ISSOP e-Bulletin
Nº 23. September 2016

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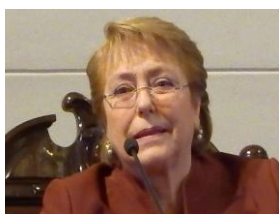
1. Introduction

In this issue of the ISSOP e-bulletin we will share news from the social paediatrics community, particularly, some highlights of the 34th ISSOP Conference held in Santiago, Chile. We also look at some work of the UN Human Rights Council, highlight a report on injury prevention and publicise the forthcoming CHIFA webinar on immunisation on 14th October – don't miss it! Thanks for the honour to have the presence of the President of Chile, Michelle Bachelet in the opening session of the Conference.

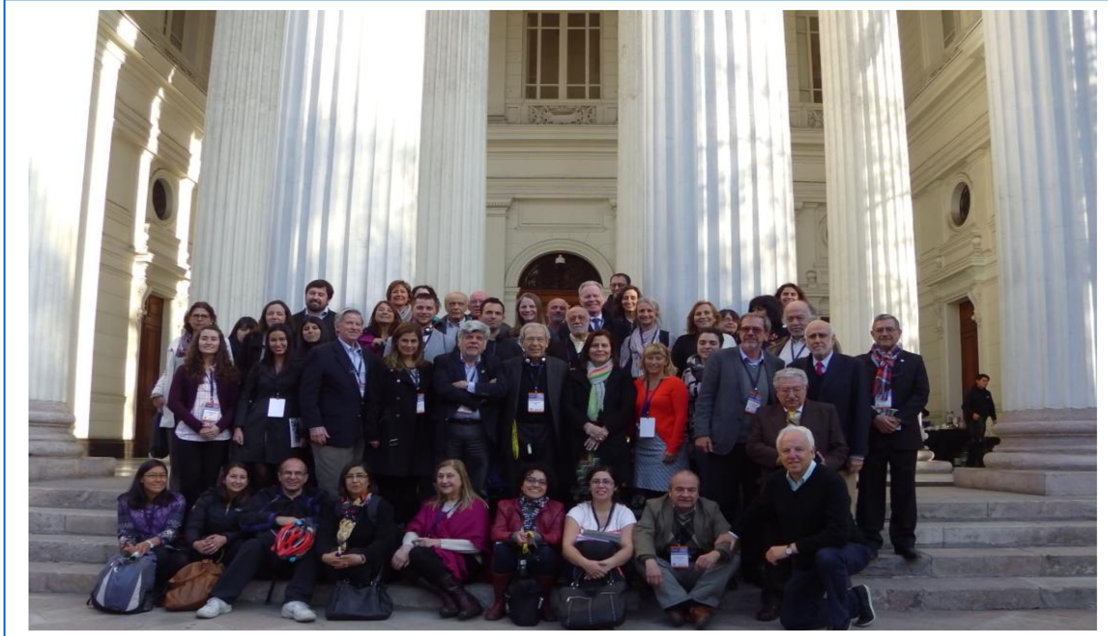
Tony Waterston – Raúl Mercer



To listen President Bachelet's speech, click this linkhttps://vimeo.com/181830465

2. Meetings and news

2.1 Report from ISSOP in Chile



Working Groups

During a pre-conference workshop, social paediatricians from ISSOP and Latin America worked together trying to establish a common agenda for future collaboration. Three groups were created, one on child advocacy, the second on education and training and the third one, on scholarship. Here are the highlights:

Activities proposed for advocacy on child and adolescent health, on the following aspects:

1. Place the children and adolescents in the public agenda, both on the political agenda and the social agenda.

2. Conduct mapping and analysis of legislation on children and adolescents.

3. Promote national ombudsmen rights of children and adolescents.

4. Exchange good practices regarding legislation for adolescents.

5. Promote comprehensive protection laws under the Rights of the Child.

6. Monitor the implementation of public policies for children and adolescents.

7. Promote the active participation of civil society in the development, monitoring and evaluation of policies for children and adolescents.

