Building a Village:

Pilipinos for Community Health's Pediatric Health Component

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Project Abstract

Children are nested in a network of relationships and systems that shape how they learn about themselves and the world around them (Bronfenbrenner, 1994). Throughout my undergraduate career, I have learned about the different levels of a child's world— ranging from family dynamics and home life, to interactions with teachers, to the even broader social, political, and economic landscapes that define their community environments. Their world is defined by these relationships; and it truly takes a village to raise a child. My mission is to build the infrastructure for this village, to bring together the people and perspectives of child development, health, policy, and community engagement in order to promote the well-being of all children and their families.

To achieve this, I dedicated my capstone to piloting a community-engaged service project in hopes of promoting the resilience of children and youth. I did this by establishing a new component within Pilipinos for Community Health (PCH), a student-led non-profit organization at the University of California, Los Angeles (UCLA). Now called the Pediatric Health Component (which we affectionately nicknamed "Peds"), my capstone combined insights from developmental psychology with PCH's approach to community empowerment and holistic health. As a leader of PCH, I viewed investments in our youngest community members as a necessary form of preventive care that advances health outcomes throughout the life course. Our Peds team and I worked to translate resilience research into child-directed activities at PCH's health fairs. In partnership with the Refugee Children Center and the North Hills Hispanic Mission United Methodist Church, we also provided childcare and resource kits during bi-monthly volunteering events.

In this report, I will discuss the inspiration behind this capstone, beginning with the research that sparked my passion for early childhood. Then, I will detail the process of building the infrastructure for the Pediatric Health Component, as well as the integration and continuation of the project within PCH.[1]

[1] Supplementary documentation related to my project's development is available for viewing in a Google Drive Folder linked here. Links to specific documents will also be included as they are referenced in the text.

Section 1: The WHO, WHEN, WHAT, AND WHY of the Pediatric Health Project

Throughout my undergraduate career, I felt like I was collecting puzzle pieces of experiences and facts from different corners of UCLA's campus. I am incredibly grateful for the multidisciplinary education I have had, but still felt that the perspectives were siloed. I had a collection of research articles that piqued my interest in psychology, a list of documentaries and essays from my humanities and history courses, and an ongoing journal of stories and reflections from my community-engaged research and volunteer work. Unsurprisingly, as my college career continued, I kept coming back to certain concepts and facts: gene-environment interactions, redlining, sensitive periods in early childhood, John Henryism[2], early education, mistrust and/or inaccessibility of the healthcare system. If any of these words seemed random to you, know that I felt the same way for most of my undergraduate career.

I was collecting puzzle pieces of experiences and facts. I just didn't know how they fit together.

It was not until I completed PSYCH 134K (The Effects of Early Adversity & Trauma) and the Applied Developmental Psychology (ADP) minor that I began completing the puzzle. I started to piece together how broader policies and systemic issues (e.g., racism, redlining, medical mistrust, inaccessibility of healthcare) shape our environments, which interact with our biological response to shape overall well-being (i.e., gene-environment interactions, John Henryism). And of course, there was a developmental piece that showed the importance of the first five years for outcomes throughout the life course (e.g., sensitive periods in early childhood, early education). Taking PSYCH 134K introduced me to the large body of research on the impact of early adversity on long-term health. I realized that if I want to promote positive outcomes, I need to start by advocating for the health of our youngest children and reducing their dose of adversity. This was the final puzzle piece I needed to see how these experiences and facts from my education at UCLA all fit together.

The Science of Early Adversity

Please note: This section will be discussing the science of early adversity and the impacts of childhood trauma, which can be triggering. I will do my best to present the data objectively, but also want to acknowledge that there are human beings behind all these numbers. If, at any point, this is challenging to read, please take time to step back and do what you need to care for yourself. A list of resources can be accessed here (ACEs Aware, n.d.).* ***Please also know that Adverse Childhood Experiences (ACEs) are not meant to be diagnostic (Anda et al., 2020). Outcomes are by no means deterministic (Goff, 2020)**. And be assured that there is incredible work being done now to treat and heal from trauma in order to promote children's resilience.*

