ISSOP e-Bulletin № 39
May 2019

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1. Introduction

The time for the ISSOP Congress in Beirut is fast approaching and this will be one not to miss, both for the subject and the chance to visit a very special part of the world. The full programme is now on the website and you can view it at www.issop.org

Our main focus in this month's bulletin is on immunisation and the very difficult situation in many parts of the world including Europe owing to misinformation and opposition to this life-saving preventive measure. What is behind this and how should paediatricians and health workers respond? See the articles at 4.1, 7.1, 7.2 and 7.3.

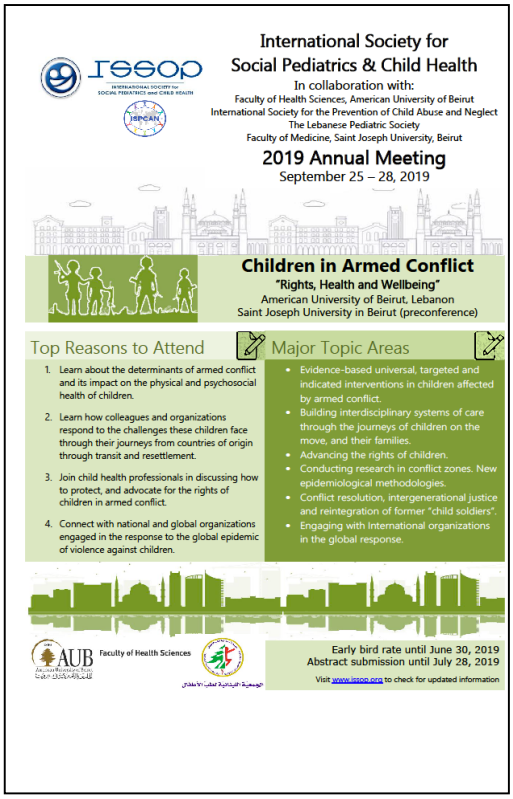
We have two interesting reports from Russia, see 2.5 and 4.3 and also report from the RCPCH and IPA meetings.

As always please send your news and reviews to editor@issop.org

Tony Waterston, Raul Mercer, Rita Nathawad, Gonca Yilmaz, Natalya Ustinova

2. Meetings and news

2019 ISSOP'S ANNUAL MEETING: A MUST DO !



The next ISSOP annual meeting will take place in Beirut, Lebanon from the 25th to the 28th of September in co-sponsorship with the American University of Beirut, the International Society for the Prevention of Child Abuse and Neglect, the International Paediatric Association and the Lebanese Paediatric Society.

The theme of the conference is related to the grave situation of Children in Armed Conflict, their rights and their well-being.

WHY IS IT IMPORTANT TO ATTEND THIS MEETING?

Because the reality of the situation shows:

- The number of children living in conflict zones has doubled since the end of the cold war and children suffer on a large scale from its indirect consequences.
- The number of 'grave violations' of children's rights in in armed conflict situations, reported and verified by the United Nations have almost tripled since 2010.
- The protection of children in armed conflict is one of the defining challenges of the 21st century.

Because recent history has shown that when there is political will, action and funding, the protection of children is possible.

For these reasons and many more ISSOP's objectives for this conference include:

- Give worldwide visibility of the actual situation of children and youth in armed conflict.
- Increase awareness of the complexity and long-term effects of armed conflict in children.
- Bring together experts and institutions dedicated to improving the response to children critically affected by armed conflict and share their expertise as well as identify gaps on research and practice.
- Create partnerships with national and international organizations and together find ways to take practical action on the ground.
- Establish a post-conference implementation plan that will operationalize the recommendations generated during the conference.

Save the date!! الـ تاريـ خ احـ فظ

Barbara Rubio, Spain

PROGRAMME

International Society for Social Paediatrics & Child Health
2019 Annual Meeting

Children in Armed Conflict

"Rights, Health and Wellbeing"
American University of Beirut, Lebanon
Saint Joseph University in Beirut (preconference)

In collaboration with the Lebanese Paediatric Society, and the International Society for the Prevention of Child Abuse and Neglect

PRE-CONFERENCE: WEDNESDAY, SEPTEMBER 25TH

Child Protection and Promotion in Armed Conflicts: Every child - All children!

08:00-09:00 **Registration**
09:00-09:30 **Opening Ceremony**
09:30–10:15 **Morning Sessions**

Plenary

- ISPCAN and the WHO INSPIRE strategies: The example of Child Protection Teams in Lebanon and the Arab region within the UN Global Partnership to #EndViolence
  Speaker: **Bernard Gerbaka**
- ISSOP and the Position Statement on Ending Violence against Children: What can Paediatricians do?
  Speaker: **Shanti Raman**

Capacity building for multidisciplinary child protection teams in conflict zones

- From case-management to policies; Tertiary Prevention, emergent protection and CPT intervention
  Speakers: **Marianne Majdalani, Pamela Zgheib,** and **Miryam Amm-AbiGhosn**

Strategies of Child Protection within the SDGs

- WHO INSPIRE adapted to children in armed conflict
  Speakers: **Samar Tawm, Alissar Rady, Serop Ohanian,** and **Howard Karaghueusian**

14:00-18:00: Afternoon Sessions

- Tools for psychosocial assessment of children exposed to conflict
  Speakers: **Saleh Al Salehi and Karen Zwi**
- Early identification of children with developmental disabilities
  Speakers: **Joseph Haddad and Donald Wertlieb**
- Clinical assessment of gender-based violence and sexual assault using a trauma-focused lens
  Speakers: **Barbara Rubio and Shanti Raman**

CONFERENCE DAY 1: THURSDAY, SEPTEMBER 26TH
VENUE: FACULTY OF HEALTH SCIENCES, AUB

08:00-09:00 REGISTRATION

09:00-09:30 OPENING REMARKS

- Iman Nuwayhid, M.D., Ph.D., Dean of Faculty of Health Sciences at AUB
- Miguel Abboud, M.D., Chair of Paediatrics, AUB Medical Center
- Jeff Goldhagen M.D., MPH, President of ISSOP

09:30-10:30 KEYNOTE ADDRESSES

Determinants of armed conflict. Can war and its impact on children be prevented?

