ISSOP e-Bulletin
Nº 24. November 2016

CONTENTS

1. Introduction

2. Meetings and news
   2.1 ISSOP in Budapest September 2017
   2.2 Fidel Castro: his legacy for child health
   2.3 What does the US election mean for child health?
   2.4 RCPCH and formula milk again

3. International Organisations
   3.1 Hungarian Paediatric association

4. Current controversy
   4.1 Brexit and child health
   4.2 Corporal punishment in Turkey

5. CHIFA report

6. Publications
   6.1 World report on Violence against Children
   6.2 WHO Global TB report
   6.3 Health disparities in the USA
   6.4 Pneumonia and diarrhoea progress report

1. Introduction

Welcome to the November issue of the ISSOP e-bulletin and very good wishes for the Holiday Season. We are coming to the end of what was a momentous year with problems of war, migration, poverty and discrimination seemingly on the increase round the world, with the need for our advocacy for child health and child rights becoming ever more pressing. Please write in with your suggestions and experience!

This month we give you advance warning of next year's ISSOP meeting in Budapest, Hungary on the topic of **Children on the Move**. Please come, this will be a new and interesting country for us to visit and a vitally important topic. We also cover the US election and the UK Brexit referendum which will both have consequences for child health. Read about measures to end corporal punishment in Turkey and reports on violence against children, tuberculosis and pneumonia together with an interesting paper on health disparities in the US. Fidel Castro has died: for those with an interest in global health, his government's work in primary health care, health promotion and universal access to health has been quite outstanding. We report in this issue. Please write in with comments on any of these articles, we welcome short contributions which should be sent to the editor (Tony.waterston@ncl.ac.uk)

Tony Waterston & Raúl Mercer

2. Meetings and news

2.1 ISSOP in Budapest, 28-30 September 2017

Children on the move: health, wellbeing and rights

It is a special privilege that we are hosting the annual general meeting of the International Society of Social Paediatrics and Child Health (ISSOP) together with the annual conference of the Hungarian Pediatric Association. The conference will take place in Budapest, Hungary, 28-30 September 2017.

Editor's note: owing to accommodation difficulties the ISSOP meeting will now be held a week after the HPA meeting, and in Budapest not Gyor.

Perhaps paediatrics is the only branch of medicine which preserved a holistic approach. A close relationship is essential among university and other hospitals and primary care to provide a high-quality care. We are pleased, that the program of ISSOP will bring social paediatric topics to the conference in addition to the medical approach. We are planning a common section between the international and the Hungarian societies.

Győr is a nice and prosperous city halfway between Budapest and Vienna; it is called "the city of rivers". It has a well preserved splendid Baroque city centre. We do hope that the scientific and the social programs will provide lasting memories. We kindly invite you to participate in our conference in Győr.

On behalf of the Hungarian Pediatric Association: Viktória Ruszinkó & Géza Muzsay

The organisers are sorry that the venue has now been changed to Budapest and the meeting will be a week after the HPA conference, that is on 28-30th September 2017.

2.2 Fidel Castro: his legacy for child health

Politicians can have a significant effect on child health. Fidel Castro who recently passed away had a significant impact on child health, not only in Cuba, but worldwide. He ensured Cuba introduced free universal health care, with a focus on primary health care and prevention. To ensure adequate delivery of health care, Cuba trained its own doctors. Medical students receive free education and are guaranteed a job on qualification. They accept that they will be posted where they are needed, including rural areas.

Child mortality rates in Cuba are lower than in the USA, a remarkable achievement for a lower middle income country. Even during the special period when the Cuban economy crashed, public services were protected. This was a conscious political decision by the Cuban government and contrasts sharply with the austerity programme of most governments.

Internationally, Cuba has always responded to emergencies and disasters in other countries, sending health professionals around the world. More than 19,000 children affected by the Chernobyl nuclear disaster have received long term treatment in Cuba. Cuba now has over 50,000 health professionals working in over 67 countries. A key feature of the work of Cuban health professionals overseas is that they work in areas of greatest need. These are often rural areas where the local indigenous population has previously not had any access to healthcare. This commitment to global child health was a personal project of Fidel Castro. Fidel's legacy to children is free healthcare and education.

