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## 1. Introduction

The ISSOP annual meeting is upon us but you can still register at [www.nhv.se/issop2014](http://www.nhv.se/issop2014)

We have much to learn from Sweden in how a state should prioritise children and young people and this should be a highly rewarding meeting – and a great chance for ISSOP members to get together. Don't forget when making your travel arrangements that you could win the ISSOP Sustainability prize for the lowest carbon footprint in reaching Goteborg – it is accessible by train from anywhere in Europe.

This month we have released to the media our first ever press statement, on the position paper on sponsorship by the Baby Feeding Industry (see [www.issop.org](http://www.issop.org) and the article on p. 2). The UNICEF press department liked the statement so much that they re-wrote the release for us and it includes endorsements from both UNICEF and WHO/PAHO. Olivier Duperrex writes about the press conference at the World Health Assembly which he attended on May 16<sup>th</sup>. Please let us know if you would like to use the press statement with your own media or national paediatric association.

In Controversy, Nick Spencer covers the new plan to get out oral rehydration to rural African villages by the well known health loving multinational Coca Cola. Is this a bad nightmare or grabbing a great opportunity? Let us know what you think.

The Child Rights training group is making progress and has developed two scenarios with more on the way. These will be reviewed in the next e-bulletin.

And we have two responses to the letter in the last e-bulletin about tackling inequalities in your clinic. More ideas are very welcome.

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## 2. Meetings and News

### 2.1 ISSOP in Sweden

The programme is now out and is available at [www.nhv.se/issop2014](http://www.nhv.se/issop2014).

The theme is measuring health and covers measuring health related quality of life, measuring child abuse, measuring marginalization and equity, and considering child rights in equity. There will be a boat excursion on Monday evening and the ISSOP general assembly will be on Tuesday at 4.30. Final reminder of the dates: Monday June 16<sup>th</sup> to Wed June 18<sup>th</sup> in Gothenburg.

### 2.2 Press release on position statement

The following press release was issued at the session organised by the **International Baby Food Action Network at the World Health Assembly in Geneva on 15<sup>th</sup> May 2014**.



#### **Paediatricians call on baby feeding industry to stop sponsorship of medical education *Conflict of interest is damaging to support of breastfeeding***

GENEVA, 15 May 2014 - An international body of paediatricians and other health care professionals today called on the baby feeding industry, including infant formula manufacturers, to end the sponsorship of medical education.

The International Society for Social Pediatrics and Child Health (ISSOP) says sponsorship damages the health of mothers and infants, and subtly portrays breastfeeding as a fringe practice. In addition, the sponsorship of pediatrician training also results in doctors who are ambivalent toward the practice.

Evidence shows that optimal breastfeeding of children under two years of age could prevent over 800,000 deaths (13 per cent of all deaths) in children under five in the developing world (Lancet 2013). Yet global rates of breastfeeding rates have remained stagnant since 1990, with only 36 per cent of children less than six months exclusively breastfed in 2012.

“The baby food industry knows exactly how to influence medical practice, and it is through sponsorships, whether from funding of paediatric education and training, research, meetings and professional journals, to booklets and leaflets given out at discharge or paediatric clinics,” said Dr. Tony Waterston, of the International Society for Social Pediatrics and Child Health. “The baby food industry shows complete disregard for the International Code of Marketing of Breastmilk Substitutes.”

In a public statement issued in April, ISSOP explains how the baby feeding industry’s lack of compliance with the Code benefits companies: “Sponsorship by its nature creates a conflict of interest. Whether it takes the form of gift items, meals, or help with conference expenses, it creates a sense of obligation and a need to reciprocate in some way. The ‘gift relationship’ thus influences our attitude to the company and its products and leads to an unconscious unwillingness to think or speak ill of them.”



Two United Nations organizations also welcome the call as a necessary measure if mothers and their families are to choose mother's milk as the best food for their babies.

"Globally breastfeeding promotes child survival, health and development," said Dr. Chessa Lutter, senior advisor, Pan American Health Organization/World Health Organization. "Pediatricians have an ethical and moral responsibility to help and support mothers to breastfeed and avoid any actual or perceived conflict of interest."

UNICEF is concerned that globally roughly two out of five infants less than six months of age are exclusively breastfed. And mothers don't breastfeed because of misperceptions about insufficient milk supply, inability to breastfeed, the return to work, and promotion of breastmilk substitutes.

