ISSOP e-Bulletin Nº 45
May 2020 – COVID Mode

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1. Introduction

As we come to the end of May, most of the countries most severely affected by COVID19 are cautiously beginning to end their respective lockdowns as the dreadful toll on elderly lives and our fragile health care systems begins to ease. In the edition of the e-bulletin we look back on the experience and forward to how we can learn from it to the benefit of children.

All parts of our lives have been affected and for those clinically involved, the emotional and physical toll has been very great. To all of them, our sincere gratitude is due. This month most of our contributions focus on COVID and in section 8 you can find reviews of the situation from our members in many countries around the world.

In section 3 we have a new update on how to encourage paediatric associations to follow the WHO International Code. This is a draft and we would appreciate your comments. See also reference to publications from WHO updating the Code status. We also feature reports on the Global Child Rights Dialogue, on IPA and immunization, and inequities in the US once again.

And please note that the November ISSOP Congress due to take place in Indonesia has been postponed to next year, we hope to run an entirely virtual meeting in November 2020 on Climate Change and Child Health, details coming soon!

Finally, we note with sadness and regret the dreadful events in the USA as the COVID tragedy is moving into general unrest over inter-racial issues, sometimes turning violent, over another death of a black man at the hands of the police. At the same time, the President of the US has withdrawn from WHO, which is struggling to cope with the world pandemic as well as an upsurge in false information about the virus and its mode of spread. How can this be a rational decision? We urge all US and global health organisations to come together in condemnation of this destructive act, and encourage the US administration to work together with other countries in finding solutions, including particularly the manufacture of a vaccine.

T. Waterston (UK) R. Mercer (ARG) R. Nathawad (US) G. Yilmaz (TR) N. Ustinova (RU)


Activist Thunberg helps launch effort protecting children from COVID-19

by Matthew Lavietes | @mattlavietes | Thomson Reuters Foundation
Thursday, 30 April 2020 13:30 GMT

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1.1. Message from Jeff Goldhagen - President of ISSOP

Hope this note finds you and your family well. Who could ever have predicted the surreal environment we find ourselves confronting? The front page of the May 24th New York Times consists of only the names

(https://www.nytimes.com/2020/05/23/reader-center/coronavirus-new-york-times-front-page.html)

and brief description of the lives of 1000 Americans who have been lost to the epidemic—only one-percent of the 100,000 people in the US who have died, and 0.3 percent of those who have "officially" died globally—a somber and poignant reflection of the toll of this pandemic.

For children, though difficult to measure, the global impact has been equally as solemn. There will be no front page of the NYT to quantify it—no "obituaries" of lost brain development, violence inflicted, malnutrition and stunted growth, children paralyzed from polio and dead from measles, etc. No condemnation of the global inequities and rights violations challenging children and youth will appear.

That is left for us and other stakeholders in child health and well-being to measure, which we are attempting to do through our regional working groups, in which we have tallied more than 70 participants. The groups have already begun to document the breadth and depth of the impact of the pandemic on children. There is still room to participate if you are interested (if so, please email me).

And yet, the carnage of children in armed conflicts, the impact of climate change, and the epidemic disparities in child health in the majority world continue—notwithstanding the pandemic. One is left to wonder if these disparities were affecting high income countries, whether there would be a metaphorical pandemic complacency. How far could the trillions of dollars being spent responding to the economic effects of COVID-19 have gone in addressing global health disparities. It is a rhetorical question, but one worth answering.

We need your continued involvement in our response to the COVID 19 pandemic, including dissemination of our soon-to-be-released Declaration on COVID. Our Declarations on the Impact of Armed Conflict on Children and Climate Change will also soon be released. We need your voice and actions in these regards as well.

Thank-you as always for your support of ISSOP, and all you do for children and families. And for which we need to thank the leaders of the groups for helping to establishing the foundation for the Social Pediatrics response to COVID-19.

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2. Meetings and news

2.1. ISSOP Annual Meeting 2020

Unfortunately, due to COVID-19, we will be forced to cancel our in-person annual meeting for 2020. We are most disappointed as our intent was to launch a renewed focus on the Impact of Climate Change on Children, and to do so in collaboration with our hosts, the Indonesia Pediatric Society. In addition, we were looking forward to learning how to structure future meetings using a virtual platform.

We are committed to schedule our next annual meeting in Indonesia, and will be planning to do so in 2021. In the meantime, we will be scheduling a virtual meeting at the end of November to focus on climate change—so hope you will be able to join us. Our Declaration on Climate Change will be released in the near future, and will serve as a focus of dialog and discussion leading up to our virtual annual meeting.

We need to thank our Indonesian colleagues for their passion, leadership and commitment to make our 2020 meeting a dramatic success. Am sure we will be even more successful in 2021! Stay tuned, more to come.

Jeff Goldhagen

2.2. Global action towards COVID-19 in Social Pediatrics

a) The proposal

Based on a proposal from the group that ISSOP leads, the need to generate an ISSOP initiative was raised to learn about the impact of COVID-19 on children and, in particular, on vulnerable children. To date, more than 70 people from all regions have expressed their interest in participating (a figure that is constantly increasing). Throughout this time, conversations have been held between regional leaders and INRICH researchers (see below). Regional working groups have been formed that have already started with their regular meetings and agendas.
We have discussed the implementation of the following components, in no order of priority:

- **ISSOP statement**. Karen Zwi and her colleagues in Australia have been working on a first draft and we already have a final version soon to be released.
- **Position argument**. The Position Statement will be a more extensive and profound document than the Declaration with the participation of a drafting group from each of the regions.
- **What we are learning**. We would like to start compiling perspectives from the regions on what we have and continue to learn and how it will translate (positive and negative) into clinical / programmatic practices, systems and policies.
- **Research**. The INRICH group will lead the development and implementation of a research project (qualitative and mixed method). They will request the participation of individuals to be part of that effort. (see below)
- **Case studies.** We are generating and systematizing case studies and identifying child health policies (positive and negative) that emerge from the response to the pandemic, in addition to responses from the community level, health services, families and children.
- **CRBA.** (Child Rights Based Approach) Convene a subgroup to develop a framework based on the rights of the child to contextualize, evaluate and discuss the impact of COVID-19 on children and adolescents.

As you can see, there are many opportunities to collaborate and learn from the impact of COVID. It is a shared and collaborative work. Please let us know if you have any additional ideas on how to proceed.

Thanks again for your participation

Jeff Goldhagen – Nick Spencer

b) COVID Research Group

ISSOP, jointly with one of our partner organizations, the International Network for Research in Inequalities in Child Health (INRICH), has established a research initiative as part of our Covid 19 work programme. The first meeting of the ISSOP/INRICH Covid 19 research group, held on 13th May, was attended virtually by 30 colleagues. The objective of the meeting was to identify research being undertaken by working group members, plan feasible new research projects & potential collaborations. To avoid 'reinventing the wheel' – identify research in areas of ISSOP/INRICH strengths particularly INEQUITY & CHILDREN'S RIGHTS.

Current & planned projects were presented including surveys of families, children and young people in a range of groups and settings – parents in New Brunswick Canada; adults and children with disabilities in Canada (& eventually globally); marginalised children in Delhi, India; parents & pregnant women in three Bradford, UK cohort studies; young people in Guinea Bissau. An inventory of ISSOP/INRICH projects is being established based on the research project summary form shown below. Research collaborations and projects initiated by the group were discussed and will be reported in future bulletins.