For more detail see Castelló González M. et al. International Medical Collaboration: Lessons from Cuba. Children 2016. doi:10.3390/children3040020

I have been fortunate in collaborating with (learning from) Cuban health professionals for the last decade, in order to understand how they deliver excellent health care. (This includes an annual workshop on child health in Cuba, where experiences are shared)

Imti Choonara, Emeritus Professor in Child Health.
Academic Division of Child Health (University of Nottingham), The Medical School, Derbyshire Children's Hospital, Uttoxeter Road, Derby DE22 3DT, UK. **A BETTER WORLD IS POSSIBLE - UNIVERSAL HEALTH CARE IS A RIGHT (UN Declaration of Human Rights)**

2.3 What does the US election mean for child health?

Rita Nathawad, Florida

In the months leading up to and weeks following the presidential election in the United States, many have been asking what impact the 45th presidential administration will have on the health and well-being of children in our country. In anticipation, our national pediatric organization, the American Academy of Pediatrics published a *Blueprint for Children: How the Next President Can Build a Foundation for a Healthy Future.* See https://www.aap.org/en-us/transitions/Pages/blueprint-for-children.aspx. This document highlights the expanding evidence base that social and environmental determinants play a critical role in shaping the health and well-being of all children. The Academy calls on the future administration to continue to support programs that; **1) ensure access to high quality health services for all children, 2) address housing, food and education inequities, and 3) build strong families and communities by decreasing violence and ensuring safe water and clean air.**

Reflecting on the media coverage of our candidates, colloquial election banter and news reporting of protests by passionate citizens, I have to wonder how all of this is viewed by our countries' children. Political discussions are typically considered only appropriate in adult circles. This year, during this election season, I had the unique opportunity to gain a new perspective. I was able to experience some aspects through a child's eyes; those of my eight-year old son. I realized that irrespective of party affiliation or beliefs, children are impacted by the discussions they hear and the conflicts that may arise from them. Without explanation and guidance children may be confused or fearful of election outcomes and it is our job as pediatricians, caregivers and advocates to ensure we facilitate conversations that reassure children of their safety and security. It is important to discuss their concerns, answer questions and clarify rumors in a developmentally appropriate manner. While we may not be able to provide all of the solutions, open communication can mitigate stressful reactions to election tensions.

On November 8, 2016, Donald J. Trump defeated Hillary Rodham Clinton, becoming the next president elect of the United States. While the future is uncertain and opinions on how our new leader's choices will impact our mission as pediatricians varies amongst individuals, we must continue to work diligently on the issues that matter most for ALL children in the United States and globally and aim to advance policies that protect and promote their health and well-being. Despite change in Washington, the election should not mute the voices of our children and the ongoing advocacy efforts of pediatricians to ensure those in power hear these voices. We must continue our work and collaborate with the new administration and Congress to ensure that children's health remains a priority and is considered in all government policies.

2.4 RCPCH and formula milk again

Tony Waterston

There was much disappointment among social paediatricians over the result of the RCPCH member survey on funding from the baby food industry. The majority of those who voted supported accepting funding in relation to specialist milks, as long as the RCPCH carried out 'due diligence' which means ensuring that the company's practice is ethical.

At a follow up meeting with sponsors of the original motion which voted against accepting baby food funding, the President indicated that the College takes the responsibility for 'due diligence' very seriously. We hope that a meeting with WHO will be arranged to discuss how this might be done. See the following blogs in the BMJ which cover the different perspectives.

What do you think?