Adverse Childhood Experiences

In their seminal Adverse Childhood Experiences (ACEs) study, Dr. Vincent Felitti and Dr. Robert Anda identified the correlation between early adversity and outcomes later in life

[2] Named after the American folklore, John Henryism describes the causal relationship between systemic racism, chronic stress, high-effort coping and high prevalence of chronic heart disease among Black Americans (James, 1994; ProPublica, 2020)

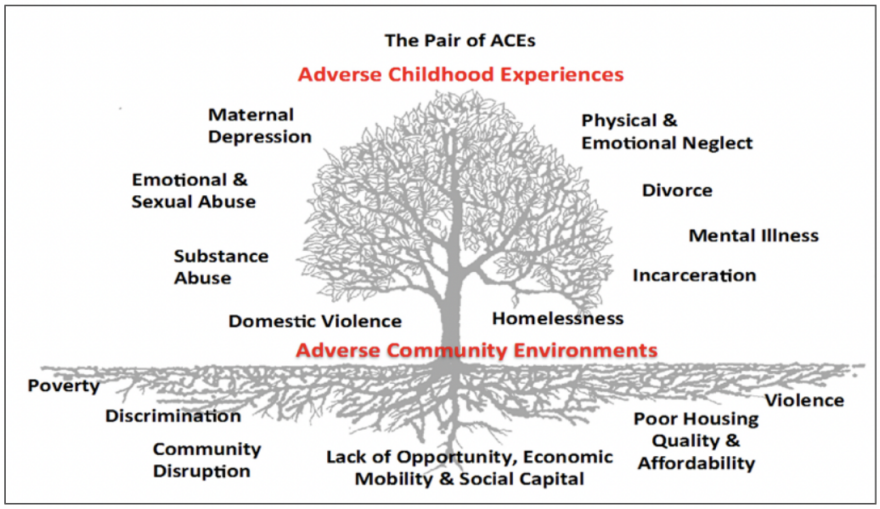
(Felitti et al., 1998). Felitti and his colleagues conducted various screenings to assess participants' physical and mental well-being and asked them to complete a survey about their experiences during childhood (before they turned 18 years-old). Each question corresponded with one of ten adverse childhood experiences that were defined in three categories:

1. neglect (physical or emotional)
2. abuse (emotional, physical, or sexual)
3. types of household dysfunction (divorce or separation, substance abuse, a parent with a mental illness, domestic violence, or a parent that was incarcerated)

If the participant reported experiencing any of these forms of adversity, one point was added to their ACE score.

Surprisingly, Felitti and colleagues (1998) found that early adversity is common, with over half of the participants reporting at least one ACE. This was correlated to poorer physical and mental health outcomes in adulthood, including heart disease, cancer, diabetes, alcoholism, and depression. Unfortunately, one adverse experience likely occurred with another, and the risk for poor health outcomes was even more severe with a higher ACE score. For example, individuals with one ACE had a 50% increased risk for depression whereas individuals with four ACEs showed a 360% increase. Individuals with four ACEs were 6.4 times more likely to report alcoholism and 12.2 times likely to have attempted suicide (Anda et al., 2006; Felitti et al., 1998, as cited by Goff, 2021). Later studies showed increased risk for five of the 10 leading causes of death in the United States (Centers for Disease Control and Prevention, 2021) and a 20-year decline in life expectancy for individuals who reported six or more ACEs (Brown et al., 2009).

While Felitti and colleagues (1998) showed how common ACEs are, we must note that the study had an affluent pool of participants: all had health insurance and a majority were White and college-educated (Goff, 2021). Dr. Wendy Ellis, a professor at the Milken Institute School of Public Health, recognized that ACEs were not equally distributed across all children. To reflect this, she created the Pair of ACEs model. Here, we see Felitti and his team's ten original ACEs as the tree's leaves and branches. But under the surface, we see that these ACEs are rooted in a network of *Adverse Community Environments*: poverty, discrimination, poor housing, community violence, etc. These contextual factors are also ACEs that put additional pressure on families and children, increasing the risk for traumatic experiences for historically marginalized and underserved groups (Ellis & Dietz, 2017).