Chair: **Tony Waterston**

Speaker: **His Royal Highness Prince El Hassan bin Talal**

Protecting Children in Conflict Zones

Chair: **Jean Bowyer**

Speaker: **Bill Forbes** (World Vision International. Global Lead, Child Protection and Participation).

10:30-1100 COFFEE BREAK

THEME 1. Understanding the Effects of Armed Conflict on Children

11:00-11:15 Introductory Keynote: Joop de Jong

11:15-12:30 PLENARY 1 - Physical Health of Children Exposed to Armed Conflict

Chairs: **Margaret Lynch & Raya Saab**

- *Direct and indirect effects of armed violence on children*
  Speakers: **Ayesha Kadir**
- *Children with chronic and disabling conditions*
  Speaker: **Nahla Ghandour**
- *Care of Children with Cancer in Conflict Zones*
  Speaker: **Miguel Abboud**

12:30-13:45 PLENARY 2 - Mental Health of Children Exposed to Armed Conflict

Chair: **Joop de Jong**

- *Prevalence of mental health problems in conflict zones*
  Speakers: **Mina Fazel**
- *Strengthening Mental Health Systems*
  Speaker: **Rabih El Chammay**
- *Resistance and Resilience*
  Speaker: **Bernard Gerbaka**

13:45-14:45 LUNCH

THEME 2. Child Rights-Based Approach to Ending Violence Against Children

14:45-15:45 PLENARY 3: Child Rights: Principles, Standards and Norms

Chairs: **Gonca Yilmaz & Charles Oberg**

- *Armed Conflict as a Violation of Child Rights*
  Speaker: **Gerison Lansdown**
- *A CRBA to the Response to Humanitarian Emergencies*
  Speaker: **Ana Isabel Guerreiro**

15:45 -17:15 PARALLEL SESSIONS

1. ***Humanitarian Responses in Conflict Zones: Médecins Sans Frontiers***
   Chair: **Ayesha Kadir**
   Speakers: **Médecins Sans Frontiers (MSF)**
2. ***Psychosocial Assessments: Innovative global tools for health professionals***
   Chair: **John Eastwood**
   Speakers: **Marit Sijbrandij and Kelly McBride (Save the Children)**
3. ***Engaging the Voice of Children: Generating Resilience and Resistance***
   Chairs: **Aimee Shalan & Gerison Lansdown**
   Speakers: **Youth Peer Educators for Beit Atfal As Somoudi (*MAP programme in Lebanon –***
   Director of Programmes: Dr Ali Dakwar)

17:15-17:30 TEA BREAK

17:30- 18:45 PARALLEL FREE PAPER SESSIONS (ORAL)

Chair: **Gulbin Gokcay**

Featured Speakers**:**
Salman Mroueh (AUBMC)**:** *The environment and lung health in children.*
Khalid Yunis (AUBMC): *Maternal health and prematurity in conflict settings*

CONFERENCE DAY 2: FRIDAY, SEPTEMBER 27TH

08:00-09:15 KEYNOTE ADDRESSES

- ***Personal & Professional Reflections: Living and Practicing Paediatrics in a Conflict Zone***
  Chair. **Joseph Haddad**
  Speaker: **Motee Ashhab** ***Palestinian Paediatric Society***
- ***Reducing the Threat of War***
  Chair: **Tony Waterston**
  Speakers: **Sam Perlo-Freeman** (Campaign Against Arms Trade - CAAT)
  Tilman Ruff (International Campaign to Abolish Nuclear Weapons- ICAN)

THEME 3.Conducting Research in Conflict Zones: Challenges, Methods and Ethics

09:15-09:30 Introductory Keynote: Elif N. Özmert

09:30-11:00: PLENARY 4: Research in Conflict Zones

Chair: **Nick Spencer**

1. *Ethics of research: Involving youth, families, the community & community researchers.* Speaker: **Anna Chiumento**
2. *Selection of research methods: RCTs, quasi-experiments, prevalence studies, mixed methods (quantitative and qualitative), systematic and narrative reviews.* Speaker**: Dr Usman Hamdani (HDR Foundation)**
3. *Challenges and barriers: Access/identifying respondents & populations/consent (issues of fear of speaking out) & safety of researchers*.
   Speaker**: Fouad M. Fouad**

11:00-11:30 COFFEE BREAK

11:30-13:00 PARALLEL SESSIONS

1. ***Research Methods in Conflict Zones***
   Chair: **Karen Zwi**
   Speakers: **May Aoun:** EASE an RCT in progress funded by War Child
   Trudy Mooren: Multi-Family approach and Education:
2. ***Pilot Study in Yemen. Save the Children***
   Chair: Stella Tsitoura
   Speakers:
   - **Kelly McBride -** Understanding direct impact and coping mechanisms of children to inform MHPSS program interventions
   - **Andrew Clarke –**Development and evaluation process of a crisis modifier framework in southern Yemen
3. ***Identifying Torture and Abuse Among Children in Conflict Zones (Part 1)***
   Chair: **Jeff Goldhagen**
   Speaker: **Colleen Kivlahan**
4. ***Public Health Response in Conflict Zones***
   Chairs: **Shanti Raman & Fouad M. Fouad**

   - *Vaccine Delivery Programmes and Vaccination Hesitancy in Conflict Zones*
     Speakers: **Naveen Thacker** (IPA)
   - *Dealing with infectious diseases epidemics in humanitarian settings*
     Speaker: **Daniel Martinez** (MSF)
   - *Responding to Reproductive, Maternal, Newborn, Child & Adolescent Health and nutrition in humanitarian settings.*
     Speaker: Egmond Evers (WHO)

