ISSOP e-Bulletin
Nº 22. July 2016

CONTENTS

1. Introduction

Apologies for the delay in the publication of the July e-bulletin, it is always difficult to obtain contributions over the summer! Do please send your contributions at any time, we are particularly interested to hear what is happening in your country in relation to social paediatrics at this time when there are major pressures from poverty, austerity and immigration. The first ISSOP congress in a country in the South is almost on us and the programme is given below. There will be opportunities to attend some sessions from a distance and we encourage you to do so if you can't make the journey to Chile. We also report on progress with the infant formula sponsorship issue in UK, and on our colleague Shanti Raman's work in the International Paediatric Association. In our controversy section we look at how to maintain a low carbon footprint whilst maintaining international collaboration and education.

Please feedback with your views on this question which is very important and relevant for ISSOP! We are pleased to report that the e-bulletin now has an editorial board and we welcome Gonca Yilmaz and Rita Nathawad to join Tony and Raul.

Tony Waterston & Raúl Mercer

2. Meetings and news- 2.1 ISSOP in Chile

34 Annual ISSOP Conference
First Chilean Congress on Social Pediatrics -SOCHIPE-
August 31, 1 and 2 September 2016
Building Former National Congress Santiago, Chile

Action for Equity in Latin America

This event is intended to become a forum and instance analysis of the social, economic and cultural inequality in Latin America and Chile, from the perspective of the rights of the child and adolescent population.The central idea is to go beyond the analysis of the situation and offer perspectives and proposals for intervention on inequities in our societies, and move from words to actions.

With the collaboration of: Committee on Social Pediatrics of the Latin-American Association of Pediatrics (ALAPE)

PRE CONGRESS Meeting andCourses Wednesday August 31st

Working Groups of Social Pediatrics Meeting
9:00-12:00ISSOP, ALAPEand SOCHIPE Social Pediatrics Committees

Pre-Congress Course Nº1: ***Early Child Protection: learning experiences.***
Pre-Congress Course Nº 2: ***Human resource training in social pediatrics***
Pre-Congress Course Nº3: ***Migration effect on child health and strategic approaches***
Pre-Congress Course Nº 4: ***Child labour. Current situation and proposals***
Pre-Congress Course Nº 5: ***Translating the Principles, Standards and Norms of Child Rights, Health Equity and Social Justice into Pediatric Practice Improving the Health and Well-Being of Children***

Thursday, September 1	
8.00-9.30	Registration/Opening Session & Welcome
9:30 - 10:30	Plenary session

Parallel Seminars 11:00 to 12.30

N°1*: Equity and inequity in the world.*
N°2: ***Public policies with a life course approach. Role of Social Pediatrics***
N°3: ***Inequalities and social media and information.***
N°4: ***Child Health care. Promoting equity in health services***

13.15-14.15	ISSOP General Assembly
14:30 -15:30	Plenary Session: Conclusions and proposals
16:00- 17:00	Panel: "The System of Warranties and Protection of Rights of Children and Adolescents in Chile"
17:00 – 17:30	Child friendly municipalities. A proposal
17:30 - 18.00	Presentation of submitted papers

Friday, September 2 – Plenary Sessions	
9:00 – 9:30	Health reform in Chile: impact of childhood and adolescence
9.30-10:00	Historic perspectives of Social Pediatrics
10.00-10.30	Integrated conferences on environment and child health

Parallel Seminars: 11:00 to 12.30

N°1: ***Rights and equity in Children: experiences and learning***
N°2: ***Successful experiences in promoting child rights in health services and programs***
N°3: ***Child rights and violence against children.***
N°4: ***Child rights in crisis situations***

14:30-16.00	Plenary: Integrated panel: *"History, present and future of social pediatrics"*
16:30-17:30:	Final Plenary: The first 1000 days of life
17:30 -18:00	Closing words: Learning and prospects. Next Conference
18:00	Closing session

