



## ISSOP E- Bulletin No 1. November 2012

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### 1. Foreword

*By Tony Waterston, ISSOP core EC*

Dear ISSOP members!

This is the first e-bulletin which will come out to members approximately two monthly, in the last week of the month in the following months –

November 2012

January 2013

March 2013

May 2013

July 2013

September 2013

November 2013

The aims of the bulletin are to bring together our international network, communicate with new members, and bring to your attention some current articles in global health. The bulletin will be a collegiate effort so do please send me your contributions, however controversial! However they need to be short, ideally under 250 words.

I’m grateful to Rosie Kyeramaten, Gonca Yilmaz, Shanti Raman and David Sanders for contributions to this issue, written to a short timescale. Readers are welcome to respond. I would also appreciate contributions on further reading, controversies and meetings attended for future issues. I would also appreciate any offers of help to make the bulletin look nicer and be more compact!

## 2. Introduction to ISSOP

By **Nick Spencer, President of ISSOP**

It gives me great pleasure to welcome you to the first edition of the ISSOP e-bulletin. We hope the content will be of interest and generate discussion and controversy. The International Society for Social Pediatrics and Child Health (ISSOP), until last year the European Society (ESSOP), is an organisation for child health professionals focusing on child health within its social context using a social determinants and child rights perspective. We invite all our readers to contribute to the e-bulletin in the form of brief articles, meeting reports and other items of social pediatric interest.

## 3. Recent meetings

### 3.1. ISSOP in St Andrews – a trainee's perspective

By **Rosie Kyeremateng**. *Rosie is a UK paediatric trainee who has been helping with the child rights course. She co-chaired a session in St Andrews and is an enthusiast for global child health. She is making contacts with trainees in other countries and would be glad to be put in touch with others.*

As a paediatric trainee with interests in advocacy for children, child public health and children's environmental health, I found the ISSOP conference to be stimulating and useful.

I felt I was in an environment where my understanding of many complex interrelated issues could develop. It was inspiring to share in experiences of colleagues and to hear about the work of a wide range of professionals, from chief medical officer for the Scottish government; to head of maternal and child health at WHO; to discussing with young people from a youth organisation the issues they felt to be important, and exploring with them how to facilitate making their voices heard.

The experience also highlighted the role of paediatric trainees. I was delighted to connect with other trainees from around the world, thus forming a network to support and encourage each other in our professional development. And it was stimulating to focus and develop our aims and resonate our ideas, helping each other to reach our shared aim of contributing more effectively to improving child health.

As well as providing the chance to network, many trainees presented posters at the annual conference; presenting cases and projects to an international audience has been a valuable experience.

As a trainee, being an active member of ISSOP provides the opportunity to direct our learning towards the issues that we feel strongly about, with the advantage of being able to access the expertise and guidance of more experienced professionals engaged in child advocacy issues.

A group of us are currently working on establishing a child rights training curriculum for healthcare providers. As part of this process, we have been comparing the training structures in each of our respective countries. This has highlighted a number of differences which we will investigate further, in order to identify how best to integrate this into current training.

Trainees can apply our enthusiasm, ideas and perspective to engage in current child health advocacy matters, regardless of our degree of experience. We can connect with young people in relation to child rights and health care, and help them to realise their voices.

There is also the potential for trainees who already have interest in an emerging topic, to continue to develop their interest, engage other professionals, and contribute to teaching.

ISSOP members believe in working together to use our skills, resources and knowledge synergistically. There are essential roles that people can become involved such as strengthening capacity and communications within the group, as well as connecting with the wider trainee body, and representing views of trainees.

In all, it has been really enjoyable to meet other like-minded people who value the global, holistic, and multidisciplinary approach to child health; to attend a conference that was great fun; and to work together to improve the health and well being of children and young people.

### 3.2. ALAPE meeting in Colombia

A report from **Gonca Yilmaz**, ISSOP EC

Dear ISSOP members, I've been in Cartagena, Colombia. Alape 2012 was excellent meeting in all fields of pediatrics. But what was more excellent was the social pediatrics meetings for two days. In these sessions there were a lot of social pediatricians from Latin America Countries (Columbia, Argentina, Chile, Panama, Puerto Rico, Honduras,,,. ). First day they have done a meeting with all representatives from these countries and they constructed their social pediatric association (ALAPE). Prof. Dr. Ernesto Duran was selected as president of this association. Main subject of social pediatric meeting was Child Rights and its training. Some representatives mentioned that they had an education program for pediatricians in their countries (Puerto Rico and Argentina), But others were trying to implement an educational program at this issue. They mentioned about low priority given child rights in their countries. And also some of them couldn't find financial resources for this training.

Prof. Dr. Jeff Goldhagen made a speech about developing a curriculum about child rights and Social and Community training in internet. All representatives accepted to join this program.