13:00-14:00 LUNCH

THEME 4. Systems, Education and Advocacy

14:00-14:15 Introductory Keynote: Margaret Lynch

14:15-16:00 PLENARY 5: International Advocacy
Chair: **Nick Spencer**

- *The role of UN agencies and NGOs: Panel Discussion*
  - MAP: **Aimee Shalan**
  - MSF: **Florencia Romero**
  - Save the Children**: Kelly McBride/Andrew Clarke**
  - World Vision International: **Bill Forbes/Amanda Rives**
  - UNICEF: TBA
  - UNHCR: TBA
  - WHO: TBA
- *The Role of international Paediatric Organizations. Panel Discussion*
  - IPA: **Joseph Haddad & Naveen Thacker**
  - AAP**: Colleen Kraft**
  - RCPCH**: Russell Viner**
  - ISSOP: **Jeff Goldhagen**

16:00-17:30 PARALLEL Sessions

1. ***Why and How Children are still being recruited into armed groups and conflict.***
   Chair: **Geir Gunnlaugsonn**
   Speaker/s: **World Vision International**
2. ***Regional Issues: Similarities and Differences: How to manage post conflict challenges. Bringing science to hope***

   Chairs: **Barbara Rubio & Olivier Duperrex**
   - *Middle East:* **Rabih El Chammay**
   - *Africa:* **To be announced**
   - *Pakistan:* **Usman Hamdani**
   - *Latin America:* **Raul Mercer / Ernesto Duran**
   - *Balkans*: **Milivoj Jovancovic**
3. ***Preparing Pediatricians to Respond to Humanitarian Emergencies***
   Chair: **Shanti Raman**
   Speaker**: Dr Saleh al Salahi**
4. ***Identifying Torture and Abuse Among Children in Conflict Zones (Part 2)***
   Chair: **Luis Martin**
   Speaker: **Colleen Kivlahan**

17:30-19:00 TEA BREAK + AGM
19:30 EVENING – CONFERENCE DINNER

CONFERENCE DAY 3: SATURDAY, SEPTEMBER 28TH

08:00-09:00 PARALLEL FREE PAPER SESSIONS
Chair**: Anna Battersby**
09:00-10:00 KEYNOTE ADDRESS

Mental Health and the War on Children
Chair: **Joop de Jong**
Speaker: **Theresa Betancourt**

10:00-10:30 COFFEE BREAK

THEME 5. Engaging Paediatricians in the Global Response to the Impact of Violence and Armed Conflict on Children

10:30-13:00 PLENARY 6
Chair: **Jeff Goldhagen**

Strategic Planning Panel Discussion
- WHO; UNICEF; UNHCR; ISPCAN; World Vision; War Child; AAP; RCPCH; IPA; UNRWA; MSF; SAVE THE CHILDREN, WHO

13:00-13:30 CLOSING REMARKS
14:00 VISITING TOUR

2.2 RCPCH motion on infant formula sponsorship

At the Annual General Meetings of the Royal College of Paediatrics and Child Health, members may propose a motion on any topic relating to the work of the College and this is a mechanism which is used to bring an element of democracy into the work of what is often a rather bureaucratic organisation.

The motion has to be voted on and the leadership must listen, though not necessarily obey! When the members voted 3 years ago to end sponsorship by infant formula manufacturers, the President and officers got around this by carrying out a somewhat biased survey of all members, which re-instituted sponsorship under rather loose conditions.

The new President elected last year is Professor Russell Viner who brought this matter back to the RCPCH Council following adverse publicity in the Lancet and BMJ, and sponsorship was ended in February 2019. The following motion was passed overwhelmingly at the AGM in May:

This meeting warmly welcomes Council's decision on 13th February 2019 to decline all future funding from Formula Milk companies. We reiterate RCPCH's enduring commitment to the World Health Organization (WHO) International Code of Marketing of Breastmilk Substitutes ("the Code"). We accept the WHO position that "The Code" and subsequent relevant WHA resolutions "must be considered together in the interpretation and translation into national measures". This includes resolution 69.9, which called upon healthcare professionals to implement a recommendation that "any donations to the health care system (including health workers and professional associations) from companies selling foods for infants and young children represent a conflict of interest and should not be allowed" and that "sponsorship of meetings of health professionals and scientific meetings by companies selling foods for infants and young children should not be allowed". This meeting requests that RCPCH encourage all its partner and subsidiary organisations to become similarly adherent to "the Code" and subsequent resolutions.

The President and officers agreed to be bound by this motion and work will continue to bring other national paediatric associations on board. Please make use of the ISSOP declaration on conflict of interest https://www.issop.org/2019/03/26/issop-declaration-conflict-of-interest-and-funding-from-the-baby-food-industry/ and take this issue up with your own national association. Your reports on any action taken will be most welcome.

Tony Waterston

2.3 IPA Leadership and the SDG's

The Lancet published a comment by the IPA leadership on paediatricians and the SDGs (https://doi.org/10.1016/S2352-4642(19)30063-X)*. Below is a short extract. It is a powerful challenge to paediatricians and their societies to "step outside their comfort zones of clinical practice and academia" and become" major custodians of the SDGs in the quest to optimise child health and development globally."

The focus on social justice and equity and the need for paediatricians to recognise and act on the social, economic and environmental determinants of child health and advocate for the rights of all children is in line with ISSOP's mission. We have promoted this approach to child health and development globally in our Position Statements on Equity(https://www.issop.org/2018/06/24/issop-position-statement-1-updated-addressing-inequities-child-health-development-towards-social-justice/) and the SDGs & Child Rights (https://www.issop.org/2016/08/15/issop-position-statement-7sdgschildrights/) amongst others and a series of Declarations on key global child health issues.