Full program is Spanish http://www.issop2016.com/es/programa.php soon will come in English
For more information: www.isssop2016.com

2.2 RCPCH consults on infant formula sponsorship

The debate on sponsorship by infant formula manufacturers continues in the RCPCH following the passing of a motion at the Annual Meeting in April, to end such funding. The College Council which is the decision-making body, discussed further action at the beginning of July, and background information was circulated to all council members on the global issues and conflict of interest. There was a long debate at the end of which the decision was taken to consult the whole RCPCH membership with a number of questions. We have yet to see these questions and despite a certain lack of cooperation in sending out information, we are endeavouring to use all means to publicise to members the recently passed WHO guidelines which state the following:

In **WHA Resolution 69.9**, the Assembly welcomes with appreciation the technical guidance on ending the inappropriate promotion, and urges Member States, in accordance with national context to take all necessary measures in the interest of public health to end the inappropriate promotion of foods for infants and young children, including, in particular, implementation of the guidance recommendations while taking into account existing legislation and policies, as well as international obligations of foods for infants and young children. It also calls upon health care professionals to fulfill their essential role in providing parents and other caregivers with information and support on optimal infant and young child feeding practices and to implement the guidance recommendations. The guidance is very clear on avoidance of conflict of interest, including for health professional associations. Recommendation 6 inter alia states that:

Companies that market foods for infants and young children should not create conflicts of interest in health facilities or throughout health systems. Health workers, health systems, health professional associations and nongovernmental organizations should likewise avoid such conflicts of interest.

[…] health workers, health systems, health professional associations and nongovernmental organizations should not:

- **accept free products, samples or reduced-price foods for infants or young children from companies, except as supplies distributed through officially sanctioned health programmes. Products distributed in such programmes should not display company brands;**
- **accept equipment or services from companies that market foods for infants and young children;**
- **accept gifts or incentives from such companies;**
- **allow health facilities to be used for commercial events, contests or campaigns;**
- **allow companies that market foods for infants and young children to distribute any gifts or coupons to parents, caregivers and families through health facilities;**
- **allow such companies to directly or indirectly provide education in health facilities to parents and other caregivers;**
- **allow such companies to sponsor meetings of health professionals and scientific meetings.**

This guidance makes it quite clear that the WHO Code applies to professional associations and that it prohibits the sponsoring of scientific meetings. Hence such activities would be in violation of the Code. Can you bring this guidance to the attention of your professional association?

2.3 IPA report, by Shanti Raman

As the ISSOP representative on the IPA Standing Committee (SC) — I have had a very active and challenging year. The various and sometimes competing tasks of leading the Quality of Care Technical Advisory Group (TAG-QC) for the IPA, representing social paediatrics and child health interests to the broader paediatric community and in particular pushing the agendas of ending violence against children, raising issues of conflict of interest between paediatricians and their relationship to industry, and inequities in child health— have been difficult at times.

TAG-QC

As Chair of TAG-QC, I wanted to build on the work of my predecessor Dr Tamburlini, but also bring in some important quality elements from the children's rights in health services and harness the impetus that is flowing from the Every Newborn Action Plan. The main activities have been:

1. Mapping activities undertaken by national and regional paediatric societies in the quality and safety and child rights arena. I developed a checklist and questionnaire and disseminated this using Survey Monkey to all IPA member societies—unfortunately the response rate was so low that it was not work analysing.
2. Promoting and monitoring Quality activities globally, with a particular focus on children's rights in health services, quality and safety initiatives in national and regional Paediatric societies, district level paediatric hospital care and Every Mother Every Newborn quality activities—this was achieved by sharing information via email and skype teleconferences within the TAG.
3. Planning for TAG-QC sessions at the 2016 International Pediatric Congress: these consist of a pre-congress workshop aimed at low/middle income countries and also a concurrent session within the Congress.
4. Forming partnerships with other relevant global agencies such as UNICEF, WHO and ISPCAN to push for training and research into the highest quality of care for children and young people, whilst promoting and upholding their rights.