"Medical practitioners and paediatricians in particular play an important role in supporting mothers to initiate and continue breastfeeding as long as possible," said Dr. France Begin, UNICEF senior advisor on nutrition.

"For mothers and families to make an informed choice, they have to be provided with unbiased information, free from commercial influence – we must not let lobbies interfere between a mother and her baby's wellbeing. This is a harmful conflict of interest that has consequences on the lives of millions of children."

The statement recommends that national paediatric societies take these issues seriously and take steps to end all sponsorship by the baby feeding industry, while ensuring that effective and independently funded educational programmes that protect, support and promote breastfeeding are included in all paediatric curricula.

Political commitment is essential to strong, sustainable global and national advocacy for breastfeeding.'

"ISSOP is committed to promoting child health globally and breast feeding promotion is important to that commitment," said Prof Nick Spencer, President of ISSOP. "The interest of the baby feeding Industry is to maximize their profits from the sale of breast milk substitutes."

"Sponsorship from the Industry of paediatric education and conferences inevitably compromises the duty of paediatricians and other child health professionals to promote breast feeding."

**Notes for editors**

The position statement can be accessed in full at

[http://issop.org/index.php?option=com\\_phocadownload&view=category&id=2:essop-position-statements&Itemid=18](http://issop.org/index.php?option=com_phocadownload&view=category&id=2:essop-position-statements&Itemid=18)

ISSOP is the International Society for Social Pediatrics and Child Health and further information is available on its website [www.issop.org](http://www.issop.org)



### Report from Geneva press launch

Olivier Duperrex, ISSOP Treasurer, attended the press conference in Geneva and his report follows.

### ISSOP contributed at IBFAN press conference in Geneva on 16<sup>th</sup> May 2014

Thanks to Tony Waterston's coordination, I was able to join the conference press held by IBFAN for the launch of their disturbing report: ***Breaking the Rules, Stretching the Rules 2014***.

Annelies Allain, Director of the International Code Documentation Centre (IBFAN Penang, Malaysia), and Mike Brady, Company Campaigns and Networking Coordinator, Baby Milk Action, UK presented the shocking evidence of violations of the International Code of Marketing of Breastmilk Substitutes and subsequent resolutions.

### 813 violations in 81 countries by 27 companies

And that is only for the last 3 years: see for yourself the brief report that is accessible online from this page: <http://www.babymilkaction.org/archives/358>. I will just quote Mike Brady: "So this is problem number one. **Company policies produce violations**. These are not mistakes or the actions of rogue employees. These practices are in line with company policies by their own admission. I say they are 'systematic', because they are produced by the company's systems." Until the edited video is available, you can access the draft of his talk here: <http://www.babymilkaction.org/archives/384>

ISSOP position statement was warmly welcomed. Interesting discussions and comments showed that we need to take it further. Paediatricians and child health professionals are naïve to the ability to "resist" to the marketing and the fact that ISSOP is stepping forward on the sponsoring issue is very important to the future of children.

Sadly, only one journalist was in the room... and nothing covered locally ... yet. So take yourself action and disturb your national pediatric association on these matters, but make also sure that what you put in place is not breaching the International Code!

**Regards from Geneva, Olivier Duperrex**

PS: You also might want to check these for further provoking thoughts:

- 10 things the baby-product industry won't tell you - Inside the \$23 billion bringing-up-baby business: <http://www.marketwatch.com/story/10-things-the-baby-product-industry-wont-tell-you-2014-04-11?pagenumber=1>
- Opening the door to Business lobbying – what's wrong with the new WHO policy proposals: <http://www.babymilkaction.org/archives/246>
- And have you heard the phrase 'No such thing as a free lunch'? Check out the website <http://www.nofreelunch.org/aboutus.htm>



### **2.3 Global Advocacy Initiative on Breastfeeding**

UNICEF and WHO, in collaboration with a range of partners, have initiated the development of a global advocacy initiative in order to increase attention, political commitment and investment for breastfeeding within the critical first two years of a child's life. The vision of the advocacy initiative is a world where all mothers and families are empowered, enabled and supported to optimally breastfeed their children, and where early initiation, exclusive breastfeeding for the first 6 months and continued breastfeeding for up to 2 years of age or beyond, together with appropriate complementary foods, becomes the social norm. The initiative aims to accelerate progress to meet or exceed the World Health Assembly target calling for raising the rate of exclusive breastfeeding in the first six months to at least 50% by 2025, to increase the rate of early initiation of breastfeeding as outlined in the Every Newborn Action Plan, and to increase rates of continued breastfeeding.