8. Promote the protection against all forms of violence against children and adolescents.

9. Promote standards to improve child nutrition and adolescent including topics such as nutritional labelling, food fortification, healthy school meals.

10. Promote favourable conditions for development and child and adolescent health environments, comprising: universal access to water and sewage, toxic environmental protection, use of clean technologies.

Activities proposed for education and training:

Training in social pediatrics at undergraduate, graduate and continuing education, as well as specific training for those more interested in the area. Training should ideally be interdisciplinary.

It is proposed to conduct both undergraduate and graduate social pediatrics program containing common minimum internationally, which may correspond to 60%. The remaining 40% would address peculiarities of the country or region where it is distributed.

Among the topics to be developed are suggested:

- Definition of child and adolescent health and well-being.

- Approach rights

- Public policies for child and adolescent health.

- Social determinants of child and adolescent health.

-Sustainable development.

In continuing education always consider other professions and their relevance in social pediatrics.

It is proposed that a common virtual course between the two associations (ALAPE, ISSOP), considering it without cost, interdisciplinary, thinking of several public, proposing specific training for pediatricians and other professionals.

Aims to optimize the use of resources of different organizations, among which are virtual platforms, and structured courses, seminars and conferences are recorded, existing publications. It is important to make an inventory and repository way to bank information of all these resources and human resources we have in ISSOP, Committee on Social Pediatrics ALAPE, academic groups, Federation of Medical Students, Open University, CHIFA and others.

In the near future a virtual network between groups and individuals working in social pediatrics and internships for undergraduate students and graduate professionals interested in issues of social pediatrics with working groups from other countries. In the medium term, the creation of joint postgraduate courses endorsed by universities in different countries is proposed.

Activities proposed for scholarship:

1. Bibliometric studies are needed on Social Paediatrics with extensive reviews of the literature generated; this will help define globally relevant research questions. Quantitative, qualitative and mixed studies, should be considered.

2. Once defined lines of research are taken, it is important to compare different databases between countries.

3. Probably the first studies to be done can be epidemiological.

4. A line of common interest is nutritional issues (malnutrition in its different forms, nutrition policies)

Closing remarks, learning and challenges: First Chilean Congress of Social Pediatrics and 34 Conference of the International Society of Social Pediatrics (ISSOP)

Social Pediatrics Approach:

Social pediatrics (SP) is a holistic and multidisciplinary approach to child health, considering the health of children in the context of their society, environment, school and family; integrating the social dimension, mental, physical and spiritual health, and child development, as well as care, prevention and health promotion, and the quality of life. SP intervenes on issues that affect growth and integral development of children and adolescents, addressing its historical biopsychosocial reality from a rights perspective, seeking to achieve the goal of healthy future citizens, freethinkers, solidarity, and builders of a more equal society. It has been very important to share the context in which children in Chile and the rest of the countries participating in the Congress are developed. This is a model of development characterized by poor income distribution with large inequities, which are expressed in unequal health outcomes. The model affects the quality of life of people with expression in working conditions, transportation, housing, environment, recreation. There is also an important environmental and energy impact at the global level (global warming).

Consequences on children and adolescents:

1. Scarce supply of healthy environments (school, neighborhood, district, city)
2. Limitations on access to basic needs: housing, education, health, food, participation.
3. Violation of rights: child labor, violence, sexual abuse, drugs, unwanted pregnancy, exclusion and discrimination against migrants, indigenous peoples, disabled.
4. Transmission of alienating messages through the social space (TV, internet, social networks, other media) that induce consumerism, individualism, competitiveness and emotional stress.
5. States are not guaranteeing the full exercise of the rights of children and adolescents. National and international law do not facilitate enforceable and effective these rights.

