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1. Introduction

Welcome to the early summer e-bulletin. The ISSOP Congress in Budapest beckons; please go ahead with registration and booking your accommodation as this will be a very exciting and informative congress. It comes at a time when the world feels unsafe and we need to stand together and make sure that our children receive protection and support as they deserve and require. This month as well as the ISSOP Congress, we feature the new Director General of the WHO Dr Tedros, the first African to take the post and a figure of high stature in his native Ethiopia. We look forward to a strong focus being give to children in illness and in health and in particular to strong advocacy from WHO for tackling child poverty and the problems of migration. Other issues we feature this month are the Framework for Engagement with Non state Actors (FENSA), we explain its rationale and benefits; a new UNICEF report on children and migration; and a report on the Concha Colomer meeting, a tribute to our loved and valued late member from Spain.

Tony Waterston & Raúl Mercer

2. Meetings and news

2.1 Latest on ISSOP Congress in Budapest

Meeting organiser Zsuzsanna Kovacs writes:
We kindly invite you to ISSOP general meeting **http://issop2017.com/** .
The program of the meeting draws the attention to the migration crisis:

"Children on the Move: Rights, Health and Wellbeing".

The meeting will provide an opportunity for paediatricians and other child health professionals to discuss and respond to the crisis facing millions of children and families. We hope that the conference will confirm the health professionals even if they have to carry out their humanitarian aid in a controversial political climate. As you can see in the final program we have invited well known experts from different countries. In addition to plenary sessions we can exchange experiences in exciting workshops. According to our plans we would like to formulate a cooperation strategy with the relevant organizations.

Please note, that the **deadline for early registration is** postponed to **15/06/2017** and the **deadline for abstract submission is 30/06/2017**. We do hope that the scientific and the social programs will provide lasting memories.

Zsuzsanna Kovács
Hungarian Paediatric Association

2.2 PAS Pediatric Meetings in San Francisco

While all other United Nations (UN) member countries have ratified the UN Convention on the Rights of the Child (CRC) and implemented programs to promote children's rights, the United States (US) has not. The practice of pediatrics in the US had for a long time followed the path of most other medical specialties where the focus was on the biomedical and not the social aspects of health. While the World Health Organization defines health as, "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity," we in the US have been slow to implement this into practice. Over the past decade, there has been a significant shift in pediatrics towards increased screening for social and environmental factors. Examples of policy statements and guidelines published by the American Academy of Pediatrics over the last several years supporting this movement include; Poverty and Child Health in the United States, Promoting Food Security for all Children, and Health Equity and Children's Rights. This signals an acknowledgement by the American pediatric community of the impact these issues have had on the health and well-being of the children we serve.

This year an international group of speakers presented a scientific plenary session entitled, "Child Rights as the Future for Child Health" at the Pediatric Academic Societies Meeting

(PAS), held from May 6 – 9, 2017 in San Francisco, USA. The invitation to give this presentation was noteworthy as it is the first time that the topic of child rights had been elevated to the prestige of a scientific platform at an American pediatric meeting. It is also important to note that a search of the conference program revealed a strong focus on abstracts and sessions related to social pediatrics such as poverty, toxic stress, social determinants, advocacy and underserved populations. The tide in the US is slowly changing and the critical role of social pediatrics is becoming more prominent.

The session, moderated by **Elisa Zenni, M.D.,** was presented by an international panel of pediatricians **--Jeffrey Goldhagen, Raul Mercer, and Sherry Shenoda,** and international child rights advocates **Gerison Lansdown and Laura Ferguson**. Participants learned about advances in social epidemiology and life course health science that increasingly require child health professionals and organizations to respond to the root-cause social determinants of children's health and well-being. These health determinants, defined by poverty, globalization, violence, climate change and other forces, are addressed by the articles of the United Nations Convention on the Rights of the Child (UNCRC) and the recently released UN Sustainable Developmental Goals (SDGs). New strategies, tools and metrics, grounded in the principles, standards, and norms of child rights, health equity, and social justice that are used by child health professionals to address the social determinants of child health and well-being were introduced. Participants learned about strategies to optimize the survival and development of all children by translating the principles and norms of child rights, health equity and social justice into the practice of pediatrics. This plenary presented a framework and strategy for structuring the response of all child health professionals to the social determinants of child health within the context of children's rights.

