1. Introduction

Welcome to the final e-bulletin of 2015 which comes at a time of international crisis over war, refugees and climate change. A time for the world to stand together for common values and for paediatricians to speak out for the needs of children who are the ones to suffer first and the most from all these three crises. We feature an analysis of SDGs by Nick Spencer, a roundup of interesting South American meetings and useful suggestions on tackling child health disparities, together with our usual reports and updates. We have just received some exciting news from Gulbin Gokcay in Turkey that the Turkish Society for Social Pediatrics has endorsed the ISSOP position statement on sponsorship of paediatricians by the baby food industry, and the statement in English and Turkish has been placed on their website. Congratulations to Gulbin and her colleagues! And on the same topic, the position statement has been accepted for publication in Child: health, care and development. More on this when we hear the publication date. All best wishes for the Christmas season and New Year!

Tony Waterston and Raul Mercer
2. Meetings and news

2.1 Universal Health Coverage day

Universal Health Coverage Day is just one month away! It’s time to build the drumbeat that will make this 12 December even more memorable and impactful than the last. I hope you are as excited as we are for 12.12.15. Thank you for everything you’re doing to make it a success. Best, Guy Bloembergen <GBloembergen@globalhealthstrategies.com>

Here are three simple things you can do right now to boost the movement:

❖ SHARE the animated graphic (GIF) to tell the world that UHC is right, smart and overdue [https://www.thunderclap.it/projects/35109-uhc-day-2015?locale=en]. To share on Facebook, please copy and paste this link as your status.

❖ FOLLOW us on Twitter and Facebook for UHC Day updates and top-notch content from The latest Tweets from UHC Day (@UHC_Day). On December 12, join a global coalition calling for universal health coverage to be the cornerstone of sustainable development.

❖ TELL us what you’re planning around 12.12.15 by filling out this form [https://docs.google.com/forms/d/1Z4BbBRKFRZPantt_8HBjWR_hLaD0n9pPN8aSusCNnf3k/viewform](https://docs.google.com/forms/d/1Z4BbBRKFRZPantt_8HBjWR_hLaD0n9pPN8aSusCNnf3k/viewform) (for ideas, check out the UHC Day 2015 Starter Toolkit [http://universalhealthcoverageday.org/about/](http://universalhealthcoverageday.org/about/)).

2.2 Seminar on Rights Approach to Health Care for Children and Adolescents (November 5-6, Santiago, Chile)

Child health institutions and health come together in this first international seminar which looked to be a space for reflection and promotion around the Rights of children in the context of health care were given. The event was organized by Luis Calvo Mackenna Hospital at the UCINF (Universidad Ciencias de la Informática) auditorium. The opening day of the seminar was the words of the Executive Secretary of the Council for Children, María Soledad Coca Herrera; the National Director of SENAME, Marcela Labraña Santana and director of the Luis Calvo Mackenna Hospital, Dr. Jorge Lastra who referred to Friendly Hospital Care Model in force in the establishment since 2008 to ensure that it is possible to force change from the institutions.

How to advance the social construction for the protection of the Rights of the Child; a vision of Latin America about paediatric health rights; positive national and international experiences on the subject; and the effects of the Convention on the Rights of children 25 years of its ratification, were some of the topics presented. The list of participant speakers was integrated by professionals from Chile, Argentina and UK.
2.3 Paris Climate talks – UNICEF speaks out
Children will bear the brunt of climate change unless we act now
November 24, 2015

Dear colleague,

As leaders from nearly two hundred nations prepare to gather in Paris http://newsroom.unfccc.int/paris/ from 30 November to 11 December 2015 to address the climate crisis, UNICEF is releasing a new report, Unless We Act Now: The Impact of Climate Change on Children http://www.unicef.org/publications/index_86337.html that documents with data and analysis what this crisis means for the world’s children.

Clear scientific consensus indicates that climate change will increase the frequency of droughts, floods and severe weather. These threats pose grave risks for everyone. But children – especially the poorest and most vulnerable – will bear the brunt of the effects. The report calls for prioritizing the needs of the most vulnerable in adaptation efforts, reducing inequities among children so all have a fair chance to recover from climate-related disasters, and cutting greenhouse gas emissions.

