LEARNING ACROSS BORDERS

7th Europaediatrics

Florence - Fortezza da Basso

13-16th May, 2015

EUROPEAN
PAEDIATRIC
ASSOCIATION
(EPA / UNEPSA)

NEWSLETTER

FEBRUARY 2015 21

INDEX

1

7TH EUROPAEDIATRICS CONGRESS FLORENCE,MAY 13TH – MAY 16TH 2015

PROFESSOR GIOVANNI CORSELLO, PRESIDENT OF EUROPAEDIATRICS 2015 AND PRESIDENT OF THE ITALIAN SOCIETY OF PEDIATRICS

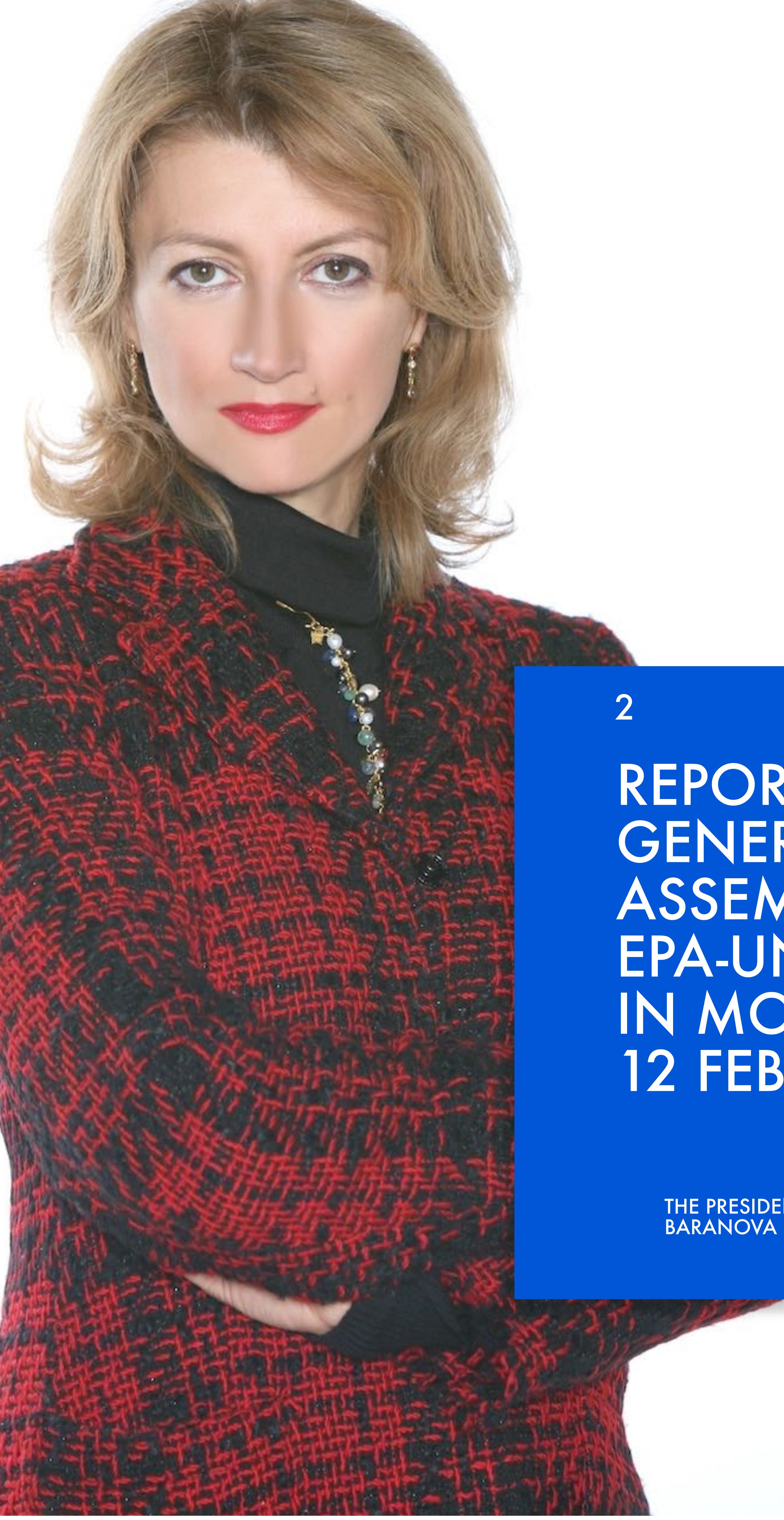
It is a pleasure to welcome European and non-European pediatricians to the 7th Europaediatrics taking place in Florence from 13 to 16 May 2015.

The biannual international congress of the European Paediatric Association, the Union of 44 National European Pediatric Societies and Associations, returns to Italy after the very successful edition held in Rome in 2000. The edition of May 2015 in Florence is an important opportunity to assess the status of pediatric science and pediatric health care in Europe. Fifteen years from the event of Rome, Europe as well as the entire World are significantly different, as unprecedented economic and social changes have taken place throughout the globe. The general perspectives that were foreseen at edge of the new millennium just fifteen years ago have in fact continued to evolve, and have been progressively reconstructed and remodeled to adapt to the new different conditions. Pediatric science and health care in Europe, as well as in the rest of the world underwent the same process. So, a different world needs a different Pediatric science and practice and the Italian Society of Pediatrics believes that the 7th Europaediatrics will offer a timely opportunity to discuss new perspectives in various areas of pediatrics, including education, health care and policy.

The Italian Society of Pediatrics is fully committed to support EPA-UNEPSA in the organization of the important meeting of Florence in 2015, which is based on a remarkably interesting and appealing scientific program, which has been conceived and designed by Prof. Terence Stephenson, in his capacity of Chairman of the 7th Europaediatrics Scientific Committee. Prof. Stephenson, also chair of

the UK Academy of Medical Royal Colleges and of the UK General Medical Council has in fact, planned an innovative format, with a mixture of plenary presentations by international child health experts and guideline sessions led by the European specialist societies which will give general pediatricians an opportunity to bring themselves up to date with the best evidence-based practice. The theme of sharing good practice will be continued in the more interactive personal practice sessions where leaders in their fields will present their approaches to the management of important pediatric conditions. The meeting will also offer the participants the opportunity to attend discussions on hot pediatric topics ("Hot topics") and pros and cons debate sessions, with the possibility to take directly part in them by the tele-vote, view posters, and participate in workshops and discussions on topics of relevance to the wider aspects of the health and wellbeing of children and young people worldwide such as diversity, equity and children's rights.
Last but not least the conference will also be accredited with the relevant European educational programs so delegates will be able to register for CME/CPD points.

In conclusion, the organization and scientific program of this important international scientific meeting is now well available and the Italian Society of Pediatrics invites you in Florence to join us at the 7th European Congress of Pediatrics in May 2015 (www.europaediatrics2015.org).



2

REPORT ON THE GENERAL ASSEMBLY OF EPA-UNEPSA HELD IN MOSCOW ON 12 FEBRUARY 2015

THE PRESIDENT, LEYLA NAMAZOVA-BARANOVA

The General Assembly of EPA-UNEPSA has been held in Russia last February 12, 2015. The delegates of the Societies and Associations member of the "Union of National European Paediatric Societies and Associations" gathered at the Scientific Center of Children Health in Moscow, to discuss and take important decisions regarding the future activities of the Union.

During the General Assembly the new Constitution of EPA-UNEPSA has been finalized, concluding a careful process of renovation that lasted four years, actively involving the Council and the Union members during the previous General Assemblies (http://www.epa-unepsa.org/page/constitution). The general perspectives that were foreseen just fifteen years ago when the previous Constitution was conceived have in fact continued to evolve, and have been progressively reconstructed and remodeled to adapt to the new different conditions. The world is substantially changed and EPA-UNEPSA needed to modernize the constitution in order for it to be flexible in dealing with various changes which have developed in Europe particularly during the last years. The Constitution that has been finalized and approved in Moscow, was not modified in its backbone, but it now includes working rules that better allows the Union to be effective in pursuing its goals and maintain its Not-Profit tax free status.

The Assembly further confirmed and emphasized the fundaments of the Union, which is to encourage scientific co-operation between not-for-profit National Paediatric Societies/Associations in Europe and between European paediatricians working in primary, secondary and tertiary paediatric care in Europe, in order to promote child health and comprehensive paediatric care. Paediatric care being defined as the medical care of human beings during and up to the completion of growth and development, from birth up to 18 years of age, therefore including the important period of adolescence.

The Assembly confirmed that among the objectives of the Constitution is to promote education of patients, families and care givers by translating special knowledge to generalists. EPA-UNEPSA will improve the quality of paediatric patient care in all European countries, including both member and non-member states of the European Union by adequate clinical research and by implementing research into practice. EPA-UNEPSA pursues a Pan-European approach to reduce diversity of child health care and to improve quality of care. The Assembly has also emphasized that an important activity that EPA-UNEPSA will strength during the next years is the scientific co-operation with other not-for-profit paediatric associations worldwide, the World Health Organisation (WHO), UNICEF, the World Bank, and any other national and international organizations, foundations or other statutory corporations and institutions operating in the field of public health care.

Finally, the Assembly of the Presidents has in charge the Council to actively promote the exchange of national experiences in the various fields of patient care and make national practices and science known to others, and to obtain information about paediatrics from national societies and associations, making it available to EPA-UNEPSA members.

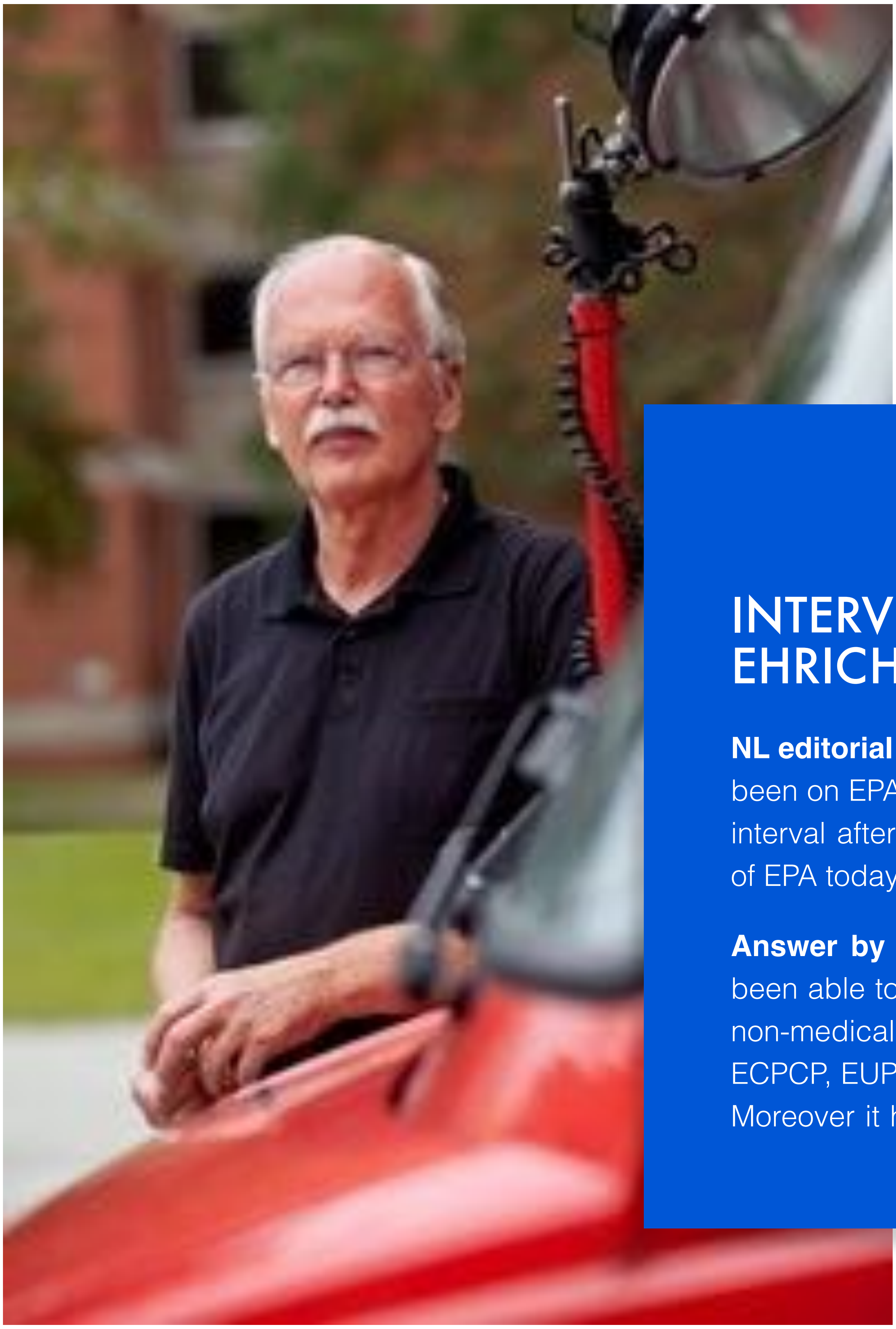
During the Assembly, five new members were elected and welcomed by the delegates as full members in the “Union”. The pediatric Societies and Associations of Kazakhstan, Montenegro, Turkmenistan, Uzbekistan and the Italian Federation of Pediatricians, are the new EPA-UNEPSA members, bringing the number of the members to 49. The number of members in EPA-UNEPSA has therefore expanded by 12 new National Organizations in 4 years, from 2012 to 2015. This positive data shows how highly regarded is EPA-UNEPSA in Europe, as well as it shows the appreciation by the European community of paediatricians for the activities that EPA-UNEPSA conducted during the recent years.

EPA-UNEPSA look forward to further develop its activities and further strength its current projects. The NewsLetters (http://www.epa-unepsa.org/newsletters) and the scientific platform of EPA-UNEPSA in the Journal of Pediatrics, the official Journal of the Union (http://www.jpeds.com/content/epaarticles), are important means of information easily accessible by the European community of paediatricians, which allow them to be constantly informed regarding the activities of their organization of reference in Europe.