IPA SC

As the ISSOP representative on the IPA Standing Committee, I have been trying to keep social paediatric issues prominently on the agenda with IPA with occasional success. The big success was getting IPA to agree to work collaboratively on ending Violence against Children with ISSOP and ISPCAN and getting ISSOP statements on child health inequities and violence against children tabled at the 2016 World Health Assembly.

IPA Congress Vancouver 2016

This Congress is a good opportunity to influence mainstream paediatricians about the importance of a public health approach to paediatrics and child health. We tried to get separate sessions or workshops for ISSOP to feature, but were reassured by the Congress organising Committee that social paediatrics and public health would be integrated into all sessions in the program. There are major plenary sessions on adolescent health, SDGs, global health, environmental health and child survival. An issue that we will need to keep vigilant about is to monitor the role of baby food manufacturers and their role in sponsorship of education sessions within the Congress.

Global Partnership to end Violence against Children

ISSOP, ISPCAN and IPA have formed a collaboration to get some practical action on preventing Violence against Children. The first step was to agree on the scope and definitions of violence in childhood, so we have committed to collaborating on a position statement. ISSOP has joined the Global Partnership to End Violence in Children. Within the IPA Congress, I have managed to organise a separate breakout session to discuss the partnership, where we are at with the position statement on Violence against Children and how to move forward with advocacy efforts.

3. International Organisations: UN Committee on the Rights of the Child

http://www.ohchr.org/EN/HRBodies/CRC/Pages/CRCIndex.aspx
The Committee on the Rights of the Child (CRC) is the body of 18 Independent experts that monitors implementation of the Convention on the Rights of the Child by its State parties. It also monitors implementation of two Optional Protocols to the Convention, on involvement of children in armed conflict and on sale of children, child prostitution and child pornography. On 19 December 2011, the UN General Assembly approved a third Optional Protocol on a communications procedure, which will allow individual children to submit complaints regarding specific violations of their rights under the Convention and its first two optional protocols. The Protocol entered into force in April 2014.

The CRC website provides valuable information on each country's progress in ratification of the Convention and achieving its aims. You can check this out on
http://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/Countries.aspx

For interest I had a look at Chile. Their last government report to the Committee was in November 2014, issues raised by the Committee were published in May 2015, and the government replied to the issues raised in September 2015. For example the first issue raised by the Committee was:

1. In the light of the constitutional reform bill, please explain how the State party intends to ensure that the rights of children and adolescents are recognized at the constitutional level in accordance with the Convention. Please also provide information as to whether or not any procedure is to be established for ensuring that children can make their voices heard as part of that process. Please also report on the measures taken to secure the adoption of a comprehensive law on the rights of children and adolescents.

Civil society organisations also report to the Committee and their reports are available on the website, in the case of Chile the main organization is a coalition - the NGO Network for Children and Youth Chile.

This process is clearly very valuable for holding the government to account in relation to its upholding of the CRC. It will be interesting to know whether Chilean social paediatricians are involved, and also of course the paediatricians from all the other countries in ISSOP, in relation to their own country's progress. Clearly health forms an important part of child rights and there is a great opportunity here for child health professionals to collaborate with other members of the children's sector in their country. If you have any experience on this, please give us a short report for the e-bulletin.

TW

4. Current controversy: International Conferences & Climate change

4.1 CHIFA posting by Sarah Walpole

I'd like to share this blog about the challenges of collaborating on international projects such as those discussed through CHIFA:
http://blogs.bmj.com/bmj/2016/07/04/collaborating-across-continents-what-is-the-best-that-technology-can-offer/

Given the effects of international travel on air pollution and climate change, how can we develop international projects and share information internationally to improve health, but also 'do no harm' (or do as little harm as possible)? If you have any suggestions or responses, they would be gratefully received on BMJ blog site or through this list. The blog refers to a particular example of a conference on medical education, but the questions relate to much of the work that we all do. A useful approach is presented in the referenced Tyndall paper on travel policy.