UNICEF has three urgent messages about children and climate change that we hope you and your organization will emphasize in your own communications and efforts to address the climate crisis:

*It is abundantly clear from the evidence that children suffer most deeply from climate change’s impacts.*

*In a world where deep inequalities already contribute to the suffering of millions of children, climate change is going to make those inequalities only worse.*

*If we care about the lives of children in the future, the time for action is now.*

Please help us put children at the centre of the global climate debate in the coming weeks by drawing attention to Unless We Act Now with a link on your organization’s Web site and by sharing it with relevant list serves. And kindly let us know how UNICEF and partners can help spread this important message about climate and children, in the important weeks ahead and beyond.

Thank you in advance for your support and interest.

Best regards,
Claudia Gonzalez
Chief of Public Advocacy, UNICEF

Comment from TW: Please can all readers do their best to spread the above message? I shall be attending the NGO session in Paris at the end of the talks from 11-13 December and shall send out a blog about the outcome and shall also feature this in the January e-bulletin.
2.4 XVII Latin American Congress of Pediatrics - 2015 ALAPE and III Peruvian Extraordinary Congress held in Lima from 11 to 14 November

DEBATE: “RELEVANT TOPICS OF SOCIAL PEDIATRICS IN LATIN AMERICA”

In the first part of the discussion group reflections from the experiences of the committees or groups of Social Pediatrics in the region, participated as speakers were presented: Ernesto Duran (Colombia and ALAPE Committee), Luis Felipe González (Chile), Ida Esquivel (Paraguay), Mario Tavera (Peru) and Maria Laura Michelini (Uruguay). In all countries progress and continuous work around critical to the health of children and adolescents issues and advocacy work towards ensuring their rights are evident. Other participants in the discussion group made reference to other national and local developments; it became clear keen to work in coordination and exchange experiences and knowledge.

In the second part of the meeting, an analysis of the situation of children and adolescents in the region and public policies aimed at influencing this situation occurred, the presentation was made by age groups with the common situation title, prospects and challenges, as follows:

- Reflections general and health in early childhood Dr. Adrian Díaz (Ecuador)
- School Health Dr. Maria Laura Michelini (Uruguay)
- Adolescent health Dr. Maricarmen Calle (Peru)

The three presentations allowed the region to see old and new health problems accumulate in a complex epidemiological mosaic of historical health problems resulting from poverty, inequality and lack of basic public services, with new problems of the XXI century; with a significant decrease in mortality, but not equal in morbidity. The policies are inadequate, remain predominantly welfarist, with some developments in health promotion and prevention. In closing the discussion group agreed to maintain these spaces for discussion and in particular to work together for the success of the upcoming conference ISSOP (International Society for Social Pediatrics and Child Health) to be held in Santiago de Chile in September of 2016.

Raul Mercer

3. International Organisations

The “Lima Declaration”

Latin American Paediatricians declare that the commitment to meet the Millennium Development Goals by 2015, have made great strides; but none has been fully achieved. This has been the starting point to raise the 17 Sustainable Development Goals by 2030 proposed by the United Nations.

It is important to recognize the rights of children and adolescents; and the participation of the family, the community to which Member States ensure compliance. Similarly it corresponds to the Latin American Paediatrics lead the development of the skills and competencies of all those responsible for the health of children and adolescents as part of a holistic and humanized care.

Finally we recognize that our region take paramount inclusion, sustainability, respect for the environment, peace and justice.

http://www.alape.org/documentos_declaracion_lima.php
4. Current controversy

4.1 Prospects for SDGs

The following contribution was made by Prof Nick Spencer to the discussion on CHIFA on SDGs.