**France Begin, UNICEF senior adviser on nutrition**

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### **2.4 Child Rights training group**

Thanks to galvanisation by Ayesha Kadir, the group is making good progress and has two scenarios in draft: one on a child's right to breastfeeding by Ayesha and Raul Mercer, and a second on informed consent by GoncaYilmaz, Rita Nathawad and Rosie Kyeramateng. The group will be discussing with the web team in Florida about incorporating these in the social and community paediatrics course and adding further scenarios. More on this in the next e-bulletin.

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## **3. International Organisations**

### **3.1 Social Pediatrics Chapter of the Peruvian Society of Pediatrics**

The Peruvian Society of Pediatrics has been for 83 years a scientific reference on issues related to health in childhood and adolescence. The society has thirteen chapters including the Social Pediatrics, one of the youngest within the Society. Our chapter became a new member of the Social Pediatrics and Child Rights Committee of the Latin American Association of Pediatrics (ALAPE) ([www.alape.org](http://www.alape.org)). This Committee advocates for Social Pediatrics and Child Rights in Latin American Region. Its next goal is the creation of Social Pediatrics interested groups in each country member in Latin America.

Peru is a multiethnic, multilingual and multinational country, with thirty million inhabitants of which 34 % are children and adolescents. In recent years Peru has been developing a set of multisectoral strategies that have improved the health indicators of children that have achieved the MDGs. However, they still face major challenges, such as reducing the existing gap in child health indicators in different regions of the country, continuing to reduce malnutrition and anemia, preventing overweight, obesity, teen pregnancy and disabilities, and reducing neonatal mortality.





Chapter activities include monthly meetings with the presentation of national priority issues in the pediatric agenda (with the participation of officials from the Ministry of Health, representatives of civil society, international cooperation agencies, pediatricians and health professionals interested in these issues . It also participates in national meetings and in policy-making spaces where decisions are made regarding child and adolescent health. .

At the end of 2013 "Early Childhood Development", was established as a priority national agenda. This year, at the annual meeting of the Social Pediatrics Chapter of the Peruvian Society of Pediatrics, the Chapter prioritized "Teen Pregnancy as a public health and human rights issue". The meeting highlighted the role of the pediatrician in the prevention and care of pregnant adolescents and their sons/daughters. This was coincident with the formulation of the "Multisectoral Plan for the Prevention of Teen Pregnancy in Peru".

The Chapter has also organized decentralized meetings in coastal regions (La Libertad), mountains (Cusco) and forest (Ucayali) debating priority health issues that affects children. Some of the topics addressed were: violence against children and adolescents, chronic malnutrition and adolescent pregnancy. For these meetings, representatives of different sectors from the government were invited to participate: health, education, justice, women and vulnerable populations, development and social inclusion, and defence. Members of the civil society were also part of this process (cooperation agencies, NGOs, professional associations and academia).

The Chapter of Social Pediatrics must assume a leading role advocating for the health of children and adolescents due to the increasing influence of social and environmental factors on the health-disease process and the need to address these issues with an intersectoral and rights based approaches.

The Chapter aims are to consolidate its presence as a valid point of reference, providing technical assistance at the national and regional decisions levels dealing with health of childhood and adolescence.

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## 4. Current controversy

### 4.1 Cola life

#### The ColaLife Trial and the ethics of initiatives linked to Coke and other multinationals

Initial findings from a trial of ORS & Zinc for childhood diarrhoea in 2 remote rural trial areas in Zambia were posted on the CHILD2015 e-forum. The trial arises as a result of an initiative by a British couple, Simon and Jane Berry, who identified that, though ORS is free in clinics in Zambia, supply chain problems meant that it was frequently out of stock in the remote rural clinics (see more details in a New York Times blog

[http://opinionator.blogs.nytimes.com/2013/07/03/making-medicine-as-easy-to-get-as-a-can-of-coke/?\\_php=true&\\_type=blogs&r=0](http://opinionator.blogs.nytimes.com/2013/07/03/making-medicine-as-easy-to-get-as-a-can-of-coke/?_php=true&_type=blogs&r=0)).



