with a high newborn mortality setting, about half come from infection,” Baqui says. “It’s a very important cause of death, and many of these infections come from cord infection, when the methods of cutting and tying don’t include clean instruments.”

Funded by USAID and Save the Children, Baqui’s research is a direct outgrowth of the UN Millennium Development Goals, one of which seeks a two-thirds reduction to the 1990 child mortality rate by 2015. Most countries are not on track to meet that goal, Baqui says, though under-5 mortality did come down to about 8 million from 12 million in the last 20 years. That decrease, however, is mostly from a reduction in older children’s deaths.

Unfortunately, Baqui says, many countries take at face value WHO recommendations to just keep the cord clean and dry, even though they include a caveat that antiseptics should be considered for babies born in unclean conditions. Now, Baqui and his colleagues at Johns Hopkins, USAID and Save the Children are working with WHO to re-evaluate the recommendations—including how they might be revised to better include developing countries where cord care is often not a priority.

“This is a globally important initiative,” says Steve Wall, a pediatrician and senior advisor at Save the Children in Washington D.C. “Newborn deaths from preventable causes such as core hygiene have been a longstanding global tragedy that we know can be prevented. Dr. Baqui and the group at Hopkins have really opened the eyes of the world to a solution that appears cost-effective and simple.”

—Lauren Glenn Manfuso

In Memoriam

Paul Meier, PhD, MS, an assistant professor in Biostatistics from 1952 to 1957 whose work revolutionized medical statistics, died on August 7 at age 87. He was one of the first proponents of randomized clinical trials and, with Edward Kaplan, developed the Kaplan-Meier curve, the standard research tool to estimate patient survival rates.

Donna Feeley, MPH, RN, who taught the course “Complementary, Alternative, Indigenous and Traditional Medicines” in the School’s Winter Institute, died on October 23 at age 58. She also worked at the American National Red Cross in Washington, D.C.
Beginnings

Special Section
To solve the darkest public health issues—suicide, sexual abuse, obesity and chronic disease—researchers see the light of day in adolescence, childhood and the womb.

Reason versus Rage
“…this is a field that needs the surgeon general as well as the attorney general.”
– Fred Berlin, MD, founder of the Johns Hopkins Sexual Disorders Clinic, on child sexual abuse
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A Radical Notion
“To say ‘don’t drink, don’t smoke,’ is not enough. We need to move on from merely limiting damage to building better people.”
– David Barker, MD, commenting on his eponymous hypothesis
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The Weighting Game
“This is the only global center of child obesity in the world.”
– Youfa Wang, MD, PhD, founder of the Johns Hopkins Global Center on Childhood Obesity
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A Path Toward Hope
“There are certain ills, certain challenges out there that we thought we would never see.”
– Ronnie Lupe, tribal chairman of the White Mountain Apache
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Beginnings
Bright and Dark
The sexual victimization of children is a subject so horrifying that it’s difficult even to address. As a society, we approach it from two extremes. Most of the time we avoid it. When forced to confront it, we run to the opposite extreme, flying into a rage, voices full of fury.

With that said, it’s time to face up to another fact: Rage is not an emotion associated with clear thinking and sound public policy. Child sexual abuse is not a subject that lends itself to the sort of rational, dispassionate decision making so essential to scientific practice. Instead, it’s a subject where the playing field seems always tilted toward punishment rather than prevention.

This is the challenge that the Bloomberg School’s Department of Mental Health is now taking up. William Eaton, PhD, the Sylvia and Harold Halpert Professor and chair of Mental Health, says the decision to do so is based not only on alarming numbers—80,000 confirmed cases annually, tens of thousands more unreported—but also on the devastating impact these incidents have on victims for decades after the crime.

“One thing that has come as a surprise to me is the way people with a history of being abused sexually as a child have a much higher risk going forward of so many major mental disorders,” Eaton says. He ticks off a list: depressive disorders, personality disorders, drug abuse, schizophrenia, suicide and more.

“This is one of the leading risk factors for the entire range of mental disorders,” Eaton says.

Worst of all, these crimes can fuel a brutal cycle, as victimized boys are at higher risk for becoming sex offenders themselves. Fred Berlin, MD, the founder of the Johns Hopkins Sexual Disorders Clinic, has seen this cycle play out in his four decades of work in this area as a psychiatrist at the School of Medicine. A mother whose son was victimized angrily confronted Berlin in a courtroom. “Years later I get a call from this same mother. Her son had now committed a sex offense, and she was wondering if there was something I could do to help. There is just so much tragedy in this.”

With the help of private donors, Eaton’s department has sought to bring public health expertise to bear on child sexual abuse. It established a partnership with Berlin and then in 2011 hired researcher Elizabeth J. Letourneau, PhD.

Letourneau and Berlin took time recently to discuss the road ahead as they
seek to move prevention-based strategies and policies to the forefront. One big challenge: combating the myths that have come to dominate public discussion of the topic.

The work will not be easy—and it might be controversial at times. But Eaton is confident that the effort will have results. “We will never eliminate child sex abuse from the picture altogether,” he says, “but I believe there are opportunities out there to lower the rate of it—and perhaps lower it by a lot.”

**MYTH #1**

**OUR SOCIAL POLICIES AIM TO PREVENT THE INCIDENCE OF CHILD SEXUAL ABUSE.**

In recent years, researchers have set out to dig past the 80,000 annual cases confirmed by the U.S. Department of Health and Human Services and gauge the real extent of child sexual abuse in this country.

On the lower end of the spectrum, a review of 16 studies published in *Child Abuse and Neglect* estimated that 7 percent of boys and 14 percent of girls in this country are sexually victimized as minors. A *Psychological Bulletin* article that averaged the results of 23 studies estimated 17 percent of boys and 28 percent of girls were victims.

Such numbers signal a public health problem of the first order, especially considering the mental health problems victims might endure in later life, problems that spread to the lives of countless siblings, spouses, future children and sometimes even whole communities, as recently demonstrated by the child sexual abuse scandal at Penn State University.

Seated in her tidy office at Hampton House during an interview, Letourneau reviews the extent of this wreckage and makes the case that society's current response to it is out of balance. On the one hand, there is the criminal justice system, where expensive policies are increasingly the norm—things like maintaining vast online databases of sex offenders and seeking extended civil commitment in specialized mental health facilities for some convicted offenders who have completed prison terms.

“We don’t put anything like those resources into prevention,” Letourneau says. “There’s virtually no money for this stuff. This is a field where it’s a big deal if the Centers for Disease Control puts out a single $1 million grant every couple of years for work on prevention.”

A few days later in his Mount Vernon office, Berlin says he shares Letourneau’s frustration on this front. His work with sex offenders has stirred occasional controversy over the years. Some have worried that his efforts to better understand offenders, their mental states and their behaviors might have the effect of destigmatizing—or “normalizing”—their abnormal behaviors, though Berlin has never suggested decriminalizing harmful sexual acts.

Questions have also arisen over his support for limited use of testosterone-reducing medications that induce “chemical castration.” In recent years, however, the use of such medications to help individuals maintain control of their sexual desires has gained increased acceptance.

“We cannot legislate this problem away, and we cannot punish it away, but that’s all we keep trying to do,” Berlin says. “That’s not the right approach here any more than it is with problems like alcoholism or drug addiction. We need a law enforcement
component, yes, but this is a field that needs the surgeon general as well as the attorney general.”

**MYTH #2**

**CONVICTED SEX OFFENDERS NEVER STOP BEING A RISK TO CHILDREN.**

Monsters exist, to be sure. But researchers who have studied this issue say that the serial-offender pedophiles who garner media attention are more the exception than the rule.

The Department of Justice regularly runs statistical comparisons of different categories of criminal offenders, and its data indicate that sex offenders have a comparatively low rate of recidivism.

Much of Letourneau’s research focuses on young offenders—boys between 12 and 14, who are at the peak age of risk for engaging in sexual misbehaviors with younger children. Such offenders don’t fit the “monster” profile.

“They are acting oftentimes out of a lack of knowledge and with a lack of adult supervision, or sometimes their behavior is basically experimental,” Letourneau says. “Rarely are they acting out of genuine sexual interest in children, though that can happen and we know it does happen on occasion. But in reality, the vast majority of these kids—something like 95 percent of them—are simply not going to re-offend.”

This trend in recidivism data applies to adults as well as children. One of Berlin’s research projects involves tracking outcomes for more than 400 adult male offenders diagnosed with pedophilia, a strong sexual preference for children. Over the first five years of the study, the recidivism rate for this group was less than 8 percent. Among the pedophiles who were generally cooperative with terms of treatment and parole or probation, the rate was less than 3 percent. Berlin’s team is now tracking this same group on a 15-year time frame, and preliminary data show no shift toward increasing rates of recidivism as years go by.

These numbers can be imprecise, given how many offenses in this category go unreported, but Letourneau expresses confidence in the quality of the research. “For younger offenders, if you follow them for 10 years, you’re going to have a very good understanding of how many are re-offending,” she says. “You might not know how often they’ve re-offended, but if they’re re-offending with any frequency over a 10-year period, at some point a victim will come forward. The same is true of adults. If you follow them out 20 years, you’ll have caught pretty much everyone who’s committing offenses.”

Moreover, she adds, rigorous, randomized controlled clinical trials have repeatedly demonstrated that even high-risk youth and—importantly—their families can succeed with treatment.

In essence, most sex offenders are not serial predators. Both Letourneau and Berlin believe that prevention strategies must include both treatment for convicted offenders and outreach to potential offenders.

This is a bridge that it took Kathy Headley a long time to cross. Victimized in her youth by a pedophile grandfather, the Indiana resident has joined with her siblings (including Stephen Moore, MD, MPH ‘93) to fund Letourneau’s position for a three-year startup period—and perhaps beyond.

Headley and Moore spoke about the long-term impact on victims and their families at an April 27 symposium, “Child Sex Abuse: A Public Health Perspective” at the Bloomberg School.

“One of the things we were asking about in our meetings is whether there is any possible way of getting to offenders before they offend and ruin children’s lives—and ruin their own lives for that matter,” Headley says. “That’s been hard for me, to get past the feeling that you should just lock them up and keep them there. But I’ve come to see that if it helps keep one person from becoming a victim, then that’s what we have to do.”

**MYTH #3**

**ONLINE OFFENDER REGISTRIES HELP COMMUNITIES KEEP THEIR CHILDREN SAFE.**

Google the topic of online sex-offender registries and you’ll arrive soon enough at this sort of proclamation: “Online sex-offender registries are an essential resource.”