1. [We have many existing interventions to reduce child and neonatal mortality (e.g. vaccines, bed nets, antibiotics, Kangaroo Mother Care, skilled birth attendance, newborn resuscitation). What is the existing local availability and accessibility of such interventions for the children who need them the most?] Medical interventions, such as those listed in question 1, are essential BUT not sufficient to reduce child mortality particularly among those children who need them most. Child survival is influenced by many other factors such as clean water, sanitation, clean air and adequate nutrition. These non-medical factors are often responsible for high levels of morbidity which then requires treatment with antibiotics etc. For example, we know that Zinc-ORS is effective in the management of acute gastroenteritis but children who don’t have access to clean water & sanitation and are malnourished will continue to be at risk of recurrent episodes. Similarly, neonatal resuscitation can ensure the initial survival of preterm, low birth weight or ill neonates; however, it does not address the high levels of prematurity etc. in LMICs which are related to poor maternal health and malnutrition. LMICs that have used their limited resources to provide access to clean water etc. for all in their countries, irrespective of ability to pay, are among those with the best child survival rates.

2. [Why are life-saving interventions not locally available? And why are they not implemented (accessible), even when they are locally available?] The UNICEF report, Progress for Children No.11 : Beyond averages: Learning from the MDGs http://www.unicef.org/publications/index_82231.html provides some of the answer to question 2.

Despite considerable global improvement in child survival and in availability of, and access to, evidence-based medical interventions, it is those children living in extreme poverty and those in rural areas (often the same children) who are both at greater risk of early death and are less likely to have access to effective interventions. These are the children most in need but least likely to get either curative or preventive interventions – what Victora (2008) refers to as “the Inverse Care Law” using the term originally coined by a GP in Wales, Dr Julian Tudor-Hart (1971). In another paper in the Lancet Child Survival series, Victora et al (2003) state: “In an ideal world, coverage levels for preventive interventions such as vaccination, vitamin A supplementation, and insecticide-treated mosquito nets would be highest in the poorest households to offset these higher risks. The reality is the opposite. The poorest children are the least likely to be vaccinated, to receive vitamin A, or to sleep under a treated net. Inequities in exposure and resistance are therefore compounded by inequities in coverage for preventive interventions, making poor children even more likely to become sick and in need of curative care compared with their better-off peers.” (p.235)
3. [What can be done to improve the availability and accessibility of life-saving interventions?]

Given my lack of direct experience in LMICs, I’m not competent to comment on what can be done on the local level to improve accessibility and availability. However, there are definite lessons which can be learnt from LMICs which have succeeded in increasing child survival despite lack of resources. Countries such as Cuba, Sri Lanka & Kerala State in India have had much higher child survival rates than other LMICs for a number of years even before the MDGs were introduced. Bendavid (2014) identifies good governance as a key determinant of improved child survival particularly of the poorest children. Good governance needs to extend to the local level with a system of feedback and accountability, whereby the local public health authorities and clinical workers can bring attention to priority health issues – and these priorities should be identified in collaboration with communities. Victora et al (2003) list policy interventions which have enabled governments to improve child survival – I’m reproducing their table here for information (Table 1 – p.237)

<table>
<thead>
<tr>
<th>Approach</th>
<th>Example</th>
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<tbody>
<tr>
<td>Improve knowledge &amp; change poor mothers’ behaviour</td>
<td>Improvements in female education in general; Nutrition counselling (Brazil); Social marketing for soap (Central America); Social marketing for mosquito nets (Tanzania)</td>
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<tr>
<td>Improve access to water and sanitation for poor people</td>
<td>Expansion in water supply favouring poor communities, by regulated privatisation (Argentina) and social investment funds (Bolivia)</td>
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<tr>
<td>Empowering poor women</td>
<td>Microcredit (Bangladesh, Ghana)</td>
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<tr>
<td>Make health care affordable to poor households</td>
<td>Cash transfers to poor families linked to utilisation of preventive services (Mexico, Honduras, Nicaragua); Subsidised health care for reaching the poorest populations (Sri Lanka, Costa Rica, Malaysia); Bias to poor people in specific child-health interventions (Bangladesh, India); School health insurance programme (Egypt)</td>
</tr>
<tr>
<td>Making health facilities more accessible to poor households</td>
<td>Road improvements to facilitate access (Viet Nam); Use of outreach facilities (Benin, Guinea); Deployment of health teams in poor municipalities (Brazil); Extend services through community health workers and non-governmental organisations (Bangladesh, Thailand); Partnership with, and some subsidisation of non-governmental organisations in underserved areas (Bolivia, Uganda)</td>
</tr>
<tr>
<td>Enhancing human and other resources in facilities serving poor people</td>
<td>Use of community organisations and volunteer health workers (Thailand); Building housing for rural staff and providing other incentives to practise in rural areas (Uganda)</td>
</tr>
<tr>
<td>Improving the user-friendliness of providers and facilities serving the poor</td>
<td>Using providers who speak language of poor indigenous groups and understand their culture and customs</td>
</tr>
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| Making budget allocations more relevant to the burden | Allocation of resources at district level according to burden of disease (Tanzania); Making simple interventions a priority against
Although these government initiated interventions include some in the health sector, they demonstrate that interventions across many different sectors have the potential to improve child survival rates.