Pair of ACEs model by Dr. Wendy Ellis. Image Credit: Ellis, W., & Dietz, W. (2017). A new framework for addressing adverse childhood and community experiences: The building community resilience (BCR) model. *Academic Pediatrics 17,* pp. S86-S93.

Why does early adversity have such a big impact on health outcomes decades after exposure? Children rely on adults to help them regulate and buffer their stress response. If adversity is experienced early in life and in the absence of adult buffers, children become hypervigilant and experience toxic stress (Shonkoff et al., 2012). This disrupts their developing nervous systems, particularly regions of the brain responsible for decision-making and regulating emotions and behaviors (Anda et al., 2006; Gee et al., 2013). This can have lasting effects when adversity occurs during sensitive periods of brain development, a time when children are especially attuned to environmental conditions and various experiences in their lives (Hensch, 2005). Adversity can actually change neural circuitry and increase the likelihood of risky behaviors that can result in negative health outcomes. However, the burden of addressing poor health should not fall upon individuals. Ellis and Dietz (2017) highlight that early adversity is a societal issue rooted in a long history of unjust, inequitable systems that manifests in our brains and bodies.

Together, this research shows just how critical the earliest years of life are for learning, health, and overall well-being across the life course. *And* that we are not doing enough as a country to support children or their families. Just in Los Angeles, there were 2.2 million minors in 2021, and 30% percent of the youngest children (0-5 years old) were experiencing poverty (Aguilera, 2021). Over 470,000 children are in families enrolled in state food stamp programs. However, these programs do not account for high inflation rates and the financial strain from the COVID-19 pandemic, leaving many parents fighting the inaccessibility to basic needs (Aguilera, 2021; Bohn & Lafortune, 2022; Danielson & Bohn, 2017; RAPID, 2022). According to the National Survey of Children's Health (2020), 31% of children in Los Angeles have experienced at least 1 ACE (as cited by Let's Get Healthy California, n.d.).

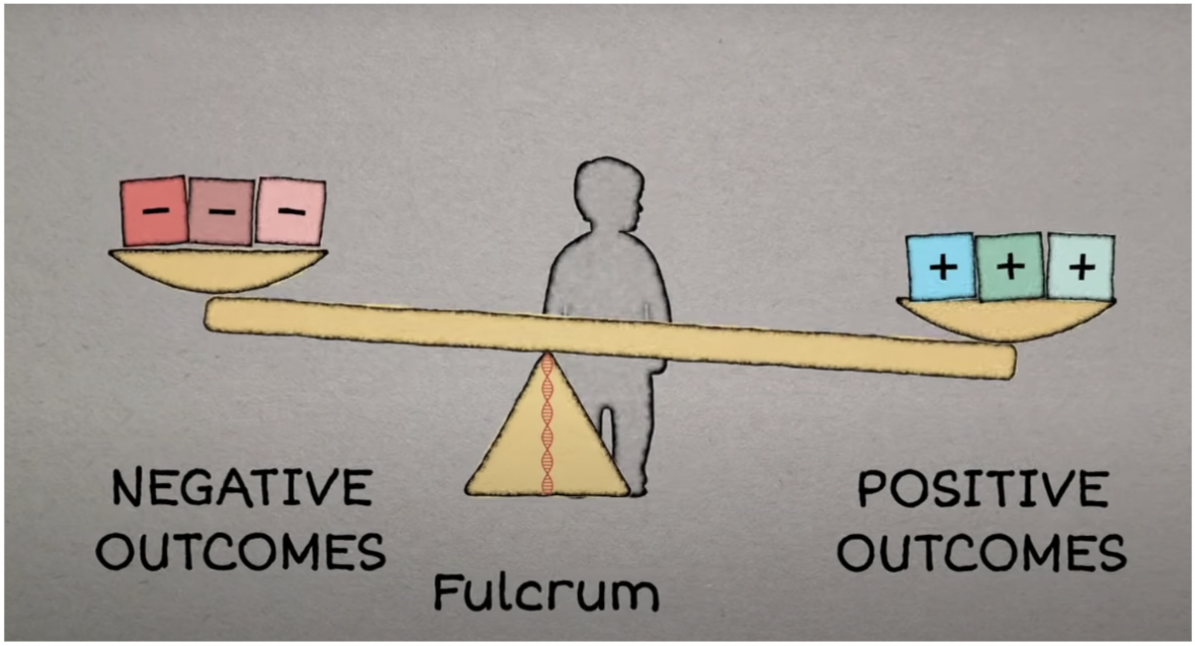
That's about 726,000 minors.