Scientific Center of Children Health, Moscow

3

PRIORITIES AND GOALS OF THE EUROPEAN PAEDIATRIC ASSOCIATION



INTERVIEW WITH JOCHEN EHRICH

NL editorial Office Interviewer: Jochen, you have been on EPA council since 1994 with only a 7 year interval after 2003. What do you think is the value of EPA today?

Answer by Jochen Ehrich: First of all, EPA has been able to build bridges with other medical and non-medical experts and societies such as EAP, ECPCP, EUPHA, HOPE, EUSUHM, TAT and others. Moreover it has brought the 40 national paediatric associations and societies closer together to stimulate “Learning across borders” and to expand on planning, performing and publishing studies on child health care services in Europe.

Last but not least EPA has attracted not only paediatricians but also other experts in child health care who are willing to be actively involved for the improvement of child health care on a European level.

Question: Which are the goals of the aEuropean Paediatric Association?

Ehrich: Firstly to improve the health of children and young people in Europe, and secondly to improve the quality of health care services for children and their families in Europe.

Question: Which are the priorities for EPA activities?

Ehrich: Among the many challenges of European child health care EPA wants to focus on

1. encouraging co-operation between National Paediatric Associations in Europe,
2. stimulating collaborative research into paediatrics in Europe,
3. improving quality of child health care in all European countries,
4. promoting the exchange of national experiences in the various fields of patient care,
5. co-operating with paediatric associations worldwide, the WHO and UNICEF,
6. organising and arranging congresses and meetings for the benefit of the members of EPA, and
7. representing European paediatricians in relation to the International Pediatric Association (IPA).

Question: What are the "big issues" facing children in 53 European countries?

Ehrich: Firstly, identifying lack of child’s rights to health, in-equities and lack of social justice. Secondly, avoiding unnecessary variations and fragmentation of services, poor transition to adult services, poor communication with children and poor participation of children in medicine, and lack of child friendly health care.

Question: How will EPA achieve its aims?

Ehrich: EPA will act by promoting evidence-based policy and being a trusted source of information on behalf of children and families (based upon EPA engagement with relevant national professional organisations in Europe).
It will promote children’s rights to high-quality services through "child friendly health care".

EPA has started in 1998 in promoting improvement and learning through the comparison of different health care services which is based upon a European data base of child health care systems being built upon a widening network with national paediatric societies and other stakeholders.

Questions: Have you been able to identify the challenges which are related with these ambitious aims.

Ehrich: EPA has to broaden its intellectual basis by creating a multidisciplinary society to avoid fragmentation of paediatrics, and to allow to tackle the legal, economic and organisational challenges of child health care in Europe, and last but not least to put the children and young people into the centre of EPA activities.

Questions: What is your message to the Presidents of National Paediatric Societies?

Ehrich: I would ask them to provide EPA with a list if their national priorities concerning child health care plus a list of questions that they would like to ask the council members of EPA.

Thanks you for your interview.

4

THE FREEDOM OF MOVEMENT ACROSS BORDERS IN THE EU

CROSS BORDER CARE IN EUROPE

JOCHEN EHRICH

“Freedom of movement across borders has been one of the top priorities of the EU. The European parliament and council directive 2004/38/EC of 29 April 2004 makes clear the right of citizens of the Union and their family members to move and reside freely

within the territory of the EU and European Economic Area member states. Although there is clearly an increasing awareness of the provision of standardised health services and cross-border collaboration throughout the EU member states, it is still not clear how national governments should respond to complex issues regarding cross-border health care."

(Mercieca C, Aquilina K, Pullicino R, Borg AA.:Freedom of movement across the EU: legal and ethical issues for children with chronic disease. J Med Ethics. 2011)

The European Paediatric Association dedicated a symposium to cross border care during its congress in 2011 in Vienna. In addition it published an article on the challenges of cross border care in Europe in 2013 in the Journal of Pediatrics (Salzer-Muhar U1, Pollak A, Aufricht C, Ehrich J, Lenton S.: European challenges: cross-border care for children. J Pediatr. 2012 Sep;161(3):574-6).

The general reasons for cross border care of children are

- Temporal visit of a country and acute illness
- Children living in border regions
- Children sent abroad by their home systems
- Children going abroad on the initiative of their parents

The specific medical reasons for referral minclude

- Diagnosis of un-known disorders or confirmation of suspected disease.
- Treatment:
  - medical or surgical or rehabilitative therapy or all
  - short term or long term treatment
  - Urgent cases: Life safing treatment for acute and chronic life threatening disease.
  - Disaster care

The financial reasons for transfer of patients to other countries Financial reasons for transfer of patients to other countries are the lack of adequate, affordable, accessible, available

diagnostic and therapeutic care and supportive technology in a given country.

The current coping strategies include:

1. Humanitarian actions supported by NGOs
2. "Private profit orientated agencies"

3. Academic partnerships
4. Individual activities of parents
5. Trust funds

The right to obtain medical treatment does not mean the right to be healthy, nor does it mean that poor governments must put in expensive treatment, but it does require fair-play in offering care when concerning age, gender, ethnicity, culture, socioeconomic status, religious-political, or other ideology beliefs of patients.

The priorities of medical care given to children may differ from country to country, however, equal health opportunities should be given to all age groups in any given country.

Cross border care should be improved and organisational pathways must be developed if there is no adequate treatment available in any given country.

Recommendations and guidelines for parents and doctors are:

Step 1. Choose one adequate center.

Step 2. Get in touch with the center via email.

Step 3. Send a medical report (including a complete medical history and medical booklet) in English to the center including scans of imaging techniques.

Step 4. Wait for the response.

Step 5. Organise a telephone conference with doctors of the center and discuss the patient in detail on the phone.

Step 6. Discuss finances and administrative necessities with the hospital administrators (and not with doctors) concerning

1.visa,

2.travel,

3. accommodation,

4. local interpreters and carers,

5. cost estimate,

6. transfer of deposit,and/or lastly, declaration that the costs will be covered by a health insurance.

Step 7. Identify experts in the native country for follow-up care after return of the patient into the family.

Step 8. Discuss future exchange of information during follow-up.

5

THE EPA-UNEPSA 2014 REPORT ON POSTGRADUATE TRAINING IN GENERAL AND SUBSPECIALTY PEDIATRICS IN THE EUROPEAN UNION.

MASSIMO PETTOELLO-MANTOVANI

Massimo Pettoello-Mantovani

EPA-UNEPSA has recently published on the Journal of Pediatrics (J.Pediatr 165(2):424-426, 2014) a report on the current status of Postgraduate Training in pediatrics within the twenty-eight European Union Countries (EU28). EPA-UNEPSA was supported in the collection of data from the EU28 Nations by representatives of the EU28 Ministries of Health, national pediatrics societies, associations and post-graduate courses. The article, which title is "Diversity and Differences of Postgraduate Training in General and Subspecialty Pediatrics in the European Union", is summarized here with the purpose to update the News Letters readers on this important matter.

The 2014 article published in the Journal of Pediatrics emphasizes first the remarkable political achievement accomplished by The European Union (EU) which has progressively expanded the number of its Member Nations throughout the years from the initial 6 to 28 Nations in 2013 (EU28), however the Authors it also comment that such important achievement has been paralleled in many European nations by the emergence of cultural values awareness and strong feelings for the preservation of the various local cultural profiles, including traditions, history and cultural roots. Furthermore, the Authors suggest that the preservation of the identitarian profiles and cultural diversity of the local systems, which characterize Europe, it is generally assumed as a capital for its development, and it may often influence the decisions in many fields, including medical education.

The analysis of the EPA-UNEPSA starts from the observation that the management of medical education in the EU28 would require appropriate coordination, baked by an adequate cultural knowledge, a balanced strategic vision and a constant supervision. However, EU does not have at the moment a clearly identified administrative structure devoted specifically to Medical Education and the responsibilities in this area are shared by different departments or agencies of the European Commission, including the Directorates General of Education and Culture (EAC), Health & Consumers (SANCO), Internal Market & Services (MARKT), and the EU Education, Audiovisual and Culture Executive Agency (EACEA).

The various European national associations of medical subspecialties including Pediatrics, are assisted in their relations with the EU28 by the European Union of Medical Specialists (Union Européenne des Méde-

cins Spécialistes – UEMS), a non-governmental organization (NGO), regulated by the Belgian law. UEMS has been active since 1958 with the aim to represent national associations of medical specialists and operate at the European level to defend and promote the interests of Medical Specialists, the free movements of medical specialists and the quality of medical care. UEMS seems therefore characterized by a specific focus on medical specialist and their professional concerns instead of patients and public health care.

An important task of UEMS has been to developing European standards in postgraduate medical specialist training for a quality assurance (QA) and quality improvement (QI). Among the aims of this NGO is in fact the harmonization of the various national curricula, to promote unifying criteria to which the training centers should conform, and ultimately to foster a European board of examination. However, a satisfactory and reliable QA and QI of postgraduate medical education lays its foundations on comparable educational goals among different systems. In absence of these factors, any sincere effort to pursue a credible QA and QI standardized analysis in higher education applicable throughout the European Nations, may be in vain. The author of the article published in the Journal of Pediatrics note that the considerable diversities and differences among the independent medical educational systems in the EU28, thus seem to represent a major obstacle to a proper and dependable QA and QI assessment.

The case of Pediatric postgraduate education provides a scholastic evidence that the achievement of comparable and assessable medical education systems is not an easy task to be accomplished in the EU28. The original data published in the Journal of Pediatrics and reported in Table 1 show how the postgraduate pediatric training is currently (2014) performed in the EU28 Nations. The 28 different national programs last from 4 to 8 years, presenting strikingly diversities. We have arbitrarily divided the Nations into two groups, A and B. Group A, includes Nations that offer a 4 years basic course in General Pediatrics and in some cases an additional 1 to 3 years optional training in selected pediatric subspecialties; Group B, include Nations that offer a 5 to 8 years basic course in Pediatrics, including General Pediatrics and part of pediatric subspecialties, which in some case may be further expanded by 1 to 3 years of specific subspecialty training. The educational system in the Group B Nations is intended to ensure that primary care pediatricians are prepared for the diversity of clinical and social problems that they will encounter, and that specialist pediatricians receive sufficient training in rare and complex disorders.

The profound diversities among the EU28 postgraduate pediatric programs showed in Table 1, are due to a multiplicity of factors, partially discussed earlier in this article. Such factors may also include the significant differences existing among the various pediatric health care systems, particularly in the organization of children’s (non-hospital) first-contact services, and it may also reflect the attention put by some Nation in providing a specific postgraduate education particularly focused on general and primary care pediatrics. In fact, the management of first-contact services is a well-recognized social issue in the EU28, subjected to the frequent changes in political visions and policies of single Nations, and frequently impacted by economic contingencies. The three existing main models are based on whether primary care general physicians, primary care pediatricians, or combinations of both are primarily responsible for care. However, comparisons between models are difficult because of the subtleties and complexities of definitions of these models. The pressure to “deliver more for less”, seems to be often the driving force forging the political strategic decisions in the area of pediatric health care and pediatric education, rather than social, cultural and economic sensitivity and competences.

Therefore the delivery of an appropriate pediatric training seems not to be related exclusively to educational motivations, but also to other factors, including social, economic and political rationales. However, the economic factors seem to be predominant. In response to current global economic pressures, and often in obedience to generalized budget restrictions imposed by local financial policies, ongoing discussions are taking place in many countries which are considering to change the structure of their postgraduate pediatric training. To such regard, an equivocated interpretation of an EU directive on training in pediatrics has offered many EU28 Nations the justification to consider reducing the pediatric training to just 4 years, presenting it as the best length for a postgraduate training in pediatrics. In reality, the EU directive pointed to the complete different goal of protecting the quality of pediatric education, by establishing a minimum period of training. The aim was in perspective to avoid unacceptable reductions of the pediatric training’s length below the limit of four years, which would affect the basic quality standards for education in this area.

The authors conclude that the ongoing discussions aiming at minimizing the length of post-graduate pediatric education in some countries, seem to follow a current trend of unhealthy rationalization, with an emphasis on ‘cutting the excess fat’ and ‘balancing the budget’, instead of following constructive concerns aimed at providing the proper health care to children, supported by properly trained professionals.