Colleagues involved in research or interested in participating in this work would be most welcome to contact:
Nick Spencer n.j.spencer@warwick.ac.uk or Eva Goldhagen at eva.goldhagen@gmail.com

ISSOP/INRICH Research Project Template

Title	
Author/s (Name, position, profession).	
Research question	
Background/rationale	
Proposed methodology	
Ethical considerations (where applicable)	
Child Rights Based Approach (CRBA)	Describe whether and how CR were considered, identified and approached in this experience. (300 words)
Principal investigator's Contact information	E – mail – website – WhatsApp – Facebook – Instagram – others
Attached information	References - Documents – Reports – Videos – Images – Links - others

c) Regional activities

In order to decentralize some of the current proposal, regional groups and respective leaders were created. In this way, periodic follow-up meetings are held with regional leaders and, in turn, specific meetings are held at each of the meetings. All work is develop on the basis of the lines set forth in point a) of the present proposal. To date, the following regions have been created with their respective coordinators:

- **North America**: Sarah Gander & Rita Nathawad
- **Latin America**: Ernesto Duran & Raul Mercer
- **Northern Europe**: Geir Gunnlaugsson
- **Southern Europe**: Perran Boran
- **Africa**: Rosie Kyeremetang
- **Asia Pacific**: Shanti Raman & Rajeev Seth
- **Middle East**: R. Coordinators: TBA

As an example, on May 18th we had the first meeting of the Latin American Region. Here we share the highlights of this meeting. We are now following the activities of the different regional groups in terms of coordinating their efforts and productions.

Date	May 18, 2020
Region	LAC
Coordinators	Ernesto Duran (Colombia) /Raul Mercer (ARG)
Participants (Names and countries)	**Peru:** Marilú Chiang, María del Carmen Calle **Chile:** Luis Felipe Gonzalez Fernandez, Fernando González, Paula Bedregal, Ivan Silva, Gerardo Weisstaub, Estefanía Siles, Thelma Suau **Dominican Republic:** Jefina Luna **Argentina**: Claudio Pedra, Erica Hammermuller, Jorge Cabana, Mirta Garategaray, Virginia López Casariego **Honduras:** Oscar Ponce **PAHO**: WDC: Betzy Butron **Absences:** Uruguay – Bolivia - Paraguay
Topics discussed	Introduction Presentation of the Project Common concerns regarding Child Health Different problems in each country **Honduras:** Digital inequity in education system, immunization programs, relation prevention/treatment, food security, chronic diseases, effect of confinement (home injuries, burns), parents separation. **Dominican Republic:** violence, children in institutions, access to child protection systems, nutrition, immunizations, **Colombia:** same previous problems, adolescent sexual and reproductive health, early pregnancies, lack of newborn registration, school system, disabilities, problems in the border with Brazil, **Peru**: CR protection (CRC), interruption of health care programs. Vulnerable children (indigenous, poor children, disabilities, LGBTI, among others). People do not want to go to health services (back to home deliveries). **Argentina**: Existence of information of child situation in Argentina. They want to promote debates in different regions. Food insecurity. Deterioration of the economic situation. **Chile**: Health of health workers (global study). Inequities, Adult-centrism. Areas of interest 1) Education, 2) Health consequences on child health 3) Vulnerable groups (migrant, adolescents of the national protection system (SENAME)). Post-COVID. National protection law. Social Pediaric Activities (Webinar).
Agreements/proposal to follow-up	- Registration to the group (send info to EVA) - Think areas of interest for the different tasks - Utilization of the LAC folder in the Google Drive (Eva)
Next meeting (date)	June 1 st 6.30 pm Colombian time

3. International Organisations

3.1 HIFA: Child Rights and COVID19

The following posting appeared in HIFA, from Neil Pakenham Walsh:

HIFA post 30.4.20 (See photo in the front cover of this issue)

"Like the climate crisis, the coronavirus pandemic is a child-rights crisis," says Greta Thunberg, the acclaimed climate activist.
Extracts below. Full text here: https://news.trust.org/item/20200430042041-b524h/

NEW YORK, April 30 (Thomson Reuters Foundation) - Teen climate-change fighter Greta Thunberg aimed her activism at the coronavirus on Thursday, helping launch a campaign with the United Nations to help protect children from the pandemic with the purchase of soap, masks and gloves.

Thunberg used funds she has raised to combat climate change to donate $200,000 to the U.N.'s children's agency, UNICEF, along with Danish anti-poverty group Human Act to kick off the campaign, UNICEF announced.

"Like the climate crisis, the coronavirus pandemic is a child-rights crisis, It will affect all children, now and in the long-term, but vulnerable groups will be impacted the most. Children will be affected severely by food shortages, strained health care systems, violence and lost education caused by COVID-19, she said…"

The U.N. issued a report recently warning that while children have been largely spared from the direct health effects of the virus, the global economic downturn could result in hundreds of thousands of additional child deaths in 2020…

3.2 The WHO Code on Breastmilk substitutes and paediatric associations

ISSOP members will be well aware of the work done by members and fellows of the Royal College of Paediatrics and Child Health to end the sponsorship of the College by the baby food industry. Over the last year the group (which includes several ISSOP members) has worked in collaboration with WHO officials to establish the next steps to encourage paediatric associations across the world to follow the precedent set by the RCPCH, recognizing the difficulties in doing this.

In order to assist such associations (which would also including nursing and other child health professional organisations) to move forward, the following protocol (currently in draft form) has been written by Professor Charlotte Wright, Glasgow with the assistance of other group members. The intention is for this protocol to be taken to such associations (which would be both national and international) by its own members to initiate the process of change and reform. Please send us your comments as there is still scope for amendments.

Tony.waterston@ncl.ac.uk

Protocol for engagement of child health related professional organisations with breast milk substitute companies and their related bodies

In February 2019 the Royal College of Paediatrics and Child Health (RCPCH) announced that they would no longer accept any funding from formula milk (FM)companies. They made it clear that this was with the aim of reiterating *"..the importance of promoting breastfeeding as the best possible method of infant feeding,"* but also expressed an intention to *"..continue to engage and work in partnership with formula milk companies with regards to specialist formula milks….. but without accepting any funding."*[1]

Navigating this area ethically can be complex, so the purpose of this document is to lay out a recommended approach, in line with World Health organization (WHO) recommendations, to guide child health-related professional organisations (CHPO) in the ways they can engage with breast milk substitute companies and their related bodies, without creating conflicts of interest (COI) for their organisation. The underpinning rationale for this has been laid out in more detail in a series of recent[2] [3]and older[4] reviews.

While child health professionals' primary interest is towards their patients, the acceptance of funding will influence their judgement, consciously or unconsciously, in favour of the funder. Thus, when doctors as individuals, or as part of an organisation, accept funding from an infant

formula manufacturer, a COI is created. *"A conflict of interest is a set of conditions in which professional judgment concerning a primary interest (such as a patient's welfare or the validity of research) tends to be unduly influenced by a secondary interest (such as financial gain)."* [5]

This influence is particularly likely with respect to nutrition education sponsored by the formula milk companies, where any funding or support is likely to create COIs. As a result, they are likely to relatively underplay the risks associated with infant formula feeding. It may also encourage them to favour particular brands, or types of formula. This is why it is incumbent on professionals and their organisations to avoid COIs created by the acceptance of any funding derived from the sale of formula milk.

What sort of funding does this apply to?

It can be challenging to understand which sources of funding can be said to be derived from the sale of formula milk, as there are associated bodies that may be closely linked to FM as well as companies that make a number of products as well as FM.