They saw an opportunity to utilise Coca-Cola's huge distribution network to get ensure regular supplies of ORS/Zn in remote areas. Early results from the trial suggest improvement in the level of ORS/Zn availability and use although there have been problems arising from the transition from free ORS to a product, in the form of a kit containing ORS sachets, Zn tablets and a bar of soap plus simple illustrated instructions, costing around one dollar. To stimulate initial demand free vouchers were distributed; however, when these expired, sales dropped by 60%.

ColaLife raises some challenging issues. Clearly it is good to ensure that children in remote areas have access to regular supplies of ORS/Zn; however, the link to Coke is an ethical minefield. While Coke could legitimately claim that they did not initiate the link, they undoubtedly benefit from the association by the word association in the ColaLife name (I initially assumed it was funded by Coke because of the name), the appearance of their logo on the material related to the trial posted on the web and the use of their distribution networks to deliver the kits. Unwittingly or not, ColaLife lends legitimacy to a company marketing a noxious mixture from which they make obscene profits while stoking up obesity and diabetes epidemics. Although superficially different from the ethical issues raised by sponsorship of medical conferences/education by pharmaceutical and Baby Food companies (see ISSOP Position Statement on Baby Food Industry sponsorship at [www.issop.org](http://www.issop.org)), the essential features are similar in that products which are detrimental to child (and adult) health are promoted.

Aside from the ethical dangers of promoting unhealthy products, linking public health initiatives to companies such as Coke is seriously problematic in other ways. I have not been able to find evidence in a web search of tax avoidance by Coke in Zambia or other African countries but in the U.S., Vietnam, Mexico, The Philippines and Greece the company is under scrutiny and facing charges of massive tax avoidance and tax evasion. A report in September 2012 by US Senator Carl Levin

(<http://www.levin.senate.gov/newsroom/press/release/subcommittee-hearing-to-examine-billions-of-dollars-in-us-tax-avoidance-by-multinational-corporations/>) ranked Coca-Cola eleventh in tax avoidance among U.S. multinational companies stashing \$13.9 billion in cash in offshore accounts. If, as I suspect, they pay next to no tax in Zambia on their commercial ventures, they help ensure that the Zambian government doesn't have the resources to properly fund preventive strategies, such as the efficient distribution of ORS/Zn, and the more fundamental public health measures such as infrastructure for water and sanitation to protect children against diarrhoea.

It is emblematic of the unequal power relations between governments and huge multinationals like Coke, particularly in low income countries but also in the US itself, that, whereas the Zambian government cannot ensure the supply of simple medicines to its clinics in remote areas, Coke have the resources to make sure their poison finds its way into the mouths of children in the remotest areas. The relative weakness of governments in comparison with big multinationals suggests that there is no alternative to linking with these companies in order to promote child and adult health in low income





countries. This is a false assumption. There are many examples of low income countries and States, such as Bangladesh, Sri Lanka, Cuba and Kerala State in India, which, with political will, have successfully initiated government funded programmes promoting child and adult health.

In the absence of political will, market-based initiatives such as ColaLife fill a vacuum and provide much needed medication to a small number of the millions of children in countries such as Zambia who are vulnerable to diarrhoea; however, the costs of unwittingly promoting the image of Coke as well as the problems associated with charging for medication as shown by the fall in sales of their kit are likely in the long run to be detrimental to the health of children in low income countries. The major task in low income countries is to overcome the fundamental problems of poverty and infrastructure which blight the lives of millions of children. Coke, along with other multinationals are in business to sell their products not to promote the health of children. It is essential to remember as Ray Rogers of the Corporate Campaign in New York City points out “Coke’s millions in philanthropy pales in contrast to billions of dollars in tax avoidance and evasion.”

**Nick Spencer 17/05/2014**

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### **Corporate Social Responsibility Movement**

By Editor Filed in News April 22nd, 2014 @ 11:20 am

**Coca-Cola is co-opting the corporate social responsibility movement.**

That’s according to Ray Rogers of the Corporate Campaign in New York City.

In an open letter to the Calvert Group and the Interfaith Center on Corporate Responsibility (ICCR), Rogers challenges the groups’ designation of Coca-Cola as “socially responsible,” with detailed documentation of Coca-Cola’s human rights, child welfare, and environmental abuses spanning decades.

“For too long, the evidence has been drowned out by the vast marketing power of Coca-Cola,” Rogers said.