After the program on "Child Rights as the Future of Child Health," the presenters hosted a roundtable discussion on how to move forward in the US to promote a child rights framework into the practice of paediatrics.

From left to right: Jeffrey Goldhagen, Gerison Lansdown, Laura Ferguson, Raul Mercer, Sherry Shenoda, and Elisa Zenni

Ideas included the integration of the concept of children's rights into the language of pediatrics, building capacity for education in child rights in the curriculum of child serving professions, development of an organization or working group to promote children's rights and social pediatrics in the US, and increased advocacy at the local, systems and policy level to promote children's rights. While the road ahead is long, the opportunity to include child rights content in a national pediatric meeting in the US is a step in the right direction. We are optimistic that despite not having ratified the CRC, the US will someday catch up to other countries and provide care to our children through a child rights lens.

2.3 Concha Colomer VI Annual Conference (May 23, Valencia,Spain)

The Center for Research in Public Health, now the Foundation for the Promotion of Health and Biomedical Research of the Region of Valencia (FISABIO), approved a few months after the death of Concha Colomer, the establishment of an annual conference for the recognition and memory of a vital and professional trajectory in the struggle for public health, health promotion, the defence of women's rights, feminist activism and the visibility of health and gender through the Women's Health Observatory

Specialist in Pediatrics and Preventive Medicine and Public Health, Concha worked incessantly for more than 25 years in teaching health professionals and in research, in different institutions (University of Valencia, University of Alicante, Instituto Valenciano de Estudios In Public Health, Valencia School of Studies for Health) and participated in other organizations and projects in Spain as well as in Europe and America. Since 2005, she has been Director of the Women's Health Observatory of the General Directorate of the Quality Agency of the National Health System of the Ministry of Health and Social Policy and since 2008 also assumed the Office's Deputy Directorate General Of Health Planning and Quality. He had management and management responsibilities in several of the projects and professional and civil society organizations of which he was a member. In addition, she was the author of numerous scientific articles and books published in Spain and internationally.
This year's conference was presented by Raul Mercer MD MSc, Coordinator of the Social and Health Sciences Program at FLACSO (Latin American School of Social Sciences) in Buenos Aires, Argentina. The theme was: **"Concha Colomer: her passions and legacies for health."**

3. International organisations
New Director of WHO takes office

Dr Tedros Adhanom Ghebreyesus has been appointed as the new Director General of WHO and the first from an African state.
Here is a short (and perhaps over-laudatory) video of his background and vision
https://www.youtube.com/watch?v=ZYFrhBuOEL4&index=1&list=PLujS9ooBebkWoeoCHUNBmni8ph26P5PdY

Here is a short article about him

Dr Tedros Ghebreyesus Adhanom is the first African to become the director-general of the World Health Organisation (WHO). He is also the first non-physician to head up the United Nations' body. He has big challenges ahead of him. He will be expected use his formidable talents – including diplomacy – to boost the WHO's image and finances, protect it against the whimsical policies of superpowers, and keep the organisation free of commercial influences. More at https://theconversation.com/three-ideas-on-how-the-new-who-dg-can-build-health-systems-from-the-bottom-up-78412

Here is a useful short piece published by Baby Milk Action

A charismatic former health minister and diplomat, Tedros, 52, pointed to his track record of developing a vast network of health centres in his country and leadership of another high-profile international health organization, the Global Fund to Fight AIDS, Tuberculosis and Malaria. In his final address to delegates, Tedros invoked the memory of his brother, killed by a common disease at the age of seven. His motivation to lead the agency, he said, came from "knowing survival to adulthood cannot be taken for granted, and refusing to accept that people should die because they are poor. I have dedicated my life to improving health, to reducing inequality, to helping people everywhere live better lives."Tedros is also the first to be elected to the post in a vote by the member countries. He won in the third round of voting Tuesday, beating British doctor and diplomat David Nabarro. Pakistani cardiologist and civil society leader Sania Nishtar was eliminated in the first round of voting. More at http://www.babymilkaction.org/archives/13494