Minnesota was the first state to launch a registry, in 1991. That move came in the aftermath of the disappearance of an 11-year-old Minnesota boy, Jacob Wetterling, who has never been found. Three years later, the feds upped the ante, requiring states to maintain online registries that are open to the public. That requirement is often called “Megan’s Law,” as it went on the books after the rape and murder of a 7-year-old New Jersey girl, Megan Kanka, whose killer was both a neighbor and a twice-convicted sex offender.

Today, different states handle these registry requirements in different ways. The most aggressive require registration for a broad range of offenses and keep even one-time offenders listed for life. Others limit registration to offenders deemed especially dangerous.

Letourneau worked previously at the Medical University of South Carolina, where she conducted a series of studies seeking to measure the impact of that state’s aggressive approach to registration. Early on, she measured whether the registry law achieved its primary goal of reducing the number of offenders who commit new sex crimes.

The answer was no. Recidivism rates showed no significant change as the state adopted its registration law and then again as the online registry went public.

Letourneau’s follow-up work on this topic is fascinating, demonstrating that the registry has had significant unintended consequences. First, she conducted a pair of studies showing that prosecutors changed their approach to juvenile sex crimes after the registry requirement went into effect.

The first study showed that prosecutors became less likely to move forward with sex-crime charges once the registry was in place—cases were simply dismissed or diverted. The second study concluded that when prosecutors did move forward on cases, they became more likely to permit defendants to plea bargain into the assault category and out of the sex-crime category.

In both cases, Letourneau’s hypothesis is that prosecutors came to regard lifelong registration as a draconian penalty that didn’t fit the crime in a significant number of cases with youthful offenders. One important concern she voices about this finding is that the offenders end up receiving
no follow-up or treatment geared specifically to their actual crimes.

Letourneau next looked at the outcomes of cases involving adult offenders that went to jury trials after the registry was launched. These are the cases, she says, that prosecutors tend to regard as slam-dunk wins as they head to trial. But she found that conviction rates in these cases declined after the public online registry was established.

“I’ve had prosecutors and attorneys of all stripes tell me about cases where the jury was deliberating and they asked the judge, ‘Will he have to go on the registry? Or will he just face time?’ It’s a punishment that’s just so harsh—juries were modifying their behavior. So we’re now setting some of these guys free—they’re completely exonerated. It’s unbelievable, but we have a policy that increases the likelihood of letting adult sex offenders go.”

Letourneau plans to build on this work at Johns Hopkins. Studies of the impact of registration in other states have yielded varying results, an outcome likely related to the different approaches taken. She is preparing to compare the results of juvenile registry policies in three states—one that aggressively registers a wide swath of offenders (Texas), one that takes a middle-of-the-road approach by giving discretion to prosecutors and judges (Maryland), and one whose conservative approach reserves the registration requirement for a very few offenders judged to be high risks (Oklahoma).

Letourneau raises one other question surrounding offender registries that deserves more attention going forward: What impact does being on a public registry have on the lives of ex-offenders, especially the ones sincerely trying to steer clear of future trouble?

“It can be very difficult for known sex offenders to maintain stable living conditions and stable jobs while on these registries,” Letourneau says. “And when you don’t have stable living conditions and stable social connections, it makes it more difficult to re-integrate into society.”

Berlin feels that registries are a prime example of what’s wrong with the way society is dealing with child sex abuse. “The goal is right—we need to protect these children,” he says. “But we need to do it in a way that’s going to work, a way that’s based on data, a way that’s cost-effective. We’re not doing that. What we’re doing instead is reacting to the emotion of the moment, and as understandable as that emotion is, it’s just not the right way to go. Effective public policy should be based upon evidence about what works best.”

**MYTH #4**

**THE JERRY SANDUSKY CASE AT PENN STATE WILL DRIVE SOCIETY TO DEVELOP BETTER POLICIES.**

The media explosion set off last year by allegations of serial sexual abuse of young boys over the course of years by Jerry Sandusky, a former assistant football coach at Penn State University, has focused sustained attention on a topic that society might otherwise avoid. Peter Pelullo, the leader of a foundation devoted to supporting victims of child sex abuse, says he’s hopeful the case will help the public grasp the true costs of sexual abuse.

“This thing has just rocked the country,” he says. “It presents a great opportunity to really put the focus on these young boys—and especially on the fact that they’re going to be living with this for 40 or 50 or more years.”

A successful music-industry executive, Pelullo is a former victim himself. His book, *Betrayal and the Beast*, recounts his journey from being raped repeatedly at age 7 by older neighborhood children to his still-in-process recovery as a 50-something adult. In between, Pelullo battled multiple addictions and endured an inability to establish bonds of trust and intimacy.

In going public as an abuse victim, Pelullo launched his Let Go … Let Peace Come In Foundation. In March, the foundation reached an agreement with the Bloomberg School to help fund research by Letourneau, Eaton and other department colleagues aimed at preventing abuse.

“To truly study this as a public health issue, that’s something that just hasn’t been done,” Pelullo says. “It’s a mammoth task, considering that this is an area where we have a hard time just engaging in a conversation.”

If the focus stays on victims and how to help them, the Sandusky case might indeed turn out to be a positive. But as Letourneau points out, we’ve seen “monster” cycles play out before—and the results have not always been productive.

“These blowups always center on the most sensational type of offenses,” Letourneau says. “If these allegations against Sandusky are true, think about it this way: How many guys go out and set up a not-for-profit agency to serve as a feeder system to satisfy their urges?”

She rates it a one-in-a-hundred-million
event. “We’re going to base policy on that?” she asks. “When you base it on the rarest, most unique, most bizarre case, you’re not going to get good policy.”

Berlin has a friend who once joked that no laws should ever be adopted in the immediate aftermath of any 60 Minutes broadcast. He feels the same way about cases like Penn State. “We tend to legislate in response to the emotion of such moments,” he says. “Let’s just say that in my opinion this does not ensure that we will get effective public policy based on data and careful thought.”

There’s another danger to this “monster” cycle as well. Since cases like these are often the only ways the general public and political leaders learn about child sexual abuse, they tend to fuel the misconception that all offenders are serial predators.

“The reality is, most offenders are people we know and even people we like,” Letourneau says. “They are people in our families, in our communities and in our social circles. What we’ve got to do as a society is figure out a way to talk about these offenders in a way that doesn’t always evoke the monster. We’ve got to get to a place where people can stand up and say, ‘I’m a little worried about my friend Jim. He’s having some troubles in his life right now, and I think he might be spending too much time with one of his young volunteers. I’m worried he might make a mistake, and I’d like to get him some help.’”

Berlin draws analogies here to alcoholism—a condition that not so many decades ago was regarded as a matter of personal weakness and shoved under the rug in family life and civic affairs. “If we ask the question, ‘Who is the person who gets involved sexually with children?’ It’s actually a lot like asking, ‘Who’s the drunk driver?’” he says. “There’s a tremendous spectrum. On one end is the chronic alcoholic who might always pose a threat to others. On the other end is the guy who wants to quit but needs help.”

Berlin surveys the landscape today and sees a balanced approach to alcoholism—one that encourages people to seek help and one that steers clear of blanket demonization while also delivering the needed criminal justice component. “With alcoholism today, we recognize that decent people can be struggling,” he says. “We see that Aunt Jane or Uncle Harry has a problem. We recognize that they could get in a car and kill somebody. But we also see them as human beings we care about and want to help.”

By contrast, the demonization of child sex offenders allows no room for such consideration.

“We hear all the time—if you are depressed or addicted or have anorexia, please come in so we can help you,” he says. “As I speak, there are some 16- or 17-year-olds out there who are privately aware of the fact that they’re sexually attracted to children. And because of how we’ve demonized people in this area, the last thing they’re going to do is raise their hand and ask for help—which is exactly what we should be encouraging them to do.”

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**School**

Much of Letourneau’s research focuses on young people between 12 and 14—a time of peak risk for sexual misbehavior with children. Here, a public health approach might target prevention of sexual harm with strategies modeled after successful anti-bullying programs.

**Offender**

What makes some men pedophiles? Surprisingly little research has been done to gain even the most basic information about pedophilia. Recent studies suggest that some men might be born with sexual attraction to young children. To evaluate this hypothesis, William Eaton and Letourneau will partner with Denmark’s National Centre for Register-Based Research to use population-level data to evaluate the relationship between early risk factors such as obstetric complications and later abuse of children.

**Organization**

This is a growth area right now, with numerous projects under way across the country to develop policies and procedures for youth-serving organizations that can help them reduce the likelihood of hiring employees or using volunteers who abuse children.

—JD
YOUFA WANG has witnessed obesity’s global surge firsthand. As a boy in China in the 1970s, access to food was the problem. Now, when he returns home, he is astonished at the number of obese kids as well as the McDonald’s ads in apartment elevators. To get ahead of worldwide obesity (which has doubled since 1980) and to stem burgeoning rates of diabetes, hypertension and heart disease, Wang founded the Johns Hopkins Global Center on Childhood Obesity (jhgcco.org) with a $16 million-plus NIH grant. A fast-talker with a computeresque command of complex data, Wang, MD, PhD, recently led Johns Hopkins Public Health editor Brian W. Simpson on a brisk tour of the global child obesity epidemic and the Center’s quest for solutions.
Eat less and exercise more are pretty simple messages. Why can’t we fix the child obesity epidemic?

That’s a good question, but a very tough one. Studies show about 70 percent of variation in obesity is due to genetics. But over the past two to three decades in the United States and many other countries, prevalence has been increasing even though people’s genes have not changed. We published a study in 2006 based on data from over 60 countries. Almost all of them saw an increase in obesity among children. That clearly suggests the environmental, behavioral triggers rather than genetics, though some will argue the gene-environment interactions are the determinant of obesity.

What concerns you most about the global child obesity epidemic?

The scope and its serious health and financial consequences. For a big country like the U.S., already one-third of the children’s population is overweight or obese. In China, the rate in the major cities is already 30 percent, though it was less than 3 percent in 1985. There are so many other countries that suffer from such a high prevalence and also an increasing rate.

If you can prevent a child from becoming obese, are you preventing her from becoming an obese adult?

Yes. In general, one-third to two-thirds of overweight children will remain overweight when they become adults. I should also say, though, that many obese adults were not obese when they were children.

Is each country’s obesity epidemic unique?

Yes, each country has its unique challenges, but we also see some common patterns. In developed countries, we know that people with higher income, better education are less likely to be overweight or obese. But in most developing countries, it’s the opposite: People who are richer have better access to energy-dense food, processed food and can afford to have more sedentary lifestyles. They are more likely to be overweight and obese. We also see considerable differences between gender, age and ethnic groups within countries.