Types of funders to avoid always

- Any company or subdivision of a company whose main product worldwide is a formula milk or other breast milk substitute (BMS) for general use or for common therapeutic applications (e.g. Cow's milk allergy, preterm infants) including breast milk fortifiers.
- Many producers of BMS also produce highly specialist BMS and/or therapeutic feeds under the same company logo as their mainstream BMS products. Thus any company or subdivision of a company who shares logos or titles with a producer of BMS, as defined above should also be avoided.
- Any trust or organisation that receives a significant proportion of its funding from one or more producers of BMS as defined above, or is financially reliant on this income.

Types of funders that may be acceptable in certain settings

- Commercial suppliers of human milk or human milk fortifier
- Manufacturers of feeding paraphernalia and equipment where related only to breastmilk expression

Types of funders that are acceptable

- Not for profit human milk banks

What types of funded activity does this apply to?

Types of funding to be avoided

- Accepting core funding support from a BMS funder for the CHPO.
- Support and sponsorship from a BMS funder for running a conference or meetings (conference accommodation costs, travel or honoraria for speakers, catering, resources such as conference packs, storage devices).
- Sale of trades stand for any conference or meeting which facilitates the promotion of BMS product.
- Support (travel, registration, accommodation, subsistence) by a BMS funder to allow individuals to attend educational activities.
- Catering, hospitality (conference dinners, other social events) provided by a BMS funder to CHPO members, when publicised by or provided through the association.
- Support from a BMS funder for other CHPO educational activities or products (websites, leaflets, books, digital materials) whether financial or in kind.
- Funding from a BMS funder for research projects or committees undertaken under the auspices of the CHPO itself.

Engagement that may be acceptable

- Involvement in a meeting of a company or subdivision of a company whose main product is a BMS used only in highly specialist therapeutic circumstances (e.g. PKU).

- The company should contribute no more than the standard rental cost of a trade stand
- The stand should only provide scientific and factual information about the BMS product, without providing any gifts or benefits (e.g. catering)

Satellite industry sponsored sessions

These should not permitted. If companies choose to organise these, they should be entirely separate from the main conference proceedings. In particular they should:

- Not be listed in the main conference programme or other official information
- Take place off-site or in a separate section of the conference venue
- No income should accrue to the conference organisers or CHPO from them
- No list or contact details of delegates should be supplied to the organisers

Dealing with individual COI

- Individual members of the CHPO may accept funding or benefits in kind in any of the above categories without compromising the stance of the society, but this creates an individual COI.
- The CHPO should make members aware that if they serve the CHPO in in any official capacity, all possibly COI within the last 5 years should be declared on the CHPO website, including any hospitality received, however modest.
- Participation in BMS funded research is recognised to be essential in some subject areas. However, the CHPO should encourage its members to ensure that any research undertaken complies with the best practice consensus guidance[1], after adequate consultation over the protocol and approval by an ethics committee. The funding basis for the research must be fully declared in presentations and publications. This should include any funding in kind for products or services received by the researchers or their clinical unit.
- The CHPO should play no part in facilitating individuals to receive this funding.

Actions to be taken where COI exists

- Individual COI should be declared:
  - On the CHPO website for any postholder
  - Before any presentation
  - Before chairing or introducing a session, Or asking a question related to the subject
- Any COI for the CHPO as a whole (e.g. sponsored sessions) should be declared clearly in publicity for the meeting or conference]

Engagement with BMS without funding

- Engagement by individual members of the CHPO with a BMSC, without being paid or receiving any support in kind for themselves or their unit, does not in itself create a COI. For example recruiting patients for a trial or advising on the development of a new product.
- However, it must be borne in mind that if the individual is awarded co-authorship of journal papers or equivalent, that this constitutes a benefit which would create COI.
- The individual should also ensure that their engagement as a health professional is not used by the company for publicity for either the company or their product.

References

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https://jamanetwork.com/journals/jamapediatrics/articlepdf/2765822/jamapediatrics_jarrold_2020_oi_200019.pdf

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3. Waterston T, Wright C. Sponsorship of paediatric associations by manufacturers of breastmilk substitutes. *Lancet* 2019;393(10172):622-23. doi: 10.1016/S0140-6736(18)32845-9
4. Wright CM, Waterston AJR. Relationships between paediatricians and infant formula milk companies. *Archives of disease in childhood* 2006;91(5):383-85. doi: 10.1136/adc.2005.072892
5. Thompson DF. Understanding financial conflicts of interest. *The New England journal of medicine* 1993;329(8):573-6. doi: 10.1056/NEJM199308193290812 [published Online First: 1993/08/19]

…And for those who missed it here is a CHIFA post dated 26th May from Marcus Stahlhofer, Technical Officer for Human Rights at WHO, about a simple and user-friendly Frequently Asked Questions document about the International Code –

Health workers have a vital role to play in educating mothers and other caregivers about infant and young child feeding. It is also their moral and professional responsibility to protect, promote, and support optimal feeding. However, health workers and health care facilities throughout the world are often used by baby food companies to promote breast-milk substitutes such as infant formula, specialized formulas, follow-up formula or growing up milks.

To assist health workers in better understanding the International Code of Marketing of Breast-milk Substitutes, and their specific roles and responsibilities under the Code, WHO has just released a simple and user-friendly Frequently Asked Questions document.

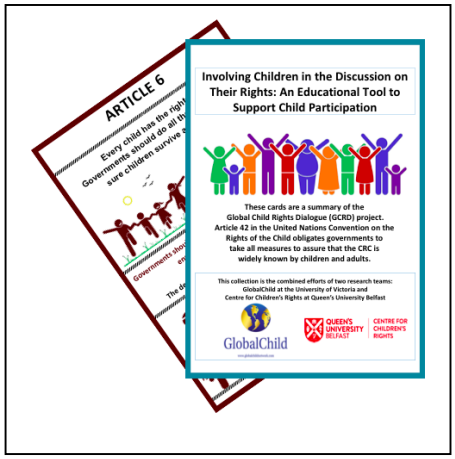
The document can be found here: https://www.who.int/publications-detail/9789240005990

See also the following link for the just released 2020 update on the legal status of the Code, from WHO/UNICEF/IBFAN https://www.who.int/publications-detail/9789240006010

Here are the recommendations from this important report – inset one of the authors, Larry Grummer Strawn of WHO

3.3. News from Global Child Rights Dialogue

The international team of GlobalChild has been working, for the last few years, to develop a comprehensive child rights monitoring platform that will assist the 196 countries that are States Parties to the Convention on the Rights of the Child (CRC) to better monitor and report on their implementation of the CRC. As part of the process to develop these indicators, GlobalChild, in partnership with the Centre for Children's Rights at Queen's University Belfast, conducted a global consultation with children to gather their opinions on their rights.



This project was called the Global Child **Rights Dialogue (GCRD)** (https://onlineacademiccommunity.uvic.ca/globalchild/global-child-rights-dialogue/) Project. The insights provided by children led to several new indicators and improved many others. The GlobalChild team will soon launch the platform which is currently undergoing the last steps of development in both English as well as French.

We are now thrilled to release a pack of child-friendly educational cards that can help children learn more about their rights under the CRC. These cards were created in partnership with children, and in close collaboration with Professor Laura Lundy and her team at the Center for children's rights at the Queen's University, Belfast. There is one card for each of the substantive rights of the CRC in Clusters 3-9: the first side articulates the attributes of each right in child-friendly language, and the second side provides quotes from the participating children of GCRD from different regions of the world. Children's voices deserve to be heard and it is our hope that card users can hear these voices and what children have to say whole-heartedly and get creative in their approach to child rights education. These cards can be downloaded for free from the GlobalChild website (https://onlineacademiccommunity.uvic.ca/globalchild/child-rights-educational-tool-cret/).