ISSOP, as an IPA affiliate, has played an important role in enabling this shift in focus and priorities by the IPA leadership and we are in a position to provide essential expertise and commitment in working with paediatricians and their organisation to promote Equity and the implementation of the SDGs and meet the challenge laid down by the IPA.

"We believe that paediatricians and paediatric societies are major custodians of the SDGs in the quest to optimise child health and development globally. Addressing issues of maternal and child health through the lens of human rights should be a core mission for every paediatrician. Ensuring that every child has access to education, freedom from gender discrimination; and safe and secure neighbourhoods and home environments are fundamental corner stones for nurturing care. It is imperative that paediatric associations move away from only health and nutrition-based activities to those that also address social and cultural determinants of health and promote equity. This task might not be easy. WHO includes individual characteristics and behaviours among the key drivers of the social, economic, and physical environment for health, including elements of deep-seated discrimination on the basis of race, ethnicity, or gender. Addressing these fundamentals should be the goal of every paediatrician in personal practice and population settings, and would require paediatricians to step-out of their comfort zones of clinical practice and academia. It would also mean they would have to take a strong, pro-active stance on social issues, such as that taken by paediatricians in North America in their stark condemnation of family separations at the US–Mexico border."

Nick Spencer

***This paper is not open access**

2.4 Equal protection for children in Scotland

I have just received this message from a Member of the Scottish Parliament, John Finnie. The Royal College of Paediatrics and Child Health supports this new legislation.

TW

Leading the Change

Dear Tony,

I am delighted that parliament has this evening backed my Bill to provide children with equal protection from assault, following the stage one debate. This is the first hurdle in a three-stage process. I was originally approached shortly after the last election, in June 2016, by the coalition of children's charities - Barnardo's Scotland, NSPCC. Children 1st and the Children and Young People's Commissioner's office - to take forward a Bill that would enshrine a simple principle in law; that children should have the same legal protection from assault as adults do and I am immensely grateful for their ongoing support and encouragement since then. The Scottish Greens believe firmly in equal rights and non-violence. I'm proud that we're leading the change, and I look forward to this Bill becoming law so that children in Scotland are protected from violence just as they are in dozens of countries across Europe and the world.

Thank you for your continuing support.

Kind regards

John

PS – If you's like to find out more, have a look at this blog I wrote last year about why I decided to bring the Bill forward

2.5 Thyroid disease in Russia

By Elena ANTONOVA, PhD, MD

Head of the laboratory for Research Forecasting and Planning, National Medical Research Center of Children's Health (Moscow). Research Interests: public health; children morbidity, mortality and disability; medical care; healthy lifestyle and prevention.

Since 2009, the World Thyroid Day has been celebrated annually on 25 May in many countries. According to medical statistics, up to a third of the world's population suffers from various problems in the thyroid gland.

Large-scale epidemiological studies conducted by endocrinologists have shown that iodine consumption in Russia is three to four times less than the daily norm (on average, no more than 80 micrograms per day). In some regions iodine deficiency is more pronounced (Republics of Tuva and Altai, Irkutsk region, some territories of the North Caucasus). According to modern estimates, the entire territory of our country can be considered to a certain extent iodine deficiency. But often, even citizens living in coastal regions have iodine deficiency.

Insufficient intake of iodine from food is the cause of 65% of thyroid diseases in adults and 95% in children. Iodine deficiency leads to a number of serious consequences: thyroid disease, miscarriage, malformations, exacerbates the course of cardiovascular disease and Alzheimer's disease. Iodine deficiency has social consequences among children. For example, it can exacerbate the deviant behaviour of adolescents and contribute to poor school performance.

Iodine deficiency has a negative economic effect: according to experts, the annual cost of treatment and rehabilitation of patients with thyroid diseases associated with iodine deficiency is more than 270 billion rubles. And that's not counting the social damage.

In Russia, almost a million children — 915,000 - are registered for thyroid diseases, 90% of which are associated with chronic iodine deficiency in the diet and require diagnostic and therapeutic measures, rehabilitation, and constant dynamic monitoring. The prevalence of endemic goiter in schoolchildren is on average 20%. It should be borne in mind that the actual prevalence is several times higher than recorded.

In the 1990s, the iodine deficiency programme was affected by known political and economic factors. Some factories for the production of salt appeared to be outside the country. Only in 1999 there was a decree of the government of the Russian Federation adopted, which set the task of eliminating iodine deficiency and proposed a number of measures. And this decision gave a significant effect: in regions were adopted related programmes, provided iodizing certain foods. But today those measures can no longer be considered sufficient.

The most effective way to solve the problem of iodine deficiency from both medical and economic points of view is the maximum possible transition to the use of iodized salt in everyday life and in the food industry. Successful experience of elimination of iodine deficiency diseases in this way was implemented in the USSR. Such a model is used today in many countries of the world, including neighboring countries – Belarus, Kazakhstan, Armenia, Kyrgyzstan. In our country, iodized salt in the diet is consumed by less than 30% of the population.

The Ministry of Health has prepared a bill providing for the phased introduction of salt iodization. The law shall enter into force in stages within three years. That is, if it is adopted in 2019, it will come into full force in 2022. Normalization of iodine consumption by the population can occur within three years from the date of full entry into force of the law. The project will help to solve the problem of iodine deficiency in 10 years. In 10-15 years, it will allow to eliminate iodine deficiency cretinism and associated disability, reduce the number of operations for nodular forms of thyroid diseases by 30-40%, increase the life expectancy of patients with thyroid diseases by 7-10 years. Such colossal results can be obtained by adding this simple trace element to the simple salt.