Can you compare China’s developing obesity epidemic to the U.S. epidemic?

In the United States, [it began in] the early ’80s. Since the mid-2000s, the data suggest a plateau. In China, the rapid increase started [in] the early 1990s. The rate of increase in China has been much faster than in the United States—about double—due to China’s remarkable economic development and social-environmental changes, which have profound impacts on people’s lifestyles and health.

Are there countries that have both rapidly developed and escaped this problem?

No, but some countries have relatively low obesity rates. South Korea is an example, though obesity has become a public health threat in recent years. The other model country is Japan, which has the best longevity worldwide.

What’s their secret?

One thing is traditional culture. Compared with China, they did a much better job preserving their traditions, including their traditional diet. In Japan, they do not use so much cooking oil or sugar, and their portion size is very small. The second part is culture. I think in the United States in general people value individualism. They value today, and they value the joy of life. But some Asian societies, influenced by Buddhism and other religions and culture values, not only look at current life but also future life and the larger population. They take a longer view. When you think about future generations, you have to control yourself.

Tell us about some of the Center’s projects.

Our Center has four key research projects and will support about 20 to 25 small-scale studies in the next five years to study the environmental, policy drivers of the obesity epidemic and find sustainable solutions. In a local study, we will [examine] the interaction between genetics and the environmental factors for the risk of obesity. Another key project is a Baltimore-based intervention study of modifying the food system.

This epidemic is global and entrenched. How could you have an effect?

It may be difficult to measure the effect this Center will bring in the next two years to five years, but we feel confident there will be several indicators people can see [after that]. One example is how many research programs our Center will be supporting in different countries, which then will result in potential policy programs. That’s what we really hope is the effect of this Center. We really hope the kind of people our Center trains—people who have systems thinking—will influence the obesity prevention effort in multiple countries.

What made you dedicate your career to childhood obesity?

I feel children, especially young children, are very vulnerable. They need care. They need support. There should be adults around them who can make a big difference in their lives. I want to become one of those adults, not only for my own children but for other children, even worldwide.

How is your Center different from others?

This is the only global center of child obesity in the world. We have researchers from epidemiology, nutrition, health policy, health economics and other disciplines. We have over 50 investigators from 15 other institutions including the NIH and institutions from other countries. Our Center will also provide grants and training scholarships to researchers worldwide to study the impact of policy or environmental changes on child obesity. We want to train the new generation of researchers, public health professionals and policymakers.

**BIG NUMBERS**

| 1.5 billion | Adults who are overweight or obese |
| 43 million  | Children less than 5 years old who are overweight |
| 115 million | People in developing countries with obesity-related problems |

**SOURCE:** WHO
Beginnings
Bright and Dark
A Radical Notion

Can Xiaobin Wang prevent chronic disease in utero?

She was full-term at birth. Back in 1962—the Year of the Tiger—preemies simply didn’t survive.

Her given name, Fenxi, translates to “Work Toward Hope.” It came to her mother in a dream and alludes to a mandate from her parents whose firstborn son had died in infancy. Auspicious though it was for a future physician-scientist, the little girl considered it “too big and not pretty” and dropped it in favor of “Xiaobin.” The nickname stuck. In years to come, it would appear on a passport and accumulate a series of academic degrees: MD, MPH, ScD. Most recently, it acquired two new titles that identify her as the Zanvyl Krieger Professor in Children’s Health and director of the new Center on the Early Life Origins of Disease at the Bloomberg School.

That her parents were pioneers who raised her in Inner Mongolia, on China’s frontier, seems relevant to Xiaobin Wang’s future as a clinician doing groundbreaking research. Her aim: to end chronic disease and fundamentally change the practice of public health and medicine in the 21st century. She is focusing on preconception, pregnancy and early childhood as the critical time windows to address diseases where multiple genes and environmental factors contribute to risk. It’s a radical notion: preventing adult hypertension or diabetes in infancy or in utero—or perhaps even before that—as opposed to waiting for symptoms to manifest many decades later. Her work was stimulated by the Barker Hypothesis, which, after being ignored and maligned for a dozen years, has given rise to a burgeoning field known as the developmental origins of health and disease, or DOHaD. Its tenets—that poor fetal growth and small size at birth are followed by increased risk of coronary artery disease, stroke, hypertension, type 2 diabetes and osteoporosis—are now espoused by an enthusiastic cadre of scientists worldwide. Bernard Guyer, for instance, Wang’s former doctoral advisor and the inaugural Zanvyl Krieger Professor in the Department of Population, Family and Reproductive Health, cites a Barker study on hypertension that made use of life-course data sets showing that specific increments in blood pressure were related to specific increments in birth weight. Most compelling, Guyer says, was the precision of the quantitative relationship between low-birth-weight babies and obese males.

If the concept of early origins of disease sounds pessimistically deterministic—
like we're pretty much doomed by the age of 2—consider this, Guyer says: “One of Xiaobin’s brilliant lines is, if we know gene-environment interactions can increase our risk of diseases, then we should be able to find gene-environment interactions that reduce the risk. If there’s an interaction, it doesn’t have to go always in one direction. We should be able to think about how we can make it go in the other direction.”

**ANIMAL STUDIES HAVE SHOWN** that a number of environmental triggers, such as poor nutrition or exposure to bisphenol A (a chemical found in plastic), alter the protein production of genes at critical times by turning them on, off, up or down; and that these “epigenetic” changes get passed down from mother to baby and even into the next generation. A striking example involves research using mice that, despite being genetically identical, are either small and brown, or obese and yellow (and prone to diabetes and cancer as adults), depending on whether or not a particular gene is activated by a simple change in their mother’s diet. Exposures in the womb get biologically embedded just when the developing nervous, immune and metabolic systems are most susceptible to being modified, essentially programming these systems early on.

These signals from the environment apparently echo far into the future, “which is why we’ve got to take seriously the public health aspects of food choices by girls and women,” says David Barker whose 1995 paper, “Fetal Origins of Coronary Disease” in the *British Medical Journal*, gave rise to the Barker Hypothesis.

A physician and professor at the University of Southampton Medical School in the U.K. and at the Oregon Health and Science University in Portland, Barker offers up a body of research suggesting that hundreds of millions of people need not have type 2 diabetes, for instance; that this and other chronic disease epidemics can be traced back to the placenta and are, he says, “unnecessary.” Prevention is simple but not easy, he explains: It requires improvement in the nutrition of girls and young women.

“Chronic disease isn’t about abnormal things happening to adults who then need fixing,” Barker says. “It’s about variations in key systems during development, which in turn cause wide variations in how well a baby is nourished. The ability of a mother to nourish her baby in the womb reflects her own lifetime nutrition, beginning when she herself was in the womb. To say ‘don’t drink, don’t smoke,’ is not enough. We’ve done that; we need to move on from merely limiting damage to building better people.”

Using good nutrition to build healthy people is hardly a new idea. (The Bloomberg School’s David Paige—decades before he taught Wang when she was a doctoral student here—developed a food voucher program in Baltimore that later served as the model for WIC.) What is news: the extent to which a developing baby’s or young child’s environment plays a role in chronic disease by silencing or activating genes. That’s why the heavy emphasis by Barker and his acolytes on birth weight: In addition to being a measure of pregnancy outcome, it’s an indicator of fetal nutrition, of whether an individual’s in utero experience was harsh or benign. Birth size implies potential in terms of metabolism, cognition and endocrine function.

If the early-origins framework that Barker built still rankles some scientists, it’s because the mechanisms remain elusive. Associating a prenatal exposure with the heart disease of a middle-aged man is one thing; directly linking the two is quite another. Lots of other potentially culpable stuff also happens in the intervening decades, muddying up the path between cause and effect. Which is why Wang is collaborating with a vast network of scientists and clinicians around the world as she leads comprehensive long-term studies into the early life precursors for pediatric and adult diseases including preterm birth, food allergy, obesity and metabolic syndrome. In Wang’s purview, the futile nature-versus-nurture debate morphs into verifiable questions with measurable answers: What environmental and social factors consort with which genetic factors; how, when and to what degree? Is the net effect a risk for disease—or resilience?

Of many adverse influences that can pull a trigger cocked by genetics, poor nutrition is a biggie. But brutal neighborhoods also belong on that list, according to Wang, as well as vicious domestic situations: “Violence is to mental health as cigarette smoking is to cancer,” says Barry Zuckerman, MD, chief of pediatrics at the Boston Medical Center and a mentor of Wang’s since she was a resident there in the late 1990s. While Zuckerman and his protégé are focused on discovering those factors contributing to low birth weight, they also are keen to identify biologic interventions and social strategies that could preempt or at least buffer the detrimental effects of environmental influences. Zuckerman’s Reach Out and Read program, for instance, goes beyond the scope of conventional pediatric practice, using literacy as “medicine” to immunize kids against the power of poverty and violence; he says that primary care practitioners must encourage parents to read aloud to babies and preschoolers.

**AT ABOUT THE TIME** when Xiaobin Wang was starting to read and ready to enter school, China’s educational system ground to a halt as a result of the Cultural Revolution.

While her classmates languished in illiteracy, Wang devoured state-approved biographies of great scientists like Marie Curie. Her parents, neither privileged nor wealthy, delighted in their daughter’s mastery of lessons elicited praise, which in turn accelerated Wang’s learning. She skipped the sixth grade; then the 12th. In 1978, China started reforming education just in time for Wang to distinguish herself on a national exam that landed her at Beijing University where she started medical school at the impressionable age of 16.

How had Wang mustered both physical and intellectual fortitude in an impoverished and corrosive environment while others around her withered? Posing that question—why does one baby, one child, one adult, have a markedly different outcome from most others despite all else appearing equal?—ultimately became central to her research.

First, she wanted to know why some women who smoke have low-birth-weight babies, while others who smoke have
normal-sized babies. Next, she wanted to understand why so many minority women living in poverty have preterm births while others living and working next to them have healthy, full-term babies.

As she investigated what part genes contributed to the puzzle and what part environment, she became convinced that there is crosstalk among dozens if not hundreds of factors—nutrition and smoking and genetic variables, just to name a potent few. Each single threat to health and well-being is difficult enough to study on its own. A “real-world” assessment involves the complication of a multitude of other threats that may exacerbate that original threat. And an even more accurate measure involves accounting for buffers that may temper some threats. Not one to shy away from seemingly insurmountable challenges, Wang insists on considering all the in utero variables she can conceive of—whether bad or potentially beneficial—no matter that this exponentially complex task has required her to devise novel methods of research.