Fostering Resilience

Learning that ACEs are a reality for so many people was a really hard pill to swallow. But Dr. Bonnie Goff, who had introduced me to the impact of early adversity, often reminded me of a guiding principle in developmental psychology: outcomes are not deterministic (Goff, 2020). Children are resilient. Early adversity does not write one's fate. With nurturing relationships from caregivers– as well as community support and policies that support these relationships– we can build up children's capacity to thrive even in these most adverse circumstances.

The National Scientific Council on the Developing Child (2015) describes resilience like a scale. Each experience during our life is represented as weights– positive experiences as blue and negative as red– that are added to tip the scale towards a particular outcome. The more positive experiences, the more the scale tips to positive outcomes.

The types of environments we are exposed to during sensitive periods of development are especially important and have the power to *shift the fulcrum* so the scale favors one particular outcome. Think back to the Adverse Community Environments in the Pair of ACEs model. If we minimize the level of adversity in a child's environment (e.g., providing basic needs, reducing community violence, and responsive caregiving), then the child's fulcrum shifts so it takes more red weights to push the child away from positive outcomes. In other words, reducing ACEs early in life makes children resilient by skewing the scale towards positive outcomes and reducing the impact of negative experiences later in life.



Resilience can be conceptualized as a scale. In order to foster resilience, we need to create environmental conditions that can shift the fulcrum such that the scale skews towards positive outcomes. We can also "stack the scale" with positive outcomes so the positives can outweigh the negatives. Image Credit: Center on the Developing Child at Harvard University.

Developmentalists have identified four ways to foster resilience: healthy diets and physical activity; mindfulness; caring relationships with adults; and stable, nurturing environments (Let's Get Healthy California, n.d.; National Scientific Council on the Developing Child [NSCDC], 2015; Redford, 2016). These strategies allow us to create environments that support and teach children to cope in the face of stress and adversity. By addressing ACEs with evidence-based strategies for resilience-building, we can start to "stack the scale" so the negative doesn't outweigh the positive (NSCDC, 2015, p. 5).

In 2019, California's Office of the Surgeon General (OSG-CA) launched ACEs Aware, the country's first state-wide initiative to reduce children's dose of adversity. This started with universal ACEs screening at pediatric wellness visits in order to assess whether children have experienced trauma and understand the health conditions which they are at risk for. ACEs Aware started by training physicians in compassionate, trauma-informed care so they have the skills to respond to patients who have reported an ACE. The initiative is now entering their next phase to build *Trauma-Informed Networks of Care:* "a group of interdisciplinary health, education, and human service professionals, community members, and organizations that support adults, children, and families… [to] prevent, treat, and heal the harmful consequences of toxic stress" (ACEs Aware, 2021, p. 20)

Dr. Nadine Burke Harris, the former California Surgeon General who led the launch of ACEs Aware, said that ACEs prevention will require "shared vision, shared understanding, and cross-sector collaboration" (ACEs Aware, n.d.). Trauma-Informed Networks of Care recognize that children's worlds are defined by different people and professionals on all levels. In order to support all facets of a child's development, learning, and health, we need to work together to best support young children. Trauma-Informed Networks of Care build the infrastructure for interdisciplinary, cross-sector dialogue.

It is building a child's village.

Translating Research to Action

Children's sensitivity to the environment is like a double-edged sword, pushing trajectories in directions for better or for worse. Our job as caregivers, educators, parents, social workers, healthcare professionals and advocates for children is to make sure it is for the better. Ultimately, our job is to create environments where children feel safe, secure, loved, and capable.