[*Editor: here is a useful quote from the above blog*:

'In her book Coming Climate Crisis?: Consider the Past, Beware the Big Fix, Claire Parkinson calculates that to share the planet's resources fairly and to keep carbon emissions below safe levels, each individual's carbon allowance would permit them ***35100 kilometers of air travel per year*** *(approximately one return trip from New York to London)—and this is only if they did not emit a speck of carbon with any other activities*.'

4.2 Tyndall Travel Strategy

By Tony Waterston

The Tyndall Centre for Climate Change research www.tyndall.ac.ukis a leading UK centre for climate change research. They have also been actively debating the role of climate change scientists in promoting a low carbon culture.
http://tyndall.ac.uk/publications/tyndall-working-paper/2015/towards-culture-low-carbon-research-21st-century
http://www.tyndall.ac.uk/sites/default/files/twp161.pdf

Here are two quotes from this valuable paper: *Within Europe, aviation is a sector whose emissions have grown more rapidly than any other over recent years (Bows et al., 2009) to the extent that future expansion of the sector is argued to be irreconcilable with emissions reduction targets (Bows and Anderson, 2007) with aviation emissions set to dominate carbon budgets unless they are offset in other sectors. Internationally, emissions are projected to double worldwide between the years 2005 and 2025 (Macintosh and Wallace, 2009). In cultural terms, whereas flying would once have been considered unusual, for many it has now become a routine, often essential practice (Randles, 2009; Urry, 2002).*

The value of being able to travel freely to pursue research objectives, and the value of curbing flights out of a motive of social responsibility thus represent contradictory pressures. We review here the facts, benefits, and motivations that drive travel emissions in research, and the technological and social alternatives that could lead to a cultural change in the research community. We also propose and document a simple way to keep track of travel emissions by researchers. Finally we argue that the research community needs to establish a common roadmap and understanding of acceptable practices to ensure continued research output delivered through a culture of practices that are aligned with its own research findings.

[Ed: For social paediatricians not involved in research, replace 'research' with 'education' in the above]

The paper goes on to examine the benefits of on-line attendance compared to physical attendance, the travel emissions of research/education, motivations and decision making related to travel in research/education, technological elements of decision-making in relation to such travel, and monitoring travel emissions.

K*ey quotes:* 'even the most environmentally aware often do not cut down flying (Barr et al., 2011) and **reducing flying is one of the least popular low-carbon behaviours** (Whitmarsh and O'Neill, 2010). In fact, multiple studies have found that there is no relationship between general environmental awareness and flying behavior (Kroesen, 2012). '