It’s good science that compels her to consider the oft-neglected protective factors that engender resilience in the face of harsh societal or environmental factors. And it’s something more, something personal. If you

Worldwide, 15 million of the 135 million babies born in 2010 were premature. — “Born Too Soon,” a UN report released May 2
talk to Wang for any length of time, you’ll be impressed by the force of gratitude that gushes from her for her parents and schoolteachers as well as the likes of Guyer and Zuckerman, whom she describes as lifetime mentors. “From my elementary school to now, I have been extremely fortunate to have so many wonderful teachers, mentors and role models,” she says. “Their vision, leadership, knowledge, guidance and encouragement have greatly influenced my pursuit for education, training and research in medicine and public health.”

The mentor who awaited Wang when she entered Beijing University was Professor Gongshao Ye, a preeminent pediatrician who established the field of maternal-child health in China and authored a definitive textbook used for 30 years. “She told me that one ounce of prevention was worth more than 10 ounces of treatment,” Wang says.

She also told Wang to head to the U.S. after med school for further training. That advice set the young woman on a trajectory
that twice would land her at Johns Hopkins, first as a doctoral student of perinatal epidemiology in the 1990s with Bernie Guyer as her advisor; and now again in 2012 as a named professor and center director. Here and now, she’s poised to fully answer the question that has occupied her since her early days: What causes preterm birth?

When it first occurred to her that question needed answering, the Barker Hypothesis was simmering on a back burner; epigenetics was not yet commonplace in scientific discourse. She was a pediatric resident at the Boston Medical Center. By then, her parents’ mandate to Work Toward Hope had gestated for some 30 years.

NEVER IN HER LIFE had Wang seen such a tiny baby.

Born at 26 weeks—three months early—the preemie’s reluctant first breath required intubation and chest compressions. If, because of the marvels of life-support technology and her colleagues’ considerable skills, this infant survived the week—and even if, in months to come, this fragile being was able to “graduate” from the neonatal intensive care unit and go home (likely with a feeding tube and oxygen)—its translucent skin seemed to Wang to be a window into a future of suffering. Prematurity is a challenge emotionally and economically demanding at a loss for how to care for such medically, chronically complicated, infants.!

As a resident in a hospital that served a low-income minority population, among which almost 20 percent of births are preterm, Wang was keen on learning from the attending physicians how to rescue babies weighing in at just over a pound. But as the preemies kept on coming, she felt responsible, not only for them but also for their disenfranchised parents who were at a loss for how to care for such medically, emotionally and economically demanding newborns. Wang couldn’t imagine how even she, a trained pediatrician, would cope as the mother of such a preemie. Empathy and indignation moved her to tears and moved her to act. There had to be something she could do in addition to saving these lives, here and now. Something preventive.

The first thing she did was to author an elegant analysis that appeared in 1995 in the New England Journal of Medicine, demonstrating the finding that low birth weight and preterm birth repeated from one generation to the next.

The next thing she did was conceive the idea for the Boston Birth Cohort.

She sensed that the complex causes of preterm birth might begin to be teased apart if she could compare a sizable population of mother-preemie pairs against a population of healthy mother-baby pairs, with all coming from similar circumstances. Gleak as the NICU was, Wang recognized it as the ideal place to start to understand why some babies ended up here, connected to tubes and wires, while another group landed safely in the “happy” nursery down the hall. A multitude of risk factors necessitated a large number of cases (preterm births) as well as controls (full-term births). Mothers would need to agree to be interviewed, allow medical records to be scrutinized and contribute samples of maternal blood, cord blood and placental tissue.

With a small seed grant and encouragement from her professors Barry Zuckerman and Howard Bauchner, MD (currently editor-in-chief of JAMA), she set out on what now is a massive, 14-year-old project involving 7,600 mother-infant pairs, 60 percent of whom are black and 25 percent Hispanic. To date, analyses of the data have generated more than 30 publications; notably, Wang pioneered the genetic study of preterm birth. With a landmark article in JAMA in 2002, her group demonstrated how smoking mothers with certain genotypes had a 10-fold higher risk of preterm birth over smoking mothers with other genotypes, revealing a synergistic effect between a genetic and an environmental factor. A finding like this paves the way for “biologic hotspotting,” a strategy that identifies genetic vulnerabilities so that individualized interventions can be targeted at a particular behavior or specific biologic variable.

Wang’s Boston Birth Cohort comprises an extensive collection of epidemiological and clinical data as well as biospecimens housed in more than a dozen freezers near her new lab space in the Wolfe Street building. This rare resource allows Wang and her collaborators to investigate environmental, genetic and epigenetic influences on mothers, infants and children. Few, if any, prospective birth cohorts in the nation are so well positioned to answer “why” in the context of a minority, high-risk population bearing a disproportionately high burden of chronic conditions and diseases such as preterm birth, obesity and allergies. Because the study spans decades, researchers may check back with the subjects to ask new questions and look at disease progression.

With that cohort still actively recruiting, Wang and colleagues have built two more: The Chicago Family Cohort, focusing on food allergies, involves 4,000 subjects from 1,000 families; and the Chinese Twins cohort involves 2,000 pairs of twins and probes the precursors of obesity and metabolic syndrome. All three studies are churning out data.

“From the Boston Birth Cohort, we have data showing that by age 6, over 45 percent of the children in the study—no kidding!—are overweight/obese,” Wang says. “Fifty percent of the mothers were overweight/obese at the time of conception. Let’s not wait until these kids walk into the doctor’s office as obese adults.”

Statistics like that are guiding Wang’s latest efforts to corral Johns Hopkins faculty from the schools of Public Health, Medicine and Nursing for investigations into the early life precursors of intergenerational obesity. One NIH grant application involves nutrition expert Laura Caulfield, PhD, and Mei-Cheng Wang, PhD, a biostatistician, both from SPH; Tina Cheng, MD, a professor of pediatrics in the SOM; and mental health expert Deborah Gross, PhD, and Sarah Szanton, PhD, a health disparities researcher, both from the SON. Among Szanton’s contributions is a “society-to-cells” resiliency model that provides a holistic context for understanding health differences and guiding interventions at six different levels. Each one of the levels, Szanton says—society, community, family, individual, physiological and cellular—represents an opportunity to exert positive change. It’s impossible to resist applying this framework

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Protecting health care workers in armed conflicts has been a veritable black hole of human rights.

Julian Goklish (top) strives to keep his "heart clean and live life"; Apaches gather for a young girl's traditional "sunrise ceremony."
IT IS A LAND OF WONDERS AND ECHOES.

From the center of the White Mountain Apache Reservation, the tribe’s four sacred directions stretch across high desert, silent canyons and sere grasslands to touch their four sacred mountains blanketed with piñon pine, Ponderosa pine and spruce. Mountain snowmelt feeds creeks that tumble into the White and Salt rivers. Elk, deer, wolves and black bear wander remote forests, while eagles glide above rust-colored cliffs. In lower elevations, dark canyons suddenly carve into rolling forests.

“There is a strong magnetism to this land,” says Ronnie Lupe, the charismatic, longtime tribal chairman. “We are part of the land. We are with the land, the rivers, the trees and all.”

Married with the landscape are stories. Places—this bend in the river, this arroyo, that mountaintop—have stories attached to them that contain ancient wisdom, collective history and ethical guidance. Some tales reach so far back in time that the landscape has changed—a spring gone dry, a tree disappeared. “The world is constantly changing,” says Lupe. “That’s the way we live. That’s how we live.”

Over the last 150 years, life for the White Mountain Apaches has changed much faster than the land. During the relentless American push westward in the latter 1800s, invaders killed many Apaches and sundered their traditional ways. Children were wrenched from families and sent to boarding schools under U.S. government assimilation policies. “Since that happened, we started to lose our identity as far as who we were,” says Ramon Riley, the tribe’s cultural resource director. “To sum up the story, it’s historic trauma. Our people have gone through many things like genocide … just like the Holocaust. Our ancestors suffered. Our grandparents suffered. We suffered and now our kids don’t know who they are. They don’t speak our language. They are not connected to the natural world like we once were.”

The tragic legacy still echoes today. The unemployment rate is more than 70 percent. High rates of suicide, alcoholism, drug abuse and other ills follow in poverty’s wake. The social and economic hardships have rent the Apache’s social fabric, leaving young people with few options. Some live and work on the reservation or in nearby towns like Pinetop. Some leave for college or jobs in Phoenix or Tucson. Others, particularly those from dysfunctional families, survey their dismal prospects and can’t imagine any way out.

ON HER ARMS, SHE HAS MORE THAN 50 CUTS, ELBOWS TO WRISTS. She knows the times and dates for each one.

The girl lives in turmoil. Last year, her father and a grandfather died. Then a friend died by suicide. Her home life is upended by alcoholism. She finds temporary refuge in school. After her classes end, she walks … anywhere but home. Late in the evening, she slips into her house to go to sleep, says Melanie Alchesay, a community mental health specialist for an innovative suicide prevention program developed by the tribe and the Bloomberg School’s Center for American Indian Health (CAIH).

Alchesay once asked the girl why she engages in cutting, a risk factor for suicide. “It’s because of my home situation, because of my family,” the girl replied. “Woman, I’m so stressed out!”

She is 14 years old.

“I wish I had a house to provide her,” says Alchesay. “I wish I could hug her and tell her you’ll be okay. I wish I had a big house. I’d take them all in.”

The suicide rate among young people ages 15 to 24 on the White Mountain Apache Reservation is among the highest in the U.S.—13 times the U.S. average, according to a 2009 American Journal of Public Health article by CAIH authors, including Apaches and Baltimore-based researchers. From 2001 through 2006, 25 people on the reservation under the age of 25 died by suicide—a devastating toll for a community of 15,500. And for every suicide, there were
36 attempts. More than 200 attempts were recorded annually in 2005 and 2006; two-thirds of the attempts were by young people under 25. (In the U.S population, suicide peaks much later in life.)

“There are certain ills, certain challenges out there that we thought we would never see,” says Lupe. “But we know how to saddle up and ride and see what it looks like in that challenge.”

Even a single youth suicide is ineffably sad, but the issue requires perspective, says David Yost, MD, clinical director at the Indian Health Service hospital who has worked on the reservation for 22 years. “We always have to remember the overwhelming majority of our young people are healthy,” Yost says. “It is important not to judge the community by what shows up in our emergency room.”

At the same time, many in the community have been touched by suicide in one way or another.

The tribe and CAIH confronted the issue by creating the Celebrating Life program that works to reduce the suicides one youth, one family, one community at a time. Every day, the program’s staff—all Apaches—help young people overwhelmed by daunting economic, historical, social and interpersonal issues.

"They just found him. I don’t know if they have a pulse. They are working on him now.”