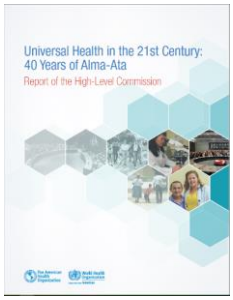
3. International Organisations

3.1 New UN Special Representative on Violence against Children appointed

The new UN Secretary General Special Representative on Violence against Children has been appointed. It is Dr. Najat Maalla M'jid, of Morocco. You can read more here: https://violenceagainstchildren.un.org/news/najat-maalla-m%E2%80%99jid-morocco-appointed-special-representative-secretary-general-violence-against

3.2 Alma-Ata is still alive

Universal Health in the 21st Century: 40 Years of Alma-Ata



Report of the High-Level Commission. PAHO/WHO
In 1978, representatives of the health and development sectors met in Alma-Ata an issued and unprecedented declaration for "Health for All in the Year 2000". 40 years after, and recognizing the accumulated experiences and the duty to respond to inequality, they called on the international community to urgent action: Health must become a condition for the well-being of all people, no one should be excluded and health should be promoted as a guaranteed human right. **RM**

http://iris.paho.org/xmlui/bitstream/handle/123456789/50742/9789275120682_eng.pdf?sequence=16

4. Current controversy

4.1 Should immunisation be compulsory?

David Elliman and Helen Bedford From UK give their views

Against a background of global increases in measles cases, some senior members of the health service have said that we might need to consider mandatory vaccination. Indeed, a recently published paper said that, for a number of European countries, including UK, this might be the only way to achieve adequate uptake rates. But is it necessary and would it achieve its objective? Uptake rates in UK, while not high enough, are not far off those necessary to eliminate measles. 95% of UK 5-year olds have had one dose of MMR and 87% two doses. The reasons for this short fall are not active antivaccination sentiments, but practical and logistical problems. We need to ensure that we provide family friendly clinics, using call-recall systems and staffed by personnel with the time and knowledge to answer parents' questions. If we attend to these issues, should mandating be considered? What form would it take? Unimmunised children being excluded from school? Denial of welfare benefits? It is likely that the disadvantaged would suffer most while the well-off would arrange alternative education or stomach any loss of income. In addition, some people who were not against vaccination per se, may object to state interference and object on principle. Might people delay having their children vaccinated until required when they start school? We should work harder to ensure these other measures are in place first. In the UK setting, mandating might be counter-productive.

David Elliman
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DE is also immunisation adviser to RCPCH

Helen Bedford
Professor of Children's Health
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London WC1N 1EH

4.2 Where will paediatric societies get their funding?

ISSOP is calling for paediatric societies to end funding from the Baby Food industry. Where then should they or can they obtain funding to run conferences and organise educational programmes for trainee doctors?
The following is my personal opinion and I would like to invite readers to propose their own solutions.

1. **Use of the internet and distance learning**
2. **In-country meetings with video conferencing**
3. **Establishment of a travel fund**
4. **Other sources of sponsorship**

- **Use of the internet and distance learning**

Questions must be raised over the educational value of overseas conferences. For researchers in a particular field it is valuable to meet colleagues and exchange data on techniques and sources of funding; for clinicians it is enjoyable to talk over different approaches to management. However, the educational benefits of lectures are known to be limited. There is now considerable research on distance learning over the internet and a large variety of courses are available which do not require any travel. Webcasts are also common and may be interactive.

- **In-country meetings with video casting.**

It's still good to get together with colleagues at a scientific meeting. Why not do it within your own country, thereby avoiding foreign air travel, and attend a centre where the conference proceedings can be beamed in over the internet? Several centres round the world could be linked together this way, it just requires efficient use of technology.

- **Establishment of a travel fund**

Still want to travel? Then plan to attend by train rather than plane, and build a travel fund to allow members from low income countries to attend – for them this could be life-changing. Set a sliding scale for conference costs and request those from upper income countries to pay in to the fund to cover the costs of those who are less well off.

- **Other sources of sponsorship**

Seek ethical sponsorship from other sources than the baby food industry, such as vaccine manufacturers. Personally, I would prefer that ISSOP eschew all sponsorship, which always comes with strings attached (and definitely to be avoided with Big Pharma). How could accepting vaccine manufacturer funding be harmful? Well those members of the public who are anxious about vaccine safety could say – 'How can we believe those paediatricians/ nurses/health workers? They are in the pocket of the vaccine manufacturers!'

Comments on this article are very welcome especially if based on experience.

Tony Waterston

4.3 Age of consent in Russia

Elena Biryukova, Russian Federation, Moscow *e-mail: elena.birukova2017@yandex.ru*

Ph.D., Head of the Laboratory "Organization of Nursing in Paediatrics" of the Ministry of Health of the Russian Federation (2012 – present time). She works in the Medical Scientific Research Center of Children's Health of the Russian Ministry of Health since 2003. She is the curator of the project for the development of nursing cohort of the Center. Her responsibilities include organizing and conducting forums for nurses of Russia together with foreign colleagues (2011–2019). The field of scientific interests is the study of the role, which a nurse plays in the development of nursing staff to raise the status of the profession, study of legal issues in the field of health care, has a second higher education with a degree in law.

Minor patient as a recipient of medical services

The legal status of a minor in the Russian Federation is understood as "the legal status of a citizen under 18 years of age directly related to society and the state."[1] The main task of the state is to protect the rights of a minor citizen, both by domestic and international law. Article 24 of the Convention on the Rights of the Child reflects the possibility of receiving the highest priority health services. The UN Committee on the Rights of the Child proposes to ensure that all minors have access to medical equipment, goods, and services, including counseling and medical services in the areas of mental, sexual and reproductive health[2].

Of particular interest is the issue of implementation of the minor's rights for medical services, which is, in fact, one of the most difficult problems. The Convention on the Rights of the Child indicates that the member states shall endeavor to ensure that no child is deprived of his or her right to access health services.