Developmental psychology gave me my *who, when, what* and *why*. I knew I had to support children and their families (my *who*), and that birth to five years-old (my *when*) is a critical phase in life that we need to do much better in supporting. I was able to identify ACEs (my *what*) as the important problem I wanted to address so all children can realize and attain all that they are capable of (my *why*).

And the Pediatric Health Component is my *how. How* we can translate this research into actual change for real people. *How* I can begin building a child's village.

Section 2: The "HOW" to building this village

I decided to craft my capstone project with UCLA's Pilipinos for Community Health (PCH) for multiple reasons. PCH strives to increase access to healthcare services and improve the holistic well-being of communities in the Greater Los Angeles Area and the Philippines. Grounded in preventive care, our organization's mission contributed to my view of early childhood and education as a form of prevention. In terms of logistics, I knew that a community-engaged project requires lots of resources: connections to community partners in Los Angeles, a dedicated volunteer team, and funding. I would not have access to this without the structure PCH already had established. For example, PCH recorded its highest number of registered volunteers (with nearly 40 members actively volunteering each quarter) who already had experience in community work. There was also an interest in fields like pediatric medicine, but no component dedicated to working with children or youth. I hoped that this capstone would increase access to resources for the communities we serve alongside, all while giving undergraduate students experience working for this population. PCH would also give this project access to multiple university grants that are available to student-run service organizations. As the director of PCH's finances, I was able to secure $1,402.09 specifically for PCH's Peds Component to purchase supplies, develop our curriculum, provide transportation for volunteers, and offer donations to our community partners. Without these resources, the project would not be able to sustain itself.

More importantly, I knew I could not– nor would I want to– build this project on my own. My capstone was conceptualized with the image of a child's "village" and the value of supportive relationships. Community was essential to the vision. PCH was my first village in my journey as a pre-health student at UCLA. It was only fitting that I did this with them.

Goals, Objectives, and Methodologies

All of PCH's service projects write goals, objectives, and methodologies (GOMs) at the beginning of the year to prepare our organization's annual programming. This was especially important in designing a brand new component. Writing our GOMs established the framework and mission for the Pediatric Health Component and helped to outline tangible steps towards officially launching the project (see Supplementary Document 1). There were two aspects to our goal: (a) pilot new service projects that advocate for the well-being of children, youth, and their families, and (b) introduce PCH volunteers to efforts that address early adversity as a means of promoting long-term health outcomes. Each goal was broken into a series of objectives which can be summarized in 4 main categories: building our Pediatric Health team, volunteer training, curriculum development, and establishing community partnerships.[3]

[3]I have reorganized our objectives and methodologies slightly and use these 4 categories to clearly define the work done to establish this component within PCH. Please refer to the Supplementary Document 1 for PCH's full 2022-23 Pediatric Health Goals, Objectives, and Methodologies.

Objective 1: Building PCH's Pediatric Health team

I spent Summer 2022 recruiting a team for my capstone, and worked with my co-Executive Directors, Nicki Añel and Urielle Gutierrez, to incorporate Pediatric Health into PCH's existing structure. This included advertising the new project to our organization's volunteers and interviewing members who wanted to be more involved in this work. From these interviews, we selected 2 interns– Derek Lance and Makayla Santos– who would join me, Urielle, and Nicki as PCH's first Pediatric Health team. I devoted the first phase of our work together to explore our team's strengths and discuss potential activities our program could offer. Makayla has illustrated children's books and brought a warmth to every interaction with the children. Derek had a knack for outreach and connecting with community members. Nicki loved to dance and thought of games to play on the spot when she was with the kids. Urielle was our logistical mastermind. I ensured our work was connected to the broader vision that supporting our youngest community members is a form of preventive care. Throughout the year, our team met biweekly to plan, write agendas for meetings with community partners, create budgets, and reflect on the challenges and lessons learned during volunteer events.