See also comments in the Lancet on the candidates for DG

http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)31847-5/fulltext

And a personal comment from Peter Byass, Sweden, the last paragraph here :

'Nobody can foresee the future with certainty, but it is clear that WHO needs a new leader who has what it takes to inspire Member States, who can effectively reform and lead WHO and its large staff, and who can thereby contribute directly to improvements in people's health on a worldwide basis. To me, Tedros is the best of the three outstanding candidates in these important respects, and I therefore urge Member States to vote for him.'

http://thelancet.com/journals/lancet/article/PIIS0140-6736(17)31354-5/fulltext

4. Current controversy

4.1 FENSA by Tony Waterston

FENSA is the Framework for Engagement with Non State Actors, a long winded title for the WHO system of working with the corporate and NGO sector. FENSA has been criticized by NGOs who consider that it allows a close working relationship between WHO and corporates whose products are entirely damaging to health, and that it will lead to conflicts of interest. WHO on the other hand feels that it is essential to encourage the commercial sector to promote public health. Here we offer reports from the Lancet and from IBFAN on the value and rationale of FENSA.

http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)31141-2/fulltext

When decisions are made that will impact on people's health, who should be represented at the policy-making table? Is it sufficient to rely upon representatives from national

governments, or should other stakeholders participate—and if so, to what purpose? To advise? Make decisions? Or as funders? These questions lie at the heart of a governance debate[1] that has been rancorously discussed in relation to WHO for some years. In May, 2016, the World Health Assembly (WHA) reached consensus in a resolution known as FENSA (Framework of engagement with non-State actors): "WHO engages with non-State actors….to encourage [them] to…protect and promote public health", in which non-State actors are "non-governmental organizations [NGOs], private sector entities, philanthropic foundations and academic institutions".

In May 2017 at the recent World Health Assembly, IBFAN (International Baby Food Action Network) issued the following statement about FENSA:

'As one of WHO's longest-standing partners IBFAN, supported by FIAN International, hoped that Member States would ensure that WHO could emerge from the Framework for Engagement with Non State Actors (FENSA) process as the lead agency in public health, able to fulfil its constitutional mandate and not just as one more actor in a 'multi-stake-holderised' global health architecture. Through ill-defined terms such as 'partnership' 'stake-holder' and 'trust' corporations and philanthropies are now claiming the right to participate and shape public health decision-making processes, side-lining governments, the UN and peoples' human rights.

Member States, while aware of these concerns, adopted FENSA with promises that there would be due diligence and increased transparency and that WHO would *"exercise particular caution...when engaging with private sector entities ...whose policies or activities arenegatively affecting human health.."*

The Gates Foundation application for Official Relations was a test of FENSA's thoroughness.It could and should have provided clarity on the relationship between WHO and the Foundation. That the Foundation has made substantial contributions to many health initiatives is matter of public record. That it might have an influence on WHO's nutrition policy setting– for good or for bad – we make no judgement here – is also no secret. Less well known are its substantial investments in food and beverage industries – investments that were glossed over in the report as: "engagements with select members of the pharmaceutical... food and beverage...health care... industries in pursuit of our public health goals." In this way the FENSA process failed its first task and public trust that it will tackle the task ahead properly has now been severely damaged.

We follow the development of the FENSA handbook in the hopes that FENSA can be a safeguard – not a funding opportunity to replace the missing untied funding that WHO so urgently needs. FENSA should be reviewed and evaluated soon and the terms partnership and stakeholder defined. ' http://www.gifa.org/wp-content/uploads/2017/05/23.3-FENSA.pdf

Clearly, there are risks of the FENSA approach as well as potential benefits to WHO. However it must always be remembered that the corporate sector is profit driven, whereas in the health sector the only profit is in improved health of the people.