Based on the review of scientific research, we see the insufficient implementation of the rights and interests of minors to consent and refuse medical intervention, as well as to preserve the medical secrecy. For example, in the area of health care for children of different ages, the general legislation provides that, upon reaching the age of 15, a minor may decide on the medical intervention, i.e. to give their consent or refusal.

Related to this age is the right of a minor to have access to information on his or her state of health.

[1] Schmantsar A. A. Quality medical care in the system of compulsory medical education // Social and pension law. -2015. - № 1. - P. 32.
[2] Convention on the Rights of the Child (approved by the UN General Assembly 20.11.1989) (entered into force for the USSR 15.09.1990) // Collection of international treaties of the USSR, issue XLVI, 1993.

However, despite the existing rule that allows minors who have reached the prescribed age to make an individual decision on medical intervention, in some cases the consent of parents is required up to the age of majority of the child.

The role of minors determines their social and legal status in the enjoyment of their rights and obligations (medical examinations, access to available information on the state of health, medical rehabilitation) and protection of their interests in the field of medical services, which are regulated by law. Therefore, it is necessary to ensure a legal balance between degrees of involvement of an adult and a child, since minors cannot fulfill themselves without the help of others due to their individual development and psychophysical characteristics.

Thus, the legal and regulatory norms that determine the social and legal status of a minor in the field of medical care should ensure that the opinion of a minor is taken into account and specify the term "free informed consent" of the minor considering their level of development and awareness of the decisions they make about their health.

5.CHIFA Report

CHIFA is looking for another volunteer moderator!

The task is not complicated but is very interesting and you will learn a lot about child health problems around the world and what is being done to tackle them. You will join a team of (currently) three who join a rota to moderate messages for a week at a time. This means reading the message, checking that it is factually and grammatically correct and adding the profile of the sender, then approving it for circulation. We like to approve new messages within a few hours of receipt. The work is not heavy, as it is unusual to have more than two messages a day and often there are none. If you are interested, contact the lead moderator:
Tony Waterston tony.waterston@ncl.ac.uk

6. Trainee report

6.1 Reflection on Being a Child Advocate

By Douglas Nordii, M.D., Paediatric Resident, University of Florida, Jacksonville

As a Paediatric trainee, I recently attended the Jacksonville *Child Friendly Cities in North America Expert Group Meeting*, interested in child advocacy and eager to learn more. Over the three days, I listened to some of the world's most influential child advocacy voices discuss the road to establish child friendly cities in the US.[3]

Throughout it all, I realized, somewhat shockingly, that our professional titles do not automatically mean we are child advocates.

[3] https://childfriendllycities.org

Some might ask "How can those who work with children not be child advocates?" Most people who work on behalf of children would certainly consider themselves advocates, and that this self-image is an important part of their professional esteem. However, considering oneself a child advocate, versus actually practicing child advocacy, may be entirely different.

During a break in the meeting, a school principal's comment was particularly poignant. He spoke about his path to making his school child friendly and summarized the main theme that lead to success: "Simply put, every decision made was based on one question, "Is this in the best interests of children?"

As we as child health professionals work to help children, do we maintain the child's best interest in mind? Do we find ourselves thinking what might be in the best interests of the child instead of including the child in discussions and decisions? Do we sufficiently question the status quo, allowing ourselves to challenge our own assumptions, institutional customs, various economic forces, and professional traditions that might interfere with the optimal outcome for our patients? Do we, as a society ask, "Is this good for children?" enough?

For me, the concept of a child friendly city is a coalition of people that acknowledge and include the rights of children in decision making. I cannot envision situations in which the question "Is this good for children?" should not be asked.

As paediatricians and child health professionals, we should remind ourselves to be purposeful in our actions, to include our patients in decision-making and to frequently question whether we are doing all we can to advance the best interests of the children entrusted to our care.

7. Publications

7.1 Evidence for benefit of mandatory vaccination

I asked Professor Helen Bedford (see 4.1 above) if there is evidence from the literature that countries with mandatory vaccination policies (such as refusing benefits or not allowing school entry for the unvaccinated) have higher immunisations uptakes and here is her reply: 'Mandatory vaccination varies in terms of whether it's linked to benefit payments/school entry etc so much between countries it is not possible to draw valid comparisons about effect. No good evidence to show it works or doesn't work. Key issue is that acceptability and effect is very context dependent. '

I found one paper which is of assistance:
https://www.vaccinestoday.eu/stories/mandatory-vaccination-work-europe/
entitled

Mandatory vaccination: does it work in Europe?

This is a review article by Gary Finnegan

Key quotes from the review are as follows:
In Europe, the picture is mixed. A 2010 study of 27 EU countries (plus Iceland and Norway) found that 15 had no mandatory vaccines. In the meantime, Italy has added 10 vaccines to its list of compulsory vaccines; France and Romania are preparing new laws that would penalise parents of unvaccinated children; and Finland will introduce legislation in March 2018 that requires health and social care providers to ensure staff are immunised against measles, varicella, pertussis and influenza. The diversity of measures taken suggests no proven strategy exists that can be universally applied.
And
The impact of mandates in European countries has been assessed by the EU-funded ASSET project which found no clear link between vaccine uptake and mandatory vaccination. The report, which has been cited by the European Commission in response to questions from Members of the European Parliament states: 'The enforcement of mandatory vaccinations does not appear to be relevant in determining childhood immunisation rate in the analysed countries. Those [countries] where a vaccination is mandatory do not usually reach better coverage than neighbour or similar countries where there is no legal obligation.'
Please can readers of this e-bulletin who live in countries where there is mandatory immunisation write in to offer any evidence of benefit or disbenefit to children?