Challenges:

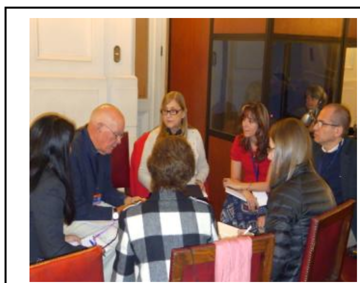
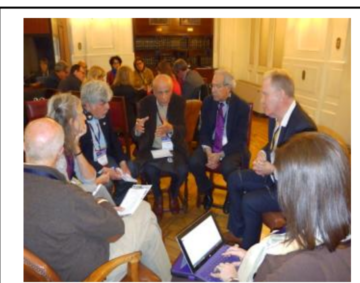
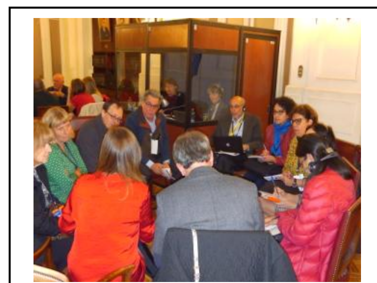
1. Training skills: It is imperative to advance in increasing the critical mass necessary to strengthen the imprint of the Social Pediatrics. Such training should be aware of the following attributes:

- Human rights approach
- Interdisciplinary and intersectoral
- Install new paradigm that privileges the quality of life of children by promoting social, environmental and family conditions that favor this.
- Training general pediatricians and family health practitioners with strong community ties.

• Development of information-management systems regarding the status of children and their development conditions, for example implementation of an Observatory.
• Install surveillance systems, promotion and protection of the rights of children and adolescents in partnership with other social actors

2. Public Policy: Advocacy is required to establish alliances with key stakeholders to promote the formulation and implementation of public policies that favor the full development of the potential of children and adolescents. The priorities that are displayed are related to:
• Confront change the development model considering the children and adolescents as strategic agents of change, ensuring full the provisions of the CRC.
• Moving towards an inclusive, supportive and participative society without discrimination or exclusion (gender, ethnicity, migrants, disabled, etc)
• Formulate laws and regulations and ensure that sufficient financial resources to meet the requirements of the International Convention on the Rights of the Child (CRC).
• It is imperative to move towards the establishment of institutions warranting the enforcement of rights: Defender of Children and Adolescents, Undersecretary of Children and Adolescents.
• Communities and child friendly cities: free from contamination with appropriate recreation spaces, decent housing, ensuring the full exercise of citizenship without exclusions of any kind.
• Policy Implementation healthy eating (food labeling)
• Control of air pollution, noise, water.
• Give public account of the status of Children and Adolescents.

3. Role of Societies of Pediatrics:
• To promote through its media and forming alliance with universities, promote pediatrician as a agents of change and connected to the needs and rights of children, adolescents and their families.
• Pediatrics Societies must have a leading role in forming public opinion regarding contingent issues affecting the health and quality of life of children.
• Promote compliance with CRC
• Identify what rights are being violated and how it affects development of children and adolescents.
• Consider the urgency of interventions, given the critical situation of children in the world.

2.2. Report from Chile by Gonça Yilmaz

- **ISSOP (International Society of Social Paediatrics) and The Committee on Social Pediatrics of the Chilean Society of Pediatrics (SOCHIPE) meeting was held in Santiago, Chile on August 31st – September 2nd. The Committee on Social Pediatrics of the Latin-American Association of Pediatrics (ALAPE) and ISSOP collaborated for this organization.**
- **Meeting was in Former National Congress Building which was a historic building with majestic architecture and picturesque gardens.**
- **Because of Turkish Coup Attempt, Turkey was in emergency situation. But although my allowance from my university to abroad and controls in Istanbul Airport and long-distance travel were a grueling process; I think this meeting was absolutely worth to attend.**
- **Latin American colleagues' hospitality and meeting program organization were excellent. Simultaneous translation was perfect and we communicated easily.**
- **Meeting program contained important social pediatric issues like analysis of the social, economic and cultural inequality in Latin America and Chile, Child Rights approach to these problems. The central idea was 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.**
- **We have learned that Child Rights and Health services curriculum was already developed and implemented to health professionals training in Latin America many years ago. I would like to give some examples about that:**
- **In Chile, a cross-national cooperative project was implemented that involved .Chilean and Argentinean training teams to orient and prepare health managers to implement the national child protection policy: *Chile Crece Contigo* (Chile Grows with You). This national program was supported by the President Michelle Bachelet.**
- **In Colombia, activities were implemented through the collaboration of the Colombian Pediatric Society (CPS), academy (Javeriana University and National University), and the National Child Rights Observatory. Dr. Hernando Villamizar, former President of the CPS was a key actor to promote the commitment of the CPS to child rights and social pediatrics.**
- **In Uruguay, the collaborative involving the Uruguay Society of Pediatrics(SUP), UNICEF, UDELAR (University), INAU (Institute of Child and Adolescence), focused their efforts and resources to train undergraduate and postgraduate health professional students in child rights.**
- **My CHIFA presentation in Santiago meeting was very useful for our Spanish speaking colleagues. They were very interested if they would talk about main social pediatrics issues together. They asked when Spanish version would be available. Some of them also interested with searchable discussion platform and mentioned it would be very effective for their work.**
- **I really thank to Raul, for organizing this great program, being key person for connection with our Latin American colleagues and giving a place for CHIFA. We learnt so many things related Social Pediatrics from our Latin Colleagues. As our President Dr. Nick Spencer says 'We are looking forward to future work together with ALAPE'.**