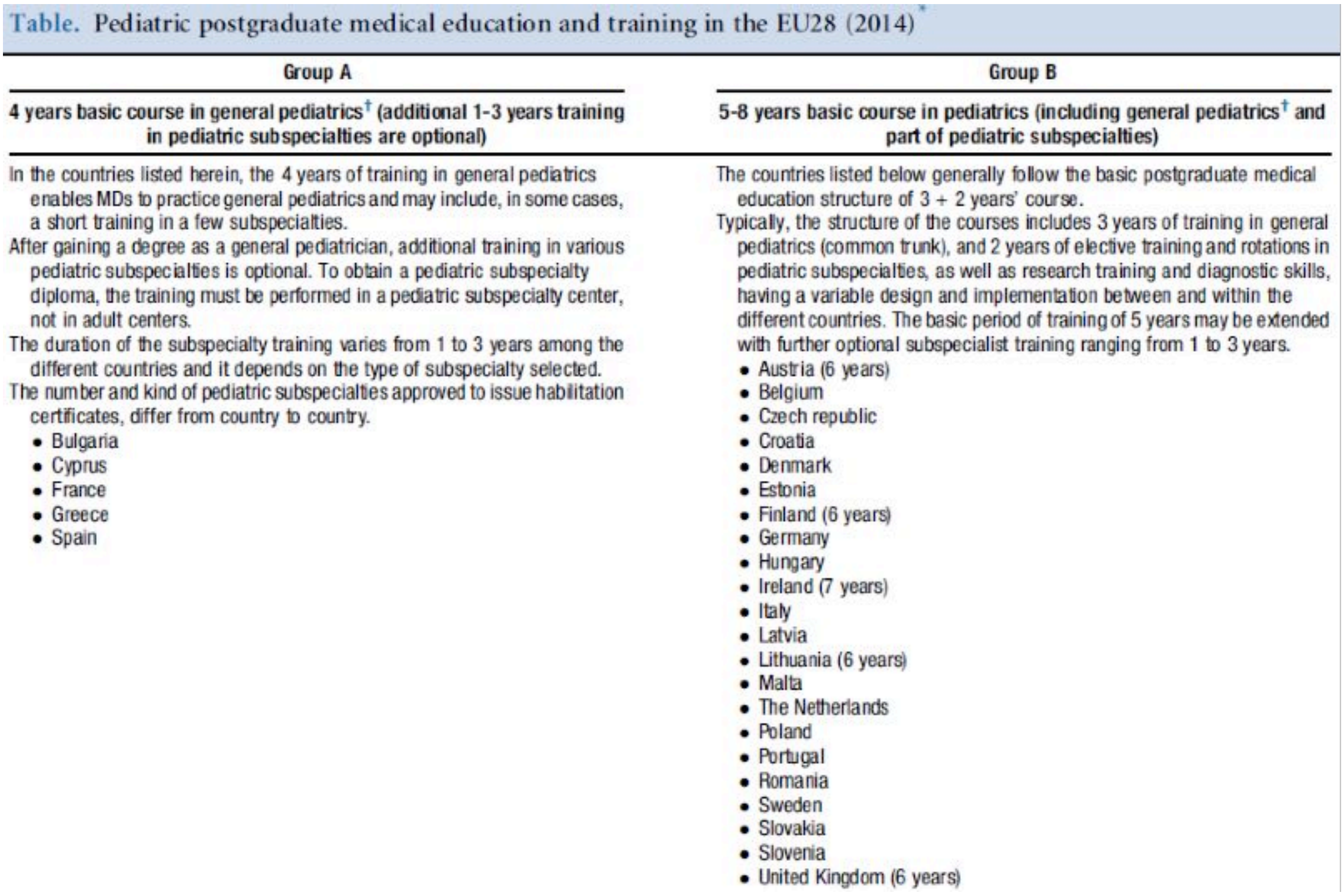


Table. Pediatric postgraduate medical education and training in the EU28 (2014)*

Group A	Group B
4 years basic course in general pediatrics† (additional 1-3 years training in pediatric subspecialties are optional)	5-8 years basic course in pediatrics (including general pediatrics† and part of pediatric subspecialties)
In the countries listed herein, the 4 years of training in general pediatrics enables MDs to practice general pediatrics and may include, in some cases, a short training in a few subspecialties. After gaining a degree as a general pediatrician, additional training in various pediatric subspecialties is optional. To obtain a pediatric subspecialty diploma, the training must be performed in a pediatric subspecialty center, not in adult centers. The duration of the subspecialty training varies from 1 to 3 years among the different countries and it depends on the type of subspecialty selected. The number and kind of pediatric subspecialties approved to issue habilitation certificates, differ from country to country. • Bulgaria • Cyprus • France • Greece • Spain	The countries listed below generally follow the basic postgraduate medical education structure of 3 + 2 years' course. Typically, the structure of the courses includes 3 years of training in general pediatrics (common trunk), and 2 years of elective training and rotations in pediatric subspecialties, as well as research training and diagnostic skills, having a variable design and implementation between and within the different countries. The basic period of training of 5 years may be extended with further optional subspecialist training ranging from 1 to 3 years. • Austria (6 years) • Belgium • Czech republic • Croatia • Denmark • Estonia • Finland (6 years) • Germany • Hungary • Ireland (7 years) • Italy • Latvia • Lithuania (6 years) • Malta • The Netherlands • Poland • Portugal • Romania • Sweden • Slovakia • Slovenia • United Kingdom (6 years)

Notes:

- **Austria**: 6 years, which include a number of mandatory subspecialties plus one year in a non-pediatric specialty. Training may be extended by 2 or more optional years, depending on the type of subspecialty selected.
- **Bulgaria**: In parallel to the 4 years training course in General Pediatrics, different 4 years training courses are established for each of the following recognized pediatric subspecialties: cardiology, pneumology, neonatology, endocrinology, rheumatology, neurology, nephrology and gastroenterology. Such courses include 2 years of General pediatrics integrated by 2 years in one subspecialty selected by the trainee.
- **Czech Republic**: The training in General Pediatrics last 5 years. Subspecialist training is optional and requires additional 2 years of training. However, the last of the basic 5 years curriculum in General Pediatrics may be included in the subspecialty training if it is spent in a clinical department accredited for the subspecialty selected.
- **Denmark**: The 5 years training in pediatrics includes 1 year of introductory training in General Pediatrics, followed by 4 years of further pediatric training (2 plus 2 years) in two different accredited pediatric departments. Although Demark do not recognize pediatric subspecialties, trainees may expand their education in pediatric subspecialties from 6 months up to three years depending on the type of subspecialty selected.

- **Estonia:** A 3.5 years of training in General Pediatrics is followed by 1.5 years or rotation in selected subspecialties. Ongoing changes will soon include a mandatory 1 year training ("General Residence") for all postgraduate courses, including Pediatrics, that will include Family Medicine and Emergency Medicine. This will increase the postgraduate training in pediatrics to 6 years.
- **Finland:** The 6 years training course in General Pediatrics include the first 3 years spent in Central Hospitals followed by 3 years in a University Hospital. General Pediatricians may become subspecialists by taking a 2 years additional course in one of the following: neonatology, allergology, cardiology, endocrinology, haemato-oncology, gastroenterology, infectious diseases, rheumatology, nephrology, social pediatrics.
- **Germany:** 5 years basic training in Pediatrics including part of pediatric subspecialties, plus 1 to 3 years subspecialty training, depending on the type of subspecialty selected (one of the three years subspecialty course, e.g. in pediatric nephrology, may be included in the initial five year training period).
- **Hungary:** The 5 years training course include 2 years of training in General Pediatrics, followed by 3 years rotations in pediatric subspecialties. Additional 2 years of training are required to obtain a diploma in one of the pediatric subspecialties accredited.
- **Ireland:** 2 years training in General Pediatrics, including 6 months neonatology, followed by 5 years of higher specialist training.
- **Italy:** Ongoing discussion are taking place at government level aimed at reducing the pediatric training to 4 years, including General Pediatrics and perhaps rotations in few selected subspecialties. Pediatric subspecialties are not officially recognized.
- **Latvia:** 4 years of training in General Pediatrics, plus 2 to 3 years subspecialty training, depending on the type of subspecialty selected.
- **Lithuania:** after 6 years of training, including 4 years of General Pediatrics and 2 years in a selected pediatric subspecialty, two separate diplomas are issued: a) in General Pediatrics, and b) in the pediatric subspecialty selected for the training.
- **Malta:** The last of the five years training in pediatrics is performed in UK.
- **Poland:** Pediatric Training is Currently 6 years, followed by additional separate training for pediatric subspecialties of typically 3 year duration. The system is in transition to adapt to the 5 (3+2) years structure, including the common trunk, followed by 2 years of training to become specialist in General Pediatrics, or 2 to 3 years of training in a selected subspecialty to become specialist in General and Subspecialty Pediatrics. However, it will be still possible to perform a 2 to 3 years of training in a pediatric subspecialty after 5 year training in General Pediatrics to acquire the additional diploma in a Pediatric Subspecialty.
- **Romania:** The training in General Pediatrics lasts 5 years with no common trunk. Subspecialties are optional and performed after the 5th year in separate programs.

- **Slovakia:** 3 additional years of training are currently required to obtain a diploma in a pediatric subspecialty. Ongoing discussions are taking place at government level aimed at reducing the basic pediatric training to 4 years.

- **Spain:** Pediatric training follows the postgraduate education structure of 3+1 years course, where 3 years are dedicated to General Pediatrics, followed by 1 year rotation is selected subspecialties.
- **Sweden:** 5 years of General Pediatrics plus 2 optional years of elective subspecialties.
- **United Kingdom (UK):** the postgraduate medical education in pediatrics includes 2 initial years of general medicine. The total length of training is 6 years, and it could be extended to up 8-9 years, depending on the type of subspecialty selected.

- LUXEMBURG does not offer postgraduate training in Pediatrics, however the specialty in Pediatrics is included in the list of medical disciplines recognized in Luxembourg. Training in Pediatrics is performed abroad based on agreements with European Universities from different EU countries (Austria, Belgium, France, Germany, Switzerland and UK). Luxembourg only recognizes Pediatric trainings of 5 years minimum. Trainees may spend 1 or 2 years training in a pediatric department in Luxembourg and at least 3 years abroad in university hospitals. Luxembourg also offers a complete training for general practitioners performed locally, with at least 2 months of training in Pediatrics conducted in an accredited pediatric department.

- (*) The training in General Pediatrics is ill defined in most countries and may include training periods within hospitals, dispensaries (polyclinics), private practices, seminars or self-study which may differ in duration and content from country to country and within countries. The training periods include primary, secondary and tertiary pediatric care, however, the training may be organized following a rather strict schedule or an optional mode.

- Data in this table were collected with the collaboration of the European Pediatric Association, Union of National European Pediatric Societies and Associations (EPA-UNEPSA), the European Medical Association (EMA). http://www.emanet.org/post-graduate.cfm, and representatives of the EU28 Ministries of Health, national pediatrics societies, associations and postgraduate courses in pediatrics.

6

THE ITALIAN FEDERATION OF PEDIATRICIANS (FIMP) HAS BECOME EPA-UNEPSA MEMBER AT THE GENERAL ASSEMBLY IN MOSCOW IN FEBRUARY 2015

THE ROLE OF FIMP IN EUROPE

Interview with the President Giampietro Chiamenti

The Italian Federation of Pediatricians (FIMP) has been elected unanimously a full member of the Union of National European Pediatric Societies and Associations by the Presidents representing the 49 EPA-UNEPSA member societies at the general assembly of the "Union", which was held in Moscow on February 12, 2015. The EPA-UNEPSA officer for international relations, Dr. Olga Komarova, has interviewed the President of FIMP Dr. Giampietro Chiamenti about the role the he envisages for FIMP within the European context during the next years.

Interview with the President Giampietro Chiamenti

Dr. Komarova: First may I congratulate you on the election of FIMP as full member of the Union of National European Paediatric Societies and Association

Dr. Chiamenti: I would like to express my great satisfaction and deepest gratitude to the General Assembly of EPA-UNEPSA for the appreciation shown to FIMP. The prestigious membership in EPA-UNEPSA is both a great honour and a great responsibility.

Dr. Komarova: Could you tell us a little about the Italian pediatric primary care system ?

Dr. Chiamenti: Since 1981 the Italian “National Health Service” has provided pediatric primary care to children through the use of community based pediatricians, which are commonly called “family pediatricians” (pediatri di famiglia). The Italian Public Health Care System requires that all children have an identified primary care provider, depending on the patient’s age. Italian pediatricians related to the Public Health System work in their own private offices, providing primary care of patients from birth to 16 years of age and are compensated under a capitation system . The pediatricians working for the Public Health Care system are usually the sole patient entrance to public secondary and tertiary care in the 0 to 6 age range, while parents can choose between a pediatrician or a general practitioner for their children’s care between 6 and 16 years of age.

Dr. Komarova: and about FIMP?

Dr. Chiamenti: The Italian Federation of Pediatricians (FIMP - Federazione Italiana Medici Pediatri) is the major professional organization of community-based practicing pediatricians. The Federation counts over 6.000 members, representing at list 85% of the Italian Family Pediatricians. Among the responsibilities of FIMP is ensuring that the high quality of healthcare services provided to children and adolescents is kept in good standing. Our Organization interacts with the State legislators and the Ministry of Health, intervening on major topics involving the healthcare of children and adolescents, as well as on any matter of importance for pediatrician, as professionals responsible for child health. FIMP is also responsible for the development and evaluation of continuing medical education programs and research projects for its large community of members.

Dr. Komarova: therefore, is continuing medical education an important aspect of FIMP activity?

Dr. Chiamenti: Absolutely. The maintenance of the professional competence of its members constitutes one the primary missions of FIMP. Naturally, pediatricians as all physicians will always remain the first motor of their own competence, but FIMP plays a major role in organizing and providing continuing medical education activities to its members.

Courses, seminars and a variety of educational activities, including “specialty schools” are regularly organized during the year in the different regional realities in Italy.

Dr. Komarova: now that FIMP is a full member of EPA-UNEPSA, do you see a role for FIMP in Europe?

Dr. Chiamenti: FIMP plans to play an important role in full harmony with the other members, working together on the basis of a shared vision and mission. FIMP does not believe “lonely players” to be truly effective in the long-run, FIMP believes in collective leadership. In fact, we regard the opportunity of working together with the 49 EPA-UNEPSA national societies and associations as a key factor to develop projects, activities and initiatives of great impact for the benefit of children

Dr. Komarova: Could you expand on what you see as the priorities for a collective action within EPA-UNEPSA?

Dr. Chiamenti: I would consider two main, yet different perspectives, such as children and healthcare services provided to them. From the perspective of children and young people there are significant variations in the health and quality-of-life for children across the nations of Europe. Such variations are unacceptable and most inevitably lead to inequalities that are likely to get larger with the economic challenges facing our countries. FIMP feels that pediatricians must stand up and act as advocates for the well-being of children. In fact, the care of well-being of children is not only ethical, but also cost-competitive. This is a concept well known by pediatricians, particularly in reference to several clinical conditions subjected to chronic evolution such as obesity or mental health problems. Prevention is certainly better than treatment.

From the perspective of the healthcare services that are provided by pediatricians, once again there are significant variations in the quality, quantity and safety of such services to children and families across the diversity of Europe. FIMP feels that the diversity should be regarded as an opportunity, and interpreted as a natural experiment from which pediatricians could learn by studying which systems and services produced better outcomes. In this perspective pediatricians should be able to learn from each other and implement relevant best practice.

Dr. Komarova: is there any specific plan or project that in the near future FIMP is planning to propose and develop in EPA-UNEPSA?

Dr. Chiamenti: FIMP believes in cooperation and collaboration among EPA-UNEPSA members and with the professional organisations that represent the interests of children in Europe. There is no doubt that this will at times be very challenging, however, we count on the experience acquired by the EPA-UNEPSA members and on its existing relations with good pan-European clinical research networks.

One important action that FIMP would like to support within EPA-UNEPSA is the collaboration among its members to further study and properly document the advantages and disadvantages of general practitioner versus primary care pediatrician providing first contact care. Again, there are huge differences in what is provided within child health promotion/screening and surveillance programmes across different nations.