For any further information, you can contact
Dr. Ziba Vaghri, Director of the GlobalChild at ziba.vaghri@unb.ca

3.4. COVID on the breadline

By Picturing Health.org

What does COVID-19 mean for the three quarters of a billion people who live on the breadline? Will they be hit harder by the pandemic - or by the measures in place designed to slow its spread? Are lockdowns making the virus spread faster? Five million children die every year of largely preventable illnesses before reaching their fifth birthday. Three hundred thousand women die in childbirth. Will the lockdowns and looming economic crisis be more fatal than COVID-19 for the world's poor, very few of whom survive to the age of 65.

"COVID really scares us - and we are taking massive and drastic measures that may make those regular mortalities worse.....This(COVID) is new and it can affect the people in power, the middle classes, us in Europe, and I think that is what's different." Stefan Swartling Peterson, Medical director, UNICEF.

"You cannot just cut and paste measures from one place to another. Some of the measures that need to be put in place actually have very very adverse impacts and could even be worse than what COVID would do." Dr Musaku Mwenechanya, President of Zambian Paediatric Association.

"We are in fact making the choice to shift the mortality burden from older populations in wealthy regions to younger populations in poorer regions." Alexander Broadbent, author of Philosophy of Medicine and director Institute for the Future of Knowledge, University of Johannesburg.

The film lays out alternative ways of slowing the spread of the virus, including flattening the curve geographically. And it shows how it might be possible to help protect people over 60 and others most vulnerable in rural Africa - where most of the elderly live.

6 minute version at:
https://www.picturinghealth.org/covid-on-the-breadline-short/
30 minute version at:
https://www.picturinghealth.org/covid-on-the-breadline/

The film is made by Picturing Health, a UK registered Charity in collaboration with the Institute for the Future of Knowledge, University of Johannesburg.

4. Current Controversy

4.1 Inequities are alive and well in the United States

By Dodi Meyer, MD
Professor of Pediatrics at Columbia University Medical Center
Director, Community Pediatrics

This is New York City's tenth week of sheltering in place. Along with the health care work force worldwide, we are exhausted and overwhelmed.

The stages that we've lived through remind me of the ones we went through in the aftermath of 911. We worked on emergency preparedness for patients who never materialized since children were not affected in the initial phases of the pandemic. We then waited expectantly for the next "attack" to come as projections of when the peak would arrive changed day-by-day. We worked to mount a defense that was hindered by insufficient PPE and ventilator supplies.

We foolishly expected our federal government to work hand-in-hand with our scientists and physicians to develop a plan of action that would protect the health and well-being of the population. Lastly our health care workers and first responders were labelled the heroes of our time.

As large swaths of the population learned to remain at home, a new normal evolved. The pediatric service line shut down to make room for the older population, conserve PPE and accommodate the large number of health workers that had to be re-deployed or recover at home. Telehealth became the only way to access a pediatrician. In-person visits were reserved for children younger than 15 months old to ensure they got vaccinated.

A newborn COVID clinic was developed to make room for all babies born to COVID positive mothers. COVID telephone hotlines and triage trees were developed, with an emphasis on diverting unnecessary ED visits.

As community pediatricians, we mounted services to respond to the increasing needs of our patient population. Northern Manhattan, where I work, is a largely immigrant community from Central America living below the federal poverty level. Many adults are undocumented and have Limited English Proficiency. Food insecurity is high and the area has a high concentration of families living in crowded apartments. During the last few years, this community has been living "in hiding" because of the current administration's policies on immigration and government assistance.

Our efforts built on existing partnerships with community agencies and on our large portfolio of community programs that address the interlinking context of biology, family and community. We expanded our food insecurity work by partnering with local community agencies and food pantries. Together with food, we are distributing diapers as they are expensive and difficult to obtain. We created child abuse prevention messages and are inserting them into care packages that included PPE for families living in homeless shelters.

We expanded our "Healthy Steps" program, which provides early childhood parenting support, to serve mothers who had to deliver without their birthing companions. We developed online tutoring for elementary school-age children, since spanish speaking families are having trouble navigating the newly established online education system. We helped enroll families in telehealth so they can contact their health care provider when needed and are continuing telephonically our social determinates of health screening and navigation programs for our patient population. All this was done by a large group of pediatricians, mental health providers and graduate students who pivoted their efforts to be active responders for this "hidden" population during the pandemic.

Weeks into our efforts, the patterns demonstrating the distribution of COVID morbidity and mortality started emerging. Heat maps overlaying social determinants of health, specifically crowding, poverty and food insecurity alongside nutrition sensitive conditions and COVID cases and deaths were nearly identical. The usual overlay between income, geography, race and disease are once again highlighted.

Scientific articles started documenting these disparities and social media and journalistic outlets keep on publishing these results.

We are now emerging from the 'first wave" and here's what we're facing: an exhausted and drained workforce, a decimated network of primary care practices, a large number of unvaccinated children, an increasing number of underreported child abuse and domestic violence, double the rate of pediatric ED admissions, a large number of untreated and undetected diseases and injuries, significant burdens of untreated stress and mental health diseases, increased rates of food insecurity, joblessness, unemployment and a population that fears the clinical setting.

As we gear up to address these increasing disparities, we are called upon to develop a new paradigm of care. One that requires us to be creative, COVID safe, ready to react to second and third waves and able to address broader determinants of health.

Since I began working in the U.S. health care system in the early 1990s there has always been a gap between the scientific knowledge generated by prestigious science institutions, and treatments that can be followed by large segments of the country's population.

As one of the richest countries in the world, we can continue to spend a large percentage of health care dollars in addressing subspecialty concerns that affect few, invest in countless needs assessments to find the obvious or we can start focusing our efforts upstream and change the reality that what determines health and wellbeing in this country is color and race.

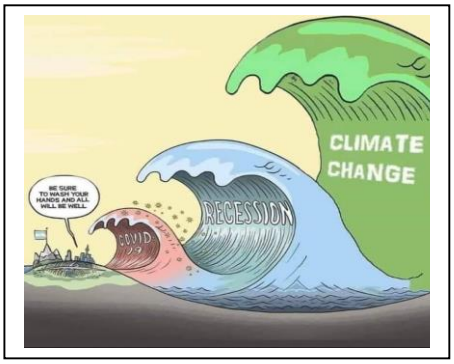
4.2. CHILD's Rebellion

In Spain, childhood barks
Did you know that in Spain dogs can go for a walk with their owners while childhood and adolescence are confined at home without being able to go out at all?
And that dogs can go for a walk with their owners?
https://www.youtube.com/watch?v=inIPTGWz_bM&feature=youtu.be

4.3 Looking to a post-COVID world

Tony Waterston

Anyone working in hospital or following the dreadful death toll from COVID19 wants the pandemic to be over just as soon as possible, whether as a result of vaccination or by efficient isolation and contact tracing. However most of us have recognized that in the developed world at least, there have been a number of changes for the better as a result of the lockdown and its impact on our lives. These should be supported by ISSOP members, and pressure brought to bear on governments to ensure that they are maintained as we recover from COVID and return to the world threated by climate change



The positive changes have included the following

- Empty streets with dramatic reduction in air pollution
- Lots of people out walking and cycling
- A return of wildlife to cities
- A growth in community support for the vulnerable
- Shops which respond to the crisis by starting up home deliveries

We can certainly do something about the first two of these and there are many initiatives developing across Europe. Even in (currently) Conservative -led Britain, the government has committed £2bn to support walking and cycling and to prevent car entry into congested areas of cities and in local neighbourhoods. If we are going to adequately tackle climate change, we have to drastically reduce car use and this means investment in cycling as well as in public transport.