Coke is accused of quashing independent investigations into allegations of the company’s complicity in labor and human rights abuses featured in the award winning documentary, “The Coca-Cola Case” produced by the National Film Board of Canada.

Coca-Cola is also accused of a long history of brutality against union leaders in Guatemala, dating back to 1976, documented in “Soft Drink Hard Labour” published by the Latin America Bureau in 1987 which describes the murder and disappearance of 12 Coke union leaders and activists.

The overwhelming legal obstacles to obtaining justice in Colombia and Guatemala are documented by Human Rights Watch among others.

“Unfortunately, the systems of justice in Colombia and Guatemala are highly compromised, and trade unionists and other families of murder victims rarely see justice,” said human rights attorney and advocate, Terry Collingsworth. “Many can wait decades for their day in court, if they get there at all. And the violence continues.”





“The scofflaw Coca-Cola Company is out of control and even its biggest cheerleaders and stockholders, Warren Buffett and Bill and Melinda Gates, can’t hide the damage their company is doing on a worldwide scale,” Rogers said.

“Coca-Cola claims that it won’t and doesn’t market to children 12 and under, yet it continues to aggressively market its sugar and chemical-laden products to children worldwide, which are known to fuel the childhood obesity, diabetes and high blood pressure epidemics,” Rogers said.

In Mexico, which ranks at the top among countries with the highest childhood obesity and diabetes rates in the world, Coke uses children dressed as superheroes including Batman, Wonder Woman and Superman to hawk its products on TV.

Coca-Cola recently announced plans to invest another billion dollars primarily in worldwide soda advertising, further targeting millions of children. In September 2012, U.S. Senator Carl Levin issued a report that ranked Coca-Cola number eleven in tax avoidance among U.S. multinational companies stashing \$13.9 billion in cash in offshore accounts. Levin said,

“Coke’s millions in philanthropy pales in contrast to billions of dollars in tax avoidance and evasion,” Rogers said.. “Coca-Cola and its defenders boast about Coca-Cola’s charitable giving while the company, in countries like the U.S., Vietnam, Mexico, The Philippines and Greece, is under scrutiny and facing charges of massive tax avoidance and tax evasion.”

“Corporate money in the NGO world can be as undermining and compromising as corporate money in politics,” Rogers explains.

The report details how NGO’s like the American Academy of Pediatrics, Oxfam America, Save the Children and the World Wildlife Fund help the company promote an undeserved image of respectability, which helps shield Coca-Cola from accountability.

The report’s key theme critiques the metrics systems and reporting procedures that are supposed to shed light on a company’s adherence to social responsibility.

“Anyone who actually believes that these metrics systems, as they operate today, from the UN Global Compact to the Global Reporting Initiative, are anything but vehicles for companies like Coca-Cola to cover up their abuses and escape real accountability, probably believe in the tooth fairy” Rogers said.

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**Following Nick Spencer’s posting of the above message on CHILD2015, a reply was sent by Jane Berry who initiated Cola Life. We felt it important to include this message since Jane responds to a number of Nick’s points.**

I would like to respond to the comments made by Professor Nick Spencer about Cola Life.

We are rather surprised that he did not contact us for basic fact-checking and insights and also at his use of such emotive language. Sarika Bansal’s article, which he cites, is one of the better-researched pieces about our work. She makes it very clear that there is no direct distribution link between the award-winning kit we designed, Kit Yamoyo, and Coca-Cola.



But that aside, this is an interesting debate, and unsurprisingly one that has played out before in many fora.

As Professor Spencer acknowledges, the ColaLife trial in Zambia was not funded by Coca-Cola, and the charity is entirely independent. The juxtaposed name is designed to provoke debate.

And it does.

However, nothing in Kit Yamoyo, relates to Coca-Cola, or in fact, to ColaLife. In-country we suppress our brand. We take no profit. We aimed from the outset to embed any successful design, IP and branding into the local private sector, to help support jobs, livelihoods, and long term sustainability.

Testing of private sector approaches is of high interest on the global health agenda. It is recognized in the literature on ORSZ that supply via the public sector alone has not succeeded in any country (eg see Fischer-Walker C, Fontaine O, Young M, Black RE. Zinc and low osmolarity ORS for diarrhoea: a renewed call to action. Bulletin of the World Health Organization, 2009; (87):780-786). Both WHO and UNICEF call for 'market-based' solutions (eg see: Diarrhoea: Why Children are still dying and what can be done 2009).