A further important project that FIMP is planning to develop in collaboration with the other member societies and associations of EPA-UNEPSA, regards the significant diversity in vaccinations schedules among European nations. The project proposed by the FIMP vice-President Dr. Luigi Nigri at the General Assembly of EPA-UNEPSA in Moscow aims at a unified "universal" EU Vaccination Schedule, and FIMP is organizing a round table on this topic at the 7th Europaediatrics, which will be held on May 13-16 in Florence. To such regard it will be important to reflect on how the existing schedules came into being and how difficult it might (or might not) be to change them. There would also need to be a short review of current and changing epidemiology, with an emphasis on the re-emergence of vaccine-preventable infections. There could be a prioritisation of vaccines: which vaccines are essential and which are nice-to-have. Coupled to this is of course pharmacoeconomics and cost-effectiveness. Finally, of interest in this regard are calculations which highlight the immense monetary and human cost arising from reductions in vaccination.

Dr. Komarova: it sounds an ambitious project.

Dr. Chiamenti: FIMP believes that there’s nothing wrong with being ambitious, when the health of children is at stake. The goals that FIMP hopes to achieve in collaboration with the other EPA-UNEPSA members may sound ambitious, but there is nothing too ambitious for the welfare of children and their families. We need to take action to make our world a better place for our children and for future generations.

American Academy
of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

7

NEWS FROM THE AMERICAN ACADEMY OF PEDIATRICS

Non-communicable diseases (NCDs) have a significant impact on children and adolescents. Approximately 1.2 million deaths from NCDs occur each year in people under the age of 20, over

13% of all NCD mortality. Furthermore, while child-mortality rates have recently decreased, mortality in adolescents has only marginally improved. Globally, many children die from treatable NCDs, such as rheumatic heart disease, type-1 diabetes, asthma, and leukemia, and there are large disparities in outcome across countries. Prenatal and childhood exposure to tobacco and alcohol, prematurity and low birth-weight, malnutrition and obesity, and diabetes have long-term impacts on health and development, including increased risk of adult cardiovascular disease, diabetes, and other social and medical problems later in life. In much of the world, road traffic and other injuries are the leading cause of death for those aged 5-15 years. Many of the behaviors that lead to adult NCDs start during childhood and adolescence; over half of all NCD related deaths each year are associated with behaviors beginning in young people. For more background on children and NCD issues please see http://www.ncdchild.org/NCD-Facts.

Both prevention and treatment interventions for children and youth are effective strategies for reducing the global social and economic burden of NCDs. Addressing the global burden of NCDs through a life-course approach can reduce both rates of NCDs, and can greatly improve the lives of those living with illness. A commitment to a life-course approach is a central tenet of the WHO Global Monitoring Framework on NCDs; however, there continues to be a lack of attention to the systematic implementation of policies and programs that reflect these principles. Of significant concern is the continuing omission of NCD prevention and management interventions targeted at children and adolescents in key global health and national development strategies and plans.

As the Sustainable Development Goals are developed at the UN, the omission of child specific measurable targets for NCD prevention and treatment has the potential to have both a profound negative impact on the national prioritization of early interventions to prevent and manage NCDs in young people. Pediatricians, along with other clinical leaders, youth serving agencies and civil society organizations must call for their countries to prioritize prevention and treatment for children and youth. National governments should be encouraged to commit to a life-course approach to NCDs and should advocate for inclusion of specific global and country specific targets, and for indicators and key measures in the NCD monitoring framework, and in the post-2015 Sustainable Developmental Goals health goal’s monitoring framework.

NCD Child is a global multi-stakeholder coalition, championing the rights and needs of children, adolescents, and youth who are living with, at risk of developing, or affected by NCDs. NCD Child is committed to the prevention of NCDs in children and adolescents, and to the treatment and palliation, care and support, protection and participation of children and adolescents affected by NCDs throughout their life-course. The American Academy of Pediatrics (AAP) serves as Secretariat for

NCD Child, and the AAP Board of Directors has made a commitment to working with NCD Child and the International Pediatric Association to call attention to child and adolescent NCD issues.

As part of this commitment, NCD Child and AAP will be conducting regional champions' workshops to engage national child health leaders, youth-serving NGOs, and national governments to be active child and adolescent NCD advocates. The workshops will include a mix of key lectures, panels, and group breakouts. The content will include advocacy training, a global overview of the state of NCDs in children and adolescents, and practical strategies to effectively include children and youth in country-level NCD agendas and prevention and treatment systems. The technical content will address general NCDs with attention to tobacco, obesity, disability, injury prevention, and mental health. Along with clinical background, participants will leave the workshops equipped with knowledge on the current status of NCDs on the global health agenda; connections to public health stakeholders through NGOs, youth-led organizations, and government officials; and strategies for championing children and adolescents within the existing agenda. The longer term goal of these workshops will be increased dialogue and, eventually, policy change related to youth and NCDs.

A European regional national NCD Champions workshop is planned for the Summer or Fall of 2015. Please look for a call for applications or write to ncdchild@aap.org for more information.

For more information about the AAP International activities, please visit
http://www2.aap.org/international/ or contact us at international@aap.org.

ROMA IMMIGRANT CHILDREN IN A SPONTANEUOS SUB-URBAN CAMP IN ROME

Ersilia Buonomo

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8

HEALTH PROBLEMS OF IMMIGRANT CHILDREN IN THE EU28 NATIONS. THE CASE OF ROMA CHILDREN IMMIGRANTS IN ITALY.

Children of immigrants have become the fastest growing segment of population under the age of

ROMA IMMIGRANT CHILDREN IN A SUB-URBAN CAMP VILLAGE PROVIDED BY THE CITY OF ROME

18 in many Countries of the European Union (EU28). Such phenomenon has developed particularly during the last decade, due to many factors, including food shortage, poverty, political changes and war. As a consequence, there has been a massive move of populations in demand for a better social conditions heading to EU 28 Countries not only from the African continent and from the near and far East, but also from European areas currently afflicted by poor economic conditions.

This emerging social condition has generated a number of health issues, which has been recently addressed by an interesting study performed by Italian researchers of the Department of Biomedicine and Prevention of Tor Vergata University and the ONLUS "Medicina Solidale" (Minerva Pediatrica, 2014; 66/1:2-8 - Buonomo E, Palombi L, Mancinelli S, Gilardi F, Iacovone G , Boscherini B, and Ercoli L).

The study emphasizes the magnitude of the phenomenon of children immigrants in Italy and their health problems. In particular the study focused on Roma immigrant children currently living in the city of Rome.

According to the 15th Italian statistic Census 2011, children of immigrants are the fastest growing segment of the Italian population under the age of 18. Numbering 993.000, they represent 24.4% of the immigrant population . Between the census of 2001 and that of 2011 there was a decrease in the resident Italian population of 250,000 individuals (-0,5%) while there was an increase in the immigrant population of 2,694,256 individuals, in part due to an increase in family reunions and in immigrant births. Overall, the demographic structure in Italy increased by 4.3%. With respect to absolute numbers, in 2011 it was calculated that immigrants numbered 4,029,145, with a growth rate of 201.8% over the preceding ten years. With respect to geographic distribution, two out of three immigrants live in the North of Italy. Regarding the distribution of age, the younger age group was most represented. The average age was 31 years, 20.2% were younger than 14. Moreover, 78,000 births were registered in 2010, equal to 14.4% of the total national number of births. Interestingly the article reports that two thirds of immigrant children, equal to 420,000, were born in Italy of immigrant parents. They are second generation immigrants and represent a powerful factor of integration with regard to their families.

With reference to their socio-economic conditions, it has been revealed that 42% of immigrants under 18 live in conditions of poverty compared to 15% of Italians. This fact compromises the economic and cultural development of these minors and is reflected by the fact that, while most immigrant children go to elementary school, few apply to secondary school.

The study by the Italian researchers has focused particularly on the VIII municipality of the City of Rome, since it is well representative of a typical sub-urban areas where immigrant populations settle. The VIII Municipality covers a vast area to the south-east of the City, outside the city's ring road. From the demographic point of view, it is the most densely populated municipality with 243,922 inhabitants, as well as being that populated by the youngest: 15.9% of the population is less than 14 years of age (Table 1). Finally, it is also the municipality with the most immigrants, 15.5% compared to 13% in Rome and that with a high number of women of a child-bearing age 26%, many of them immigrants, contributing to a high rate of births and fertility, the rate of which is 9 times higher than that of the city itself. The VIII Municipality of Rome is also characterized by social fragility, a high rate of unemployment and a high rate of scholastic abandonment: 15% with respect to 9% in Rome. Moreover, the majority of immigrants have access to the National Health Service (NHS) only in cases of emergency.

The University Policlinic of "Tor Vergata" in collaboration with the ONLUS "Medicina Solidale", has dedicated a service to the health needs of the immigrant population in the area of the VIII Municipality of Rome. The objective of their study has been to analyze the growth, health and nutrition status of immigrant children who accessed the health service from February 2004 to May 2012. The pediatric medical records of the children who requested health assistance at the ambulatory of the "Medicina Solidale" were examined and the socio-demographic variables, country of origin, health problems and nutritional status were analyzed.

The results of the study published by the Italian researchers show (Figure 1) that more than half of the families (62%) were from Romania, 11% from Nigeria, 11% were children of Roma families, 5% were from North Africa, 4% from various Eastern European countries, 3% from Latin America, 2% from Albania and Turkey, 1% from Sub-Saharan Africa,1% from Sub-continental Asian countries and the remainder from Western Europe and North America.

Males were 53.1% of the sample and age distribution shows that 31.8% were infants (0-12 months) and 23.0% were school-age children (60-120 months). With respect to living conditions, it was observed that 68% declared living in regular housing, while 5.9% lived in Roma camps, 6.8% declared they were of no fixed abode and the remainder lived in community shelters. Regarding the hygiene and sanitary conditions of these dwellings, it is significant that in 25% of cases there was no water supply and, consequently, immigrant families had no access to running water, reflecting inadequate hygiene with respect to their living conditions, to food preparation and conservation and, above all, to their personal hygiene.

Health problems in immigrant children living in a sub-urban area of the city of Rome

Although the Italian National Health Service (NHS) states a referral paediatrician for all children, more than half of the sample, 811 children (62%), had never had a paediatrician of referral, 21% did not respond or referred to having had relational or economic difficulties within the NHS. Therefore only one in five children had actually a pediatrician of referral. With respect to the distribution of health problems on admission the figure 2 shows an epidemiological picture similar to that of another regional survey and is characterized by health problems regarding child growth (29%) and neonatal problems (22%), related to breastfeeding and weaning. In agreement with other reports, the most frequent reasons for requesting medical assistance were infectious diseases of the upper and lower respiratory tracts (UARI and LARI), which resulted 12% and 7% respectively. This was in line with a recent study which showed that an increase in respiratory symptoms in immigrant children was associated with the number of years of life spent in Italy, once more indicating a risk factor linked to unhealthy dwellings. The dermatological problems such as scabies, nappy rash, and other skin conditions commonly associated with poor hygiene represented 6%.

Malnutrition, represented 5% of health problems on admission. It is also an indicator of disparity and of the diffuse food insecurity among immigrants in this area. As expected, among pediatric pathologies a significant portion is represented by gastroenterological problems (5%) including infectious and parasitic diarrhea. Moreover, it is notable that the ONLUS “Medicina Solidale” has identified and treated four cases of pulmonary tuberculosis in three Romanian adolescents and one of Nigerian origin resident in Italy over an extended period of time. The study also reports a case of HIV/AIDS of vertical transmission.

Roma children

Analysis of anthropometric evaluation performed by the study has highlighted that the subgroup of Roma children presented all anthropometric indices significantly lower respect to the entire immigrant sample (Table 2). In particular HAZ values, an expression of linear growth, at birth equal to -0.77 and in children up to 5 years of age, remained negative with an average equal to -0.49. Such an index is an expression of social inequality . In the case of Roma children, low HAZ values clearly indicate social inequalities in this ethnic group.

With respect to compulsory childhood vaccinations, 30% of the sample was unable to give information about immunization coverage, 66.4% reported that their children had been vaccinated in Italy or in their country of origin, whereas 3.4% had not been vaccinated. It has been estimated that being Roma the risk of not been vaccinated is equal to OR=5.4 (IC:95% - 2.8-10.1). Such a result reflects the recent epidemic of measles in Bulgaria with a significant rate of mortality among Roma children ,which confirms, once again in Europe, the gravity of the exclusion of basic human rights on the part of the Roma population and indicates the urgent need for the reorganization of public health services in the fields of immunization and prevention.

Among children who were not vaccinated. 77.4% of parents had never attended school. Having an illiterate parent implicates the risk of not being vaccinated and such a risk has been calculated as equal to an OR=15.36 (IC:95% 6.4-36.4). Therefore, parental illiteracy, an indicator of absolute poverty appears to be the most important risk factor in the lack of preventive medicine

The conclusions drown by the article indicate that the population studied presents high prevalence of malnutrition, growth retardation, skin infections and low vaccine coverage, exacerbated in Roma children. The Italian researchers also emphasize that to eliminate the cause of inequality and marginalization and improve the access to National Health Service particularly for Roma children represents a social and public health priority. It appears urgent to review the rules for obtaining the citizenship for children of immigrant born in Italy, facilitating access to vaccination and ensuring a paediatrician to immigrant children.