Novalene Goklish talks urgently on her cell phone to a colleague on a March afternoon, in Apache and English. A young man on the reservation has attempted suicide. Goklish stands on the porch of CAIH’s headquarters. It is in a portable building behind the Indian Health Service hospital in the town of Whiteriver, near the center of the 1.6-million-acre reservation. Behind her, a bright noon sun casts short shadows on the Ponderosa pines of Gold Butte.

Usually quick to joke or share an ironic aside, the senior field program coordinator for Celebrating Life has gone quiet. Her face is stilled with concern. Between calls, she confides, “Right now you’re hoping for the best. They’re doing everything they can to save him.”

As Goklish leaves to take another call, Francene Larzelere-Hinton sits pensively. The director for the White Mountain Apache site of the Native American Research Centers for Health, Larzelere-Hinton had expected a joyous day; she is going to a traditional ceremony in the evening, part of the multi-day “sunrise dance ceremony” that marks an Apache girl’s transition to womanhood.

“You can feel heaviness,” she says. “I don’t know if you can tell, but you can feel the heaviness.”

Concern for the young man weighs on them. So does worry that the suicide attempt may lead to others. Suicides can erupt like contagions, as happened here in the early 1990s when 11 young people died by suicide in less than a year. In response, some tribal elders were mobilized to visit people who were suicidal. The elders would talk and pray with them, staying at their homes for days, if need be, to guide them out of danger. The group was formally known as Apaches Helping Apaches, but people called them the “ghostbusters.”
Tribal leaders knew more was needed so they turned to a friend they could trust.

Back in 1980, a young pediatrician and researcher named Mathuram Santosham had arrived in the dry, manzanita-dotted valley surrounding Whiteriver. Lupe and the tribe were wary; they had been burned before by researchers who took grant money, gathered data and then just left.

Santosham earned the tribe’s trust by confronting a lethal epidemic of diarrheal disease. “Truly, kids were dying of diarrhea just like in developing countries,” says Santosham, MD, MPH ’75, and now a professor of International Health. The tribe embraced his recommendations for widespread use of oral rehydration solution. Diarrheal deaths soon fell almost to zero.

Next, with the Apaches’ help, he proved the effectiveness of vaccines against Haemophilus influenzae type b (a leading cause of meningitis) and later, rotavirus (a cause of diarrhea), quelling epidemics and saving more young lives. Data from these efforts helped transform health care standards in the U.S. and the world. Along the way, Apaches received public health training to help their neighbors.

So when the suicides erupted in the 1990s, the tribe drew on Santosham and the CAIH. Apache leaders came to Baltimore to meet with researchers, and together they devised a public health answer to prevent more young deaths. They would train Apaches as paraprofessionals who would specialize in community mental health and preventing suicide.

Tribal leaders and the CAIH team (including Santosham, John Walkup, MD, Raymond Reid, MD, MPH ’81, Larry Wissow, MD, MPH ’84, Allison Barlow, MPH ’97, and others) knew they needed data and an understanding of the problem’s root causes. So the tribe mandated in 2001 that all suicide attempts, completions and even ideation be reported by first responders. Later, the reports were collected in a central registry. It is the first community-based suicide surveillance system in the U.S. “The tribe is very innovative in their thinking. They say, we are not going to stand for this suicide epidemic,” says Barlow, now a CAIH associate director. “They treat suicide as an infectious agent that is foreign to their community and have directed their collective will around containing it and getting rid of it.”

In 2004, the tribe and CAIH researchers began to regularly analyze data from the suicide registry, helping them uncover valuable information: The suicide rate is highest among the 15- to 24-year-olds, with 128.5 suicides per 100,000. (The all-ages U.S. suicide rate is 10.7.) Although Apache males and females attempt suicide at roughly the same rate, males are five times more likely to die. Hanging is the primary method of suicide, followed by firearm and overdose. Saturday is the most common day for suicide deaths.

“Suicide seems scary, a mystery, an unapproachable topic to many people, but we know it is a preventable public health problem,” says Barlow. “No one in the U.S. is addressing it with more courage and science than the White Mountain Apache people.”

In 2010, the Celebrating Life team collected 543 surveillance reports. Each...
yellow report triggers a visit to the young person by an Apache community mental health specialist trained by CAIH, who verifies what happened, begins a dialogue and refers the youth to Apache Behavioral Health Services for counseling. The specialist also gets young people to recognize what upsets them and to create a “safety plan” of actions to take when they are upset. Together, they also brainstorm ways to overcome barriers to counseling like transportation or privacy concerns. The specialists try to stay in touch with the young people, sharing advice and lending a sympathetic ear.

“We have taken an important leap to train native community mental health specialists to do diagnostic screening and crisis management,” says Barlow. “Local people are more credible and more compassionate to the youth and their families.”

With NIH and Substance Abuse and Mental Health Services Administration support, the Apache-Hopkins research team is assessing Celebrating Life by following more than 30 Apache adolescents who attempted suicide and then enrolled in the program. Initial results are encouraging. Youth in the program have reported fewer depressive symptoms, a reduced negative outlook and an increase in peer social support.

During the first or second visit, a specialist will try to help the youth understand the seriousness of a suicide attempt by playing a short, gender-specific video. In the video for young men, a teenage boy responds to a break-up with his girlfriend by hanging himself, but is saved by his mother. Tribal elders, speaking in Apache with English subtitles, share the tribe’s beliefs about the sacredness of life and each individual’s responsibility to the Apache web of life.

The team also offers a nine-session program for youth that helps them with conflict resolution and problem-solving and coping skills. In addition, more than 120 teachers, coaches, parents and others have taken two-day workshops that train them to recognize those at risk and help them effectively. An outreach program called Family Spirit gives teen mothers and fathers skills to help them raise healthy, emotionally resilient children. Another program called NativeVision enrolls third to fifth graders in afterschool classes in fitness, healthy lifestyles and tribal culture. The team also has led eight prayer walks with spiritual leaders to call attention to the suicide problem.

Lupe recalls addressing a sea of young faces in a school gymnasium after a recent prayer walk in his home community of Cibecue. He told them the ancient story of a young White Mountain Apache boy. Guided by a voice and helped by a spider and a gopher, the boy gathered an eagle feather, sinew from an elk, a stick, obsidian and other materials and made the first bow and arrow. “I want them to understand that we depend on the young generation,” Lupe says. “I want them to know that they have a responsibility. They can create a weapon for us. They can create motivation where the White Mountain Apache tribe can be so strong and so powerful.”

For their innovative approach, the Apache’s suicide prevention team was honored in October by the American Psychiatric Association with a bronze Psychiatric Services Achievement Award.

Despite their remarkable efforts, however, sometimes they still must deal with the sorrow of a suicide death. A little while after the first flurry of phone calls about the suicide attempt on that March afternoon, Goklish gets bad news. The young man has died.

Goklish and Larzelere-Hinton get in a blue Ford Escape and pull away from the hospital complex and head south on Arizona 73. They are driving to the family’s home to offer what comfort and counsel they can—and hopefully prevent any spark spreading from the first suicide of 2012.

**FOR ALIDA ANTONIO, SUICIDE IS A SPIRIT.**

The spirit has stalked her family since January 14, 2005. That day her 14-year-old niece took her own life.

Grieving, Antonio retrieved her niece’s pictures, books, knickknacks and souvenirs. Some possessions, in the Apache tradition, went into the grave with her; the rest were stored in her daughter’s room. “We didn’t have an elder to tell us to not keep it in the house,” she recalls.

Nine days later, Antonio’s daughter, distraught by her cousin’s suicide, started drinking and, later, throwing her cousin’s pictures in her room. Antonio called the

**“We’re there to listen, to make sure at-risk individuals are safe and to let them know that we care.”**

—Novalene Goklish, with Francene Larzelere-Hinton
police. When they arrived and peered in the bedroom window, they saw her hanging. She was alive but would never regain consciousness. She died in a Phoenix nursing home three years later.

Then late in 2011, Antonio’s 13-year-old son attempted suicide. He survived and later said he did it because he “just got so mad” at his brother. Suicides by young people are often precipitated by emotional conflicts.

Meeting with a Celebrating Life team member and watching the video had a strong impact on her son, says Antonio. He also has been getting counseling. “It’s opened up his eyes to a lot of things,” she says. He says he will never again try to kill himself. But she still checks on him when he goes to his room. “I always have to worry,” she says.

Antonio has shared her experience with others in hopes of preventing future suicides. She urges parents to talk more with their children and reminds young people how suicide hurts families and the whole community. “The ones who are here afterwards … we are the ones who suffer,” Antonio says. “I just pray it doesn’t happen to anyone again.”

At some point Antonio realized her niece’s books and pictures had been moved into her son’s room. She worried they carried the spirit. “The books, I burned, but the pictures I saved are not in my house. They are outside,” she says.

A spirit, a dark figure, a dark force … the idea of a malignant being behind the youth suicides comes up frequently in conversations here. Outsiders may be tempted to label it a manifestation of depression or a reflection of emotional disturbance, but that assumption is wrong, says Goklish, who has led the suicide prevention team for eight years.

“You tend to expect certain things when you live in an area where there was bloodshed a long time ago,” she says. She recalls a fourth-grade girl who told her a nightmarish story. The girl said that while she was walking near her home, a dark figure in a black jacket appeared beside her and told her to walk to a nearby mountain where she would find a playground that she had never seen before. There, the figure told her, she would always be able to play and would never have to worry or be sad ever again. But first, the figure said, she would have to kill herself. The girl bolted, ran home and later told her teacher. The school nurse alerted the Celebrating Life team.

Johns Hopkins researchers take such reports very seriously. “In the communities we serve, the spiritual realm is important,” says Mary Cwik, PhD, a child clinical psychologist and a CAIH assistant scientist. “Maybe that dark force has always been around but in past times, the Apache people and other Native Americans were much closer to their original way of life. And built into that were things that discourage the [bad] spirit.”

Goklish says her Apache ancestors had many ceremonies and prayers that were woven into daily life. “You were told to get up in the morning and do prayers. If you are not feeling right, or out of balance, you were told to pray,” she says.

Some believe a return to traditional beliefs and ways is the answer. Others think suicide prevention starts with listening. Novalene Goklish’s son Warren, 14, may have saved a friend’s life. A target for bullies, the friend talked about feeling worthless and contemplating suicide. Warren broke up one bullying incident and counseled his friend against even thinking of suicide.

Sitting in his aunt’s house in Whiteriver, Warren stares at his hands, his fingers interlocked as if in prayer. “I told him there are always people who will be there for you. I told him suicide is not the answer,” Warren says quietly. “I guess I helped him. I guess it turned around for him.”