4. [What new interventions are needed to accelerate progress towards the child mortality targets?] I would argue that concerted political will to institute some of the interventions listed in Victora et al’s table would have the effect of greatly improving survival among poor children. However, there are considerable barriers for governments in LMICs to overcome. Apart from internal political challenges such as corruption, lack of political will and resistance from powerful elites and vested interests, there are the huge global forces which work against improving the circumstances of the poor in LMICs (and in rich nations). The problems of these countries are almost invariably posed as problems of poverty but their poverty is a consequence of resources being channelled into the rich nations and into the hands of a very small number of extremely wealthy individuals mainly, but not exclusively, based in rich nations. This wealth imbalance is now so extreme that the 85 wealthiest individuals in the world now have a combined wealth equal to that of the bottom 50% of the world’s population, or about 3.5 billion people. Daunting though it may seem, it is essential that this imbalance is addressed to ensure that LMICs have sufficient resources to improve the lives of families and children. Tax avoidance by multinational companies is hugely damaging to the resources of LMICs with major adverse consequences for children. For example, Action Aid estimates that global brewer, SABMiller is ripping off poor countries in Africa to the tune of £20 million a year using its network of 65 tax haven companies (http://www.actionaid.org.uk/tax-justice/the-sabmillerguide-to-tax-dodging) This is only one company among many engaged in tax avoidance depleting the financial resources of already poor countries.

5. [What is the role of the research/academic community and other stakeholders to improve the availability and accessibility of life-saving interventions?] In my view, academic research has tended to focus more on establishing the evidence-base for curative and preventive interventions delivered by health workers and services than on the underlying causes of causes such as those listed in my response to question 1 above. This is not to diminish the importance of these interventions but the focus has tended to detract from the problems of accessibility and affordability of health services as well as the environmental and socio-economic drivers of poor health among children in LMICs. I think there needs to be a rebalancing of the research agenda to give as much importance to these aspects as to the curative and preventive interventions themselves. Much current research is based on a top-down approach, usually from high income to low income country, where researchers and donors determine which research questions should be studies and what the hypotheses for these questions should be. People who are the target of research and interventions have a right to participate in the design and implementation of research that will affect them.

References:
Bendavid E. Changes in child mortality over time across the wealth gradient in less developed countries. Pediatrics 2014;134:e1551-59

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ISSOP President
4.2 Child poverty
Child health at risk from welfare cuts

The following letter was published as a rapid response to the British Medical Journal by ISSOP trainees lead by Dr Caomhe McKenna.

http://www.bmj.com/content/351/bmj.h5330/rr
BMJ2015; 351 doi: http://dx.doi.org/10.1136/bmj.h5330 (Published 14 October 2015)

The poverty of our approach

Dr Taylor-Robinson and colleagues write about the projected impact of recent welfare reforms on children and child health. Child health at risk from welfare cuts BMJ2015; 351 doi: http://dx.doi.org/10.1136/bmj.h5330 (Published 14 October 2015)

As paediatricians working in North London we share these concerns. In our own work we are increasingly seeing the effects of child poverty and deprivation on the front-line of the health service.

The relationship between poverty and poor child health is not controversial: poverty makes children sick (1, 2). As levels of poverty rise (3) we can expect to see even more sick children accessing our already over-burdened services. This could be the uncontrolled asthmatic living in a damp home, the diabetic who keeps missing appointments as their family struggle to afford transport, the child with pneumonia in overcrowded accommodation, or the young person who presents to A&E with repeated, deliberate self-harm. Or perhaps, it’s the single mother seen last week, who – despite working full-time - is having to choose whether ‘eat or heat’. She is understandably worried about what a reduction in tax-credits would mean for herself and her child. As a result of the proposed welfare reforms lone parents will be the biggest losers (4).