- http://blogs.bmj.com/bmj/2016/10/31/neena-modi-the-rcpch-and-funding-from-infant-formula-companies/
- http://blogs.bmj.com/bmj/2016/11/04/why-the-rcpch-should-stop-taking-funds-from-the-baby-food-industry/

3. International Organisations

Hungarian Paediatric association (www.gyermekorvostarsasag.hu)

Dr KovacsZsuzsanna

Hungarian Pediatric Association was founded in 1924. It is the main national professional society of the Hungarian paediatricians. It counts some 2000 members. There are regional branches and specialization relevant sections within the organization- one of them is the social paediatric group. The association publishes a scientific journal bimonthly in print and online and also publishes a postgraduate medical journal. General meetings are organized annually. The regional branches and the other sections also have annual conferences.

The association maintains international relations:

- European Academy of Paediatrics (EAP)
- European Paediatric Association (EPA/UNEPSA)
- Paediatric Association of the Balkan
- Bilateral contacts with many national paediatric societies
- Contacts with other societies: EAACI, ESPGHAN,ESPID, ISSOP etc.

4. Current controversy

4.1 The impact of Brexit on children's health protection

It is likely that the vast majority of social paediatricians in the UK, as well as their colleagues around the world, are deeply disturbed as well as shocked by the outcome of the referendum on leaving the European Union. Will there be an impact on children? Almost certainly, not least as a result of the economic stringencies which are likely to result. Will there be an impact as a result of changes in legislation? In the paper from Liverpool University below, the impact on children's health protection as a result of Brexit is assessed.

From the European Children's Rights unit, School of Law and Social Justice, University of Liverpool
https://www.liverpool.ac.uk/media/livacuk/law/news/BREXIT,BRIEFING,6-Child,Health.pdf

How does the EU address health risks for children and youth?

So far, the EU has made laws to protect children against irresponsible advertising, to control the production and sale of tobacco, and ensure that claims made about food are truthful. The Audiovisual Media Services Directive forbids direct targeting of minors in commercials for alcoholic beverages.

The annex to the Tobacco Products Directive includes mandatory health warnings on cigarette packaging such as: "Your smoke harms your children" and "Smokers' children are more likely to start smoking". It is unlikely that a UK directive equivalent would prioritize children as being vulnerable to tobacco abuse.

Council Recommendation on the prevention of smoking 2003/54 recommends that EU Member States "adopt appropriate legislative and/or administrative measures... to present tobacco sales to children and adolescents." It also suggests protection from exposure to tobacco smoke especially in educational establishments and places providing services to children.

The European action plan to reduce the harmful use of alcohol 2012 – 2020 is an action plan that the WHO has put forward, working with the EU Member States to reduce the harmful usage of alcohol, based on 10 recommended target areas.

WHO European Childhood Obesity Surveillance Initiative (COSI) was a system set up to monitor and understand the progress of obesity within primary school children in order to respond with the appropriate action by member states.

EU Action Plan on Childhood Obesity 2014-2020 is an action plan that was proposed by the Member States to develop policy on tackling childhood obesity. This was done as a result of EU Health Ministers declaring their commitment after a broad consensus that overweight and obesity in children and young people should be prioritised in health agendas.

Under the 'Fund for European Aid to the Most Deprived', £4.27 million of the UK's funding allocation has gone to supporting breakfast clubs and programmes in order to tackle poverty and child malnutrition.

What will happen if the UK stays in the EU?

EU law creates an obligation for Member States to focus and amend their domestic laws to accommodate children's rights. With the UK staying a member of the EU, it will have direct access to funding under EU initiatives to help pull children and families provide better children's health and wellbeing. The Directives in place to target specific issues of alcohol use and obesity, there is a focus on improving lifestyles and upholding the rights of young people.

And if the UK leaves the EU?

Members of the EU are responsible for protecting children from risks specific to their own countries. However, they cannot easily protect children from risks that are universal. For example, Member States are not able to prevent a multinational company from irresponsibility advertising products that are harmful to children – a company can promise to play by less strict rules in one country, so that it can advertise to children to other countries, in accordance with those rules.