2.3. Report from BACCH conference by Caoimhe McKenna

In September the British Association of Community Child Health held their Annual Scientific meeting. I had the opportunity to present the results of a survey undertaken with paediatricians working in North London. The survey asked 43 doctors to reflect on their experience of the social determinants of health (SDH) and social risk factors in clinical practice. Our findings suggested that paediatricians recognised the importance of social risk factors (e.g. poverty, poor quality housing, and food insecurity) in child health but most did not feel confident addressing these issues. Respondents called for more training, greater awareness of the local services available to support families, political engagement and an increase in social care resources. Social risk factors often feel beyond the scope and expertise of the clinician but there are several achievable things which we can do to address the SDH. Locally, we can start by routinely asking parents about social risk factors, recording these experiences and discussing with colleagues is an important first step. We should also aim to increase the profile of SDH in training and reinforce the doctor's responsibility to address these issues. A simple and useful intervention is to have a list of local services which support families in all clinical areas (e.g. Citizen's Advice Bureau, food banks, children's centres and charities which provide free housing, debt or legal advice). Nationally, we must advocate for our patients. Political advocacy can include discussing concerns with your local MP or providing evidence to the Health Select Committee. We can also contribute to research which aims to better understand the relationship between social risk factors and child ill-health, or to design evidence based interventions. Finally, as doctors we are in the privileged position of having a voice which is generally considered credible and listened to. We can use this voice simply by talking with colleagues or on a wider platform, for example writing articles, blog posts and participating in social media. It can also be more effective to work with organisations, such an ISSOP, who already have a lot of experience advocating for children. At present paediatricians are downstream of the problem, attempting to pluck children out of the water after ill-health has already occurred. We must move upstream, address 'the causes of the causes', and stop children from falling in.