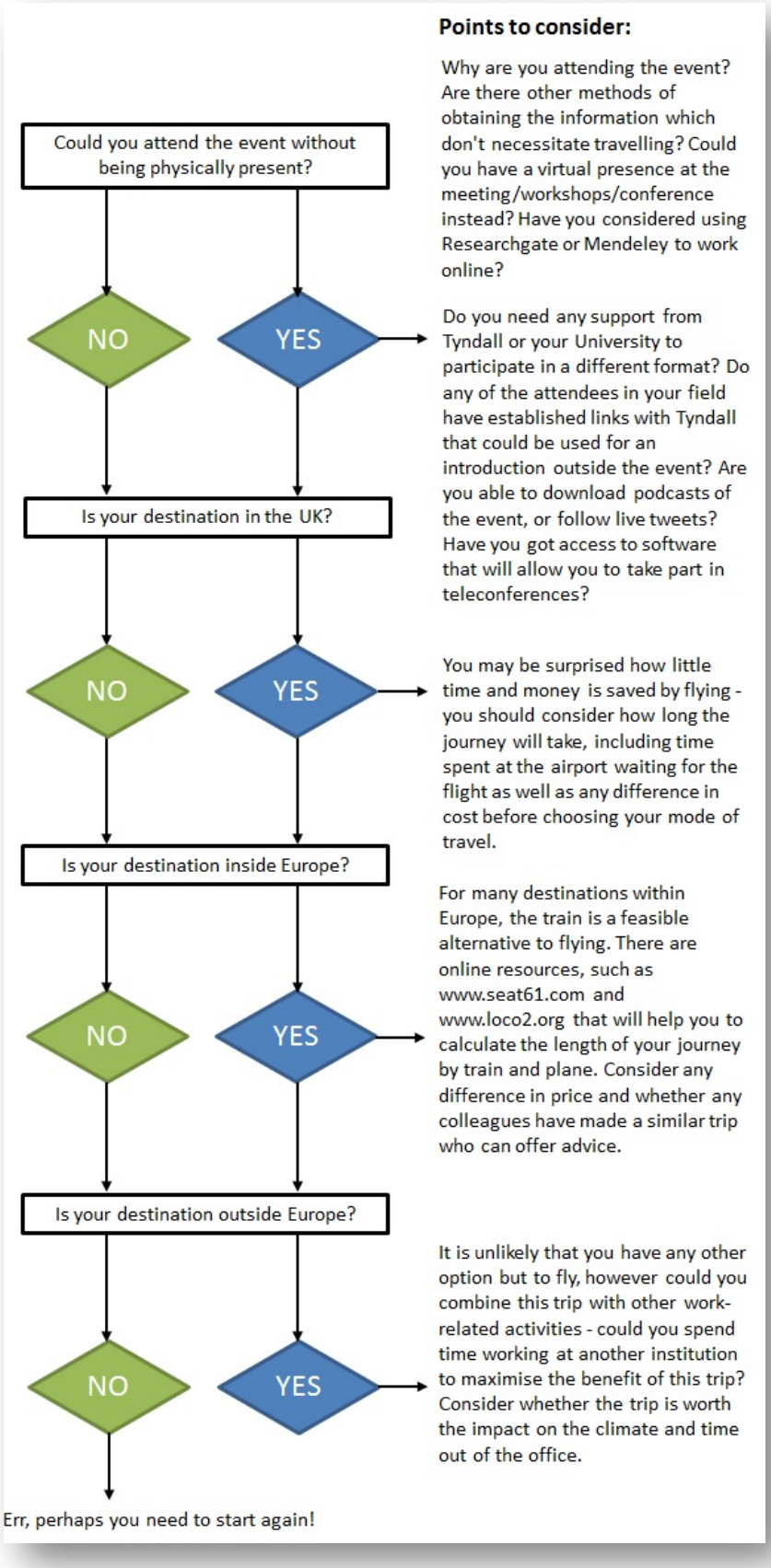
[*my emphasis: TW]*

'Motivations could overlap since business travel may often align with opportunities for leisure and tourism. In the context of international conferences, these include the prospect of social and cultural events, and the chance to experience a new or appealing part of the world (Høyer and Naess, 2001) '

The Tyndall centre is more specific in describing its Travel Strategy – perhaps this is a blueprint for ISSOP?http://www.tyndall.ac.uk/travel-strategy

Code of Conduct to support a low-carbon research culture:

- **Monitor and reduce**. I will keep track of the carbon emissions of my professional activities, and set personal objectives to reduce them in line with or larger than my country's carbon emissions commitments (see 'Set your targets below).
- **Account and justify**. I will justify my travel considering the location and purpose of the event, my level of seniority, and the alternative options available.
- **Prioritise, prepare and replace**. For activities that I organise, I will chose the location giving high priority to a low carbon footprint of travel of the participants, and I will encourage, incorporate and technically support online speakers and webcasts to reduce unnecessary travel.
- **Encourage and stimulate**. I will resist my own FoMo (Fear of Missing Out) from not attending everything and work towards sensitizing others to the need of the research community to walk the talk on climate change.
- **Reward**. I will work with my peers, Institute and Funders to value alternative metrics of success and encourage the promotion of low-carbon research as a realisable alternative to a high-carbon research career.
- **Before you travel:** Check the decision tree below. It will help you identify low-carbon travel alternatives and maximize the benefits of your travel emissions.