TW

4.2 RCPCH and formula funding latest

Tony Waterston reports (this message was circulated on CHIFA on 28th April)

In today's Lancet (28.4.17), the President of the Royal College of Paediatrics and Child Health (RCPCH) with four colleagues reply to the criticisms of Dr Anthony Costello and other senior officers from WHO made in the Lancet on February 11th (previously reported on CHIFA), see http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)30277-5/fulltext

The grounds for the WHO criticism of RCPCH acceptance of funding from the baby food industry were the breaching of the WHO International Code and relevant WHA resolutions, the conflict of interest which would ensue, and the difficulties of a paediatric association carrying out 'due diligence' (meaning checking which companies are breaching the Code).

In the Lancet today there are seven letters in response to the original WHO letter, three of them in support of the RCPCH (including one from the RCPCH President and one from a representative of the food industry) and four in support of the WHO critique, including one from myself and colleagues and one from Bangladesh paediatricians. These letters can be found at the following links and key quotes are given below.

Professor Modi (RCPCH President)
http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31057-7/fulltext

Waterston et al
http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31060-7/fulltext

O'Brien (food industry)
http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31058-9/fulltext

Forsyth
http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31059-0/fulltext

Savage (World Alliance of Breastfeeding Action)
http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31061-9/fulltext

Parry et al (Public Health, North Carolina)
http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31062-0/fulltext

Talukder et al (Centre for Woman and Child health, Dhaka, Bangladesh)
http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31062-0/fulltext

Modi: 'We believe that dialogue and collaboration, not isolation and non-engagement, are the way forward to benefit babies around the world.' (please note that Modi's declaration of interest includes funding from Nestle)

O'Brien: 'Health-care professionals are experienced individuals who obtain information and support from many sources. The assertion that they need to be further protected from industry, above and beyond the rigorous safeguards already in place, demonstrates the authors' lack of confidence in the integrity and professionalism of health-care professionals.'

Savage: 'The RCPCH should give an exemplary lead to the profession, and to fellow organisations in other countries, to stand up to the infant formula industry in accordance with the International Code of Marketing of Breast-milk Substitutes, and it should find other sources of financial support that are free from conflict of interest.'

Taludker: 'Whenever members of the RCPCH now sit on policy-making committees, we fear that their opinions will be tainted by conflicts of interest. We therefore add our voice to the growing number of concerned professionals from across the world who are asking the RCPCH to reverse its decision to continue taking financial assistance from BMS manufacturers.'

The RCPCH has just announced its policy on due diligence which can be seen at http://www.rcpch.ac.uk/news/rcpch-and-commercial-organisations

This states that 'The evidence provided to date has not given sufficient assurance to enable the RCPCH Board of Trustees Due Diligence sub-group to conclude that Danone, Abbott, Nestle and Mead Johnson are meeting the criteria above. Therefore these companies will not be able to have a stand at the 2017 RCPCH Annual Conference. ' This statement is welcome. We wait to hear whether this exclusion of manufacturers of breast milk substitutes will be permanent.

Please report on CHIFA your own experience with paediatric associations in relation to funding from the baby food industry.

5. CHIFA report

On 18th May, a webinar was held on the Children for Health programme founded by Clare Hanbury. You can view the recording of the webinar at the following weblink:

https://vimeo.com/218018815, with many thanks to Raul Mercer and FLACSO in Argentina.

Here is a summary of the programme reported by Clare and Bibiche during the webinar.

PCAAN: Children's Participation in Action and Learning for Nutrition (PCAAN) in Mozambique

In Mozambique the dreadful facts are that 44% of all children under 5 suffer from chronic malnutrition. This limits the potential of these children and makes them more prone to disease.

Children for Health understands that school-going children are often carers of these young children and can be mobilised to learn about and address nutrition problems and influence family nutrition practices. Therefore, we are working to embed a participatory approach to nutrition education in 15 primary schools in Provincial Government of Tete using their system of school clubs, called 'Interest Circles'.

Since 2014 and in partnership with DANIDA, we have worked with educators at all levels to adapt our content and methods that fit into the government system and thereby create a participatory, sustainable and effective nutrition education programme.

A recent evaluation of the programme (2016) suggests that it is having a powerful impact on the lives and the health of children under 5's and friends and family describe the children

involved as "heroes". In particular, the approach was already having a positive impact on food choices, breastfeeding and hygiene practices.