One can find pictures of Kit Yamoyo in Coca-Cola crates on our website, because we genuinely wanted to trial that delivery option – not managed by Coca-Cola in any way, but within the secondary, independent distribution chain – a donkey cart, a bus, or a bicycle.

We don't 'promote' Coca-Cola. Can such tiny organisation affect the world's biggest brand in any meaningful way? In fact, as some have pointed out, quite the opposite has happened: apparently, we have 'hacked' their brand.

We didn't plan it, but that image has won the global audience's attention. It is a visual metaphor that, like our name, begs the question: If you can buy a Coca-Cola in an African village, why can't you buy lifesaving medicines? That debate is useful. It has been addressed by Melinda Gates, and by an invaluable advisor to us since 2009, Professor Prashant Yadav (eg Learning from Coca-Cola, Yadav P, Stapleton O, Van Wassenhove L, Stanford Social Innovation Review, Winter 2013). It's a question that some very helpful people in Coca-Cola helped us to understand. That image, isn't, however, seen by Kit Yamoyo customers.

In one year, 26,000 Kit Yamoyo were distributed – we estimate a child's life was saved for every 333 kits. Use of the decade-old WHO/UNICEF recommendation - ORSZ - went up from under 1% to 45%. Distance to access point for this life-saving therapy was reduced by two thirds. However, delivery in crates proved not to be a key enabler – a finding we have shared openly. So, in Zambian villages virtually no-one has ever seen (or will see) Kit Yamoyo in a cola crate. In fact, we are changing and localizing the packaging, to bring down costs, while maintaining the promising customer benefits. The trial has taken us to an entirely different solution to the one we expected. And that solution has been demonstrated to work in a highly rigorous trial. The findings will be published later this year, as Ramchandani et al.



Given those facts, perhaps Professor Spencer might revisit his conclusion, that copying Coca-Cola's successful techniques and thinking, and applying those to a new product, to give people an affordable, private sector choice close to home, to save their child's life is 'likely in the long run to be detrimental to the health of children in low income countries'.

Village children in Africa don't get to drink Coca-Cola very often – let alone get 'poisoned' by it. It's a luxury – a treat enjoyed by adults. And far from suffering from obesity or diabetes brought on by fizzy drinks, 46% of children in Zambia are stunted (up to 70% in some places.) On the other hand, around 30 children a day in the developing world die of diarrhoea.

So, yes, parents in Zambia are willing to pay, and the people they are paying are shop-keepers in their own village, and a manufacturer in their own capital city. Since the voucher scheme ended, over 17,000 kits have been sold.

Independent Willingness to Pay studies show that about a third of people in rural areas of Zambia, when newly introduced to Kit Yamoyo, will pay 5 Kwacha (~\$1). Once they are familiar with the product (through the trial) we found double that amount of people willing to pay. Many are poor, and they have to make hard decisions: about whether to walk 10 km in the sun with a sick child to a health centre that may be stocked out. Or catch a lift, at a cost of 15 to 20 Kwacha (~\$3-4). Or spend 5 Kwacha on Kit Yamoyo in their village. They might choose to spend a similar amount on 5 eggs, or a bar of soap, or a beer, or two games of pool in the village centre. Or a bottle of coke – or one of the many cheaper substitutes you can now get all over Africa. But those choices are theirs to make.

It is true that corporates do all they can to maximize profits and many try to avoid paying tax. IBM, for example, is actually worse than Coca-Cola, as this graphic shows <http://www.bloomberg.com/infographics/2014-03-12/offshore-profits-avoid-irs-reach.html>

Co-incidentally, our home is near Warwick University, so we know that it too receives a lot of corporate money, (including in the past from IBM), and has been criticized for so doing. We point this out to illustrate that corporates are an unavoidable part of our world; there are some things they do well and times when their help can be useful. Indeed, Professor Spencer's comment on corporate support for health in developing countries could equally apply to education in the UK: 'the relative weakness of governments in comparison with big multinationals suggests that there is no alternative to linking with these companies ...'. A point acknowledged by Warwick's former Chancellor, Sir Nicholas Scheele: "As government funding changes, the replacement could well come through private funding from companies, individuals and grant-giving agencies." So, actually, we find ourselves in the same boat.