3. International Organisations

3.1. Prevention of child mortality and human rights: an unfinished agenda by Andrew Clarke

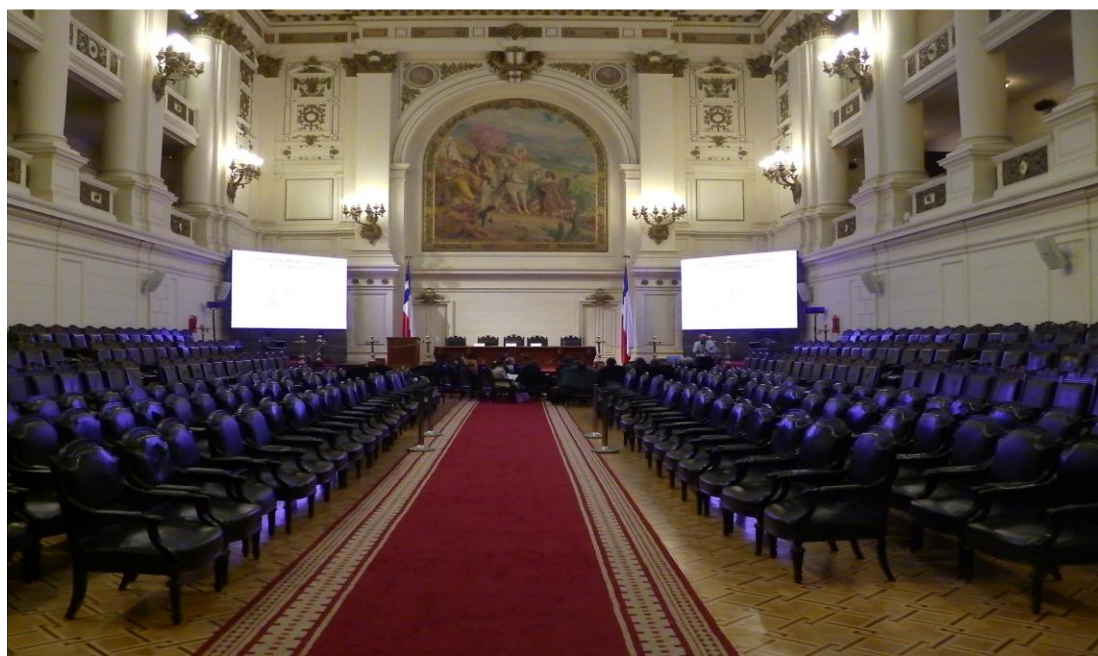
Two years ago the technical guidance on a human rights-based approach to eliminating child mortality was presented to the United Nations Human Rights Council (UNHRC). A follow-up report highlighted specific areas requiring greater focus, including the newborn child, quality of care in health services and the impact on children of attacks on health facilities in conflict areas.

On 26th September in Geneva, a meeting of the UNHRC was held, titled 'Prevention of child mortality and human rights: an unfinished agenda' attended by diplomats and representatives from many countries. The aim was to inform the UNHRC, providing tangible examples of human rights integration in these specific areas and illustrating the complexities; and to underpin the connection between these and the Global Strategy for Women, Children and Adolescent's Health and the High Level Working Group on Health and Human Rights.

It was moderated by Kate Gilmore, the Deputy High Commissioner for Human Rights, supported by Patricia O'Brian, Ambassador of Ireland to the UN. There were speakers from Zanzibar, Syria, MSF, and Physicians for Human Rights, as well as myself; with final remarks from Dainius Puras, Special Rapporteur on the Right to Health. I had the opportunity to share experiences and findings from integrating rights-based approaches within public health programmes for improving maternal and newborn health, and also in the practical delivery of child health services, citing examples from Nepal, Chile, Uganda and others.

The current crisis in Syria dominated the discussion that followed, but the speakers were well received and there was recognition that human rights based approaches have a powerful role to play in improving health and quality of care.

Former Congress of Chile, historic building where the ISSOP Conference was held



3.2. International Pediatric Association (IPA): Petition

As health care providers, we believe that all children deserve hope in a safe environment. The petition asks governments to:

a) The UN convention on the Rights of the Child, which all countries of the world have signed, must be fully implemented everywhere, especially in conflict zones.

b) We call upon the UN Secretary General to take the strongest action possible for protecting children and families in conflict zones and for ensuring that the at-risk families and children of Aleppo be evacuated to save them from becoming innocent victims of war. We call upon the UN to fully enforce the laws protecting civilians, women and children and health care workers in such settings.

c) We urge the UN agencies and global community to recognise the risk of a lost generation in the war zones of the world, especially Syria and Iraq, and in addition to the immediate measures listed above, to ensure that adequate facilities and support for mental health and long-term psychosocial support are provided to all families at-risk.

d) We condemn the deliberate targeting of hospitals and health-care workers in these settings; these must be absolutely protected by all warring factions and depoliticised.