My own city Newcastle upon Tyne has made a big splash of its own measures –
https://www.forbes.com/sites/carltonreid/2020/05/15/parking-cull-and-pocket-parks-for-englands-finest-street-as-newcastle-plans-post-pandemic-future/amp/?__twitter_impression=true

Partly the result of persistent campaigning by activist cyclists over the years. Let's see if they stick to their guns.

5. CHIFA Report – IPA Report

Tom Hutchison, a member of the CHIFA moderating team, writes with an update on the progress of the forum.

We would like as many people as possible from around the world to make use of CHIFA, to pose questions, raise their concerns about health information, and contribute their own comments and ideas as well as vital data sources that might not be well known.

Topics that have arisen In the last year have covered a wide range. Examples are:

- UK Royal College of Paediatrics and Child Health end infant formula sponsorship
- Children in armed conflict
- Developing messages for children about oral health
- Misinformation about HIV in textbooks for children
- Children with disabilities in resource limited settings
- Teenage contraceptive advice
- Global eradication of wild polio virus
- Child and adolescent stigma from mental health conditions
- Partogram use
- Child health and climate change
- Rights of migrant refugee stateless and undocumented children
- Integrated management of childhood illness
- Immunisation: many posts
- Diarrhoea prevention and control
- Nutrition education resources for children
- Banning of corporal punishment of children in Japan and most recently Covid 19 Pandemic issues for children.

The Japanese society of social medicine became a supporting member on July 2019. The Indian Academy of Paediatrics and the European Academy of Paediatrics became supporting organisations in January 2020. We expect the steady growth in members will continue as management of information takes increasing importance in health care.

Currently we are seeking new voluntary moderators for CHIFA, please write in if you are interested to tony.waterston@ncl.ac.uk - it's fun and you can quickly expand your horizons!

5.2 The IPA sponsored webinar titled; "Immunization during the COVID-19 pandemic" may be accessed. By Rita Nathawad

at https://www.youtube.com/watch?v=DiLGaIunTbo

> *"Life or death for a young child too often depends on whether he is born in a country where vaccines are available or not."*
>
> ***Nelson Mandela***

The webinar describes current trends in immunization coverage across the world with a focus on the impact of COVID-19 on vaccine programming. Recognizing that immunization coverage may act as a proxy for access to other health services such as nutrition, primary health care services and maternal health programs, tracking of such services is vital. Programs have been disrupted due to both supply chain issues and by physical distancing measures making large campaign style immunization programs no longer feasible.

The challenge of keeping both health care workers and communities safe is ongoing. Systems must also combat fears and myths about COVID-19, as false information could also hinder future program implementation. The impacts are significant with data revealing that "greater than 173 million children are at risk of missing out on measles vaccine in 40 countries" due to disturbances in vaccine initiatives. In addition, surveillance for surges in vaccine preventable conditions has also been interrupted, making identification systems for polio and measles weaker and lagging. The WHO, GAVI and other partner organizations are working intensely to monitor the situation and develop catch up plans that may be deployed post-pandemic to provide some damage control.

Considering immunization as an essential health service has driven the creation of specific guidance on how we may deliver vaccines safely during and after the pandemic. The key to following these guides will be in the hands of communities as there is no "one size fits all approach" and each area will need to develop implementation protocols according to local needs and resources.

Also, of note as stated by Dr Anuradha Gupta during the talk is the impact on economies and livelihoods that will take a hit as well; those living in poverty will be pushed into extreme poverty, unemployment will increase, food shortages will occur and gender related violence will also be exacerbated. With all this going on in the background, the disruption of routine vaccinations will trigger outbreaks in conditions such as yellow fever, measles, meningitis, cholera, polio, and Ebola.

There was significant discussion around COVID-19 vaccine development, with numerous potential vaccines in the pipeline. Owing to experience with other coronavirus outbreaks, such as SARS-CoV in 2002/2003 and MERS in 2012, much is known about this virus, however the novel COVID-19 strain also brings many new features with regards to pathogenicity and transmission that require further investigation. The potential for a novel vaccine also brings challenges of equitable access and we will need advocacy efforts on the part of pediatricians to ensure ALL children are covered.

6. Trainee report

6.1 Mental Health in Adolescents During the Coronavirus Pandemic

According to the National Alliance on Mental Illness, "50% of all lifetime mental illnesses develop by age 14 and 75% develop by age 24". The coronavirus pandemic is a likely trigger for mental stress and will potentially have a profound effect on the mental health of the pediatric population now and in the future.

Adolescents typically have a heightened reactivity to stress. The conditions of social distancing intensify this reactivity and may exacerbate the difficulties of adolescence to the point of crisis. Teenagers are now required to attend classes virtually, distance themselves from peers, and are unfortunately missing out on milestones such as prom and graduation that many have been awaiting since they were freshman. These changes, while trivial to some are significant for youth.

Social identity in adolescents is often shaped through peer interactions and school and extracurricular activities. While much of adolescent socialization has shifted to online and social media platforms over the past decade, in person contact is still vital to development. The people they rely most on for advice and self-growth—their friends and peers, are no longer

accessible in person. Some youth may have limited access to technology or digital platforms for connection with peers. Every adolescent will respond differently to social distancing. Some may be angry and anxious, others more introverted, while others are happy and continue to engage socially through digital means. But no matter the reaction, the isolation is affecting their well-being.

It is important for caregivers to facilitate a regular routine that involves healthy diet and exercise and ensure social distancing without social isolation. Now and after the pandemic, it is critical that parents, teachers, healthcare providers and others engaged with youth continue to monitor for signs and symptoms of anxiety and depression. It is thus important for all of us connected to youth to be aware of the signs and symptoms of mental health conditions that may unfold. If concerns arise, referral to pediatricians will help to ensure youth receive the care they need.

Yekaterina Kokidko, DO
University of Florida College of Medicine – Jacksonville
Pediatric Resident

7. Publications

7.1 Corona virus and exercise

Coronavirus Disease-2019: A tocsin [*alarm signal*] to our aging, unfit, corpulent, and immunodeficient society

• The world's population is becoming older, more obese, and more physically inactive, increasing the likelihood of pandemics such as coronavirus disease-2019.
• Aging, obesity, and physical inactivity adversely impact immune function and host defense.
• Regular moderate-intensity physical activity improves immunosurveillance against pathogens and reduces morbidity and mortality from respiratory illnesses.
• Coronavirus disease-2019 is a wake-up call, a tocsin, to the world to focus on primary prevention countermeasures.
https://www.sciencedirect.com/science/article/pii/S2095254620300600?dgcid=raven_sd_aip_email

This paper in the Journal of Sport Health and Science offers an interesting connection between primary prevention measures that benefit general health and reduce obesity, and those which could prevent outbreaks such as COVID19.
For this reason, it has been great to see so many people out walking and cycling during the lockdown here in the UK. Clearly it will help a lot if we can make sure this continues (see 4.2 above).