Points to consider:

Why are you attending the event? Are there other methods of obtaining the information which don't necessitate travelling? Could you have a virtual presence at the meeting/workshops/conference instead? Have you considered using Researchgate or Mendeley to work online?

Do you need any support from Tyndall or your University to participate in a different format? Do any of the attendees in your field have established links with Tyndall that could be used for an introduction outside the event? Are you able to download podcasts of the event, or follow live tweets? Have you got access to software that will allow you to take part in teleconferences?

You may be surprised how little time and money is saved by flying - you should consider how long the journey will take, including time spent at the airport waiting for the flight as well as any difference in cost before choosing your mode of travel.

For many destinations within Europe, the train is a feasible alternative to flying. There are online resources, such as www.seat61.com and www.loco2.org that will help you to calculate the length of your journey by train and plane. Consider any difference in price and whether any colleagues have made a similar trip who can offer advice.

It is unlikely that you have any other option but to fly, however could you combine this trip with other work-related activities - could you spend time working at another institution to maximise the benefit of this trip? Consider whether the trip is worth the impact on the climate and time out of the office.

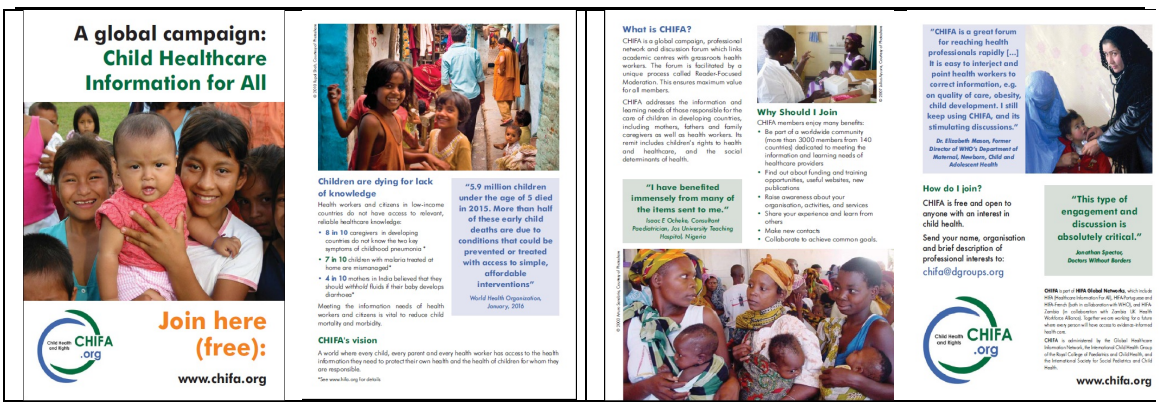
5. CHIFA report by Abigail Enoch CHIFA Desk Officer

Over the past 6 months we have been working on a project to contribute to strengthening the sustainable capacity of CHIFA in order to enable wider long term reach. The specific outputs for this project are to a) restructure and expand CHIFA's organisational and financial support base, b) increase the human resources to support diversified CHIFA roles, and c) create a suite of training and promotional tools to support added capacity.

To this end we have begun recruiting a team of CHIFA Country Representatives to help support and promote CHIFA in the Representative's countries. So far we have 26 CHIFA Country Representatives, representing 22 countries. Additionally we are in the process of inviting organisations to become CHIFA Supporting Organisations. These organisations could help CHIFA to grow its membership, contribute to the CHIFA community (e.g. through sponsoring a CHIFA discussion), and/or provide technical or financial support. So far we have three new CHIFA Supporting Organisations.

We have updated the CHIFA leaflet, which we have begun distributing widely, as well as various supporting documents, e.g. on how organisations can contribute to CHIFA's activities. We have also developed two Powerpoint presentations about CHIFA that can be adapted and used by CHIFA Country Representatives, the CHIFA Working Group, or other CHIFA members to promote CHIFA at meetings and conferences; we have had offers to have these translated into Spanish, Arabic and Indonesian Bahasa.