Table 1 – Socio-demographic characteristics

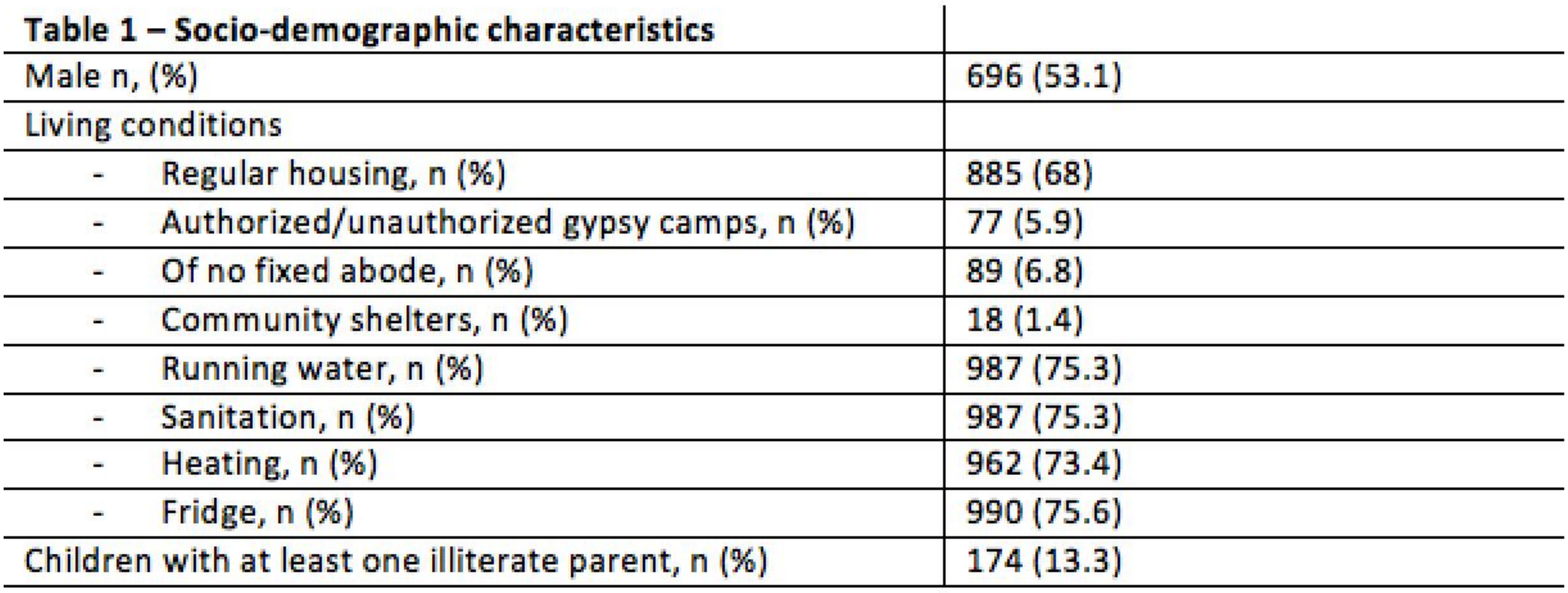

Table 1 – Socio-demographic characteristics	
Male n, (%)	696 (53.1)
Living conditions	
- Regular housing, n (%)	885 (68)
- Authorized/unauthorized gypsy camps, n (%)	77 (5.9)
- Of no fixed abode, n (%)	89 (6.8)
- Community shelters, n (%)	18 (1.4)
- Running water, n (%)	987 (75.3)
- Sanitation, n (%)	987 (75.3)
- Heating, n (%)	962 (73.4)
- Fridge, n (%)	990 (75.6)
Children with at least one illiterate parent, n (%)	174 (13.3)

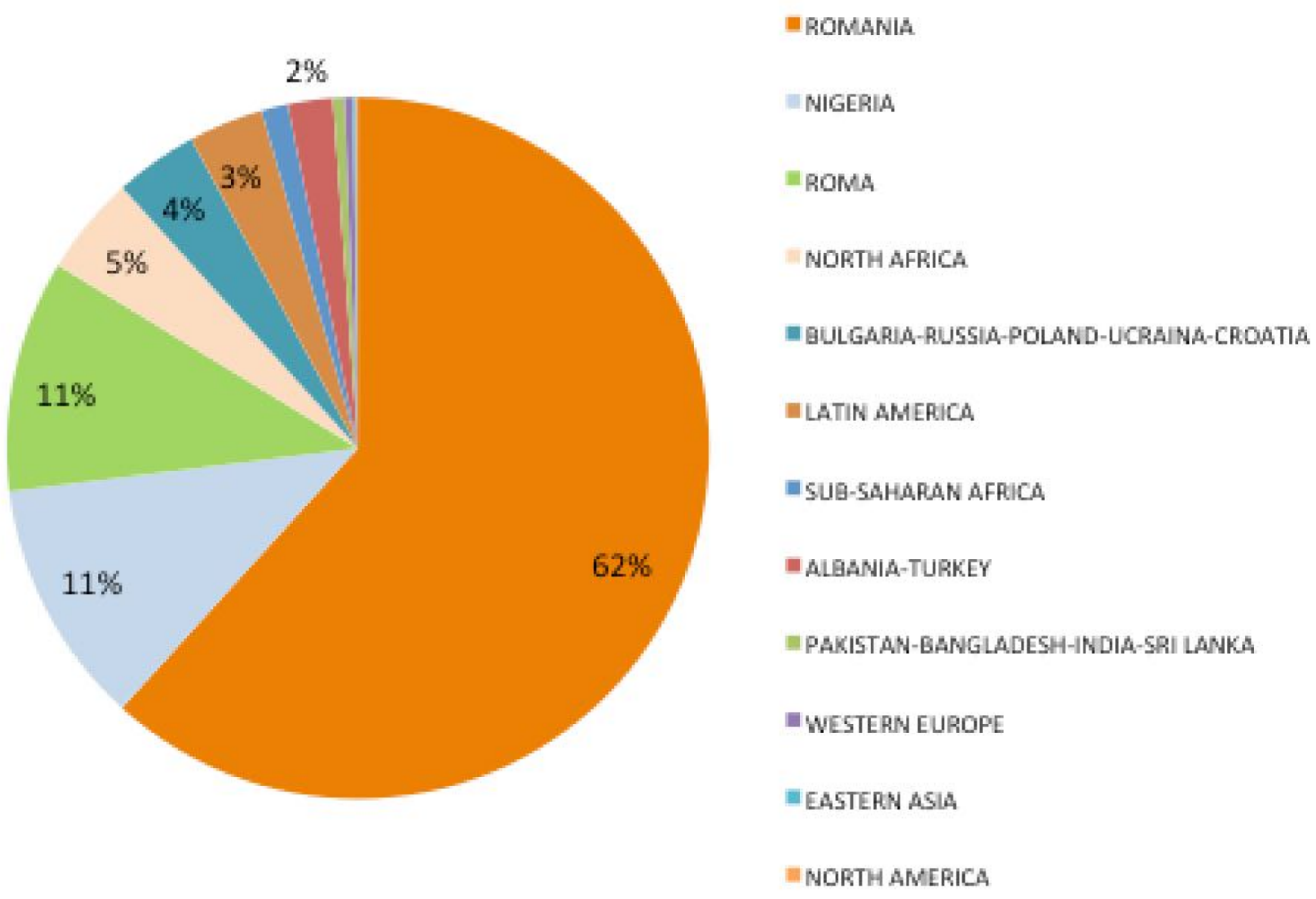

Figure 1- Percentage distribution of immigrant children living in a sub-urban area of Rome (Italy) on the basis of ethnic group and country of origin of families.

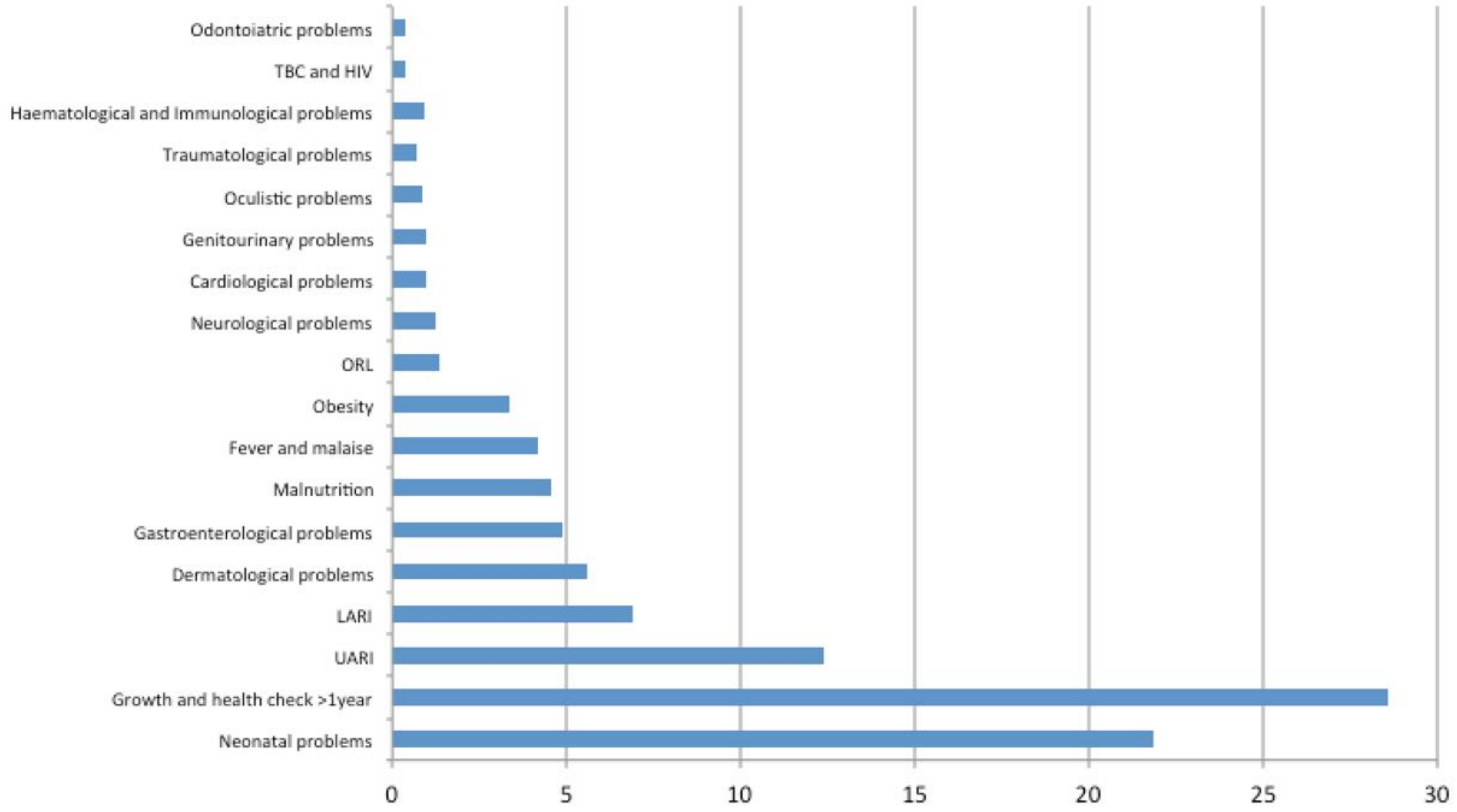

Figure 2 – Main health problems (%) shown by immigrant children living in a sub-urban area of Rome (Italy)

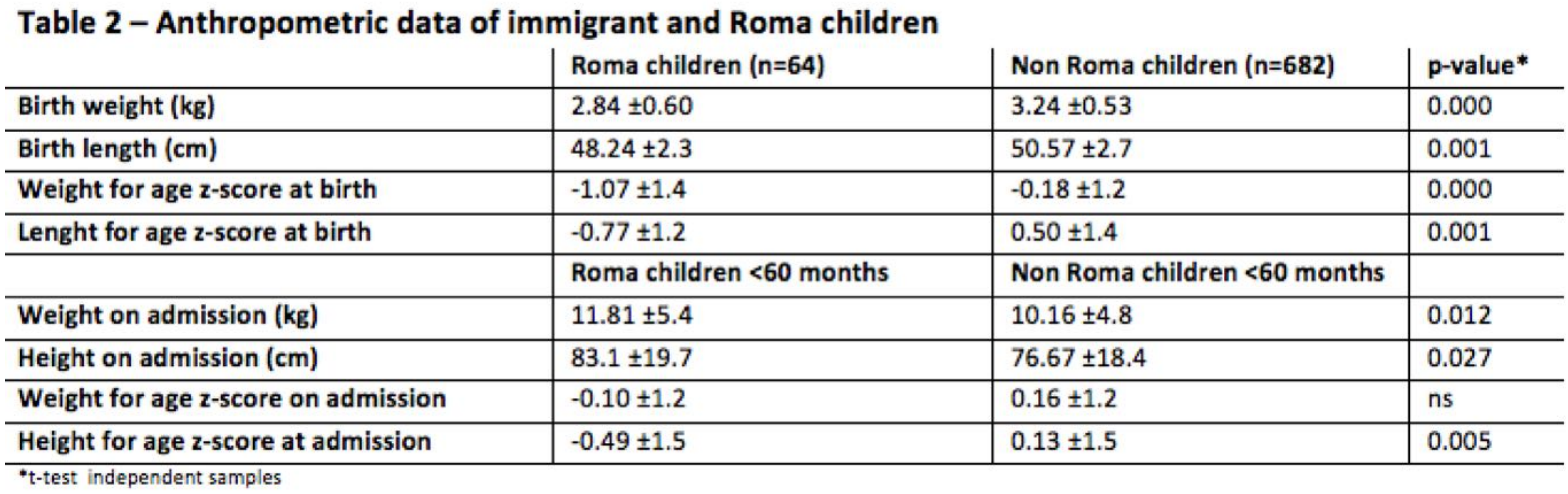

Table 2 – Anthropometric data of immigrant and Roma children

	Roma children (n=64)	Non Roma children (n=682)	p-value*
Birth weight (kg)	2.84 ±0.60	3.24 ±0.53	0.000
Birth length (cm)	48.24 ±2.3	50.57 ±2.7	0.001
Weight for age z-score at birth	-1.07 ±1.4	-0.18 ±1.2	0.000
Lenght for age z-score at birth	-0.77 ±1.2	0.50 ±1.4	0.001
	Roma children <60 months	**Non Roma children <60 months**	
Weight on admission (kg)	11.81 ±5.4	10.16 ±4.8	0.012
Height on admission (cm)	83.1 ±19.7	76.67 ±18.4	0.027
Weight for age z-score on admission	-0.10 ±1.2	0.16 ±1.2	ns
Height for age z-score at admission	-0.49 ±1.5	0.13 ±1.5	0.005

*t-test independent samples

Table 2 – Anthropometric data of immigrant and Roma children

9

IMPLEMENTATION OF THE UN CONVENTION OF THE RIGHTS OF THE CHILD: WHAT WE CAN DO?

L. Namazova-Baranova

EPA/UNEPSA President

L. Namazova-Baranova
EPA/UNEPSA President

Dear colleagues and friends!