4.2 Corporal punishment ban and Turkey

Gonca Yilmaz MD, Erkan Dogan MD

Dear colleagues,

I made a speech at Turkish Social Pediatric Society Meeting, which was held on 16 th-18 th. November, 2016. I would like to mention about it.

My speech topic was 'Prohibiting corporal punishment in Turkey'. As you know corporal punishment to children in home environment is legal in Turkey. And you also know, now, there is growing progress towards universal prohibition of this most common form of violence against children: **51** states (Last country is Slovenia) have prohibited all corporal punishment of children, including in the family home. At least **55** more states have expressed a commitment to full prohibition.

Turkey is one of these 55 countries. However, there is no movement recently to make corporal punishment illegal in Turkey. I was really surprised to see how Latin American countries were ready to ban this type of physical discipline. And then, from literature, I understood that it was a cultural tradition for Latin American Countries and they were more protective for their children.

Although there is no epidemiological study on this subject, some studies showed that Turkish families are using corporal punishment frequently **(http://www.endcorporalpunishment.org/progress/country-reports/turkey.html)**. At least, I can say that my son's friends' families prefer to hit or beat their children when they get low score in exams. Can you imagine these children are 14 years old? (I am learning this from his friends' speeches).

In my speech, I talked about Sweden experience in this subject (The first country which banned corporal punishment to children). After this law, public support for corporal punishment has declined, identification of children at risk has increased, child abuse mortality has been rare, prosecution rates have remained steady, and social service intervention have become increasingly supportive and preventive. Can such a law be successful in Turkey?

Without increasing awareness in our society, without family education about positive discipline, I would say ‘No’. Why?

Firstly, beating children is a cultural behaviour in Turkey. We have many sentences rationalizing this behaviour (Beating originates from heaven; if you don’t beat your daughter, you beat your knee…)

Secondly, another important reason for frequent corporal punishment is decreasing social environmental support for families. Turkey is a developing country, families are losing their social support when they come to live in cities and becoming desperate without knowing alternative positive discipline techniques for their children. And another reason for this type of discipline is public’s becoming more conservative, more Islamic. In Islamic family model, after 7 years old children should behave according to Islamic rules; girls should take their mothers as a model and boys should take their fathers as a model. In this family model, physical discipline would be a part of their daily discipline. Lastly, although Child Right’s Convention was implemented by Turkish Law, awareness and training about child rights is very rare. Children don’t know their rights. Families and government officials can see themselves as owner of child.

So can we decrease our corporal punishment rates without a law prohibiting corporal punishment?

I would say again ‘No’. Because laws can be very powerful tools for social change and education. We are not waiting for the results of spouse anger management training for preventing violence against women from their husbands. Children have the same rights as women against violence. So why would we wait for results of family education for preventing children against corporal punishment? I have mentioned what social pediatricians or pediatricians can do in this important issue in my speech.