The CHIFA Desk Officer whose role is to lead these capacity-building efforts, has also taken up the role of assistant moderator, so she and Tony Waterston are alternating the weeks they lead the Reader-Focused Moderation of the CHIFA forum. We have developed a draft training tool for training a new assistant moderator; we will soon be seeking a volunteer for this role and will pilot the training guide in training them.



6. Publications

6.1 Kids Right's Index

The Kids Right's Foundation and the University of Rotterdam just published the Kids Right's Index for 2016.Its a global Ranking about how countries are adhering to children's rights. You can find more information about the children's rights index at this webpage: http://www.kidsrightsindex.org/

6.2 Book Review: Sir James Spence: the Origins and Evolutions of his Legacy reviewed by TW

James Spence was responsible for many of our current ideas in social paediatrics, in the UK and globally. Born in the last decade of the 19th century, he graduated in 1914, fought in the first world war and went on to work in Newcastle from 1922 until his death in 1954. He was one of the first physicians to become a full time paediatrician and the first Professor of Child Health in the UK, and his legacy is recognized in the leading position of Newcastle in training social and community paediatricians.

A new book about Spence by a former colleague of mine Hans Steiner reveals more about Spence's life and in particular, about the nature of childhood and child diseases in poverty-stricken Newcastle in the 1920s and 30s. What is valuable about this biography is the new insights into Spence's character, and the detail from hospital reports which though dry convey an extraordinary picture of the severe toll of malnutrition, TB, infectious diseases and congenital malformations on infants in those grim times.

Space does not allow more than a brief summary of the Spence legacy. Four themes emerge:
- mothers reside in hospital with their sick infants
- the careful analysis and recording of admission and mortality data to build a picture of child disease, and the development of a clinical research unit in 1938
- the initiation of the first UK cohort study (the 1000 Families) in 1947
- reaching out to organisations outside the hospital to promote prevention in child health.

Spence is best known for his early initiative to invite mothers to come into residence with their sick children in a homely and welcoming environment. Steiner points out that this was for pragmatic reasons and Spence did not at that time have more than a superficial understanding of children's emotional needs nor of the value of child psychiatry and psychology. However the reforms he introduced were seminal in leading to the establishment of one of the first children's mental health units in the UK, as well as to a completely modern approach to the incorporation of parents into the life of a children's ward.

The 1000 Families Study recruited all 1142 babies born to mothers resident within the city of Newcastle upon Tyne in May and June of 1947 into the study (less than 0.5% of families refused to participate). The study members had a red spot placed on their GP record to identify them as being in the study and subsequently were known as 'Red Spot Babies'. The commitment of families were so great that follow up has been possible up to the age of 60.

See http://research.ncl.ac.uk/plerg/Research/1000F/1000history.htm

In welcoming Donald Court (who succeeded Spence as Professor of Child Health in 1954) he memorably said 'The first aim of my department is comradeship, not achievement'.
- Notwithstanding, the achievements of Sir James Spence in all fields of pediatrics live on to this day.

Tony Waterston

Sir James Spence – the Origins and Evolution of his Legacy
Hans Steiner, Elizabeth Greenacre, Alan Craft. Blackthorn Press, 2016.
Obtainable from: 'Newcastle upon Tyne Hospitals NHS Charity and write 'GNCH Foundation' on the reverse.
Address: Charitable Funds Office, Peacock Hall, Royal Victoria Infirmary, Newcastle upon Tyne. NE1 4LP - Tel: 0191 2137235 - email: charity.matters@nuth.nhs.uk

6.3 Prevention of Child Labour in Turkey

By Dr. Erkan Doğan & Prof. Gonca Yilmaz,
Karabük University Department of Pediatrics, Turkey

The destiny of a country depends directly on how well its children are looked after. Children are important assets of any nation as they are the future citizens. Every worst forms of child labour are violence against children and should not be found in any civilized society. The United Nations adopted the Convention on the Rights of the Child (CRC) addressed child labour under Article 32.