The final petition will include name, degree, city and state only and may be shared with the press. Other information provided is only for validation purposes, feedback and will not be shared. If you wish to stay engaged on this issue as part of an ad hoc group, please contact separately. Those that sign this petition express voluntarily and publicly their individual opinion and take full responsibility of their opinion. The petition will be delivered within the next 30 days to recipients indicated below. After signing please consider sharing this petition with other colleagues that you know personally.

http://ipa-world.org/ipa-petition.php

Reference: Children of war: urgent action is needed to save a generation. Bhutta ZA, Keenan WJ, Bennett S. Lancet. 2016 Sep 24;388(10051):1275-6. doi: 10.1016/S0140-6736(16)31577-X. Epub 2016 Sep 6.
www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(16)31577-X.pdf

Petition will be sent to
Permanent members of the United Nations Security Council;
Permanent Representative of the to the United Nations (non-permanent members of the Security Council and/or members of the International Syria Support Group) : Angola, Australia, Canada, Egypt, Germany, Iran, Iraq, Italy, Japan, Jordan, Lebanon, The Netherlands, New Zealand, Oman, Qatar, Russia, Saudi Arabia, Spain, Turkey, the United Arab Emirates, Ukraine, Uruguay, Venezuela and the United Nations Secretary General

French cartoonists and the burkini ban

And now a bit of light relief: the BBC has circulated a bunch of cartoons in French papers on the Burkini ban and I especially liked this one which focuses on two angles to intolerance:

5. CHIFA News

5.1. ISSOP-CHIFA Webinar

Vaccination and Child Rights coming up on the 14th of October at 13:00 GMT. This is organised by the CHIFA Working Group in association with the International Society for Social Pediatrics and Child Health (ISSOP).

LINK TO ACCESS THE WEBINAR: flacso.adobeconnect.com/chifa

Speakers: Gonca Yilmaz, Rita Nathawad

Moderator: Tony Waterston

Duration: 45 mins (talk 30 mins, discussion 15 mins)

Theme: The webinar will cover the application of the UN Convention to child vaccination. Anti-vaccine movements focus on the decision of parents not to vaccinate their children. This decision can harm other children and increases the risk of outbreaks. In this webinar, we will address the child rights approach to protecting children's health.

Gonca Yilmaz is a member of the executive committee of the European Society for Social Paediatrics and Child Health. She is a social pediatrician in a training hospital in Ankara, Turkey, and has a postgraduate degree in social pediatrics. Her interests include child rights, child abuse and neglect management, well child baby care, and infant nutrition.

Rita Nathawad is a pediatrician in the Division of Community and Societal Pediatrics at the University of Florida, College of Medicine in Jacksonville, Florida, United States. She is board certified in both pediatrics and in pediatric infectious disease. She is also in the final year of a Master's Program in Global Health Policy through the London School of Hygiene and Tropical Medicine. Her research interests include child rights, health care transition and youth participation in vaccine decision making.

Tony Waterston is a retired consultant paediatrician who worked mainly in the community in Newcastle upon Tyne, UK. He spent 6 years working in Zambia and Zimbabwe and directed the Royal College of Paediatrics and Child Health Diploma in Palestinian Child Health teaching programme in the occupied Palestinian territories. He was an Editor of the Journal of Tropical Pediatrics and is on the Executive Committee of the International Society for Social Pediatrics. His academic interests are child poverty, advocacy for child health and children's rights.

6. Publications

6.1 Injury prevention saves lives: report from WHO

WORLD'S EXPERTS GATHER TO EXCHANGE KNOWLEDGE AND PRACTICE ON PREVENTING AND INJURIES AND SAVING LIVES

18 SEPTEMBER 2016 | Tampere, Finland - Every day violence and injuries take the lives of more than 14 000 people. Experts gathered for Safety 2016, the 12th World Conference on Injury Prevention and Safety Promotion, are sharing the latest evidence and experiences from prevention programmes which have demonstrated dramatic success in saving lives.

Injuries caused by violence, road traffic crashes, falls, drowning, burns and poisoning, among others, kill more than 5 million people every year, accounting for 9% of the world's deaths. These and other injury-related causes are among the many addressed by Safety 2016 under the theme "From research to implementation".

Globally, of injury-related deaths, 24% are due to road traffic crashes; 16% from suicide; 14% from falls; 10% from homicide; and 7% from drowning. Around 2% of injury-related deaths result from war and conflict.

Violence and injuries affect all age groups, but have a particular impact on young people and those in their prime working years. For people 15-29 years of age, three injury-related causes are among the top five causes of death: road traffic injuries (1st), suicide (2nd) and homicide (4th).