Objective 2: Volunteer Training and Certifications

Our team jumped through many logistical hurdles to launch our service project. At UCLA, all student organizations working with youth are required to have volunteers complete a Youth Safety Training (YST) session to learn about the legalities of working with minors. This included confidentiality, how to file injury reports, policies regarding mandatory reporters, and a brief overview of developmentally appropriate conversations with children and teens. We collaborated with the Student Risk Education Committee (SREC) to organize these workshops before each of our events, and kept a roster of members eligible to volunteer with our project. I also worked with our organization's advisor, Ms. Pam Cysner, to discuss best practices for youth programs and worked with Urielle to write PCH's first YST Protocol.

I did notice, however, that the trainings the university required only talked about the legal risks associated with working with youth. Of course, these are critical to ensure children's safety and privacy. But it portrayed our work with children *without the actual children*, their developmental needs, nor the principles for interacting with them in a way that honors their interests. After conversations with Dr. Elisheva Gross, my mentor and the director of the Applied Developmental Psychology (ADP) minor, I created a list of videos to train volunteers in respectful interactions with young children. We observed the skilled teachers and discussed the strategies they have in communicating. The developmental research I offered was informed by the challenges our volunteers reported after our site visits, such as how to establish relationships with a child despite a language barrier (e.g., videos from Teaching at the Beginning). I also provided materials that related childcare directly to medicine and public health to help members see support for youth as a means of improving health outcomes for the long-term (e.g., Dr. Nadine Burke Harris' TED Talk on ACEs and the NSCDC's Resilience Series).

By the end of the year, we had 12 volunteers YST-trained and approved to work with the project. I hope that the additional materials I shared from my own training in early education provided a framework that guides volunteers in respectful, responsive interactions with the children and families on site.

Objective 3: Curriculum Development

At the beginning of each year, PCH completes an assessment report where we research community demographics and needs to inform our organization's programming (see Supplementary Document 2). This includes researching census data on age, race, and class distributions within the communities we work in. We also use the data to understand how socioeconomic factors may create barriers to care. Census reports, however, are not always representative, especially since our organization works with historically marginalized folks. We look towards our partners to fill this gap, and acknowledge that they know their communities best– both the pertinent challenges and what change community members hope to see. The Pediatric Health team also looked to developmental research on resilience for guidance in creating a curriculum specifically for children. These three pieces of data– census reports, qualitative interviews with partners and community members, and developmental research– ensured our Pediatric Health team's new program was evidence-based.

For our team's first event, we organized a Kids Corner during PCH's Fall Health Fair that primarily serves the Black community in Crenshaw, California. In previous years, post-event evaluations and observations from our staff showed that parents were receiving less care than other attendees during the event, despite the services being completely free. While researching community demographics, we found that about 32% of all families in Crenshaw are headed by single parents. For Black families in Crenshaw, this rate is just over 50%– the 16th highest rate of single-led households in Los Angeles County (Demographic Statistical Atlas of the United States, 2018). In response to these findings, our Pediatric Health team oversaw the development of the Kids Corner where the children could play and learn while their parents received the care they needed.

The Pediatric Health team oversaw the Kids Corner at PCH's Fall 2023 Health Fair. This offered multiple arts activities and books with themes surrounding positive coping and self-efficacy.

We saw this as an opportunity to provide activities based on the four ways to promote children's resilience (Let's Get Healthy California, n.d.; NSCDC, 2015). To encourage more physical activity, we bought a sports set with hula hoops, cones, and bean bags. The children even challenged our Peds team to a dance competition. We did age-appropriate arts activities, such as origami with the teens and more open-ended drawing with the younger children. All the younger children were given art supplies to bring home with them as well. We also bought books for the children to read with volunteers at the Kids Corner. We specifically picked *Listening to My Body* and *I Can Do Hard Things* by Gabi Garcia because of the themes that promoted healthy coping strategies and children's self-efficacy. Both books featured characters from racially diverse backgrounds, and this representation was important for building confidence and sense of belonging.

Developing supportive relationships is the most critical piece to promoting resilience (NSCDC, 2015). This was particularly challenging for our team because the Kids Corner and health fair was a one-day event. To make the most of the time we had with the children, we decided that the same volunteers would be at the Kids Corner for the entire fair. It takes more than eight hours to build a relationship, but I did watch the children look for specific members of our Pediatric Health team. I watched them hold onto our volunteers' hands as they walked around the fair, and gave them big hugs when their parents picked them up at the end of the event. It meant the world when one of the fathers said his daughter wanted to visit us at UCLA.