His older cousin, Julian Goklish, helps his own friends and has warned them about cutting: “You know what happens if you hit the main vein? You’re going to go black. You’re not going to see your family no more. You’re not going to have a joyful life with friends. You’re not going to see them all no more. You’re just going to see yourself in hell.”

Julian, 20 years old and taking online classes in computer technology, says he lives

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“We live and breathe
knowing there’s tons
and tons of work to be
done yet.”

—Ronnie Lupe, tribal chairman
Over the past 28 years that Bob Gilman, MD, has spent in Peru, the international health professor and his colleagues have accomplished a lot. They’ve developed a new test for tuberculosis that dramatically shrinks the time and sample size needed to reliably detect even drug-resistant strains that other tests are hard-pressed to identify—a boon for the tens of thousands of Peruvians struck with tuberculosis each year. They’ve identified city drinking water as an important source of *Helicobacter pylori* infection in Peruvian children, and thus a way to prevent widespread gastritis and ulcers. They’ve also discovered previously unknown bacteria and protozoa that are causing emerging infections, including *cyclospora*, a protozoa that causes diarrhea.

His work in Peru has resulted in more than 400 papers in prestigious journals. He even learned to live well there as a foreigner, raising two kids with his wife, Jo Gilman, and residing in the country throughout the uprising by the Maoist insurgent group, the Shining Path.

But the accomplishment that seems to matter the most to Gilman is the strong...
me, and that's what I've always wanted.”

—Bob Gilman

network of research colleagues and trainees that he’s strung together across this country.

“If I had to say what I’ve been really good at doing, it’s bringing Peruvians to the U.S. for training and getting them back to Peru to build what I hope is a sustainable operation,” he says. “The people here need me like a hole in the head. My goal is to build a sustainable unit that doesn’t depend on me in most ways.”

By choosing smart junior colleagues and students and giving them responsibility for projects, Gilman empowers them to eventually become leaders in their own fields. Later, after many of these young researchers pursue further training in the U.S. and other countries, they come back to launch their own labs—taking Gilman’s philosophy to a new generation.

Gilman’s trainees stretch across Peru like “a giant fan,” he says, sometimes working individually on their own projects and grants, sometimes coming together to pool their expertise.

“These people are completely able to do everything without me,” he says, “and that’s what I’ve always wanted.”

Four members of the vast Gilman network share their stories on the following pages.
I basically consider Bob to be a second father. I have worked with him for more than two decades. He has guided and assisted my personal and professional growth since I entered the health field.

When I was in engineering school, I did a small mathematical modeling project on malaria transmission. Hugo [Garcia] found out about this—he’s my first cousin. He’d been working with Bob for a few years, and he wanted me to show my project to him. When I did, Bob was very enthusiastic, and I went on to work with him on various projects. Eventually his wife hired me to do data analysis work for her NGO. The best part was being around to continue to work with Bob and his students.

Eight years later, I was looking for the next step. I knew that Bob had helped several of the young people he worked with go to Hopkins to get their PhDs, including Hugo, but I thought it was something I might be ready for in five years or so. Bob said, “Why don’t you apply now?”

I went to Hopkins, and it changed my life. A year after I returned to Peru, an opportunity at the U.S. Naval Medical Research Unit No. 6 in Peru opened up. Now I’m head of the Department of Parasitology here, and I also run the Public Health Training Program that, among other activities, has a master’s in epidemiology [program] as a joint project between Universidad Peruana Cayetano Heredia and the U.S. Navy.

I’ve learned so much from Bob, and it would be presumptuous to say I’ve taught him much. But from me, I’m sure he’s learned that people can be very stubborn. He thought starting this master’s program was a very ambitious task—not that we couldn’t do it but that we might be aiming too high. But we stuck to it, and it’s really paid off. We’ve trained over 100 junior scientists to do research in our own country. They’re Peruvians committed to solving Peruvian public health problems.

Whenever I introduce myself, I say I’m a “Gilmanite,” one of the children of Gilman, and now the students I work with are the third generation in this family.
When I was in the beginning of getting my master's degree in microbiology from Universidad Peruana Cayetano Heredia in 1984, Dr. Gilman came to Peru wanting to do research on giardia, an intestinal parasite that causes diarrhea. When Dr. Gilman asked if he could work with some students, my mentor volunteered me. That was very lucky because in Peru it’s very difficult to do research since we don’t have much funding.

Dr. Gilman encouraged me to get a PhD in microbiology in Peru, and then used a training grant so I could get a second PhD in public health from Johns Hopkins. I’m now an associate professor at Universidad Peruana Cayetano Heredia. I would never have been here without his encouragement. Here, I’m part of a team doing cellular and molecular biology work to help improve our understanding of a variety of tropical diseases. For example, we recently published a paper about a mechanism that *Taenia solium* larva use to adhere to host tissue, findings that help us understand the mechanism this parasite uses to cause cysticercosis.

For a good researcher, it’s important to do not only research but also to teach. Not all researchers have this mentality, especially in my country. But Dr. Gilman says that he doesn’t keep secrets from anybody—he loves sharing everything. Now, I advise students in the same way that Dr. Gilman taught me, teaching them everything they want to learn, and encouraging them to leave and teach others. Something very peculiar is that Dr. Gilman is always motivating people to continue to prosper in their careers, to learn to write articles and grants. He is also a very kind person because he always cares about the welfare and the personal life of each person working with him.

I’ve known Dr. Gilman now for nearly 28 years, and over all that time he’s never gotten tired of working, and he has an incredible memory—even though he might have been away from Peru for two months, he’ll remember everything that people said at the last meeting. I tell Dr. Gilman that he’s younger than all the young people around him! He has so much energy.
During my first weekend in Bamako, I learned that in Mali, music means a lot more than Top 40. It’s a way of life. And the people who make music—including traditional West African storytellers, called griots, and the more recent wave of pop music stars—can be powerful agents for change.

Riding the capital’s dusty red dirt streets on a motorcycle one Sunday afternoon, I soon witnessed the griot tradition. Under a white tent spanning the middle of a residential block lined with mango trees, a local griot serenaded wedding guests, accompanied by several djembé, or Malian drums. The bride and guests laughed at the teasing story she sang about their families and origins, which she surmised partly from their names (akin to how we know baking professionals lie somewhere in a Baker family’s ancestry).

Societal changes of the last two decades have blurred the line between traditional griots born into the tradition by family, and others who choose to be musicians by trade. The professional musicians bring in new styles from jazz, blues and Latin music, but still perform traditional songs with griots at weddings and naming ceremonies.

Woven together with the playful banter, skewering satire and sage advice that these honey-toned singers have passed down for centuries are new messages—messages aimed at saving lives across West Africa. With the help of Voices for a Malaria-Free Future, a project of the Bloomberg School’s Center for Communication Programs active in four African countries, the singers have become the newest foot soldiers in the battle against malaria. They are reaching out with their artful blend of song and storytelling to galvanize public and private resources against a disease that claims nearly 700,000 lives a year, most of them in Africa and most of them children, according to WHO. (A February *Lancet* article offers a direr estimate, placing global malaria deaths in 2010 at 1.2 million.)

In malaria, the griots face a foe as adept at improvisation as they are. The constantly shifting malaria parasite can acquire drug resistance quickly, and a vaccine has remained elusive. That’s why Voices for a Malaria-Free Future, with Gates Foundation funding, has combined national dialogue and local action to change people’s behaviors. Claudia Vondracek, who heads the project, told me they adapt their strategy to social forces already present in each country. Malians have used mosquito nets for decades, but typically only during the rainy season. So the project made a strategic choice to focus on widening net use for prevention. (According to WHO, full use of insecticide-treated mosquito nets in sub-Saharan Africa could reduce child mortality by 18 percent on average; that would save more than five lives per year for every 1,000 children under 5 who are protected.) The project also chose the cultural resources available in traditional griots and popular music as a key channel for behavior change communication (BCC).
Musicians showed the practical power of Mali’s music culture when the project started in 2006.

A bureaucratic logjam had kept nets warehoused in the capital for months. So the Voices staff mobilized a group of high-profile advocates—including top musicians, legislators and health officials—to film public service announcements, explains Mali country director Djiba Kane Diallo.

Salif Keita, Mali’s first world music superstar, brought results immediately. “We went together to the Ministry of Health and filmed,” recalled Diallo. “[Keita] stood in front of the Ministry of Health and said, ‘It’s almost the rainy season, so we need to give nets to people and alert them to use them.’ We made the PSA and aired it. A day or two later the Minister of Health herself called and said, ‘Okay, what do you need?’”

From that came an annual distribution of nets at the district and community levels, with more nets provided by the Global Fund to Fight AIDS, Tuberculosis and Malaria and the President’s Malaria Initiative. After the 2007 campaign provided treated nets to more than 2.8 million children, a survey showed that 80 percent of households with children under age 5 had treated nets. The next question: Would they use them?

Among the hurdles to fighting malaria, the biggest may be long-standing public acceptance of the disease. You need a powerful message to tackle a mountain that people have come to accept as part of the landscape.

Abdoulaye Diabaté, one of Mali’s most popular musicians, said, “I suffered too much from malaria.” He recalled the high fever and headaches, the vomiting and diarrhea and the repeating cycle of shivers and sweats through the night. “It was not just me, it was all children my age, catching the same illness,” he said. “We grew up that way, accepting the disease. We didn’t know it could be different.”

First, Voices of Mali enlisted top health officials to articulate the message to policymakers. These champions included Ogobaro Doumbo, who heads the Malaria Research and Training Center at the University of Bamako. Doumbo helped Voices sensitize legislators from Mali and 17 other countries across West Africa to how they could help, starting with increasing the proportion of national budgets devoted to health.

One evening at Point G, a century-old hospital on a bluff overlooking the capital, Doumbo explained this high-level advocacy. To motivate public figures, Doumbo said, “you have to use an exact but simple message.” Malaria is a specific fever, he explains, and by improving diagnosis and prevention it can be beaten. Then he marshaled a compelling comparison: “This is equal to three to four tsunamis happening every year to African kids.

“Africa has lost a lot of Einsteins, a lot of Pasteurs, a lot of Bill Gateses because of malaria. So if you’re able to eliminate malaria, you will see it increases the general creativity in this country and the ability of people to innovate and bring science to make their own solutions.”