Professor Spencer is right, too, that in Zambia, tax avoidance is a problem. It isn't purveyors of fizzy drinks, but the mining industry that is most worthy of attention: for tax avoidance, pollution and creation of really 'noxious' substances and 'poisons', not to mention 'obscene profits'. Indian and Chinese companies are among the worst offenders. Here are just two examples:

<http://www.zambian-economist.com/2014/05/zambia-is-mocked-by-vedanta.html>  
<http://www.zambian-economist.com/2014/05/when-mining-companies-prevail.html#more>



Neither myself nor my husband have any qualification in health, logistics or ethics. But we have been very generously helped by some of the best experts in the world – across academia, the private sector, government, and, most importantly, by Zambian mothers and carers themselves. They told us what would help. We've provided a solution. Small village shop-keepers are making a profit. And customers are buying it. Is that going to harm children in the long run? We'll have to wait and see.

Yours sincerely,  
Jane Berry

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The correspondence on this topic continues on CHILD2015, please check in to find a variety of views. You may also write in to the e-bulletin with your own perspective.

## 5. CHILD2015 Report

There are three developments to report in relation to CHILD2015.

- First a name change: since 2015 is nearly on us, it cannot remain an end-point for child health information and our parent group HIFA2015 (Health Information for All) is to become simply HIFA. We cannot do the same as CHILD alone is not meaningful, so have agreed to morph into CHIFA. This change will come about in the near future.
- Secondly, owing to an initiative lead by Raul Mercer (on behalf of ALAPE [www.alape.org](http://www.alape.org)) plans are underway to develop a CHIFA Spanish version to meet the information needs of South and Central American child health professionals, as well as those in Spain itself. Many thanks to Raul for this exciting development.
- Thirdly, a webinar will be held during the ISSOP meeting on local strategies to tackle child abuse and neglect. The provisional time for this will be between 1130 and 1230 Swedish time on Tuesday June 17<sup>th</sup>. More details to come on CHIFA and do please keep up the contributions and inform your colleagues about joining.

## 6. Recent publications

The Lancet published 2 important papers on trends in neonatal, infant and U5 and maternal mortality from 1990-2013 as part of a series on the Global Burden of Disease Study.

### **On U5M they conclude:**

*“Only 27 developing countries are expected to achieve MDG 4. Decreases since 2000 in under-5 mortality rates are accelerating in many developing countries, especially in sub-Saharan Africa. The Millennium Declaration and increased development assistance for health might have been a factor in faster decreases in some developing countries. Without further accelerated progress, many countries in west and central Africa will still have high levels of under-5 mortality in 2030.”*



They note an increase in the proportion of U5 deaths due to neonatal mortality from 37.4% in 1990 to 41.6% in 2013.

**On Maternal Mortality they conclude:**

*“Global rates of change suggest that only 16 countries will achieve the MDG 5 target by 2015. Accelerated reductions since the Millennium Declaration in 2000 coincide with increased development assistance for maternal, newborn, and child health. Setting of targets and associated interventions for after 2015 will need careful consideration of regions that are making slow progress, such as west and central Africa.”*

They draw attention to the huge gap in maternal mortality rates globally with an MMR/100,000 live births of 956.8 (685.1–1262.8) in South Sudan compared with 2.4 (1.6–3.6) in Iceland.

**Full titles:**

Wang et al. Global, regional, and national levels of neonatal, infant, and under-5 mortality during 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013. *Lancet* May 2<sup>nd</sup> 2014 [http://dx.doi.org/10.1016/S0140-6736\(14\)60497-9](http://dx.doi.org/10.1016/S0140-6736(14)60497-9) Kassebaum et al. Global, regional, and national levels of maternal mortality during 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013. *Lancet* May 2<sup>nd</sup> 2014 [http://dx.doi.org/10.1016/S0140-6736\(14\)60](http://dx.doi.org/10.1016/S0140-6736(14)60)

*Submitted by NS*

## 7. Correspondence

**Two responses have been received to the letter on tackling inequalities in health which appeared in the March e-bulletin.**

### Response 1: Prof Nick Spencer

Dear Colleague,

You raise an important and challenging question. Many paediatricians feel powerless to influence social determinants of child health because of lack of training and because the solutions are often seen as political rather than medical. In addition, as you point out paediatric training and paediatric associations tend to be quiet on these issues. There are, however, things you can do either at an individual or a national level which contribute to reducing the impact of poverty on the health of children as well as helping to influence policy makers to reduce child poverty.