Tony Waterston

7.2 Anti-vaxx controversy
New York Review of Books, May 2019

The following link to a recent article in the New York Review of Books is worth following and the long article is worth reading for providing a history of vaccination as well as of the anti-vaxx movement, by Gavin Francis a physician and writer from Edinburgh.
https://www.nybooks.com/articles/2019/05/23/anti-vax-resistance-immunity/

The article begins as follows:
New York City mayor Bill de Blasio at a news conference declaring a public health emergency in parts of Brooklyn in response to a measles outbreak among Orthodox Jews, April 2019

Not far from the hospital in Edinburgh where I work there's a graveyard; it can be a calm, if morbid, place to reflect after a tough shift. Passing it acts as a *memento mori* on days when I need to be reminded of the value of medical practice—which for all its modern complexity remains the art of postponing death. Benches are set out in the shade of trees, between red-shingle walkways and rows of Victorian tombstones. Many of the stones commemorate dead children, but there's a memorial near the entrance that always stops me short. It's dedicated to Mary West, a woman who died in 1865, at the age of thirty-two—two years before Joseph Lister published his ground-breaking work on antisepsis. The reason for her death is unrecorded. Beneath her own name are listed the names of her six children in their order of death—at ages two, eleven, four, twelve, and fourteen. Only one lived to adulthood.

The death of any child is a tragedy, but to lose so many is now almost unthinkable.
…..Yet working in the emergency room recently I saw a girl with a rash, fever, conjunctivitis, swollen lymph glands—all classic symptoms of the measles virus. "Do you know if she has had her MMR [measles, mumps, and rubella] vaccine?" I asked her father. He nodded, but something made me doubt his sincerity.
"Are you sure?" I asked again.
He nodded, then broke my gaze. "Maybe she skipped that one," he said at last.

7.3 Information Wars

A recent editorial in the BMJ (13th May) by Martin McKee discussed how to tackle the problems of immunisation mis-information.

Information wars: tackling the threat from disinformation on vaccines
https://www.bmj.com/content/365/bmj.l2144 (not open access)

The author identifies three sources of false information:

- '**The first it termed Russian trolls**. Trolls are people who conceal their identity to post false accusations or inflammatory remarks, often sponsored or coordinated by an organisation. Many of those identified were associated with the Russian Internet Research Agency, which has also been implicated in messaging in the 2016 US presidential election and the UK EU referendum.[13] These accounts, many using the hashtag #VaccinateUS, spread messages both for and against vaccination, seemingly designed to create discord and undermine trust in authority. Thus, they included messages rarely found elsewhere, linking vaccines to issues that are especially divisive in the US, such as race and religion, or the idea that vaccination is a conspiracy by the elite.

- **A second source is sophisticated bots**, which are automated accounts that promote particular content, although some also have some human participation that makes them hard to identify using algorithms. These also contained a mix of messages for and against vaccines.

- **The third, characterised by antivaccine messages** that seem designed to stimulate curiosity, comprise "content polluters," devised to spread malware or unsolicited commercial content and to direct readers to sites that generate income. '

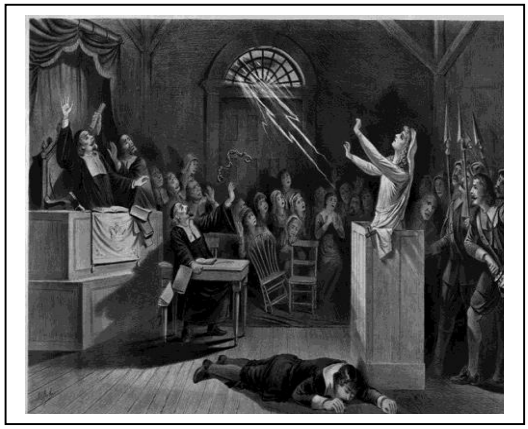
McKee goes on to make the following suggestions on tackling the problem:

'Those responsible for vaccination programmes must ensure they have a detailed understanding of knowledge and beliefs in their populations and employ much more sophisticated messages, recognising that many traditional ones can backfire and reduce the likelihood that those already sceptical will support vaccination. They should draw on a growing body of research, some in related fields such as climate change, on confronting disinformation. It is important not to overcomplicate messages or repeat erroneous ones, even to correct them; "inoculating" the public with the facts before disinformation takes hold may be effective.'

I would add from my own experience that it is important for the clinician to show understanding of a parent's anxieties about immunisation. Balanced information is reassuring, but the mother and father still have to consider that their healthy child is to be given an injection which could have side effects. Disparaging their anxieties will be counter-productive as can paternalistic attitudes that 'we know best what is good for your child.' A calm and full explanation of vaccine safety together with offering key website links or written information can work wonders.

Tony Waterston

7.4 Yes, I am a Sorceress



Social media has become a forum for vaccine advocates and anti-vaxxers to argue and feud over immunizations and their benefits. On May 7, 2019, a member of the Texas House of Representatives, Jonathan Stickland, posted on Twitter, accusing Dr. Peter Hotez, a prominent vaccine researcher and advocate from Baylor University of being bought out by the vaccine industry and accusing him of peddling "sorcery". Being bullied by anti-vaxxers on social media has become a legitimate concern for many vaccine advocates trying to use this forum to educate and promote awareness for lifesaving vaccination.

Dr. Rachel Pearson, M.D., Ph.D and paediatric resident, wrote this article, https://www.texasobserver.org/yes-i-am-a-sorceress/ which was published in the Texas Observer as a response to Stickland's accusations. It is a pleasant read that pokes fun at the ridiculous comments made by Stickland. It is also an example of how many child advocates have been banding together to support each other in efforts to ensure accurate vaccine information is delivered to the public.

7.5 Gender equality

Review by Rita Nathawad

Gender equality in science, medicine and global health

https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)33135-0/fulltext

As a woman, mother, educator and paediatrician, the topic of gender equality seems to sneak its way into many conversations. A recent article in the Lancet, "Gender equality in science, medicine and global health: where are we and why does it matter?" summarizes the pitfalls of current gender data collection, reviews worldwide progress toward gender equality and provides evidence for why gender equality matters to health and social outcomes. We are far from reaching sustainable development goal #5 of gender equality and much work is ahead of us. It is clear that across the world, gender equality is not elevated to the level it should be in political agendas.