What role can we play in helping parents and patients like these? We call on all paediatricians and health professionals who work with children to be mindful of rising levels of child poverty. Ask families about their home circumstances at every encounter and, critically, document what you are seeing. It is our job to advocate for these patients - by speaking to local MPs, writing in newspapers or by simply ‘keeping count’ in the context of an enfeebled public health system. Only this way can we build the case for protecting children and families from the developing epidemic that is poverty.

References:
5. CHIFA report

CHIFA membership continues to rise and in the New Year will benefit from the grant from the International Child Health group reported in September. An appointment of a new staff member will take place and this will contribute to further expansion and outreach to new countries. More on this in the next e-bulletin.

6. Publications

6.1 Child Health disparities – what can a clinician do?

Tina L. Cheng, MD, MPH,a,b, Mickey A. Emmanuel, BSc, Daniel J. Levy, MDd, Renee R. Jenkins, MDe

DOI: 10.1542/peds.2014-4126 - Accepted for publication Jun 3, 2015

Abstract

Pediatric primary and specialty practice has changed, with more to do, more regulation, and more family needs than in the past. Similarly, the needs of patients have changed, with more demographic diversity, family stress, and continued health disparities by race, ethnicity, and socioeconomic status. How can clinicians continue their dedicated service to children and ensure health equity in the face of these changes? This article outlines specific, practical, actionable, and evidence-based activities to help clinicians assess and address health disparities in practice. These tools may also support patient-centered medical home recognition, national and state cultural and linguistic competency standards, and quality benchmarks that are increasingly tied to payment. Clinicians can play a critical role in (1) diagnosing disparities in one’s community and practice, (2) innovating new models to address social determinants of health, (3) addressing health literacy of families, (4) ensuring cultural competence and a culture of workplace equity, and (5) advocating for issues that address the root causes of health disparities. Culturally competent care that is sensitive to the needs, health literacy, and health beliefs of families can increase satisfaction, improve quality of care, and increase patient safety. Clinical care approaches to address social determinants of health and interrupting the intergenerational cycle of disadvantage include (1) screening for new health “vital signs” and connecting families to resources, (2) enhancing the comprehensiveness of services, (3) addressing family health in pediatric encounters, and (4) moving care outside the office into the community. Health system investment is required to support clinicians and practice innovation to ensure equity.
6.2 Understanding the impact of the economic crisis on child health: the case of Spain

Luis Rajmil, Arjumand Siddiqi, David Taylor-Robinson and Nick Spencer
International Journal for Equity in Health (2015) 14:95
DOI 10.1186/s12939-015-0236-1

Abstract

Introduction: The objectives of the study were to explore the effect of the economic crisis on child health using Spain as a case study, and to document and assess the policies implemented in response to the crisis in this context.

Methods: Serial cross-sectional data from Eurostat, the Spanish Health Interview Survey, and the database of childhood hospitalisation were analysed to explore impacts on child health, and key determinants of child health. A content analysis of National data sources/government legislation, and Spanish literature was used to describe policies implemented following the crisis.

Results: Unemployment rates in the general population (8.7 % in 2005 and 25.6 % in 2013), and children living in unemployed families (5.6 % and 13.8 %) increased in the study period. The percentage of children living under the poverty line, and income inequalities increased 15–20 % from 2005 to 2012. Severe material deprivation rate has worsened in families with Primary Education, while the number of families attending Non-Governmental Organisations has increased. An impact on children’s health at the general population level has not currently been detected; however an impact on general health, mental health and use of health care services was found in vulnerable groups. Investment in social protection and public policy for children showed a reduction as part of austerity measures taken by the Spanish governments.

Conclusions: Despite the impact on social determinants, a short-term impact on child health has been detected only in specific vulnerable groups. The findings suggest the need to urgently protect vulnerable groups of children from the impact of austerity.