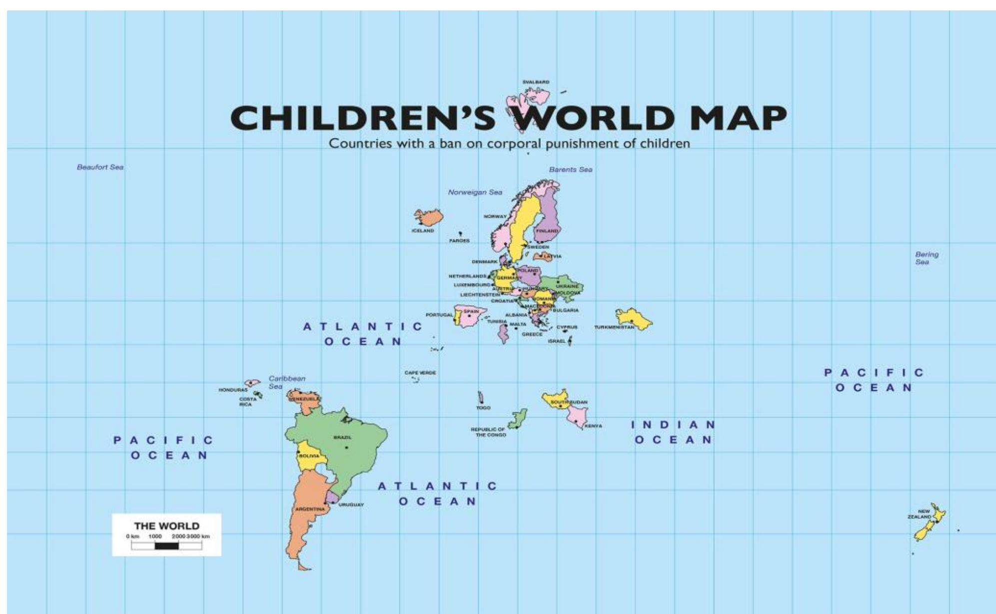
Firstly, pediatricians who see patients individually can encourage and support parents in adopting positive discipline methods in a number of ways. First, they can provide information about typical developmental stages to normalize parenting challenges and reduce angry and punitive parental responses. Second, they can provide a list of resources on positive discipline. Thirdly, pediatricians or social pediatricians can also contribute to attitudinal and behavioural change on a broad scale.

Many countries have adopted public health strategies aimed at informing parents about the physical and psychological impacts of physical punishment and encouraging them to adopt positive disciplinary approaches. These initiatives are increasingly erasing the arbitrary line between punishment and abuse. And from studies, it is recognized that a public education message must be clear and unambiguous. Such broad messages can be complemented by more individualized parent support and education delivered by health care professionals.

And lastly, we have a campaign initiative which aims to reduce or eliminate corporal punishment of children in Turkey, called ‘Partnership network against violence’. Social workers, lawyers, pediatricians, politicians are working in this partnership. In response to my speech, our association, Turkish Social Pediatric society will also join this network. And in a short time, we will publish a statement against corporal punishment to children. Lobbying with politicians on this issue has tremendous importance in our country.

Resources:

- http://www.endcorporalpunishment.org
- Daly, Mary (ed.), *Parenting in contemporary Europe – a positive approach:* Avrupa Konseyi Yayını, Strazburg, 2007.
- *Eliminating corporal punishment – a human rights imperative for Europe's children*, fully revised second edition: Avrupa Konseyi Yayını, Strazburg, 2007.
- *Ending legalised violence against children – Global report 2007: Global Initiative to End All Corporal Punishment of Children, 2007.*
- Wolraich M, Aceves J, Feldman H. Guidance for Effective Discipline. Pediatrics. 1998; 101(4):723–728. Available: http://elibrary.ru/item.asp?id=4892642. Accessed 2013 April 28. PMID: 9521967
- Osterman K, Björkqvist K, Wahlbeck K. Twenty-eight years after the complete ban on the physical punishment of children in Finland: Trends and psychosocial concomitants. Aggress Behav. 2014; 9999 (February):1–14. doi: 10.1002/ab.21537.
- Zolotor AJ, Puzia ME. Bans against corporal punishment: a systematic review of the laws, changes in attitudes and behaviors. Child Abus Rev. 2010; 19(4):229–247. doi: 10.1002/car.1131.
- duRivage N, Keyes K, Leray E, et al. Parental use of corporal punishment in Europe: intersection between public health and policy.PLoS One. 2015 Feb 12;10(2):e0118059. doi: 10.1371/journal.pone.0118059. eCollection 2015