Beyond deaths tens of millions of people suffer injuries that lead to hospitalization, emergency department visits, and treatment by general practitioners. Many are left with temporary or permanent disabilities; violence and injuries are responsible for an estimated 6% of all years lived with disability.

"We need to step up action to avoid this unnecessary suffering of millions of families every year," notes Dr Etienne Krug, Director of the WHO Department for the Management of Noncommunicable Diseases, Disability, Violence and Injury Prevention. "Safety 2016 provides an opportunity for the world's leading violence and injury prevention researchers, practitioners and advocates to discuss and share successful strategies which if scaled up across countries could do much to prevent violence and injuries and save lives."

Preventing violence and injuries will further attainment of the United Nations' Sustainable Development Goals (SDGs) through which world leaders have recognized injuries as urgent priorities for action. A number of SDG targets relate specifically to violence and injuries, including targets 3.6 to cut road traffic deaths by 50% by 2020; target 5.2 to end violence against women and girls; target 11.2 to provide safe and sustainable transport; and target 16.2 to end violence against children.

Effective strategies to prevent violence and injuries include setting and enforcing laws on a range of issues from speeding and smoke detectors to hot water tap temperatures and window guards, among others; reducing the availability and harmful use of alcohol; limiting access to firearms, knives, pesticides and certain medications; implementing vehicle and safety equipment standards; installing barriers controlling access to water, including wells and swimming pools; and improving emergency trauma care. These are all strategies where both national and local government officials from across multiple sectors can play a role.

RELATED LINKS:

http://www.who.int/violence_injury_prevention/en/
https://www.thl.fi/en/web/injury-prevention/safety-2016
http://apps.who.int/iris/bitstream/10665/149798/1/9789241508018_eng.pdf?ua=1&ua=1&ua=1

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7. Correspondence

7.1 Letter from Nick Cunningham to the Editor of Johns Hopkins

John Hopkins Magazine, 19 September, 2016
Johns Hopkins University, 3910 Keswick Road, Suite N 2600, Baltimore, MD 21211

To the Editor,

Greg Rienzi's perceptive review, A Global Rx, (J.H. Magazine, fall 2016) of Randall M. Packard's excellent 2016 tome, A History of Global Health, cites two initiatives discussed by Packard, "that global health might want to emulate".

The first is Paul Farmer's Partners in Health; the second is the Aroles' Jamkhed Comprehensive Rural Health Project. Rienzi implies that one reason they might deserve emulation is their sustainability, "though Partners in Health is perhaps not a model that is applicable everywhere because it requires a lot of resources"...

"Jamkhed", which was inspired by what Drs. Raj & Mabelle Arole learned from Carl Taylor while at Hopkins, is a primary care system fitted to meet the needs of poor people in rural Maharashtra State: community based, low cost, basic curative and preventive care, delivered not by doctors but by paraprofessionals comfortable living and working away from hospitals and specialty clinics.

The 1978 "Alma Ata" World Primary Health Care Conference, largely designed by Carl Taylor and WHO Director General Halfdan Mahler, envisioned such care for *everyone,* but especially for those lacking any care: "rural and remote populations, slum dwellers and nomads".

Packard explains how Alma Ata failed for many reasons but most importantly:
- Because it was seen as visionary: too ambitious, too expensive & too slow and,
-Because "Lack of statistical evidence limited the ability of programs to convince donors that primary health care was more cost effective than selective interventions."

These assessments need to be re examined. Global malaria eradication was overall a protracted high cost failure. Small pox eradication succeeded but its impact on mortality was negligible.

Carl Taylor questioned the cost benefit of a polio eradication campaign as against building primary care systems, while Packard (47 years after Alma Ata!), and quotes WHO Director General Chan, in response to news of a potentially effective Ebola vaccine: "there is no replacement for very strong and good, resilient health systems with the capability for surveillance."