Story books, a recipe book, teaching and training guides have all been co-created with teachers and children involved with the programme. Some of the teaching materials are still being translated but the story books and one teaching guide in English are all available from the Children for Health 'Shop'.

Please click this link to access copies of the case study, video and a slide show.

http://www.childrenforhealth.org/how-we-do-it/children-for-health-partners/pcaan/

Clare Hanbury

There will be further webinars later this year on prevention of teenage pregnancy, the age of weaning and interventions on child mental health – look out for announcements on CHIFA. Tony Waterston

6. Publications

6.1 A Child is a Child

Unicef have published an important report on protecting migrant children from violence, abuse and exploitation (available at https://www.unicef.org/publications/index_95956.html).

The report proposes a six-point agenda for action:

- Protect uprooted children from violence and exploitation
- End the detection of refugee and migrant children by offering practical alternatives
- Keep families together and give children legal status
- Help uprooted children to stay at school and stay healthy
- Press for action on the causes that uproot children from their homes
- Combat xenophobia and discrimination

The Report provides a comprehensive up-to-date picture of child migration and, although the agenda for action may read like wishful thinking, the Report lays out important principles and practical approaches to guide this agenda. This Report is essential reading for all paediatricians and child health workers and compliments the ISSOP position statement which can be read at www.issop.org. It is timely as it gives further reasons for paediatricians and child health workers to attend the ISSOP conference **– Children on the Move: Rights, Health and Wellbeing** – to be held in Budapest, Hungary on 28th -30th September, 2017.

6.2. Brazilian government is the first to make specific commitments in UN Decade of Action on Nutrition

http://www.who.int/nutrition/decade-of-action/brazil-doa-commitments.pdf?ua=1

Although this is the dullest publication you are likely to read all year, it represents an important series of commitments to political action to address obesity in Brazil. The list of commitments to be met by 2019 include actions to encourage healthy eating not simply through education but also by regulation of the food industry and assistance to families and schools to help them promote healthy eating. This is a good example of an enabling state promoting population-wide health and wellbeing.

Nick Spencer

6.3 Children's Health in Europe

ISSOP founder Lennart Kohler writes on the challenges for children's health in Europe

https://academic.oup.com/heapro/article-abstract/doi/10.1093/heapro/dax023/3831737/Children-s-health-in-Europe-challenges-for-the?redirectedFrom=fulltext

Abstract

These reflections from a Child Public Health perspective underline the dramatic changes in children's conditions in Europe over this last century, including a considerable improvement in health. However, we still face problems, disturbing facts and alarming signs. There are important gaps in our knowledge about essential areas of children's health panorama and about particularly vulnerable sub-groups of children, which are less healthy, less well cared for and not enjoying the good conditions of life. We also see an evident lack of the *child's* perspective, implying acknowledgement and action on the views of the children themselves. Moreover, in spite of the generally improving standard, societal inequity in economy, education and health is increasing and the recent economic crises have struck hard on families with children. There are many good signs implying continuing progress for children and their conditions and also an improved respect for their rights. But with the increasing segregation in our societies, the risk is imminent that the health problems will increase, and that some groups get left far behind. Although actions on this field are primarily a political responsibility, people working with children can make a difference. There are also many examples of projects, particularly on local levels, where professionals act to promote children's health, prevent their ill-health and facilitate their health behaviour, rather than to repair their diseases. Children's particular needs and protection is now generally accepted, and the growing concern for their rights opens a window to the future for a more powerful child health advocacy.

6.4. Promoting social and emotional development and wellbeing of infants in pregnancy and the first year of life: a NHMRC report on the evidence, by Shanti Raman(Australia)

The National Health and Medical Research Council (NHMRC, Australia) recently analysed the evidence on programs and services delivered during pregnancy or the first year of life that may influence infant social and emotional development and wellbeing. A Report of this evidence was released by the Chief Executive Officer of NHMRC, Professor Anne Kelso AO, in early May 2017. There is increasing recognition that foetal development and infancy are vital periods of rapid physical, physiological, psychological and neurological growth. Emotional development is the child's growing capacity to express and regulate emotions and understand how these relate to their experiences. Social development is the process whereby the child gains the life skills for understanding and responding to other people, including having their emotional needs met within relationships. Combining social and emotional development allows the infant to establish asense of identity, beginning from the earliest days and continuing through life. The family and family environment are the main sources of the child's experiences, and therefore have a key influence on a child's social and emotional development.