5. CHIFA report

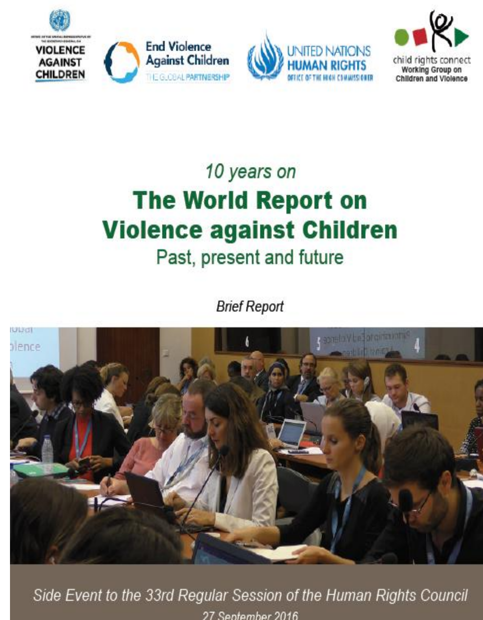
CHIFA continues to expand and is shortly to appoint a new assistant moderator from a low income country. There is now an increasing network of country champions as a result of the work by Abigail Enoch the desk officer. We are looking for topics for further webinars next year and welcome suggestions. CHIFA is one of the best means for ISSOP to expand its network around the world and to improve the understanding of social paediatrics so please send in your questions and responses to CHIFA@dgroups.org

Tony Waterston

6. Publications

6.1 World report on Violence against Children

Shanti Raman - ISSOP representative on IPA Standing Committee



In 2006, the landmark United Nations (UN) study on violence against children was tabled by Professor Paulo Pinheiro, Independent Expert for the UN Study, at the 61st General Assembly of the UN. That study was the first comprehensive, global study conducted by the UN on all forms of violence against children. Violence against children was acknowledged to manifest in a variety of forms and be influenced by a wide range of factors, from the personal characteristics of the victim and perpetrator to their cultural and physical environments. The study identified the magnitude and pervasive nature of the problem. Violence against children cut across boundaries of geography, race, class, religion and culture. It occurred in homes, schools and streets; in places of work and entertainment; and in care and detention centres.

The majority of violent acts experienced by children being perpetrated by people who they know and are part of their lives: parents, schoolmates, teachers, employers, boyfriends or girlfriends, spouses and partners.

Now 10 years since, a side event to the 33rd session of the Human Rights Council was convened to record progress since the World Report. Key panellists were Professor Paulo Pinheiro, Ms Marta Santos Pais (Special Representative of the UN Secretary General on Violence against Children) and Dr Etienne Krug (WHO). While there has been clear progress since 2006, children continue to be victims of violence. More than 50 States have a clear legal prohibition of all forms of violence against children, including corporal punishment, but in practice, many children are still not fully protected. The objectives of this commemorative event were: to contribute to raising awareness of the urgency to prevent and address violence against children; to discuss the link between the Sustainable Development Goals (SDGs), in particular, violence against children related goals and targets; and to share strategies to prevent, address and eliminate violence against children.

There are exciting new developments in this space including the Global Partnership to End Violence against Children, which was launched by UNICEF in July 2016. The New Partnership has three main goals, namely: 1) continue to build political will; 2) accelerate action at national and local level in order to tackle all forms of violence against children; and 3) strengthen collaboration between all parts of society, all sectors, international agencies, etc. Alongside the launch of the Partnership, was the launch of INSPIRE: a technical package of

seven strategies to prevent violence against children. September 2016 marked the first anniversary of the adoption of the SDGs. **Target 16.2,** *to end all forms of violence against children, and ending the abuse, neglect and exploitation*, is a critical component of **Agenda 2030**.

Another body specially created and charged to respond to the global issue of violence against children is Know Violence in Childhood. This is a global learning initiative aimed at leveraging available evidence from around the world to tell the story about violence in childhood – not just its forms, drivers, impacts and costs – but more importantly, what can be done to reduce violence effectively to contribute to the agenda of improving child well-being.K**no**w Violence, will be releasing their global report in early 2017. The report will serve as an information 'baseline' on countries that are in the process of eliminating violence against children. It will offer evidence and ideas for the most effective strategies that we believe can help end violence in childhood.

Finally ISSOP, ISPCAN, IPA, the Partnership and Know Violence in Childhood are working together to produce a technical report and position statement on Violence against Children. Watch This SPACE!