Recent social movements such as the online #MeToo and #NiUnaMenos against violence, intersectional feminism, awareness of men and masculinities and the global transgender rights movement have helped to push the gender equality agenda to the forefront of global health conversations. Yet, we continue to see major divisions in the percentage of woman leaders in global health organizations and other health fields, wage disparities, gaps in educational opportunities, states that continue to observe strict gender roles as the norm and barriers to accurate data collection related to gender inequality. Evidence shows that gender equality in science, medicine and global health has the potential to lead to substantial health, social and economic gains by promoting innovation, improving productivity and appealing to a broader audience. It is time we frame gender equality in the context of a human right and a critical social determinant in order to advance health and well-being across the world.

Actions we may take to promote gender equality in science, medicine and global health are as follows:

- Support social movements to promote awareness about gender inequality and help to shift cultural norms of gender discrimination.
- Development of better tools and methodology to assist with gender analysis in health, with a focus on updating gender definitions according to current conceptualisation of gender.
- Provide equal access for educational opportunities in STEM (science, technology, engineering and math) across genders.
- Ensure gender diversity in leadership positions of global organizations and state policy makers.

7.6 Policies of exclusion: Implications for the Health of Immigrants and Their Children

Perreira K.M, Pedroza J.M Annual Review of Public Health 2019. 40:147-166

Public policies play a crucial role in shaping how immingrants adapt to life in the US. Federal, state, and local laws and administrative practices impact immigrants' access to education, health insurance and medical care, cash assistance, food assistance, and other vital services. Additionally, immigration enforcement activities have substantial effects on immigrants' health and participation in public programmes, as well as effects on immigrants' families. This review summarizes the growing literature on the consequences of public policies for immigrants' health. Some policies are inclusive and promote immigrants' adaptation to the United States, whereas other policies are exclusionary and restrict immigrants' access to public programmes as well as educational and economic opportunities. We explore the strategies that researchers have employed to tease out these effects, the methodological challenges of undertaking such studies, their varying impacts on immigrant health, and steps that can be undertaken to improve the health of immigrants and their families. **RM**
https://www.annualreviews.org/doi/full/10.1146/annurev-publhealth-040218-044115

7.7 A Roadmap to Reducing Child Poverty (2019)
The National Academies Press (US)

This publication is based on a specific request of the US Congress to provide the following information: 1) a review of research on linkages between child poverty and child well-being, 2) objective analyses of the poverty-reducing effects of major assistance programmes directed to children and families; and 3) policy and programme recommendations for reducing the number of children living in poverty-including those living in deep poverty(with family incomes below one-half the poverty line) in the United States by half within 10 years.
https://www.nap.edu/catalog/25246/a-roadmap-to-reducing-child-poverty

RM

8. Correspondence

8.1. Ilaria Simonelli (Italy), shares with us the experience of the Task Force on Health Promoting Hospitals-CA, that has been presented in the last International Conference of HPH that took place in Warsaw (May 28-31).

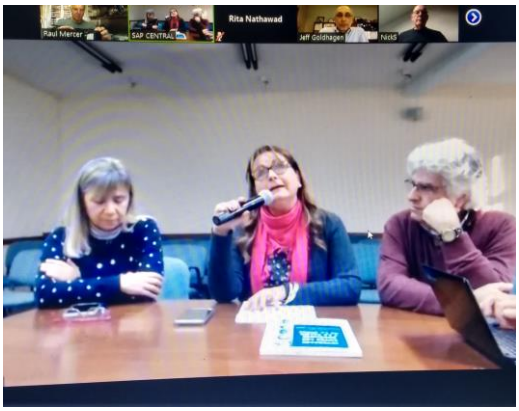
This year the HPH conference focused on the relationship between high tech and high touch: how can technologies improve health and healthcare services without giving up -and possibly enhancing - the relational aspect? How can technologies be used at their best avoiding isolation and exclusion and promoting involvement, empowerment, equity? Many international meaningful experiences and practices have been presented.

The key issue is for professionals to be able to use advanced data, IT, evidence databases to be updated, relatable, responsive to people's needs. For patients using technologies can support empowerment, informed choice and a facilitated access to healthcare. In the international conference framework, the HPH- CA task force presented its work results in terms of children and adolescents health promotion, and was renewed for the next three years by the Governance board and by the General Assembly. The TF standards, latest work of the TF, have been requested by Georgia and Taiwan and in this last case they were used to define their National standards together with WHO standards. The next three years will be crucial to disseminate the tool even more and to implement it. Poland and Italy have already requested the standards which can be downloaded from the TF official website. The next challenge for the TF will be to create an internationally tested training tool for professionals in order to support the Standards vision and to guide healthcare staff throughout the implementation process for advancing children and adolescents' rights in healthcare services worldwide.

Ilaria Simonelli

8.2 ISSOP+SAP: more than an MOU

ISSOP and the Argentine Society of Paediatrics (**SAP**) signed a memorandum of understanding (MOU) for collaboration in Social Paediatrics and Children's Rights. This agreement arises from a meeting held during the IPA Congress held recently in Panama between the President of ISSOP (**Jeff Goldhagen**) and the President of SAP (**Stella Maris Gil**). On June 3, a videoconference was held with the participation of SAP and ISSOP professionals. Personally, I consider it a very good starting point for other Paediatric societies in the world to join in collaborating with ISSOP in the fulfilment of its mission: the promotion of the rights, health and well-being of children.



Videoconference ISSOP-SAP

As Jeff says ***"the isolated voices of individuals or institutions can do little to visualize the situation of children, only working together we can achieve our mission***". A very special thanks to the professionals, colleagues and friends of both institutions for laying the foundations of this important agreement.

Raul Mercer