TW

7.2 Webinar on the Lancet Report: A future for our world's children?

Child Health Task Force

May 28th

The webinar focused on three themes in the report of immediate relevance to child health program implementers. The discussion addressed the funding options and perspectives of professional associations/pediatricians, NGOs, and other partners.
Presentations

- **Anthony Costello,** Professor of Global Health and Sustainable Development, University College London

- *Overview: the what and why of the Commission?*

- **Aku Kwamie,** Technical Officer, WHO
  - *A multisectoral approach and governance framework for addressing child health and development*
- **Tim Powell-Jackson,** Associate Professor in Health Economics, London School of Hygiene and Tropical Medicine
  - *Investing in child health and development and its benefits*
- **Tanya Doherty,** Chief Specialist Scientist, Health Systems Research Unit, South Africa Medical Research Council
  - *The role of data*

You can access to the recorded version of the webinar through this link
https://jsi.zoom.us/rec/play/vpYtf-j7rTo3Gd2UsQSDVqBwW47pLqisgSkYqfsMyEzhVyQDYQXwZ-EXa-OTro8tcX5-Iiu_X4u-laMh?continueMode=true&_x_zm_rtaid=14CGuYTvQGGnCGJQV2Djnw.1591047579551.0119890c32b5e2d4741d9cef5d620918&_x_zm_rhtaid=312

And this password 0j*%*8d+

7.3 Where is the voice of the child weighing the cost in this pandemic?

We are grateful to Ann Battersby (ISSOP formerly trainee group chair and now consultant paediatrician in London) for sending her letter which has just been published in the BMJ, written with a group of her colleagues. **https://www.bmj.com/content/369/bmj.m1669/rapid-responses**

Where is the voice of the child in weighing the cost of this pandemic?

Dear Editor,

As frontline paediatricians advocating for the rights and safeguarding of children, we applaud Dr Green's editorial (1) and call upon the government to shift the focus to children and the collateral damage they have suffered as a result of the pandemic in terms of their health and well-being.

Information regarding the pandemic has not been communicated in a child and youth friendly manner. New Zealand and Norway have both held press conferences for children only, whereas our government has never done this since the pandemic broke (2,3).

As a collective we share concerns around the vulnerability of our children and young people. We worry for the children at home, hidden from society and some living with the perpetrator of their abuse. Their voices and cries cannot be heard.

Calls to Childline have dramatically increased (4) and domestic violence arrests are up by 25% (5) but by contrast, our child protection referrals are down. Teachers, social workers, health visitors, community midwives – all partners in safeguarding - have had their interaction with children and young people reduced.

As paediatricians on the frontline, we have seen an overall decline in attendances to the emergency department (ED) but witnessed families and young people coming to ED for issues that would have been absorbed by community and safeguarding teams: babies exhibiting poor weight gain who may have been picked up via our community services pre-Covid-19; distressed mothers bringing their constantly crying babies who may have avoided medical attention with the presence of extended family to support; parents presenting late with their septic babies, fearful to come to hospital due to the virus.

We worry for the mental health of young people who we are seeing attending ED in crisis with nowhere to turn. Their triggers are varied (6) but isolation has certainly played a part (7). Having

previously been warned of the dangers of spending too much time in cyberspace, children and young people are now spending a vast amount of time online for education and socialisation and the risks are very real (8). Meanwhile their lives are on hold, impacting both emotional resilience and mental wellbeing.

Protecting children is everyone's responsibility and never have those words been more meaningful. We must all act now to give children a voice: not just the professionals to whom this role would ordinarily be given, but their local communities. By empowering neighbours, delivery drivers, supermarket workers and those who now may be the only ones seeing our young, through education, they may speak up and report any concerns to the NSPCC or Children's social care.

We call upon Government to direct resources to enable community workers from health, education and social care to visit homes and connect with children at risk. We also need a strategy to safely bring all children back to school.

We call upon Government to move quickly and decisively to try and repair the harm suffered by young, vulnerable people during this pandemic. Failure to do so will come at a price too high. Where is the voice of the child in weighing the cost of this pandemic? These children need a voice.

Reference:

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7.4 How prepared is Africa to face COVID-19?

By Raoul Emeric Guetiya Wadou and Andrew Clare

The epidemic of COVID-19 in China caused by the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) has become a global concern and subsequently labelled a pandemic by the WHO on March 11th. As the world mobilizes to contain the COVID-19, scientists and public health experts are increasingly alarmed about the potentially catastrophic effects of an outbreak in Africa. The establishment of Africa CDC and Prevention by the Africa Union in 2017 was an unprecedented move toward strengthening national responses, so far enabling all fifty-member states with confirmed cases of COVID-19 to adequately respond, break chains of transmission and effectively contain the spread of SARS-CoV-2. We enter an uncertain and challenging period that may severely test the preparedness, organizational resource and resilience of African states and the fabric of their societies. However, we speculate that the fear associated with COVID-19 may also lead to some of the long-standing messages about simple measures to reduce the spread, such as hand washing, finally becoming absorbed and more universally adopted by health workers and the public. Is it possible that regardless of the terrible threat posed by SARS-CoV-2, the increased adoption of these health protection measures may result in a reduction in the spread of other infectious diseases?
Full text in: https://www.panafrican-med-journal.com/content/series/35/2/1/full/

8. Correspondence + COVID-19

This month we have asked members to provide brief reports on their own and their country's experience of coping with COVID19.

8.1 Sweden: Staffan Janson

There has been a great international interest about how Sweden has handled the Corona epidemic, as Sweden has tried to keep the society as open as possible in contrast to many other countries. The basic idea has been to trust ordinary people´s sound judgement and ability to follow instructions from the National Public Health Authority about a good hygiene and social distancing. There was an early decision to keep pre-schools and nine-year compulsory schools open. The rationale behind this was that children need schooling, social stimulation and to meet with their peers. Isolation of younger children at home may have bad side effects. Many of their parents, needed in the health care and in the social service sectors, would have had to stay at home to look after their children. There is also a well-known greater risk for interpersonal violence and child maltreatment in isolated families with frustrated and unemployed parents.

Overall, the Swedish policy seems to have worked well except for the capital, Stockholm, where people´s response was slow. Consequently, the infection entered homes for older citizens, with high death tolls. Sweden also has much bigger contingents of refugees and immigrants than the other Scandinavian countries, and the infections spread quickly among them, as it took some time for information to penetrate these population segments. Compared to Scandinavia as a whole, where there has been an almost complete lock-down, Sweden has a higher death toll, mainly due to the reasons mentioned above. At the same time, Sweden has much lower death tolls than Belgium, France, Spain, Italy and Great Britain.

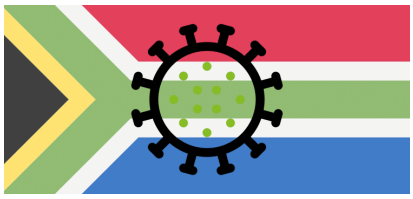
In spite of the "open society policy", some children are suffering. The teen-agers in the upper secondary schools and the university students have to follow the education through the internet staying at home. Most schools have adapted quickly to this type of education, but it does not fit all children and children become weary over time. Teen-agers with neuro-psychiatric disorders have great problems. There are also reports from the social services of a certain increase of social problems, addictions and maltreatment. Overall, children´s situation up to now seems to be well protected and the health services are working well for them.

An important and interesting discussion is that Sweden does not have any national ethical framework for decision-making during pandemics. There is i.e. no guidance how to handle a situation on how to keep a dignified farewell in the final stage of live when it comes in conflict with infectious dissemination.

Shall the country be locked down completely or stay open? Shall means to limit infectious dissemination be obligatory or voluntary? Is the idea of reaching a herd immunity always right or do we have to be more careful with the spread of unknown infectious diseases? Sweden, since long protected from war and major catastrophes woke up late, and have a lot to learn.