Doumbo added, “When you say that to parliamentarians, they listen.”
A Grassroots Shift

After focusing their message on national decision makers, Voices advocates needed to inform the public of policy changes and persuade them to adopt preventive care for pregnant women and appropriate malaria treatment. In 2009, the second phase launched the BCC component. Increasingly, Voices of Mali involved griots and popular stars to take the message to village-level action. Again, project staff trained the champions to deliver key messages in concerts and on radio spots. For example, for World Malaria Day they worked with Diabaté on the message that pregnant women need to get prenatal care. The lyrics of one song urged, “Pregnant women, please get your consultation prenatal, to be sure you receive your nets.” Local NGO affiliates created watchdog committees, with women and a representative each from schools and health agencies—six or seven people per village. The committees organized town meetings focused on how to avoid mosquito bites and the proper use of nets. “They also go gate by gate, family by family,” Diallo said, encouraging people to use their nets nightly, stressing the importance for children’s health.

Next door in Senegal, a national net distribution campaign coupled with BCC—led by a coalition of the National Malaria Control Program (NMCP), the Peace Corps and other organizations, including NetWorks, a CCP project—yielded big gains.

By January 2012 the campaign covered 10 of Senegal’s 14 regions and distributed more than 3.8 million nets. It had received a boost two years earlier from Youssou N’Dour, a Senegalese world music star, who grew up in a griot family and has crossed over with songs that weave in outside influences. “In Senegal, everybody knows Youssou N’Dour’s songs by heart. If you can get 8 million people to memorize these songs, we should be able to lead to a change in behavior,” observed Yacine Diop Djibo, who heads the NGO, Africa Speak Up. A song that N’Dour recorded with Viviane Chedid, titled “Our Society,” aired frequently on radio stations for months, with a refrain that in the Wolof language sounds danceable: “Our society is booming/We stand strong and proud/We fight malaria/To finally kick it out of Senegal.”

As one of the key partners in the Senegal coalition for distributing the bed nets and getting people to use them consistently, NetWorks operates differently from the Mali CCP program, explains Joan Schubert, NetWorks team leader based in Dakar. With funding from the President’s Malaria Initiative, NetWorks has developed technical strategies for logistics, communications, and monitoring and evaluation, says Schubert. To monitor overall progress, NetWorks will track indicators annually, including the percentage of households with one or more insecticide-treated nets and the percentage of people who slept under nets the previous night. During home visits a week after the distributions, outreach workers look at how many nets were properly hung and used the night before. NetWorks also launched a 24-month qualitative study in January on the culture of net use; the study will help refine future communications work.

Senegal has seen a steep drop in malaria, from 1.5 million cases in 2006 to 175,000 in 2009, according to a 2010 NMCP study. Improved diagnosis (determining other causes of fevers) accounts for a large share of that decline, but the public campaigns appear to be having a remarkable impact. By January, more than 13,400 health workers and more than 1,200 traditional health workers have received BCC training.

“Build it and they will come” doesn’t always work in public health. “You can have all these great solutions to public health problems, but they’re not solutions unless they’re adapted, adopted and utilized,” says Susan Krenn, director of the Center for Communication Programs, which designs and deploys strategic communication programs to educate and influence health behaviors.

Established in 1983 and now housed in the Department of Health, Behavior and Society, CCP has more than 60 active projects in nearly 30 countries and a staff of nearly 600. Its health communication programs address a broad range of health issues, including HIV/AIDS, reproductive health and family planning, malaria, water and sanitation and tobacco control.

The Center is a leader in the use of entertainment as a vehicle to deliver health messages to large audiences. There’s Bol, the Pakistani feature film about family planning and maternal health that has grossed more than any movie in Pakistan’s history; Chenicheni N’chiti, a radio program in Malawi that addresses HIV/AIDS issues; and Intersexions, the Peabody Award-winning South African television series, which traces the HIV virus through a network of sexual relationships.

“All of our entertainment education programs combine quality production and engaging stories as well as vitally needed health messages,” she says.

Krenn says that one of CCP’s great strengths is that the creativity of the work is grounded in communication research and theory.

“We use a proven process to get to something that’s going to address key issues, to resonate, to be relevant and to get the population to take up behaviors that will help them and change their lives,” she says.

—Jackie Powder
communicators had received NetWorks training on the message, “All the family, all year, every night.” In French it is known as the Trois Toutes campaign: Toute la famille, Toute l’année, Toutes les nuits.

In Mali, griots with Voices incorporated the message into their traditional performances. Performing at a wedding, they’d interrupt singing to say, “I need to talk with you about malaria.” After the wedding, where gifts can include a mosquito net, the griot would urge, “Now please sleep under the net because it’s important.”

After I peppered Diallo with questions about griots, she called Abdoulaye Diabaté. “Bonjour, Papa,” she said, then eased into Bambara (another West African language). She succeeded in getting me an interview with this nationally famous musician for the very next day.

The next morning outside the Voices office I heard Diabaté bantering with the staff well before I saw him. Then the man with the resonant voice moved into the office with an easy grace, garbed in a flowing white robe and fez-like hat. Diabaté, who comes from a long line of griots, says: “A griot is someone who retains a lot in their head. For changing people’s thinking, you need people who retain a lot.”

He nodded toward the laptop nearby and his own two cell phones. “Now we have computers, we have phones, we have machines. Before, it was only the griot who had that function.” Yet even with these new technologies, he said, the griot retains authority as “the mouth of the people, the ear of the king.”

Like N’Dour, Diabaté straddles the line between griot and pop artist. His songs have long addressed social themes including illness, inequality and the role of science. He became involved in the fight against malaria through songs about his experiences growing up in the countryside, where, like other children, he suffered from malaria.

One night soon after, Diabaté deployed his charismatic blend of griot and Afropop rhythms at a fundraiser for a local youth association. He connected with his audience, young and old, as they shouted the lyrics to his driving song “Sere,” which addresses adolescent health and possibilities for the future.

As the hot season steamed into April 2011, Voices ratcheted up the awareness campaign leading to net distributions in western villages near Kayes. I found glimmers of the campaign in a bus station four hours east of the capital, where the lettering on one young man’s shirt read, “Free Africa from Malaria Now.” In a rural clinic several hours away, Dr. Karamako Nimaga explained that malaria was still the main reason for clinic visits during the rainy season.

As Mali emerged from a scant rainy season last November, Voices received Gates Foundation funding to focus on advocacy and private sector partnerships. In Mali, the high-end Azalai hotel chain committed to promoting use of mosquito nets among its employees and hotel guests; and Orange, a major cell-phone carrier across Francophone Africa, sponsors soccer tournaments to promote awareness in the countryside.

“For me, a Mali without malaria will bring a blossoming of cotton, millet and rice,” Abdoulaye Diabaté told me. Now I understood: Malaria strikes not just individuals but entire communities who manage the fields and run the fishing boats in the season when the haul is most fruitful.

Diabaté said this was more than simply a fight to end an illness, as important as that would be. “People who are completely free of malaria can work in their fields, they can fish.” Then he added ruefully, “I don’t want my children to suffer from this disease and say, ‘Abdoulaye didn’t do anything.’

“A Mali without malaria is an abundant Mali,” he said. “That’s the hope.”

David Taylor traveled to Mali in 2011 with support from the International Reporting Project.
David Abrams, PhD, professor, Health, Behavior and Society (HBS), has been named a Fellow by the American Academy of Health Behavior.

Chris Beyrer, MD, MPH ’90, professor, Epidemiology, and director of the Center for Public Health and Human Rights, received an honorary doctorate in health science from Thailand’s Chiang Mai University. The degree was conferred by Her Royal Highness Princess Maha Chakri Sirindhorn.

Robert Black, MD, MPH, Edgar Berman Professor and chair, International Health, received the Raulin Award for Outstanding Contributions to Science from the International Society for Trace Element Research in Humans.

Terry R. Brown, PhD, professor, Biochemistry and Molecular Biology, received the Distinguished Service Award from the American Society of Andrology.

Nilanjan Chatterjee, PhD, adjunct professor, Biostatistics, received the 2011 COPSS Presidents’ and Snedecor awards at the Joint Statistical Meetings.

Kevin Frick, PhD, MA, professor, Health Policy and Management (HPM), received the Distinguished Service Award from the Vision Care Section of the American Public Health Association (APHA).

Andrea Gielen, ScD ’89, ScM ’79, professor, HBS, and director of the Johns Hopkins Center for Injury Research and Policy, has been named the 2012 Research Laureate by the American Academy of Health Behavior.

Diane Griffin, MD, PhD, chair, W. Harry Feinstone Department of Molecular Microbiology and Immunology, delivered the George Khoury lecture at NIH in December.

D. A. Henderson, MD, MPH ’60, Dean Emeritus, received a gold medal award from the National Institute of Social Sciences.

The HPTN 052 HIV prevention trial was named the 2011 Breakthrough of the Year by the journal Science. Two of the 13 HPTN study sites were led by Bloomberg School professors: David Celentano, ScD ’77, MHS ’75, the Charles Armstrong Chair in Epidemiology (Thailand site); and Taha Taha, MBBS, PhD ’92, MPH, professor, Epidemiology (Malawi site).

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Intersexions, the HIV drama series co-produced by Johns Hopkins Health and Education in South Africa with USAID PEPFAR funding, received an International Peabody Award in April.

Alain Labrique, PhD ’07, MS, MHS ’99, assistant professor, International Health, was named a 2011 Top mHealth Innovator by the mHealth Alliance and the Rockefeller Foundation for developing the mCARE project with co-investigators Christian Coles, PhD ’00, MPH, MA, Luke Mullany, PhD ’05, MHS ’02, and Elizabeth Jordan, DNSc ’04, MSN.

Philip Leaf, PhD, professor, Mental Health, was presented with the Agus-Shehan Interfaith Leadership Award from the Central Maryland Ecumenical Council.

Orin Levine, PhD ’94, professor, International Health, was elected president of the American Society of Tropical Medicine and Hygiene Committee on Global Health.

W. Henry Mosley, MD, MPH ’65, professor emeritus, Population, Family and Reproductive Health (PFRH), received the 2011 Carl Taylor Lifetime Achievement
Award in Recognition of Outstanding Lifetime Achievement in International Health from APHA’s International Health Section.

**Kate O’Brien**, MD, MPH ’94, professor, International Health, and **Brian Caffo**, PhD, MS, associate professor, Biostatistics, each received a Presidential Early Career Award for Science and Engineering, the highest honor bestowed by the U.S. government on science and engineering professionals early in their research careers.

**Elise T. Pas**, PhD, MA, assistant scientist, Mental Health, received the Association of Positive Behavior Support’s Ted E. Carr Initial Researcher Award.

**Keshia Pollack**, PhD ’06, MPH, assistant professor, HPM, was one of 50 people statewide to be named by The Daily Record in 2011 as one of Maryland’s Very Important Professionals Under 40.