They were very happy to see us there as ISSOP. I hope in the future we can do collaborative works with Latin America Social Pediatric association.

Thanks

## 4. International organisations

*This is the first of a series on international organisations whom we might work with in ISSOP. Future contributions welcome.*

### 4.1. People's Health Movement

By **David Sanders** and **Anneleen de Keuklaire**, Peoples Health Movement. This article was contributed by Prof David Sanders and a colleague at the University of the Western Cape, South Africa. DS was one of the founders of the PHM and spoke by skype at the St Andrews meeting described above.

**The People's Health Movement** < <http://www.phmovement.org/> > is a global network bringing together grassroots health activists, civil society organizations and academic institutions from around the world, particularly from low and middle income countries (L&MIC). PHM currently has presence in around 70 countries.

**The People's Charter for Health – PCH**, developed in 2000 during the first People's Health Assembly, is the framework within which PHM acts and offers strategic guidance to the movement. It is a tool for advocacy and a framework for action. By subscribing to this Charter in support of its realisation, one becomes member of the movement. The PCH endorses the Alma Ata Declaration, and affirms health as a social, economic and political issue but above all, a fundamental human right, and PHM undertakes actions to promote such an emphasis in global and national approaches to health .

Several programs are coordinated at a global level, such as

- **The People's Health Assembly** < <http://www.phmovement.org/en/node/6536> > which is held approximately every 5 years, bringing health activists from across the world together to share experiences and strategise in solidarity towards future jointly coordinated actions.
- **The International People's Health University** < <http://www.iphu.org/> > which is PHM's main educational and research program directed at civil society activists, operating in health and health-

related areas. The IPHU has organized over 20 short courses across the world, entitled 'The Struggle for Health', of 2-week duration each.

- [The Global Health Watch](http://www.ghwatch.org/) (GHW) < <http://www.ghwatch.org/> > which provides an alternative to WHO's annual World Health Report. Three reports have been published and we are planning for GHW4 to be published in 2014.
- The Right to Health Campaign (RTH) <http://www.phmovement.org/en/campaigns/145/page> is a global framework for different health actions by civil society networks and social movements around the world, and aims to inform and influence governments to address structural and systemic weaknesses in health system. Approximately 20 countries presently operate RTH campaigns, which greatly between countries, being focussed around key current health challenges.

PHM has had a particular focus on child health –related issues in successive editions of GHW. For example, GHW1 carried a chapter on Food/Nutrition; GHW 2 had chapters on:

Globalisation/Trade/Food; Sanitation/Water, Transnational Corporations' activities on Tobacco/Breastmilk substitutes; GHW 3: chapters on the Global Food Crisis, Challenging the Population Climate Connection. GHW has a section on 'Watching' ie monitoring the activities of health-related agencies. Thus, in different GHWs there have been chapters on governance and commercial influence of UNICEF, as well as one on UNICEF and the Medicalisation of Child Malnutrition.

PHM was formed in response to disturbingly slow progress in global health where, notwithstanding average improvements in health in most regions (but with extremely slow progress in Africa and reversals in the former Soviet Union) and rapidly increasing inequalities between and within countries. PHM's view is that a broad and strong global health civil society movement, which includes child health advocates, is urgently necessary to address the continuing disgraceful gap between available resources and technologies and their availability to those who most need them, amongst which children are disproportionately represented.

## 5. Current controversy

*This article was contributed by **Shanti Raman**, a community paediatrician from Sydney, Australia. Shanti has an interest in social paediatrics, child abuse and cross cultural issues in child health.*

### 5.1. Male/Female Circumcision of children: A Child Rights Issue?

Recently the case of a father (from an African country) requesting a paediatric surgeon to perform elective circumcisions for his 9 and 11 year old sons, caused widespread debate among our Community Paediatric fraternity in Australia. Both boys were healthy and there were no medical reasons for circumcision according to the surgeon. The boys were interviewed alone and told the surgeon they did not want to be circumcised. When the father was told about the surgeon's decision not to operate on the boys, he became angry and threatened to circumcise the children himself. Opinions among our paediatricians ranged between those who suggested that we should find a medical pathway for circumcision of the boys as there were strong cultural practices of circumcising boys in African countries regardless of religion and as circumcision is known to be protective against HIV (in high prevalence settings); to those who opposed circumcision on the basis of it being against the rights of the child. Paediatricians suggested getting support from hospital ethics committees, getting legislative (State) guidance and policy support from our professional bodies<sup>1</sup>. The RACP policy on circumcision states<sup>2</sup> that "When parents request a circumcision for their child, the medical attendant is obliged to provide accurate unbiased and up to date information on the risks and benefits of the procedure" and that "parental choice should be respected." The AAP policy statement says<sup>3</sup>: "Systematic evaluation of English-language peer-reviewed literature indicates that preventive health benefits of elective circumcision of male newborns outweigh the risks of the procedure" and that "parents ultimately should decide whether circumcision is in the best interests of their male child." This is in sharp contrast to the AAP position statement<sup>4</sup> on genital cutting in female minors which reiterated "its strong opposition to

female genital cutting and counsels its members not to perform such procedures.”