8.2 South Africa: David Hall

We have been largely silent observers of ISSOP, but felt it was time to respond. We have longstanding connections with South Africa and retired there in 2005. Without education SA cannot make progress in health and without literacy education is futile - so we have been very interested in the reasons why SA has just about the worst literacy rates in the world (see PIRLS studies). Since 2013 we have been supporting and working with an early literacy programme in Langeberg, initially in the Coloured community but just starting up in Zolani and Nkqubela, Black townships.



Currently we are locked down in UK as our return flight was cancelled but we are in regular touch with our project team in the area and supporting them as far as possible. Since President Ramaphosa took decisive lockdown action to try and slow the spread of COVID which could devastate the townships, hunger is the number one problem. but the response of local communities is amazing and humbling;

We also have a concern about whether immunisation rates can be sustained (a concern that also applies to Europe). We know what happened in Russia when the Soviet empire collapsed and diphtheria came back, we are sure there is polio in Angola and from pre-vaccine experience we know what measles can do in a susceptible under-nourished population. Fortunately there is an excellent public health worker network in SA - thanks to HIV and TB.

8.3 Spain: Reflections from the Frontline and Confinement COVID'S 19 Silver Lining, By Barbara Rubio

They say that every cloud has a silver lining.

I've been trying hard to find one to Covid 19.

One morning as I was driving to work in the week of srictest confinement measures during national lockdown, mine was one of the few cars you could see on the road. Nearly all of Madrid's road traffic had come to a halt and I found myself smiling and happy about it. It was a bright April spring day with clear blue skies and scattered white clouds. The air was clean and silent except for the different song tunes of the birds that were fussing all over as if one of Mozart's Flute Concertos was playing .

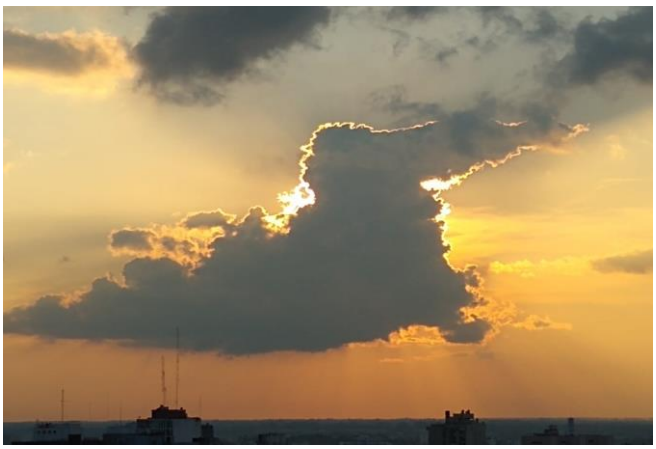


Photo: RM

As most of Madrid's citizens were forced indoors, I felt guiltily priviliged to be able to sense this cleanliness, this freshness and this unimaginable beauty of my city in midst of the horror of COVID 19. It was then that I wondered if there could be a silver lining to this dark cloud.

Arriving to the hospital though, and having to change into my scrubs and protective equipment, an adrenalin surge soared through my body and in one blink all the beauty I had sensed vanished into

thin air. Instead, I was confronted with the frightful look in the eyes of the men and women I had to medically assist as well as my own fears. Fear of not being able to succeed in treating them, fear of having to communicate another fatality case, fear of becoming another victim of COVID 19.

I wish COVID 19 had never happened. There is no justification for the loss of so many lives and all the sorrow of all those who remain. There is no justification for the loss of so many dreams and opportunities and for the deepening of the gap of the most vulnerable.

On the other hand, I don't want to go back to the life before COVID 19. Don't want to go back to the polluted air and the unbearable traffic. Don't want to go back to the ferocious consumerism, and the unsolidarity and indifference of society.

If COVID 19 has taught me something, it is that we don't need much to find happiness. It is the importance of having a family, friends and neighbours that love you and care for you, even from the distance. The comfort that a hug can give you and the rewarding gratitude of sharing and helping others. That no matter where you come from, north or south, east or west, you can always find a lending hand.

As we all search for a better world, let us use this pandemic as a catapult to reach that goal. Let us use the solidarity and generosity risen amongst us during the global pandemic and lockdown to create a better planet where every human and living being counts, and no one is left behind.

Let us, from our own little place in the world, join forces to build a silver lining to the pitch-black cloud of COVID -19.

8.4. Health and social impact of the COVID- 19 Pandemic on the lives of vulnerable children and families in New Delhi, India

Dr Rajeev Seth, Ananya Rattani, Yawar Qaiyum, Dr Shanti Raman

India is home to the largest child population in the world. Today, India's biggest challenge is to contain the COVID-19 public health crisis; prevent community transmission, provide diagnosis and treatment, while giving poor and marginalised populations economic and social support.

With rapidly increasing numbers of official cases, India stands at the 10th position in the list of worst-hit countries worldwide. The Government mandated lockdown measures to contain the pandemic, ranked as the most stringent in the world and implemented in the most draconian manner, has caused losses of livelihood and income of >400 million daily wage earners in the informal economy. Children of these poor families are particularly impacted by sudden school disruptions, neglect of health, nutrition, exacerbation of stress, abuse and exploitation including child trafficking, child labour and child marriage.

Bal Umang Drishya Sanstha (BUDS) (www.budsngo.org), a registered, non-profit organization led by social paediatricians – operates a mobile health van, drop in centres, provides meals, life-skills education and vocational training programs for at-risk adolescents in the urban slums of Delhi. Ever since the lockdown, BUDS' programs have switched to addressing the distress calls of starving families, supplying them cooked food, arranging dry ration, health education materials and essential supplies. BUDS has also liaised with different wings of the state government to provide relief for migrant communities in financial distress, by uploading their applications for e-rations and direct cash transfers.

BUDS front line workers come into contact with many children and families who are in extreme poverty. BUDS has reached out to over 6000 individuals with supply of dry ration thus far, with demand growing exponentially. Some of the challenges faced were captured by stories from young people:

Roshni (name changed), a 19-year-old girl, lives with her family of four. Her father was a daily wage worker, but due to an accident at work four years ago, he became paralysed. Since the accident, Roshni and her mother have been working to run the family, supporting her younger brother who dropped out of school. Roshni worked as a saleswomen, her mother as a house maid; the family survived on a total income of Rs 9000 ($120) /month.

Due to the lockdown, both Roshni and her mother lost their jobs. BUDS were able to connect her with a Government social-worker, who has helped arrange food delivery for affected families. Roshni has since then volunteered tirelessly to help BUDS distribute food and helped families by guiding them to the night shelter.

Roshni and her family are unsure if they will have jobs after the lockdown is lifted. Their plight is shared by many. But Roshni, like many other marginalised young people in India, is passionate about wanting to be part of the solution.

BUDS aims to raise awareness about the effect of the pandemic on the health and wellbeing of these marginalised children, make their voices heard by decision-makers and importantly build on young people's innate strength and resilience.

8.5 Corona Virus in Australia

By Kishor Napier-Raman, Shanti Raman

Australia has handled the COVID-19 pandemic better than most other Western countries. As of 24th May 2020, Australia has recorded 7109 cases (with just 501 still active) and 102 deaths. Since late March, the curve has flattened, and Australia's pandemic appears to be in its long tail phase.

The secret to Australia's success is multipronged. Non-residents coming from China were banned in January, and on 20th March, the borders were effectively closed. Returning travellers were forced to undertake a 14-day hotel quarantine. Since 21st March, all states have imposed tough social distancing measures, with all non-essential services including schools-shut, forcing the population to stay home.