**Ciro de Quadros**, MD, adjunct associate professor, International Health, won a BBVA Foundation Frontiers of Knowledge Award for Development Cooperation.

**David Sack**, MD, professor, International Health, received the Esther Pohl Lovejoy, M.D. Leadership Award from the Oregon Health & Science University. He also shared with his brother **R. Bradley Sack**, MD, ScD ’68, MS, professor, International Health, the Donald Mackay Medal of the American Society of Tropical Medicine and Hygiene. R. Bradley Sack also received the Richard T. Jones Distinguished Alumni Scientist Award from the Oregon Health & Science University.

**Freya Sonenstein**, PhD, professor, PFRH, and director, Center for Adolescent Health, was presented with the Researcher of the Year Award by the Healthy Teen Network.

**Peter C. van Dyck**, MD, MPH, senior associate, PFRH, was awarded APHA’s 2011 Martha May Eliot Award.

**Peter Winch**, MD, MPH ’88, professor, International Health, received the 2011 Dory Storms Child Survival Recognition Award from the CORE Group.

**Barry Zirkin**, PhD, professor, Biochemistry and Molecular Biology, was elected as Fellow of the American Association for the Advancement of Science.

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**Cohen Honored with Bloomberg Professorship**

Joanna Cohen, PhD, MHSc, a leader in the field of tobacco control and director of the School’s Institute for Global Tobacco Control, is the inaugural recipient of the Bloomberg Professorship in Disease Prevention. Celebrating Cohen’s achievement on April 12 were (from left) Michael J. Klag, dean of the Bloomberg School of Public Health; New York City Mayor Michael R. Bloomberg; Cohen; and Ronald J. Daniels, Johns Hopkins University president.
A Radical Notion (continued from page 29)

He described his department’s efforts to develop a birth cohort focusing on early exposure to toxic metals: The group is collecting maternal and cord blood from mother-infant pairs in northeastern Oklahoma where families live next to mountains of mining waste containing lead and zinc. Brain’s related animal studies demonstrate that anemia (iron status) increases lead uptake. The take-home message: Treating anemia could reduce the risk of brain damage by lead poisoning.

“One of the things we’d like to talk to Xiaobin about,” he said, “is how can we use that birth cohort, and apply some of the methods, insights and technology that she has?”

Sitting primly in the front row, wearing a petite white suit and butter yellow top, Wang appeared a genial force of nature, as likely to sweep people up as to be swept up. (“After you talk to her,” asks a colleague, “don’t you feel like your hair has been blown straight back?”)

As is her habit, she smiled easily, often nodding in the affirmative. Hailed by all as an indefatigable researcher and frequently described as a doting mother of her twin teenage sons, Wang was ready to accept their challenge. Her agenda, big and broad, is inclusive, extending beyond one person, institution or discipline.

“We have heaped enormous expectations on her,” Bernie Geyer cautioned the crowd during an affectionate introduction of his former student. “As her colleagues, students and friends, how do we help her to be successful?”

Wang was reflective: “My most challenging and difficult periods turned out to be my most productive and creative periods. I don’t underestimate the challenges before me. With interdisciplinary colleagues down the hall, and collaborators across the street, this is the right place for me now to leverage all the tremendous resources for the best chances of success and for translation.

“That’s my big dream.”

A Path Toward Hope (continued from page 35)

by his grandparents’ admonition to “keep our heart clean and live life.” He goes on “sweats” and participates in Apache ceremonies but also chooses not to emphasize differences between his tribe and other peoples. “We are all brothers and sisters,” he says. “Apaches, Navajos, Mexicans, blacks, whites—we’re all the same. We all bleed the same blood. That’s the way I look at everybody on the whole world. We’re all one.”

This message is not lost on the Celebrating Life staff. Novalene Goklish and Francene Larzelere-Hinton have already made presentations about the program to other tribes interested in preventing suicides among their young people.

The model would be most applicable in other limited-resource settings, such as inner cities, rural areas and international locations, notes Cwik.

MEN BEAT ON DRUMS AND SING.

They lead a procession late Friday afternoon at the old fairgrounds on Whiteriver’s outskirts. “The dressing,” a key event in a girl’s sunrise ceremony, is about to begin. People from the godparents’ camp are dancing and walking to the camp of the young girl. Cars, trucks and dancing raise a powdery dust that envelops the ceremony in a cloud, made orange by the late afternoon light.

The men sing in waves of rising volume and shifting pitch as they file into the girl’s camp. A cell phone ringtone suddenly erupts but is quickly drowned out by the music. Some people stand on dusty white benches to get a better view.

The singing stops as medicine man Harris Burnette explains the ceremony’s journey in Apache. Before him lies a blue tarp covered with an elaborately beaded buckskin top, eagle feathers and traditional jewelry. A young girl in a white dress stands in front of him.

Her godmother dresses her in the buckskin top, patiently attaches the traditional jewelry, ties an abalone shell on the girl’s forehead and affixes a single white eagle feather to the back of her head as children play in the dirt and people snap cell phone pictures.

The sun starts to sink below the mountains. The people dance and sing with the young girl’s family, wishing her hope for a pure and untroubled future.

At the ceremony’s end, everyone in the crowd turns around once in a clockwise direction, a rapid sweep of the four sacred directions of the Apache and an implicit acknowledgment of their sacred mountains and the beautiful land around them.

Francene Larzelere-Hinton makes her revolution and explains, “It’s our way of saying Amen.”
A Memory for the Future

A trail of fire and sparks stabbed the night sky.

I had fired off either a Roman candle or a bottle rocket during a backyard Fourth of July party many years ago. Fire. Explosion. Loud noise. Smoke. For a 7-year-old boy, those are fun’s most satisfying ingredients.

For the first time, I had set off fireworks myself. I felt a surge of pride and leaned against the charcoal grill in which my dad had cooked the evening’s hamburgers and hot dogs. Searing pain shot through my arms. My parents rushed me to the hospital. The party was over.

At some point while we were pulling together our special section on youth and public health, this story came back to me. A moment from childhood, a flash of experience, a sudden transformation of joy into something else. How quickly a young life can shift. Sensing parallels with the section’s topic, my brain unearthed the memory and brought it to the fore.

We call the section “Beginnings, Bright and Dark” because it best reflects the theme. Across cultures, youth represents promise, a future of possibilities. That’s what all parents want for their children. Yet reality sometimes delivers something quite different.

The stories in our special section look into some of life’s darkest corners: child sexual abuse, adolescent suicide, childhood obesity and early origins of chronic disease. These are manifestly difficult issues, topics most people would rather not think about.

Fortunately, many public health experts do not shy away from a challenge. They push the concept of prevention toward the earliest possible opportunity to make a difference. Researcher Elizabeth Letourneau confronts conventional wisdom about child sexual abuse with myth-exploding evidence. Xiaobin Wang untangles incredibly complex threads that link a child’s in utero environment to his or her risk for hypertension or diabetes decades later. Youfa Wang tackles the expanding global childhood obesity epidemic. And White Mountain Apaches collaborate with our School’s Center for American Indian Health to prevent youth suicides.

In late March, I was fortunate enough to travel to the White Mountain Apache Reservation in eastern Arizona and see firsthand their remarkable efforts. When I spoke with tribal chairman Ronnie Lupe, he said, “We live and breathe knowing there is tons and tons of work to be done yet.”

When it comes to ensuring the best possible future for our children, that’s true for all of us.

BRIAN W. SIMPSON
Editor, Johns Hopkins Public Health bsimpson@jhsph.edu

Letters to the Editor

A Stronger Disaster Response

I value Christine Grillo’s article [“Fall and Rise,” Fall 2011] on our unprepared public health community in the face of disaster. As a student studying public health, I believe we could better respond to a situation like 9/11 with more government funding to train health professionals and coordinate the activities of agencies and institutions.

We must abandon the notion of public health workers sitting behind a desk doing policy and administrative work. They have the power to improve the well-being of our citizens.

Jane Ye
Berkeley, California

Awaiting Part Two

I am eager for the results of the follow-up study [“Weight Counseling in Black and White,” Spring 2011]. I wonder if the time allotted to providers during an office visit actually plays a part in the lack of or insufficient weight counseling.

Due to my patient demographic (U.S. Coast Guard members at a military outpatient clinic), I am not faced with that issue. However, smoking cessation counseling is equally important. When you constantly remind patients who smoke about the cardiac risk factors and the high likelihood of lung cancer and pulmonary issues, and the vast majority responds with a nonchalant attitude, it can be discouraging.

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A Call for Road Safety Research in Tanzania

The article “International Health at 50” [Fall 2011] was very inspiring. The International Injury Research Unit (IIRU), led by Adnan Hyder [associate professor, International Health], attracted my attention.

Road traffic accidents in Tanzania are a great public health challenge, causing many deaths, injuries leading to disabilities, and, ultimately, to economic losses. Technological and economic developments have brought many motorcycles to both rural and urban areas, and motorcycle-related accidents account for a large portion of all accidents.

My wish is to have the IIRU help our country to address all facets of the problem.

Eliudi S. Eliakimu, MD, MPH ’10
Dar es Salaam, Tanzania

A Good Walk

What a wonderful and inspiring story [“Walk with Me,” Technology Issue 2012]. I’ve known Sheila Fitzgerald [associate professor, Environmental Health Sciences] for years and was moved last year when she was able to participate in the School’s Convocation. We all cheered when she walked on the stage for the first time to sit among her colleagues. She truly rocks!

Janice Bowie, PhD ’97, MPH
Associate Professor, Health, Behavior and Society
via Magazine Comments

Enthralled? Appalled? Send us your comments: editor@jhsph.edu.
Like all grandparents, an Afghan woman and a Pakistani man pass along more than family stories and their hair color. Scientists are discovering how harsh environments in early life can influence chronic disease risk in adults and even their children’s children. (See page 24.)

Photos: Shehzad Noorani
Our students can’t see the future—but they will create it. Scholarship programs like the Sommer Scholars and Brown Scholars bring the world’s best students to the Bloomberg School. With the knowledge and experience gained here, they will apply creative, world-changing solutions to the great health problems of today and tomorrow. In the lab, the field and the halls of government, our graduates will make discoveries, lead programs and forge policies whose impact will be measured in lives saved and the improved health of millions. Join us in creating the future.
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NEXT ISSUE THE BODY’S FRENEMY

THREATENED BY AN INVADER like the flu virus, the human body marshals an inflammatory response. It’s a vital defense mechanism, but scientists now link inflammation to cancer, COPD and other diseases. More about our foe/friend in the Fall 2012 edition.