Packard references Johns Hopkins Professor Richard Morrow's elegant model illustrating the relatively low costs of primary care for the many as against expensive tertiary care for the few. More specifically, as a doctoral student at Johns Hopkins, I was able to show that the annual cost of the "Under Fives Clinic" (the primary MCH

care system created in 1955 by David Morley & Margaret Woodland in rural Nigeria) was $4.43 per child in 1967 dollars, yet after eleven years it had achieved>90% immunization coverage, eliminated malnutrition and cut 0-5 deaths in half.

Why these remarkable results have been so neglected puzzles me; this deficit is one of the few to be found in A History of Global Health, but is important as the debate re the benefits of disease specific interventions versus the building of sustainable primary care for all, becomes ever more relevant! (It is probably no accident that the two leading spokespersons for these contrasting global health strategies, Carl Taylor and D. A Henderson should have found themselves confronting each other at the JHU School of Hygiene!

Packard describes the dichotomy as follows: ..."two distinct visions of global health - one focused on the rapid deployment of cost-effective interventions from above; the other on building a broad base of health services from below that addresses community needs as well as the social determinants of health."

And of course we now know that among these social determinants of health, women's education is probably the most powerful, and should therefore be incorporated into any primary care system.

Respectfully,

Nicholas Cunningham MD (JHU '55), Dr. P.H. (JHU '77)
Emeritus Professor of Clinical Pediatrics & Public Health
Columbia University

7.2 Letter from HIFA on health partnerships by Neil Pakenham Walsh

Dear HIFA colleagues,

Below is the full description on "What are health partnerships?" from the THET website (http://www.thet.org/our-work/what-we-do):

What are health partnerships?

Health Partnerships are a model for improving health and health services based on ideas of co-development between actors and institutions from different countries. The partnerships are long-term but not permanent and are based on ideas of reciprocal learning and mutual benefits.

A health partnership is an on-going collaboration between health institutions in high income countries and those in low and middle income countries. By utilising the skills of volunteer health professionals, a partnerships primary aim is to share knowledge and information to train health workers and improve health services. They work to improve healthcare in a broad range of health areas by responding to needs identified

by the developing country partner.

Health Partnerships are a unique model for delivering effective overseas projects that improve healthcare in the communities that need it most. At the heart of our support for partnership work are our Principles of Partnership – eight principles that support health partnerships to improve the quality and effectiveness of what they do.

The page concludes with the following:

'While the primary focus of our work is to bring lasting improvements to healthcare in developing countries, our approach results in mutual benefits for both partners. We believe that international volunteering is a valuable asset to the UK health service and continually work to ensure volunteering achieves recognition of the contribution it is making to the quality of health services overseas and in the UK.'

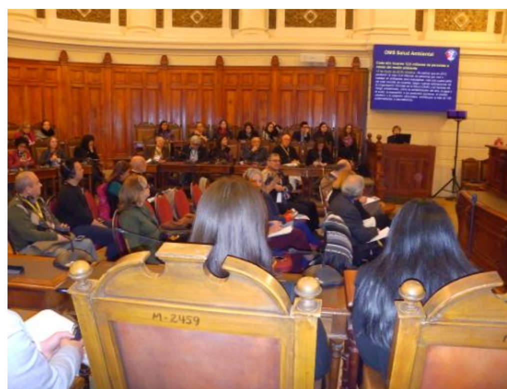
Best wishes,
Neil

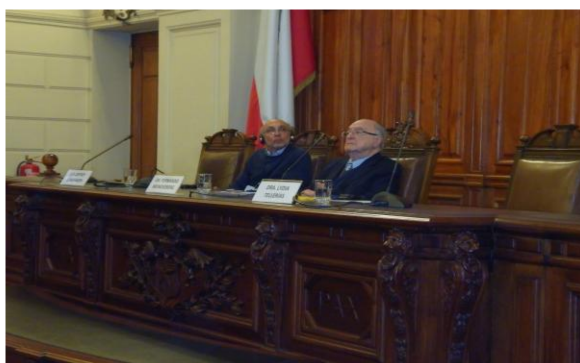
IMAGINE

Unicef has recently launched a campaign to promote a better world for children to live, with no violence, no poverty, no discrimination....just hope.

To see the video, please access to this link: http://vast.am/imagine

Images from Chile….





Thanks!