Australia also dramatically scaled up its testing capacity, and has one of the highest testing rates in the world. Being an island makes border restrictions easier. A rule-abiding, well-educated population largely followed social distancing rules without fuss. The government put in place an economic stimulus package including free child care and a living wage.

Still, there have been missteps. The decision to let passengers disembark from a cruise ship without testing anyone was a disastrous failure of Australian Border Force and state health officials. By April, one in 10 Australian cases could be linked to the cruise ship.

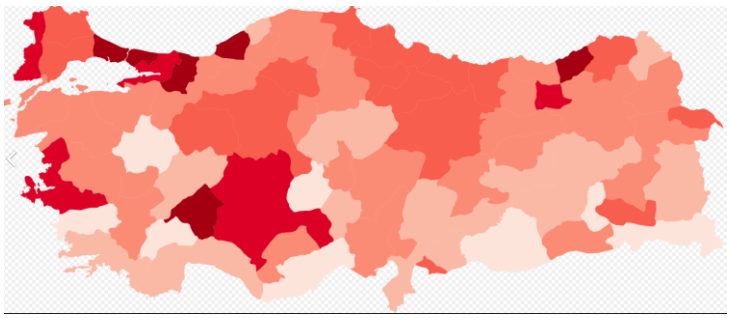
Prime Minister Scott Morrison downplayed the pandemic's seriousness early on. In spite of economic support packages, workers in many sectors have had little help from the government, and unemployment has jumped.

From a children/young people perspective, the impact of the virus itself has been minimal, with roughly 200 infected and no deaths. Although measures are in place to mitigate some potential harms to children associated with pandemic prevention interventions, there are a number of cohorts of children for whom interventions pose increased risks to health, welfare and survival.

These include children in the care and protection system, children of Aboriginal background, refugee or migrant background, children of families already diminished by dislocation, isolation, poverty, homelessness and illness.

8.6 COVID 19 and Child rights in Turkey
Gonca Yilmaz

COVID-19 disease was confirmed to have reached Turkey on 11 March 2020, after a man who had returned to Turkey from Europe, tested positive. The first death due to COVID-19 in the country occurred on 15 March 2020 and by 1 April, it was confirmed that COVID-19 had spread all over Turkey. On 14 April 202 0, Turkey has reached its peak in the fourth week and started to slow down.



Turkey map with variations in COVID-19' case-incidence (modified RM)

In contrast to many developed Western countries, Turkey is among the group of countries that are successfully combating the pandemic. The rapid increase of the confirmed cases in Turkey did not overburden the public healthcare system, and the preliminary case-fatality rate remained lower compared to many European countries. Discussions mainly attributed these to the country's relatively young population and high number of available intensive care units.

Despite the mild nature of this pandemic, children's lives have been turned upside down by Corona pandemic in Turkey. In my country too, children were not the face of this pandemic but they have risked being among its biggest unseen victims (UN Policy Brief, April 2020).

What happened to children rights in Turkey, if I summarize here:

Families have lost their jobs, child poverty has increased sharply. The Turkish Governmental response to this pandemic, has laid bare and execarbated pre-existing long time social inequalities and vulnerabilities in the country (Right to standard living adequate for the child's development, Right to non-discrimination).

Unable to go to school or participate in activities outside of the home, children have experienced a significant loss in their education, limited connection with classmates and reduced physical activity. Many families don't have a laptop, tablets or computer so reliance on online learning has a discriminatory effect. Between schools being closed and playdates being cancelled, children's routines were anything but routine.

Risks to child safety have increased within lockdown. Homebound children may have been exposed to more domestic violence and abuse

(Right to to freedom from all forms of violence).

We should also think about impacts of poor housing on homebound children.

Some children have lost connections with those who care for them, for instance grandparents etc.

Hospital appointments have been cancelled due to the outbreak. It has been crucially important for some children with chronic disease (Right to highest attainable standard of health).

Mental health impacts have been huge. While caretakers were under tremendous stress, children were feeling the impact, too. Even young children with little or no grasp of current events were sensing the anxiety of those around them and adjusting to new routines. I have seen many damaging effects of psychological stress in children at this period. Many had developed anxiety symptoms, depression, lethargy, sleep disturbances and impaired social interaction. Reduced appetite have been very common. Temper tantrums have also increased.

In my clinical practice,

1. I have seen that my children patients have had many questions about coronavirus, and needed age-appropriate answers that don't fuel the flame of their anxiety. Child-friendly and accessible information were so important. I have listened to them directly and helped them to express their concerns.
2. I have spoken in a plain and clear language, based on information that our government has provided us. I have tried to steer away them from fake news.
3. I have helped them understand the rules of washing their hands, keeping a distance, respecting the rules. Sometimes I have used figures and pamphlets.
4. I have recommended families to keep them occupied with things that they like to do as a family.
5. I have provided mental and psychosocial support to children and families.

I think there is no specific child rights assesment related to the corona outbreak in Turkey yet. We need data and studies on this important subject.

8.7 What about Russia and the pandemic?

Nataliya Ustinova

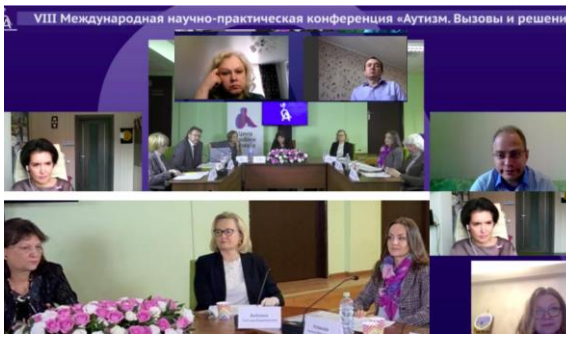
Pic. Typical Soviet «dacha" – cheap small summer cottage (they became again in demand during the pandemic)

By and large, the pandemic response of the authorities and people in Russia is about the same as in most European countries. Therefore, I do not want to repeat, but I dwell on some features.

Firstly, such high prestige of doctors as during the pandemic has never been before in Russia. A doctor in Russia is a profession formally respected but not adequately paid. It can be assumed that this is due to the free of charge (*depreciated*) health care which existed in Soviet times. I would like to hope that after the pandemic, the prestige of the profession will increase, and the state financing of health care will increase as well.

What else? The fact that the *relatively* calm passage of the pandemic is associated with the preservation of some features of the Soviet health care system (many hospital beds, long hospitalizations, centralization of administration of hospitals, state health care system).

Now my professional interests are related to families with autism. This is an issue, how do they survive a lockdown. For children with autism, routine activities (walking, sports), the continuity of the educational process, and social interactions are very important for a good level of adaptation. The pandemic robbed them of all these activities. Parents wrote a letter to the mayor of Moscow asking to allow children with ASD to walk but were refused. Moreover, not all parents supported the request, many believed that everyone should comply with the lockdown. Given the lack of scientific data, it is difficult to determine who is right.



During the pandemic, an important event was held in Russia for everyone involved in autism problems: families, patients, specialists: online marathon conference: "Autism: challenges and decisions". This conference is being held by the society of parents of children with autism. Leading experts from different countries (Canada, USA, EU, Russia) spoke: scientists, doctors, ABA-therapists, and others.

This is the 8th conference, the previous 7 were in a full-time format. So, many parents from the regions of Russia admitted that thanks to the pandemic, they had the opportunity to participate in the conference for the first time. Finally, two round tables discussion were held on important issues of multidisciplinary support for ASD patients with expanding the role of the paediatrician and providing educational needs.

I guess the online format will not go away, as for many people this is the only access to information. During the pandemic, we all have gained such experience.