6.2 WHO Global TB report[1]
Nick Spencer

The WHO Global TB Report for 2016 opens with the following statement:
"Global actions and investments fall far short of those needed to end the global TB epidemic"

Despite the aim for planned reduction in global TB outlined in the 2014 WHO End TB Strategy, the Report finds that the TB epidemic is bigger than previously thought. Worldwide, the rate of decline in TB incidence remained at only 1.5% from 2014 to 2015.This needs to accelerate to a 4–5% annual decline by 2020to reach the first milestones of the End TB Strategy. In 2015, there were an estimated 10.4 million new (incident)TB cases worldwide, of which 5.9 million (56%)were among men, 3.5 million (34%) among women and1.0 million (10%) among children. People living with HIV accounted for 1.2 million (11%) of all new TB cases.

The Report highlights key areas for improvement in the strategy to end the epidemic. TB prevention and care, financing, and treatment availability through universal affordable health care need to be improved. TB research and development remains seriously under-funded despite some progress in new diagnostics.

It is clear from this report that TB remains a major global public health problem and far greater resources will be required to bring the epidemic to an end. This Report is important reading for paediatricians internationally, especially those in India, China, Indonesia, Nigeria, Pakistan and South Africa, the countries most affected by the epidemic. Diagnosis and treatment are essential but not sufficient to end TB; action at global and national level to improve living standards for the poorest is required along with action to ensure access to universal, affordable health services. Paediatricians have a key role in advocacy for these changes.

[1] http://www.who.int/tb/publications/global_report/en/

6.3 Health disparities in the USA[2]

Comment by Rita Nathawad

Abstract

OBJECTIVES: To more clearly articulate, and more graphically demonstrate, the impact of poverty on various health outcomes and social conditions by comparing the poorest counties to the richest counties in the United States and to other countries in the world.

METHODS: We used 5-year averages for median household income to form the 3141 US counties into 50 new "states"-each representing 2% of the counties in the United States (62 or 63 counties each)-by using the 2015 County Health Rankings National Data. We compared the poorest and wealthiest "states."

RESULTS: We documented dramatic and statistically significant differences in life expectancy, smoking rates, obesity rates, and almost every other measure of health and well-being between the wealthiest and poorest "states" in the country. The populations of more than half the countries in the world have a longer life expectancy than do US persons living in the poorest "state."

CONCLUSIONS: This analysis graphically demonstrates the true impact of the extreme socioeconomic disparities that exist in the United States. These differences can be obscured when one looks only at state data, and suggest that practitioners and policymakers should increasingly focus interventions to address the needs of the poorest citizens in the United States.

"This study demonstrates that looking at state-level data hides the impact of socio-economic disparities on both the best-off and worst-off counties in the United States."

Traditionally public health spending and programming is determined by state level data, which may inadequately identify the areas in greatest need. This study conducted by a group at East Tennessee University, Johnson City, Tennessee, USA, highlights the importance of disaggregating data in order to identify the most extreme disparities that may exist within smaller regions or populations. Researchers reclassified 3141 counties (based on counties listed in County Health Rankings (CHR) National Data) into 50 "new" states on the basis of 5-year average median household income. Data on negative health behaviors, access to clinical care, social and economic environment and demographics was analyzed to determine disparities between the wealthiest and the poorest "state"; statistically significant differences were found in most domains. For example, those in the poorest "states" have double the smoking rates, significantly lower high school graduation rates and twice as many persons per primary care physician when compared to wealthier "states". Authors also examined years of potential life lost due to disparities and reported that both males and females in the wealthiest "state" enjoy longer life expectancies than those in the poorest "states", with differences of 10 and 7 years respectively. When compared with life expectancy in other countries, it was found that more than half the countries in the world have a longer life expectancy than the poorest counties in the United States.