1. Arm yourself with the data on the impact of poverty on the health of children and its impact into adulthood. From your letter, you are clearly aware of how poverty affects children but if you are to influence others (see below) you need to have good data. I published two briefings for the End Child Poverty Campaign which give chapter and verse on the consequences of poverty for child and later adult health. You can download these at <http://www.endchildpoverty.org.uk/news/publications/child-poverty-and-health---supplementary-chapter-2/26/123>. We also published an ESSOP (ISSOP's predecessor) position statement on child health inequalities in the journal *Child: care, health and development* (doi:10.1111/j.1365-2214.2008.00826.x)



2. Overall, your practice should be guided by a child rights approach based on the UNCR. Poverty tends to lead to violation of all the rights in the Convention. ISSOP published a position statement on child rights in the same journal (doi:10.1111/cch.12118) accompanied by a commentary by Dr Elspeth Webb.
3. In your individual practice you can ensure that you provide a high standard of service to children and their families living in poverty. These families sometimes get a poorer standard of care partly because they may find it difficult to negotiate the system and partly because of prejudice and often unintentional discrimination against them. If you work in clinics outside hospital, try to work in where access for low income families is relatively easy. If you work in a system in which families have to pay for child health services, try to find ways of working in services that low income families can afford.
4. In your individual practice be aware of the costs to low income families, even in free-at-the-time-of-use health systems, of accessing health care. Ask families directly about the costs and look for ways of helping them with these costs (most hospitals have funds for this purpose). Try to avoid giving advice which low income families can't afford or is not sensitive to their needs or beliefs. For example, much nutritional advice fails to take account of what is affordable. The best approach is to try to develop a genuine partnership with families which recognise their skills in relation to their own children and circumstances as well as yours as a clinician. Essentially it is a negotiation between skilled participants.
5. Advocacy at the individual level is important. For example, many low income families live in poor household conditions affected by damp which is likely to either cause or exacerbate respiratory problems. You can work out with the family how you might help to address these problems. Remember - as a paediatrician, you carry much more weight in discussions with landlords or those responsible for housing. Similarly, assisting families with children with disabilities to obtain aids and financial assistance is an important advocacy role.
6. Paediatric training in many countries does not include social determinants and their implications although this is changing notably in the UK and the USA. If you have students or trainee paediatricians joining you in your clinic you should ensure that they understand the impact of poverty on child health. This is where it is important to have the information on the social determinants of child health at your fingertips.
7. Although you are right to point out that many paediatric associations show little interest in the social determinants of child health and the consequences of poverty for the health of children across the life course, there are now some good examples of associations taking these issues seriously. The Academic Pediatric Association jointly with the American Academy of Pediatrics have established a Taskforce on Child Poverty (access at [www.academicpeds.org](http://www.academicpeds.org)) - they state: "*The APA and the AAP have both made reducing childhood poverty in the US and alleviating the effects of poverty on child and well-being a strategic priority*". The Royal College of Paediatrics and Child Health in the UK is also starting to address the issue of child health inequalities both through the curriculum for paediatric training and in a recent workshop for UK paediatricians. If your paediatric association is not active in this area, you might use these examples to try to change their approach. Advocacy at national and international levels is best done by paediatric associations and you may consider contributing to advocacy which is taking place in your country. There are also non-medical NGOs advocating on child poverty such as Save the Children.



Apologies for this lengthy response but you have touched on an issue which is central to social paediatrics and a particular interest of mine. As paediatricians, we shouldn't shy away from confronting difficult political issues that have a direct impact on children's survival, health and well-being. Remember that some of the pioneers of paediatrics, such as Jacobi, were committed advocacy on behalf of children.

**Nick Spencer,  
President of ISSOP and retired Consultant Community Paediatrician**

**Response 2: Prof Mitch Blair**

I saw a child with a complex disability living in seriously poor social circumstances. His mother had begged on the street to get sufficient money to pay for transport to come and see me. When I told this tale to a group of primary care doctors, there were some very worrying narratives of cancer patients unable to get to specialist tertiary units because of distance and cost thus perpetuating health inequalities. Politicians need to hear such incidents. Let's use our collective experiences to gather the evidence of day to day consequences of child poverty.

**Mitch Blair**

**Bring back our girls!**



**President of Chile, Michelle Bachelet, with her cabinet members, calling for freedom of the Nigerian girls. On the right, Dr. Helia Molina, Health Minister and Social Paediatrician. Santiago, Chile, May 2014.**