We recognize the limitations from a single-day health fair, especially when relationships should be at the core of the work we do with children and youth. Our Pediatric Health team is working to establish a model that promotes continuity of care (see Section 3: Next Steps) so all the methods to building resilience are incorporated in our curriculum. While the four steps to promoting resilience seem straightforward, I recognized for the first time how difficult it is to translate this research with the resources available and in a way that is curated for the specific populations we work with. Throughout this process, I learned that if I wanted to do community-engaged work, we could not only reference academic articles; community voices had to be at the center. There is wisdom and insight in people's lived experiences. I learned that, if I were to bridge the disciplines of developmental psychology, health, and community engagement in this village we were building, I had to see these approaches as compliments to one another in creating an evidence-based curriculum.

Objective 4: Establishing Community Partnerships

The component's success this year is largely attributed to the relationship we formed with the Refugee Children Center (RCC) and the North Hills Hispanic Mission United Methodist Church. RCC's mission is to provide a "healing embrace and dignified welcome to children and their families who have made the perilous journey from the South of the U.S.-Mexico border" (Refugee Children Center, 2023). They take a holistic approach, offering youth empowerment, childcare, workshops to support parents' personal and professional development, as well as legal services. With the North Hills Hispanic Mission United Methodist Church, they also hold

monthly food pantries through their basic needs program. All of their work is designed to ease the children's and their families' transition to life in the United States, all while fostering a sense of cultural pride and community:

"Every event we hold at the Center is to bring a healing experience where folks can feel the freedom to be present; to take a moment to breathe and center themselves." -Kendra Rivera, RCC Legal Services Assistant (K. Rivera, personal communication, April 11, 2023)

"We strive to give our community a place for them to spend time, explore new hobbies and most importantly a place of support." - Dayna Mendez, Children and Families' Department Coordinator (D. Mendez, personal communication, April 11, 2023)

The Staff at RCC and the North Hills Hispanic Mission United Methodist Church with our Pediatric Health volunteers.

PCH started working with both organizations during the pandemic by delivering fresh produce to families in North Hills. Ever since our partnership started, that welcoming, warm embrace they give to their community extended to all of PCH's volunteers. While we loved working with them, PCH did not have the capacity to provide regular support during the year. I hoped that our Pediatric Health Component would allow for regular volunteering events at the Center and give the organizations a home within PCH's operations. The conception of my capstone coincided with the expansion of RCC's Children and Families' Department. Our team supported this work and met monthly with RCC's Staff where we arranged days for our team to "shadow" their current programs, begin building relationships with community members, and assess ways for PCH to address current needs.

The first event our team volunteered for was RCC's *Cocinando para el alma* ("Cooking for the Soul" in Spanish). For this program, one of the moms volunteers to cook a traditional meal from their home country to share with the entire Center. Just as Dayna described above, this event is designed to build community and, equally as important, honor and keep alive the cultural practices each family holds dear. The Staff fosters a sense of ethnic and cultural pride, ensuring the children never lose sight of who they are even as they transition to life here in the U.S. During *Cocinando para el alma,* the moms taught Derek, one of our Peds interns, to cook tamales. Urielle and I supervised and played with the children, so "the kids can just be kids" as their parents got legal services from RCC's Staff. (M. Medina-Núñez, personal communication, February 18, 2023). We served 60 plates and ate as, in Pastor Ervin's words, "one huge family celebrating each other" (E. Aguilon, personal communication, January 21, 2023).

Throughout our conversations with RCC's staff and families, we learned that meeting basic needs (e.g., toiletries and cooking supplies) and finding childcare are two main challenges the families face on a daily basis. In response, our team and I applied for university grants to create resource bags for their families. This included shampoo, toothpaste, toothbrushes for parents and the children, towels, and kitchen supplies (e.g., sponges and measuring cups). Our volunteers assembled 50 bags with these materials which were distributed at RCC's annual *Celebración del Día de la Niñez* and at the Center's monthly Legal Fair.