The aim of this evidence evaluation was to assess the effectiveness of interventions, programs or messages for parenting/caregiving practices and behaviours through pregnancy and the first postpartum year. These interventions and programs had a focus on social and emotional development of infants, with a view to having a lasting effect into childhood and adolescence. NHMRC[1] was interested in practices that were effective both at a population level, and for more vulnerable and disadvantaged groups such as infants of parents with mental health problems. Such practices ranged from preventive measures and early intervention strategies, through to clinical interventions.

The NHMRC used a rigorous, internationally recognised approach to systematically assess and consider the evidence. GRADE (Grading of Recommendations Assessment, Development and Evaluation) provided a comprehensive framework for an independently contracted reviewer to evaluate 51 systematic reviews, and prepare for these findings to be translated into the Report by NHMRC's expert committee.

The Report

The Report is available at https://www.nhmrc.gov.au/book/promoting-social-and-emotional-development-and-wellbeing-infants-nhmrc-report-evidence as an online platform for ease of navigation, as well as in a printable pdf format. It is aimed primarily at policy makers, service providers and researchers.

What were the main findings?

Suitable for universal implementation in Australia:

- antenatal and postnatal education and/or support
- interventions for enhancing sensitivity and/or attachment security

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[1]The NHMRC Mental Health and Parenting Working Committee guided this work. Several members were also RACP members. Details of the full committee can be found at https://www.nhmrc.gov.au/health-topics/parenting-and-child-wellbeing

- Neonatal Behavioural Assessment Scale (NBAS)-based interventions.

Each of these interventions is also suitable for adaptation to suit targeted intervention.

Suitable for targeted implementation in Australia:

- antenatal and postnatal education and/or support (also suitable for universal implementation)
- home visiting interventions
- interventions for enhancing sensitivity and/or attachment security (also suitable for universal implementation)
- interventions for parents of preterm and low-birthweight infants
- kangaroo (mother) care
- Neonatal Behavioural Assessment Scale (NBAS)-based interventions (also suitable for universal implementation).

Suitable for parents/caregivers to adopt, if they choose:

- infant massage by a parent or primary caregiver.

Insufficient evidence for promoting infant social and emotional development and wellbeing:

Whilst there was not enough quality evidence to allow a comment regarding implementation in Australia for the specific purpose of promoting infant social and emotional development and wellbeing, the following interventions may, however, have benefits not discussed in the Report.

- anticipatory guidance
- behavioural sleep interventions
- early childhood education and care interventions
- interventions for fathers
- interventions for parents with alcohol or drug problems
- interventions for promoting effective parenting
- skin-to-skin care interventions.

What was not included?

Interventions were not evaluated if they did not meet inclusion criteria for target age or were not included in systematic reviews that contributed pooled numerical results. Examples of interventions initially identified in the literature searches but not eligible for inclusion in the evidence evaluation included interventions to promote various parenting styles (e.g. positive parenting, responsive parenting), interventions to support breastfeeding, antenatal psychosocial assessment, various therapeutic approaches (e.g. solution-focused brief therapy, counselling, play therapy, parent–child interaction therapy, trauma-focused cognitive–behavioural therapy, motivational interventions, psychotherapy), mindfulness techniques, support for intellectually disabled parents, infant education programs, arrangement of services for parents with serious mental illnesses, telephone support, social support interventions, and specific programs (e.g. programs for Indigenous parents and their children, parenting programs for mothers in prison, foster parent training programs, the Triple-P Positive Parenting Program, the Incredible Years parent training, and Healthy Families America).

Access: the accompanying Plain Language Summary<http://nhmrccommunications.cmail19.com/t/r-l-yuitlha-klhiykuktt-d/>