ILO (International Labour Organisation) helped lead the Worst Forms Convention 182 (C182), prohibits worst forms of child labour, defined as all forms of slavery and slavery-like practices, such as child trafficking. According to ILO estimates, more than 12% of the world's children aged 5-9 are at work. The figure rises to 23% in the case of children aged 10-14.

We can identify six important emergencies in the management of child labour. These emergencies are both causes and consequences of child labour. These emergencies need utmost priority and political will.

1. Education Emergency: Education is a child right. In Turkey and Eastern Block European countries, there are many drop-outs in secondary school. In rural areas, uneducated children can be harder to reach. Quality of education is very important that families should see schools worthy to send their children rather than work.

2. Employment Emergency: Millions of people are unemployed because of cheap child labour also. Children cannot challenge, go to courts and cannot contact trade unions.. We have to break this vicious circle.

3. Enforcement Emergency: Countries like Turkey have international and national binding child labour laws but enforcement of these laws is very weak. Although many worst cases of child labour, prosecutions and convictions are rare and negligible. We have to have empowered, bigger capacity inspection systems, speedy trial systems and working social protection systems.

4. Economical Emergency: Rates of child labour is declining with wealth so that if parents have enough money and they are sure the family is able to live on, they don't want to send their children to work.

5. Ecological Emergency: With climate change, potential loss of livelihood for millions of families could mean that more children will be needed to support household income.

6. Ethical Emergency: There is an important question we should ask ourselves: Should a multinational company use child labour if it is allowed in the host country? How can we purchase of product produced using child labour? Everyone should feel moral responsibility to children.

What should paediatricians do to prevent child labour?

1. Paediatricians need to be aware of child labour. They should become knowledgeable about industries in their area and the hazards associated with working in those industries. They should evaluate their child patient's status with their family, social and environmental conditions. Child rights based interventions are so necessary.
2. Paediatricians are extraordinarily well positioned to speak out against the abuses of child labour, to urge strengthening of regulation and legislation. They can serve as advocates for working children.
3. Traumatic injuries to children may be work related. The child or his/her family may be reluctant to reveal that work was the source of trauma. They should try to open up these children with patient dialogue.
4. Working with ILO, organising pediatric meetings about child labour can be very useful as well as being in contact with local NGOs who are working in the field.

References:

1. www.un.org/en/globalissues/.../**childlabour**/intlconvs.shtml
2. www.unicef.org/**crc**/files/Rights_overview.pdf
3. http://www.ilo.org/global/standards/subjects-covered-by-international-labour-standards/child-labour/lang--en/index.htm

6.4 Advocacy and the paediatrician by Tony Waterston

Paediatrics and Child Health
Volume 26, Issue 5, May 2016, Pages 179–184

In this recent review of advocacy in child health (unfortunately not open access) the foundations of advocacy are described
http://www.sciencedirect.com/science/article/pii/S1751722215002541
Most of this paper will not be new to ISSOP members and I will simply extract one table which I have found to be useful -

Requirements of successful advocacy by paediatricians

Personal characteristics

- Determination, diplomacy, empathy, understanding of injustice

Application

- Knowledge of Convention on the Rights of the Child
- Knowledge of the healthcare system
- Knowledge of the political system at local and national level and how to influence
- Contacts within paediatric association

Techniques

- Ability to write a summary of evidence in simple format
- Publish in medical journal or other publication
- Blogging and use of mass media
- Use of social media
- Writing to influential figures/lobbying
- Reaching out to the wider public via the internet
- Using the influence of paediatricians

Topics

- Significance in morbidity/mortality
- Achievability - how quickly can change be brought about
- Relation to core work of paediatricians

Your own views and experience in advocacy will be most welcome to the editorial team!

Please write to tony.waterston@ncl.ac.uk