We, pediatricians, are the acknowledged advocates of childhood. We have to watch closely for the fact of respect and protection of the rights of the child. Unfortunately children all around the world keep needing the grown-ups' protection - from hunger and violence, natural disasters and social upheavals, and, unfortunately, sometimes from the activity (or inactivity) of their own parents. The Convention on the Rights of the Child was ratified 25 years ago. But up to now it remains unknown to large parts of the population.

In such situation we are sure that our international pediatric community has to take the responsibility for sharing this information among patients and their families.

Therefore we are pleased to introduce the new educational project of EPA /UNEPSA and Union of pediatricians of Russia - Child rights in the multinational fairy tales. This project is directed for promoting of knowledge about the child rights in the accessible and knowing manner. Fairy tales are the most readable books in childhood. Reading fairy tales parents and child learn more about their rights, and young readers, growing up become the parents enriched with new knowledge of the children.

Fairy tales help to form the concept about such important categories like good and evil, love and hate, cruelty and generosity, as well as the lack of rights and justice. These categories are typical values for any nation. Tale containing morality can bring people together to reveal the similarities in the perception of human values.

Exactly fairy tales provide the idea that child's rights it not an abstract legal concept but the reflection and generalization of centuries-old spiritual heritage of the various peoples gained in the cultural development from the stage of indifferent disregard through interest and sympathy for the protection of children and consolidation child's rights in the basic law.

Would be pleased to suggest you, dear colleagues, to follow this Project and combine our efforts to translate it for maximum languages. Sure, that it would open the perfect perspective to make our world more open and rightful.

10

FIRST-EVER CLINICAL GUIDANCE ON ATAXIA-TELANGIECTASIA PUBLISHED

The publication of the first ever clinical guidance on the treatment of ataxia-telangiectasia was enthusiastically welcomed by clinicians, therapists and families living with the condition. Ataxia-telangiectasia in children: Guidance on diagnosis and clinical care was produced by members of the multidisciplinary team from the A-T Specialist Centre at Nottingham City Hospital, the University of Birmingham and the A-T Society.

Ataxia-telangiectasia is a rare genetic multi-system neuro-degenerative disorder, which from early childhood leads to increasing physical disability and significantly shortens lives. It affects some 200 children and young adults across the UK.

The complexity of A-T means that each child is seen by a wide range of clinicians and therapists, but its rarity means that very few will know anything at all about the condition and information on the course of the condition and its treatment is scattered and fragmentary.

This guidance will ensure that for the first time there is a shared understanding of the symptoms and progress of the condition and a consistent approach to treating it, based on the experience of the world's longest-established multi-disciplinary A-T clinic.

The document is primarily aimed at clinicians and other health professional who have little first-hand experience of treating A-T. However, it will also to be used by those caring for children with A-T to ensure that they are receiving the best possible care.

The guidance will be promoted internationally, via the A-T Clinical Research Network and the upcoming A-T Clinical Research Conference in Nijmegen in November 2014. It is likely to be received with great interest as this is the first document of its kind.

In addition to covering the key clinical areas of genetics, neurology, respiratory care, immunology and treating cancer the guidance looks at physiotherapy, dietary management and the implications of undertaking surgery in people with A-T.

The document can be downloaded from the A-T Society's website www.atsociety.org.uk/clinical-guidance or a printed copy can be requested from info@atsociety.org.uk.

Welcoming publication of the document William Davis, chief executive of the A-T Society said:

“This is a hugely important document and a very big step forward for children and families living with A-T. When all children with A-T are receiving the regular monitoring and care set out in this guidance, I am confident we will see major improvements in quality and length of life. I particularly welcome the guidance on respiratory care, which I believe could deliver some of the advances seen in treating conditions like cystic fibrosis.”

Sinead Ward, mother of four-year-old Orla who has A-T said:

William Davis
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“I’m really happy that this guidance has been produced. I talk to other parents and we often know more than the professionals treating our children. This booklet should change that. It is there in black and white how and when my daughter should be examined and treated. Like any parent, all I want is the right treatment for my daughter!”

Dr Mohnish Suri, Director of the A-T Specialist Centre at Nottingham City Hospital said:

“I am delighted to see this document published and to be able to make the experience we have built up at the world’s longest-standing A-T clinic available to clinicians and therapists across the country and indeed beyond. The consistent and focused approach this guidance advises should deliver real advances in the care of children with A-T and real improvements to their lives.”

Alastair Kent OBE, Director of Genetic Alliance UK said:

“The UK Strategy for Rare Diseases is demanding much greater coordination between national specialist centres and local teams and the development of shared protocols. This guidance document on A-T is an excellent example of how this can be done, and of what can be achieved by professionals and patient groups working together. I warmly welcome it.”

More information is available from www.atsociety.org.uk or contact William Davis on +44 (0)1582 760733, william@atsociety.org.uk

Ataxia Telangiectasia (A-T)

A-T is a complex genetic condition which from early childhood causes increasingly severe problems with co-ordination and movements, and shortens lives. Children seem normal at birth, become increasingly ‘wobbly’ and will probably be making full use of a wheelchair by the age of 10. Their immune systems are affected making them vulnerable to frequent infections and to cancer, particularly leukaemia and lymphoma. Around one third will die of cancer, the rest from lung-disease, on average before their mid-twenties. There are currently no effective treatments.

It is likely that over 200 families in the UK have one or more children with the condition. Around one in every 250 people will be unknowingly carrying the A-T gene, and any of these could have children with A-T, should their partner also carry the gene.

The A-T Society

For 25 years, the A-T Society has been supporting people living with A-T and funding research into the condition. As well as information and emotional support, we provide practical assistance and advocacy to ensure families get the services they need and financial support for equipment and to meet the other costs of disability.

We are in touch with almost every family with a diagnosis of A-T in the UK and Ireland. We organise annual meetings where families come together, share information and get the latest information, as well as activity weekends and respite breaks.

In 1994, the Society established the world's first specialist A-T clinic at Nottingham City Hospital. Today we work closely with the NHS to support two national specialist centres and to improve standards of care locally for people with A-T.

The A-T Society have invested around £1.5 million in research which has led to major advances in our understanding of the condition and has significantly strengthened international cooperation in research to find a cure.

11

PAEDIATRIC VIDEO CASES: INVITATION TO A PANEL SELECTING THE BEST TOPICS

Patient video cases improve clinical training

Recent research has shown that authentic patient video cases (PVCs) are valuable components of undergraduate and postgraduate paediatric training (Kamin 2003, Balslev 2010). Interactive analysis of PVCs has been shown to enhance learning, promote shared understanding and improve diagnostic expertise. Very importantly, teaching and learning with PVCs may expand exposure to common and uncommon clinical pictures.

Figure 1

Stills from a video with a 6-year-old boy with deteriorating gait. What is the important clinical finding?

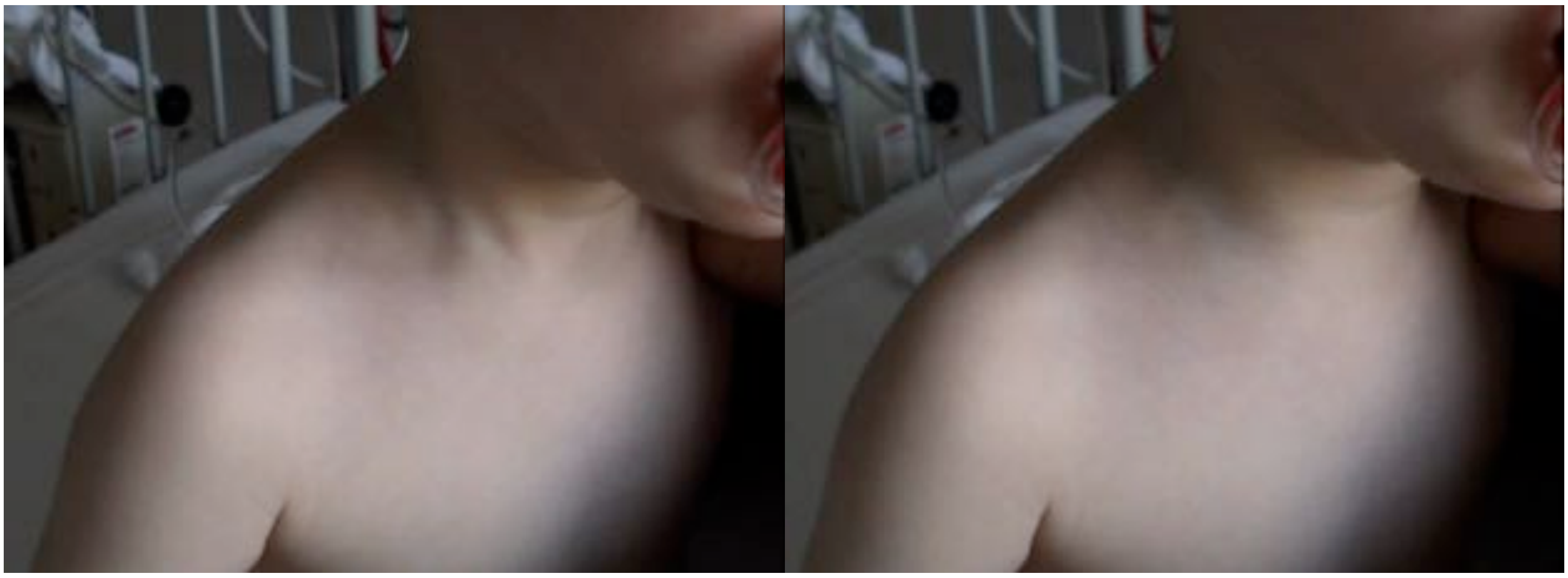

Figure 2

Stills from a video with an 18-months-old febrile girl with a cough. What is the important clinical finding?

Which PVCs are the most important ones in clinical training?

We believe that PVCs are particularly helpful in demonstrating movements that are periodic (like abnormal breathing) or paroxysmal (like epileptic seizures). The challenge is that medical students and trainees in paediatric and general practice often do not encounter clinical examples of all representative patients. Although libraries of PVCs exist, we know little about the most important selections for inclusion of cases in curricula for medical students, residents or specialists.

Figure 3 Residents and a clinical teacher analysing a video case

Our study: Is it possible to obtain consensus?

We wish to explore whether it is possible to obtain international expert consensus on lists of topics for desirable, suitable educational paediatric PVCs. We will use a Delphi technique to acquire expert consensus on the lists of the best topics for PVCs. Information is gathered from clinical teachers from around the world through a series of web-based Delphi rounds. We are presently building a panel of approximately 40 teachers who already use PVCs for clinical teaching. These experts will then rate and briefly comment on two or three consecutive lists of potential topics for PVCs. Time consumption will be less than 15 minutes per list

Study outcome – a help to build libraries of PVCs

The lists will be available to help paediatric centers around the world build libraries of PVCs. This may facilitate high quality teaching and enhance diagnostic expertise to the benefit of our patients.

If you are a clinical teacher using PVCs and wish to participate in the panel, please e-mail Thomas.Balslev@midt.rm.dk. You will receive information on how to proceed.

Finally: Did you get the cases right?
Figure1: Gower sign probably caused by proximal muscle weakness
Figure 2: Retractions probably caused by pneumonia

Kindly,

Thomas Balslev, consultant and associate professor, MHPE, PhD

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MAGYAR
GYERMEKORVOSOK
TÁRSASÁGA

12

VISITING / PREVENTIVE NURSE SYSTEM AND BSC COURSE IN HUNGARY

Laszlo Szabo

Laszlo Szabo
Head of the Department of Family Care Methodology, Faculty of Health Science, Semmelweis University, Budapest, Hungary

Head of the Department of Family Care Methodology, Faculty of Health Science, Semmelweis University, Budapest, Hungary

Past President of the Hungarian Pediatric Association

Visiting / Preventive nurses deal with pregnant women and organize preventive screening for them. They perform different examinations independently. The first home visit for newborns after delivery is compulsory within the first 48 hours of them. Preventive nurses control the newborns, the infants during their first year frequently, and then less frequently during childhood at home and in an office. Preventive nurse helps mothers achieve efficient breastfeeding, and control and perform the vaccinations etc. Preventive nurse cares the families and completes family doctors work.

The preventive nurse system was established in 1915 in Hungary. Ceremonial founding session was organized at city hall on 13th of June in 1915 with the patronage of princess Stephanie. Stephanie Belgian princess who was the wife of Rudolf hereditary prince. Rudolf died very early and Stephanie got married count Elemér Lónyai. „The most importan task of protection work was the PREVENTION" was her message in her introductory speach. Vilmos Taufer said: „Intelligence of our people is not sufficient yet. We have to penetrate into the people, visit them at home."

As a result of this system the infant mortality rate decreased from 300/ 1000 live births to under 5/1000. We know that different paramedical experts provide the same assistance for families in different European Countries. Midwives deal with pregnant women. Child nurses give advice on infant nutrition, others about vaccination.

University education for preventive nurses started in 1975. The course consists of 8 semesters at the Faculty of Health Science of the Medical Universities in Hungary. The basic aim of the University is to train preventive nurse who are able to provide safe and effective professional care, who are capable of preventing health problems of pregnant women foetus, newborns, infants and children, identifying and evaluating their health problems, planning and implementing evidence-based interventions to solve them. Workplace of preventive nurses are at the territory with primary care pediatricians, at family docotors, or at schools, or at Hospitals or at other health services, employment in research, surveillance, health promotion and/or enviromental health among other areas. At the private sector with the pharmaceutical industry and management consultancies, or at international aid agencies.

The European pregnant and children have right for preventive health care by a higher educated paramedical. We will organise this course for foreigners in English from September 2015. Qualification: Bachelor of Science (BSc) in Preventive Nurse. How to apply http://www.studyhungary.hu/ or the official website of Semmelweis University. www.semmelweis-english-program.org

13

NEW WAYS OF PAEDIATRIC REHABILITATION IN EUROPE

THE EDERHOF IN THE AUSTRIAN ALP MOUNTAINS AS A NATIONAL AND INTERNATIONAL CENTRE OF COMPETENCE FOR SALUTOGENESIS OF TRANSPLANTED ADOLESCENTS AND THEIR CARE GIVES.