The study was limited in that within the counties themselves there are pockets of poverty and wealth that may be missed and therefore the methods used likely still underestimate the

---

[2] Am J Public Health. 2016 Nov 17:e1-e6. *Health and Social Conditions of the Poorest Versus Wealthiest Counties in the United States.* Egen O, Beatty K, Blackley DJ, Brown K, Wykoff R.

differences in health between counties. The analysis did not look at causality and the link between poverty and health, which is also relevant to the discussion.

This study suggests that public health policymakers, public health professionals, funders and other stakeholders need to shift focus from state to county level data in order to spend limited resources in a more successful manner. By looking more closely at the region most in need, governments can allocate funds to develop targeted local programs which may better reflect the community they are meant to serve and thus be more effective. We are reminded of the powerful effect economic inequality has on health and that broad population data is not reflective of the immense disparities that may exist within a country or region.

6.4 Pneumonia and diarrhoea progress report
Nick Spencer

The circulation of these two reports by the IPA to its constituent societies (including ISSOP) represents a significant shift in priorities and a major commitment to the pressing problems of global child health. Pneumonia and diarrhoea, both eminently preventable, are the biggest killers of children between one month and five years of age. ISSOP fully supports the commitment of the IPA to prioritise global child health and actively contribute to the international drive to ensure that all children have access to effective prevention, management and treatment of these conditions.

The Lancet Series on Pneumonia and Diarrhoea (see the Executive Summary for all papers in the series[3] was published in 2013, two years before the end date of the MDGs. The series is still relevant to addressing the challenge of these conditions. In 2015, together these conditions claimed the lives of 1.5 million children under 5 years according to the 2016 report of the International Vaccination Action Centre (IVAC). 75% of these deaths occurred in 15 countries. Both the Lancet Series and the IVAC report acknowledge that, despite considerable progress in reducing child mortality from these and other conditions, insufficient progress is being made. The IVAC report identifies the need to re-evaluate if we are serious about meeting the new SDG target on child health of reducing mortality to at least as low as 25 deaths per 1000 live births in children under the age of 5 years.

The Lancet series identifies 15 evidence-based interventions which, “if delivered at high coverage and quality, would eliminate 95% of diarrhoeal and 67% of pneumonia deaths in children younger than 5 years by 2025.” Eight of the 15 are preventive or treatment interventions dependent on health service delivery, three depend on effective health promotion, two are mass supplementation programmes and two are structural environmental interventions. The IVAC report focuses on 10 interventions which are included in their Global Action Plan for Pneumonia and Diarrhoea (GAPPD) – five vaccines, four treatment regimes for pneumonia and diarrhoea and exclusive breastfeeding.

[3] http://www.thelancet.com/series/childhood-pneumonia-and-diarrhoea

THE LANCET

www.thelancet.com

Childhood Pneumonia and Diarrhoea

Executive Summary of *The Lancet* Childhood Pneumonia and Diarrhoea Series

These predominantly health service-based interventions are necessary but not sufficient to achieve the SDG goals. Child mortality from pneumonia and diarrhoea (and other treatable conditions) in low and middle income countries are underpinned by poverty and malnutrition, the elimination of which form SDG Goals 1 and 2. Vaccination, appropriate case management and promotion of breast feeding, hand washing and safe disposal of faecal waste are all essential; however, if high levels of poverty and malnutrition persist, pneumonia and diarrhoea will continue to end many young lives. Millions of children continue to be deprived of the most basic needs for health including adequate nutrition, safe water, sanitation, adequate shelter and education. In addition to depriving children of these basic health needs, poverty excludes many from adequate, accessible and affordable health care. As a consequence, the poorest children are most likely to die from pneumonia and diarrhoea and are least likely to benefit from vaccination and other health service-related interventions.

Advocacy by the IPA for interventions to improve global child health carries a clear message to paediatricians and their societies to contribute to addressing the implications of delivering them, as the Lancet series argues, at high coverage and quality. The advocacy would be further strengthened by adopting a clear equity, rights-based strategy, consistent with the SDGs, addressing the underlying social determinants of child mortality alongside health service-based interventions outlined in the lancet series and the IVAC report.