PCH Volunteers assembled 50 resource bags to be distributed at RCC's *Celebración del Día de la Niñez*. Image Credit: Refugee Children Center.

After shadowing, we officially launched volunteer sites with RCC in Spring. This involved an introduction to the component at PCH's general meeting to educate members on ACEs and the importance of investing in children, youth, and their families. In total we had five sites with RCC all year, three of which were open to PCH's general members. After each site, volunteers expressed a newfound interest in supporting young children and connecting this work to broader social determinants of health.

Section 3: Next Steps

I am touched and excited that PCH will continue the Pediatric Health Component, officially adding the project as the organization's fifth Community Outreach project. I am in the process of transitioning my two new successors, Kayla Saffold and Makayla Santos, in preparation for next year.

Evaluating and reflecting on our work this year is critical to improving our project. As part of PCH's CSC Community Assessment (see Supplementary Document 3), we interview service recipients and our community partners for a first-hand account of the challenges pertinent to their communities. We also ask how we can improve the services we offer as an organization, then revise our Goals, Objectives, and Methodologies to reflect this feedback. Now that the project has launched, the Pediatric Health team should focus on 3 new objectives: a) continue partnerships with RCC and the North Hills Hispanic Mission United Methodist Church, b) establish a model for continuity of care, and c) volunteer training and education.

One challenge involved communication with families and their children. RCC's families primarily speak Spanish and Indigenous languages from Guatemala. PCH volunteers, however, had basic or no knowledge of these languages. We have to find ways to address this barrier to communication and ensure that community members see people of similar backgrounds as leaders in efforts to support them. In response, we reached out to another UCLA organization: Students for Community Outreach, Promotion, and Education (SCOPE). One of their projects, called Hablamos Juntos, collaborates with pediatricians to teach Spanish-speaking parents strategies to support their child's speech development. Many of their volunteers also hoped to practice their Spanish and expressed interest in being translators on site. We tried to establish pairs between PCH and Hablamos Juntos volunteers to ensure a non-Spanish speaking volunteer was always with someone who knew the language. This was not fully achieved this year, but the collaboration with Hablamos Juntos should be a priority to improve our interactions with RCC's families.

Second, PCH should consider having a group of volunteers that can commit to attending Peds sites at RCC for the whole quarter, or even better, the whole year. Research shows the best way to promote children's resilience is through supportive, secure relationships with caregivers (NSCDC, 2015). This continuity of care is critical for children's development and can only be formed if there is a regular group of volunteers that support our partners. Next year's Pediatric Health team must build this model within PCH's existing structure.

Lastly, we need to dedicate more time to understanding the issues pertinent to refugee families so we can both provide more informed care and appreciate our service recipients' strength. The team should continue to read literature on ACEs and ask RCC for resources to understand the immigration crisis that their community is facing. This may involve a curriculum to guide the Peds team's development as providers in this field, including reading *(Refugee) Children's Stories* which was published here at UCLA to recount the unique experiences of refugee children at RCC in 2019 (Weaver, 2022).

Overall, PCH's Peds Component was successful in establishing the framework for a new service project this year, and we cherish the interactions we had with the children, families, and staff at RCC. Now that the framework has been built, the project can focus on training volunteers with the skills to provide respectful, informed support to children, youth, and families. Just as our work strives to help all children attain their full potential, I am excited by the potential for this service project to improve health outcomes through health equity and advocacy for children and their families.

The Pediatric Health team at PCH's annual Candlelight ceremony. The flowers and candles symbolizes the growth and igniting of our passion for service while transitioning from the current team (top row) to the next groups of leaders (bottom row). From left to right: Urielle Gutierrez, Makalya Santos, Karen Madamba, Kayla Saffold, Nicki Añel

Acknowledgements

The Pediatric Health Component is both the capstone and passion project of my undergraduate career. I hold dear the idea of building a child's village because of the people that have been part of my own village. Thank you for being the spark behind my work, and inspiring me to share this same love with many children in the future. I would like to send a special thank you to...

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