Jochen Ehrich, Robert Weichselbraun, Otto Mehls, Massimo Petoello-Mantovani

Background: The European Paediatric Association evaluates since more than ten years how health services and reforms allow in different European countries to cope with the challenges of recent changes in child health and the spectrum of new morbidities.

The previous EPA surveys have shown that there is an enormous difference in health care service systems in the Europe of 53 countries. Unnecessary variations were found to exist in primary paediatric care and in tertiary paediatric care in Europe resulting in inacceptable mortality rates in several countries.

Therefore, the current EPA work plan is to identify specific service issues ranging from first access care to rehabilitative care in order to stimulate 1. learning across borders, 2. cross-border medical and health care, 3. implementing child friendly health care into practice, and 4. developing a culture and structure for service improvement. This short report describes a survey on rehabilitative care for transplanted adolescents in young adults in the German speaking countries.

Health promotion can be performed in different ways including empowerment of children, child friendly health care and excellent medical care leading to health literacy. The financial crisis in Europe has given rise to slogans such as “better health care for less money” which reads like a paradox. However, the crisis was certainly a stimulus to look for new chances of improving health care, for example the life course model. The life span model explains that early prevention and intervention during childhood may avoid diseases and complications later in life. More precisely, the ROOTS-CAUSE-EFFECT-OUTCOME-CONCEPT puts children into the centre of activities for improvement of life long conditions because the roots of diseases must be identified early and adequately treated.

Excursion of patients to an alpine hut at 2100m altitude.

Children with irreversible organ failure have to undergo organ replacement therapy such as transplantation. Transplantation may be the beginning of a new illness progressing into adulthood. It holds true for children and adults that chronic organ failure and organ replacement therapy is associated with co-morbidities affecting cardiovascular, psycho-neurological, pulmonary and renal function, as well as with malignancies. Obviously the patients developing organ failure during childhood will have the longest duration of treatment, initially under the care of paediatricians and later on by adult professionals. Furthermore, co-morbidities may develop during childhood and only become apparent as late as in adulthood. The second lesson from the past is that chronic organ failure and organ replacement therapy is associated with hearing, visual, mental, skeletal and motor disabilities in about one third of children. Disabilities and psychosocial disorders affect schooling, vocational training, permanent education, employment, social integration and families.

An own study on rehabilitation of 617 European adults aged 21-35 years starting renal replacement therapy as children showed that 44% of all adults were unemployed. The major factors influencing employment were the presence of disabilities, lack of education, the method of treatment, the underlying primary disease and geographical factors. Therefore, transplanted children do not only need rehabilitative care during the acute and post-acute phase but also long term empowerment through health education, intensive communication with care givers and participation during decision making processes to reduce costs originating from preventable late complications.

Ederhof in summer

Concept of the Ederhof: The Ederhof is a non profit rehabilitation clinic financed by German and Austrian health insurances, by donations and by the non profit Kuratorium for dialysis and Renal Transplantation (KfH). The concept of the Ederhof is supporting not only young patients prior and after solid organ transplantation but also their families to adapt to a life with permanent challenges and burdens. Many patients suffer from genetic abnormalities which often affect not only one solid organ but also other organs including brain development as indicated above. Despite transplantation the patients remain chronically ill.

Young patients are accompanied by their complete family. Not only the patient but also the overloaded and stressed parents and the missed out siblings are supported by interdisciplinary activities including physical and psychosocial support as well as complementary care such as healthy nutrition, health education, and others. Adolescents and young adults are treated in absence of family members. Targets of patient care are improvement of physical strength, self-confidence, social competence and compliance. Families learn from families, adolescents from adolescents (peer group effects).

EPA and the Ederhof rehabilitation centre: Three of the authors worked with 31 transplanted adolescents aged 13-20 years for 3 weeks at the Ederhof which is situated at 1000m altitude in the beautiful Lienzer Dolomiten in Austria. The majority of patients had been transplanted for more than 2 years (range 4 months to 11 years). The concept of the paediatricians was to offer salutogenesis and empowerment during their three weeks long 24h service. They were supported by an experienced team of nurses, psychologists, dieticians, physiotherapists and teachers.

Ederhof in winter

The two members of EPA council wanted to study the question if the European paediatric community could learn from the Ederhof and thus facilitating EPA to develop the criteria for an international centre of competence for the rehabilitation of children with long term conditions such as organ transplantation.

The concept of the Council of Europe on child friendly health care was applied throughout the rehabilitation course and great emphasis was put on teaching “protection, prevention, provision and participation”. Special training was provided for transferring health information into self-management and health competence. The evaluation and monitoring of the success of rehabilitative measure included medical, psychological, paedagogic, social and nutritional aspects of the patients’ life conditions.

Prof. Massimo Pettoello-Mantovani Prof. Otto Mehls Robert Weichselbraun

Conclusions: At the end of their stay the two EPA council members concluded that the Ederhof fulfilled the criteria for a centre of competence for children with long term conditions such as kidney, liver, lung and heart transplantation. Currently, the Ederhof is treating patients from German speaking countries, however, there may be chances to transform the Ederhof into an international centre of competence for all transplanted European children.

One of the key experiences of the paediatricians was the fact that their “round the clock service” offered new ways of identifying their interaction with the patient. In fact they developed new sensors for their own and their patients’ feelings. They came to the conclusion that they had learned more about their transplanted patients than they could learn if they would see them only during in-or out-patient hospital care. When asking the patients how they felt, one half of adolescents answered: “We are healthy and normal”. The other half objected to this statement and said: “No, we are chronically ill.”

The paediatricians concluded: “It’s life - but not as we paediatricians know it.”

PEDIATRIC DIABETES CLINIC, THE QUEEN SILVIA CHILDREN´S HOSPITAL, SAHLGRENSKA UNIVERSITY HOSPITAL, GOTHENBURG, SWEDEN GUN FORSANDER

14

SWEET - SECURING APPROPRIATE SERVICES AND INFRASTRUCTURE FOR PEDIATRIC AND ADOLESCENT DIABETES

"SWEET" is an acronym derived from “Better control in Pediatric and Adolescent diabeteS : Working to CrEat CEnTers of Reference” and is based on a partnership of established national and European diabetes organizations (www.sweet-project.eu) led by the International Society for Pediatric and Adolescent Diabetes (ISPAD) with valuable contributions of IDF Europe, FEND, and PCDE. Peer audited Centers of Reference (COR´s) and Collaborative Centres (CC´s) with a continuous electronic documentation of at least 150 pediatric patients with diabetes treated by a multidisciplinary team based on the ISPAD Clinical Practice recommendations have been created in 18 countries. Although these clinics should not be regarded as representative for the whole country, the acknowledgement as COR or CC includes a common objective of targets and guidelines as well as recognition of expertise in treatment and education at the centre.

The corresponding SWEET Online platform currently enables 26 paediatric diabetes centres from 21 countries to connect to one unified diabetes database. Aggregate data is de-identified and exported for longitudinal health and economic data analysis and includes now more than 173,800 patient visits. The number of patients increased continuously: When in 2006 the register counted 1,201 patients, it is now up to 16,174 patients. Data are documented of 15,453 youth with type 1 diabetes, 210 with type 2 and 511 with other diabetes forms. The median age is 13.32 years and diabetes duration is 4.48 years. The median HbA1c is 7.8%. The number of valid HbA1c's in the data base rose from 4,377 (mean H bA1c: 7,5 %) in 2006 to 24,791 (7.9%) in 2013.

Ongoing collection of benchmarking data motivates centres to improve data collection and to use them in quality control circles to exchange best practices in order to optimize their diabetes therapy. Through their network the COR´s and CC's wish to obtain political power on a national and international level and to facilitate dissemination of new approaches and techniques. SWEET hopes to continue extending their group of centres within countries, throughout Europe and beyond.

In the following passage three SWEET centres introduce themselves and tell us about their experience with SWEET.

Sweden

Pediatric Diabetes Clinic, The Queen Silvia Children´s Hospital, Sahlgrenska University Hospital, Gothenburg, Sweden Gun Forsander

The Pediatric Diabetes Centre at the Queen Silvia Children´s Hospital, Sahlgrenska University Hospital in Gothenburg, Sweden, cares for around 500 children and adolescents with diabetes. The clinic serves all patients 0-18 years old in the region of Gothenburg. 97 % of the patients are diagnosed with Type 1 diabetes, the others with Type 2 diabetes, monogenetic diabetes, neonatal or secondary diabetes. All new patients are tested for HLA and diabetes specific antibodies to assure a correct diagnosis and treatment. Around 60 % of the patients are on insulin pump treatment. About half of the patients use CGM (continues glucose monitoring), either connected to the pump or as a separate system. The median HbA1c value of the patients at the clinic who are needing >0.5 U/day is 57.3 mmol/mol in Nov 2014, according to the day-by-day updated online Swedish Pediatric Diabetes Registry (SWEDIABKIDS). The diabetes team, consisting of 4 pediatric diabetologists (2.7 full-time), 4 diabetes specialized nurses, 2 dieticians (1.2 full-time), 1 psychologist (0.6 full-time) and 3 social workers (1.5 full-time) are working in accordance to ISPAD guidelines, SWEET guidelines and the Swedish National Pediatric Diabetes Guidelines. The research activity of the clinic is high with 15 peer reviewed publications during the last year. Members of the team are responsible for National diabetes team courses as well as National courses for paediatricians and National guidelines.

Being a part of SWEET study since 2008 and recognized as a SWEET CoR since 2011, our clinic has benefit a lot by the extended network all over Europe. The repeated meetings, creation of SWEET Guidelines and discussions on country differences in treatment traditions and options are stimulating and have led to further efforts to improve the pediatric diabetes care, both on a regional and national level. The opportunity to benchmarking the outcome data of different SWEET centres in Europe is very appreciated, also for the head of the hospital, who is very supportive to the new treatment possibilities.

Hungary

The Pediatric Departement, Semmelweis University, Budapest, Hungary

László Madácsy

The Pediatric Departement of the Semmelweis University in Budapest, Hungary is a University affiliated, non-profit institute that cares for more than 600 patients. The Centre has 14 in-patient beds for children suffering of diabetes mellitus and of endocrinological diseases. It also has an out-patient clinic that is dedicated to the provision of education for patients. Last year 2500 patients were seen in this clinic. The Centre's staff is multidisciplinary and consists of four Pediatric diabetologists, one pediatric endocrinologist, one pediatric resident, one pediatric psychologist, two diabetes nurse/educators, one dietician, and one social worker.

The 1st Department of Pediatrics of Semmelweis University was founded in 1839, with the foundation of the Poor Children's Hospital by Agost Schöpf-Merei. Since the middle of the 20th century a regional and nationwide Centre for children and adolescents with diabetes mellitus has been developed in the 1st Department of Paediatrics with the leadership of Professor Lajos Barta, who has written and published the first medical textbook on childhood diabetes in Hungarian in 1961. Following the political changes in Central and Eastern Europe, the very first ISPAD (ISGD) Postgraduate Course behind the formal „iron courtain" has been organised by the members of the Center with the leadership of

Professor Bruno Weber (President of ISPAD) at Dobogókő, Hungary in January 1991. During the last 25 years an intensive cooperation in scientific research developed between the members of the Center and several famous foreign Pediatric Clinics as the Children’s Hospital of Helsinki, the Freie Universitat of Berlin, the Kinder- und Jungenkrankenhaus of Hannover and the Karolinska Institut of Stockholm. The average rate of scientific publications was 7 per year in the last ten years.

The representative of the Center has had the option to participate - as an active member of the Group - in the realization of the Europroject SWEET (2008-2010). Then, in the year of 2011, the Center - by fulfilling the criteria and requirements for a SWEET Collaborative Center - obtained the certification.

The clinic benefits from being in the SWEET network by having access to standardized patient education programmes and pediatric training programmes for young pediatricians interested in diabetology and endocrinology. The opportunity to participate in international research projects is a great benefit as well. We strongly hope, that in the near future the developing SWEET network will be able to improve the care of children and adolescents with diabetes and to increase the efficacy of the prevention of long-term diabetic complications across Europe and beyond.

Italy

Regional Centre for Diabetes in Children and Adolescents, Marche Region, Ancona, Italy

Valentino Cherubini, Lucia Ferrito

The Regional Centre for Diabetes in Children and Adolescent of “Salesi Hospital”, located in Ancona, East Coast, Central Italy, is a Complex Unit within the Department of Women’s and Children’s Health. The Hospital includes many paediatric structures such as surgery, emergency, neuropsychiatry, oncology, cardiology, and nephrology. The Centre’s staff consists of two full time doctors, one medical student, two nurses, one dietician and one psychologist. The Centre continuously follows about 300 patients less than 18, and more than 150 for occasional consultation. We are proud to observe very low rates of acute complications and a good average metabolic control (mean HbA1c: 7.53%), with the target HbA1c reached by more than 45% patients. Currently more than one third of the patients are using insulin pumps, and 10% a glucose sensor. Our attention is also addressed to inpatients with critical conditions, diabetes-related education, organization of at least three camps per year, and arrangements of meetings in schools to facilitate the child readmission after the diagnosis. Clinical research is another consistent part of our interest. A regional server stores the electronic records of young and adult diabetic patients and allows data sharing among centres, also facilitating the transition of subjects to the adult centre. We manage the regional registry for diabetes in young patients and the national coordination of the "Registry for Type 1 Diabetes in Italy", established in 1997. The SWEET network gave us the opportunity to better analyse the current status of the diabetes care provided by our Centre, and comparing to other EU centres. We get significant information on weaknesses and strengths of treatment, on potential predictors of its success and possible measures of life quality. Since our inclusion in the network we tried to optimize diabetes care and outcome by further enhancing the general diabetes-related education, the skills training, the psychosocial issues and the behavioural and self-management component. We also strengthened the multidisciplinary approach, the electronic registries of patients and the participation in both clinical research and research into health service provision. We really feel that the SWEET network plays a key role in the continuous improvement of paediatric diabetes care and we are proud of being part of it.

15

THE 11TH CONGRESS OF CROATIAN

Marija Radonic, President of the Local Organizing Committee and Julije Mestrovic, President of the Scientific Committee

The 11th Congress of Croatian Pediatric Society with international participation and the 10th Congress of Pediatric Society of Croatian Nurses Association, organized by Croatian Pediatric Society, Pediatric Society of Croatian Nurses Association and General Hospital Dubrovnik, were held in Dubrovnik from 16th to 19th October, 2014.