In practice is there such a difference in the actual harm to a child between ritual genital cutting of males or females? Is age a factor in recognising the rights of the child (i.e. neonate versus the older child)? The recent report<sup>5</sup> on ‘Harmful practices based on tradition, culture, religion or superstition’ by the NGO Council on Violence against Children, strongly advocates a child rights-based approach to prohibit and eliminate all harmful practices against children. Both male circumcision and female genital cutting are included in the list of harmful traditional practices. The Council noted that global action against harmful traditional practices had largely focused on female genital mutilation, child marriage, honour crimes and other practices affecting girls and women. They encouraged in addition, a UN-led and children’s rights-based global campaign to identify, analyse and eliminate the whole range of harmful practices affecting children based on tradition, culture, religion or superstition. In its 2011 General Comment No. 13 on “The right of the child to freedom from all forms of violence,” there was a non-comprehensive list of harmful practices including female genital cutting and corporal punishment. Female genital cutting is listed as downright ‘harmful’, while male circumcision is listed under the ‘potentially harmful’ category in Koramoa’s traditional child rearing practices continuum<sup>6,7</sup>. In June, 2012, the German city of Cologne banned the procedure on the grounds of child rights violation, and charged a Rabbi with inflicting “physical harm” on an infant after he did the operation. However this led to a worldwide condemnation of the ban from religious bodies with a rare unity between Jewish and Islamic leaders. As the Lancet pointed out<sup>8</sup>, the new AAP guideline has declared that the benefits of circumcision for newborn boys outweigh the risks, and this is likely to lead to a resurgence of requests for non-medically indicated circumcision of newborn boys in the USA.

When taking on a child rights based perspective, is the right to cultural self determination less important than the freedom from all forms of violence and the right to survival? Why are our professional bodies, giving greater weight to parental wishes than children’s rights? These are big and weighty questions with no easy answers, but need to be debated and grappled with intelligently, compassionately and with the best interests of the child at their core. The International NGO Council<sup>5</sup> provides some wise counsel to health practitioners, and suggests that we “should be encouraged to work actively to eliminate these harmful practices as part of (our medical) codes of ethical conduct.”

Clearly, any approach to ban male circumcision has to move carefully owing to the strong religious interests.

As social paediatricians and child health advocates, I suggest that we fearlessly take on this challenge, and come up with practical guidance to our clinician colleagues in the frontline.

## References

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5. International NGO Council on Violence Against Children. Violating children’s rights: Harmful practices based on tradition, culture, religion or superstition. New York: International NGO Council on Violence Against Children, 2012.
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7. Raman S, Hodes D. Cultural issues in child maltreatment. *Journal of Paediatrics and Child Health* 2012;48(1):30-37.
8. Safeguarding male circumcision. The Lancet [Volume 380, Issue 9845](#), Page 860, 8 September 2012

## 6. CHILD2015

By **Tony Waterston**

As co-moderator of CHILD2015 I am biased in its favour. However I feel that it has achieved much in its short history and is a marvellous and unrivalled way of connecting health professionals globally without needing to travel. Air flights will be unsustainable in the future low-carbon world and are outside the scope of most health workers from low income countries. So connecting by the internet has to be the solution. We need more ISSOP members to join and to contribute – this is how we can spread our message! If you haven't already, please do now-  
[child2015-admin@dgroups.org](mailto:child2015-admin@dgroups.org)

## 7. Recent publications and links

### 7.1. Child health in the European Union

This report was edited by ISSOP members Adriano Cattaneo and Giorgion Tamburlini and includes chapters on social determinants, mental health, accidents, maltreatment and obesity and contains much of interest to ISSOP members.

[https://webgate.ec.europa.eu/sanco/heidi/images/b/b3/Chiled\\_Health\\_in\\_the\\_European\\_Union.pdf](https://webgate.ec.europa.eu/sanco/heidi/images/b/b3/Chiled_Health_in_the_European_Union.pdf)

### 7.2. Born Equal: Save the children

Inequality in developing countries is twice as high among children as among the general population, as this report reveals, with new quantitative analysis of 32 countries.

**Born Equal** assesses the effects of inequality on child development. Drawing on eight case studies from Brazil, [Canada](#), [China](#), [Ghana](#), [India](#), Indonesia, [Nigeria](#) and [the UK](#), it looks at which policies and interventions have reduced inequality and delivered better outcomes for children.

The report concludes with four recommendations to seize the major opportunity presented by the year 2015, when a new global development framework will be established.

**Born Equal** calls on the international community to place inequality front and centre.