The Congress was opened by the Mayor of Dubrovnik, Dr. Andro Vlahusic.

In the ceremonial part of the Congress, authors of three most successful papers presented their works published between two Congresses. Two young pediatricians presented their papers published in the scientific journals.

Plenary lectures were given by distinguished invited speakers: Leyla Namazova Baranova, president of EPA, “Implementation of the UN Convention of the rights of the Child: how pediatrician can support initiative of EPA/UNEPSA”; prof. Johan Erich, treasurer of EPA, “Child Health Care in Europe: Can we learn across borders?”, “Growing up - Long term Care of Patients with Chronic Diseases”, by prof. Georg F. Hoffmann, chairmen/Dpt. of Pediatrics, University of Heidelberg.

There were more than 600 participants registered from Croatia and neighboring countries.

Subspecialists gave their lectures introducing mainly algorithms in certain topics. Twenty presentations were selected for oral presentations and the rest, about 150, in form of poster presentations. At the same time, there were also three satellite symposia. This resulted in fruitful discussions, new contacts and open ways for future collaboration.

Nurses had separate sessions where they presented 70 oral and poster presentations.

The main message of the Conference was multidisciplinary work and cooperation between primary, secondary and tertiary level of pediatric care and the international cooperation.

There was also an interesting social program, so we hope that Dubrovnik, with beautiful sunny weather, offers participants possibility to enjoy their time.

Finally, we were very proud to be able to host our colleagues from abroad and from Croatia, and we would like to thank them for coming and contributing to the success of the Congress.

Marija Radonic
Director
Department of Pediatrics

Picture 1

Delefates at the Opening ceremony

CONGRÈS NATIONAL de la PÉDIATRIE SOCIALE et la RÉUNION ANNUELLE de L'ASSOCIATION INTERNATIONALE de PÉDIATRIE SOCIALE

(ASSIPS)

CLUJ-NAPOCA | ROUMANIE

Figure 1

INTERNATIONAL CONGRESS OF SOCIAL PAEDIATRICS IN CLUJ-NAPOCA, ROMANIA

2014: International Congress of Social Paediatrics in Cluj-Napoca, Romania

As a prove to the professional and cultural ties between Romania and Western Europe, Romanian Society for Social Paediatrics (President Professor Nicolae Miu) and the International Association of Social Paediatrics (AssIPS, President Doctor Michele Blanc-Pardignon) were associated to discuss the pain and the suffering child in May 2014 at Cluj-Napoca, Romania during the 9th Romanian Congress of Social Paediatrics.

From the physical pain to the recognition of the mental suffering in children

Not long time ago, the pain was considered as a natural symptom in children, sometimes valuable for the diagnosis and the evaluation of the disease progression. To ease the pain is necessary to improve the knowledge and the understanding of specificities

in children. Medical knowledge about pain has grown rapidly over the last 30 years. Today, the possibilities to evaluate, treat and alleviate pain in children are much improved.

The personal experiences (education, culture, attention and emotions), the causes and circumstances of the occurrence of pain contribute to the distress in child. The fight against all forms of child pain, acute or chronic, must meet the ethical and humanistic aspects. If the determination of one whole care team to fight the pain cannot be disputed, it seems essential that it should be based on knowledge sharing, to enable a common language, a professional attitude and consistent communication. Pain management is the duty of all: from doctor to nurse, psychologist and parents.

This meeting proposed two types of approach:

- A contribution to the knowledge needed for a better understanding of the phenomenon of pain: identification, understanding, comfort, presentation specificities of the pain in children

- A reflection on personal practice and the care of the child: various members of the care team presented their experience, what has been achieved and what remains to be improved.

The meeting program allowed to the professionals of all paediatric specialties and parents a better understanding of pain and skills needed to take into account all aspects of the child's world for identifying, understanding, addressing and treating his pain and sufferance.

Many lecturers from Romania, France, Belgium and Switzerland were presented and confronted their theoretically and practically views, their clinical experience on the diagnosis and management of pain in children. The main objective of this meeting was the progress in pain management, which should not only be just a drug or medical problems, but must be the subject of the work of the whole team. The audience and quality of interventions indicated that the aim of the meeting was reached in a cordial atmosphere.

Tudor L. POP, MD, PhD

General Secretary of the Romanian Society of Social Paediatrics

BELGRADE, 5-8 OCTOBER 2014

17

SECOND CONGRESS OF PEDIATRICIANS OF SERBIA WITH INTERNATIONAL PARTICIPATION

The Congress was held at the CrownePlaza Hotel with the participation of 485 registered participants: pediatricians, physicians specializing in pediatrics, and general practitioners. Among them, 426 participants were from Serbia, 37 from Montenegro, 13 from the Republic of Srpska, 2 from the Federation of Bosnia and Herzegovina, and 2 from the Republic of Macedonia and guests from Russia, Norway, Germany, Turkey and Croatia.

There were 4 invited speakers (Russia, Germany, Norway, Turkey), including the presidents of the European Pediatric Association (EPA / UNEPSA), prof. Leyla Namazova Baranova(Russia) or the European Academy of Paediatrics (EAP), prof. Tom Stiris (Norway).

Congress topics were:

Health care of children and youth in Serbia

Nutrition and eating disorders

Vaccinations and their complications

Adolescence as a specific age

Development and its disorders in the newborn and child

Neonatology

Pharmacotherapy in pediatric s/ Infections in childhood

Various topics

Each topic was represented with introductory lecture, oral presentations with the discussion, and poster presentation with discussion.

The 21 introductory lectures, 53 oral presentations, and 76 poster presentations were presented.

Abstracts of papers (invited lectures, introductory lectures, oral and poster presentations) are published in electronic form as the Book of Abstracts, which is registered in the National Library of Serbia.

Based on the proposal of moderators or chairpersons, first authors of best oral or poster presentations were awarded.

Thanks to the support of Radio Television of Serbia, Congress was very well represented in programs of this media . On the last day of the Congress ,Tanjug, national news agency of Serbia, conveyed the main message of the Congress, which was transferred by several electronic and print media. The articles on e Congress were published by leading daily newspapers.

Scientific and Organizing Committee of the Congress / Presidency of the Association, adopted

the following

CONCLUSIONS OF THE SECOND CONGRESS OF PEDIATRICIANS OF SERBIA

1. The unfavorable demographic trends, one of which is decreasing number of newborns – the most important for pediatrics and pediatricians, was present in Serbia for a long time, expressed from 1992 with an open depopulation. This phenomenon represents a direct threat to the survival of the nation and at the same time is a key factor of uncertain future of pediatrics and the status of pediatrics and pediatricians.

Pediatricians of Serbia urge the state authorities to put a question of sustainable recovery of the Serbian population in the first place on the list of top priorities.

2. The number of pediatricians in Serbia, especially in primary care, is steadily declining which, with unfavorable age structure, already threatens the way of implementation of the health care of children and youth, or pediatric care model, with pediatrician as a doctor of the first contact, especially for patients under seven years of age.

Pediatricians of Serbia insist on preserving the pediatric model of health care for children and adolescents, ie. retaining a position of pediatrician as a chosen doctor and taking emergency measures to ensure a sufficient number of pediatricians for the optimal provision of of care for this part of the population.

3. While continuing improvementsof indicators of health status and health care are evident, it is likely that tasks from the fourth National Development Goals will not be achieved on time (projected reduction in the mortality rate of children under five years of age, infants and newborns, predicted immunization coverage and increasing rates of exclusive breastfeeding up 6 months of age).

Pediatricians of Serbia advocate for the prompt achievement of the above goals and for this purpose suggest:

a) immediate implementation of National standards for health care tailored to the needs of mothers and children,

b) the adoption and implementation of the Standards of regional neonatal health care system in Serbia,

v) modernization and elargement of the program of compulsory immunization against infectious diseases, while fighting to increase the coverage as well as to suppress all forms of "anti- vaccination movement" actions.

4. The National Program of Health Care for Women, Children and Youth (2009) provided a good basis for a modern and comprehensive health care and continuity in its delivery. However, the method of applying the principle of the chosen doctor and capitation as basis for the payment of doctors in primary health care, endanger the functions and even the very existence both Early childhood development and Youth counseling services, which represent an adequate response of pediatric health services to contemporary achievements in science and profession or the growing participation of "new youth morbidity" in the structure of morbidity.

Pediatricians of Serbia strongly plead for strict compliance and creating conditions for the implementation of all measures and activities to achieve the goals of the National Program of Health Care for Women, Children and Youth. They especially advocate for strengthening both Early childhood development and Youth counseling services.

5. In the field of hospital health care, pediatricians of Serbia remains firmly of the view that children and young people should not be discriminated with respect to providing the highest attainable standards in terms of personnel, equipment and facilities, as guaranteed by the Convention on the Rights of the Child.

6. In times of crisis and limited resources, pediatricians of Serbia advocate for rational use of available resources. One of the tasks of is the development of protocols (guidelines) for a large number of diseases or conditions, in the first place for those with the largest share in the structure of morbidity.

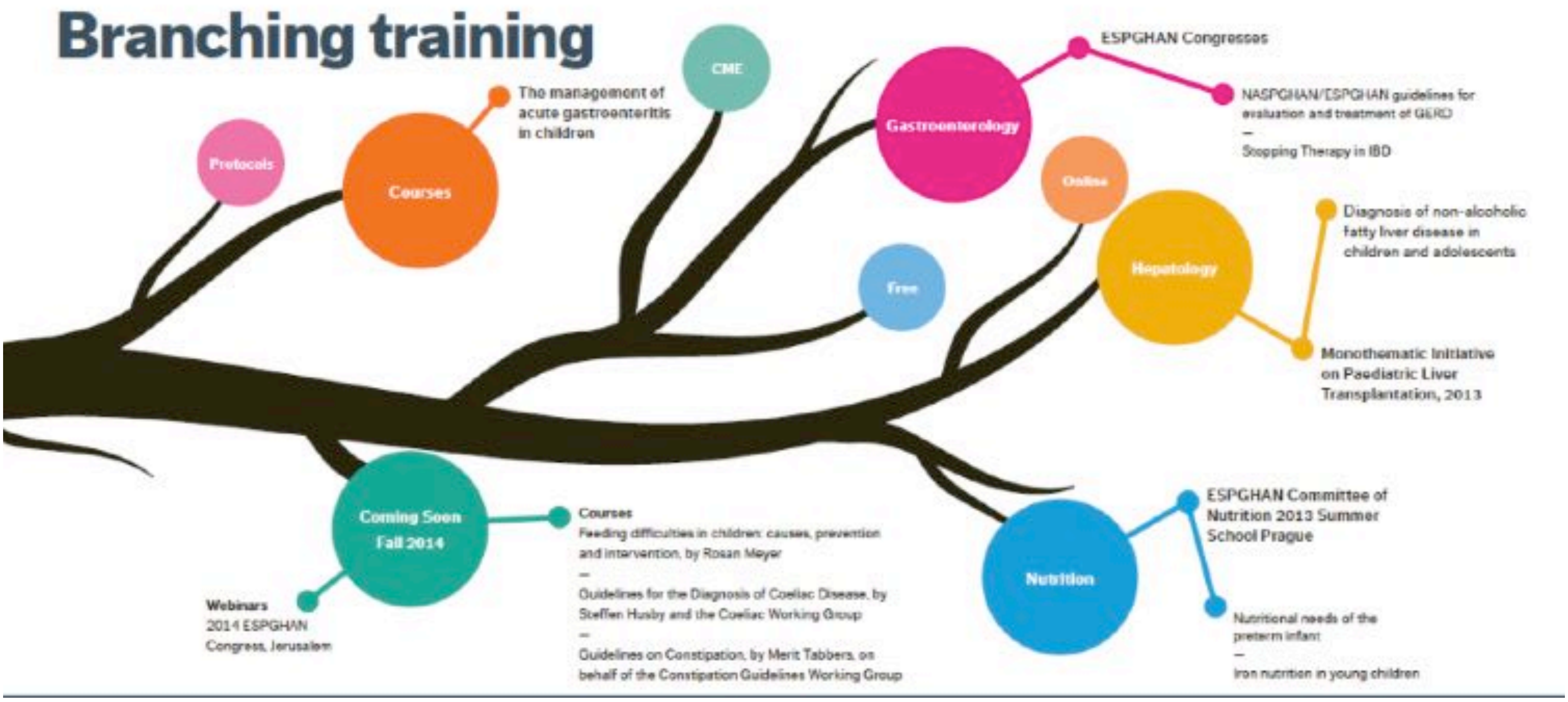
President of the Pediatric Association of Serbia,

Prof. Dr. Radovan Bogdanovic

18

ESPGHAN E-LEARNING OPPORTUNITIES

E-learning represents an instrument of education in medical science with promising results. It is convenient, it provides access to educational materials at any time, it allows progress at the individual learner's own pace, and it accommodates many learning styles enhancing the learning process with the use of multimedia and interaction.



Since 2012, European Society for Pediatric Gastroenterology, Hepatology and Nutrition (ESPGHAN) has launched its own educational e-learning program, in collaboration with UEG (Editor: Professor Alfredo Guarino, Naples, Italy)

Initiatives dedicated to General Paediatricians

At Europaediatrics 2015 meeting in Florence there will be two ESPGHAN sessions on e-learning. During each of the two sessions e-learning on ESPGHAN guidelines on Acute Gastroenteritis and Coeliac Disease will be presented, respectively. The sessions will be interactive and feedback from participants will be collected. You are invited to participate in these two sessions and to experience our e-learning programs.

To access the online contents for free please login or register at myUEG register at https://www.ueg.eu/myueg/myueg/

Tudor L. POP, MD, PhD

Associate Editor ESPGHAN e-learning

EPA/UNEPSA MEMBER AND AFFILIATED ASSOCIATIONS AND SOCIETIES 2015

Albania
Albanian Paediatric Society

Armenia
Armenian Association of Paediatrics

Austria
Oesterrechische Gesellschaft fur Kinder-und Jugendheilkunde (OEGKJ)

Azerbaijan
Azerbaijan Pediatric Society

Belgium
Societe Belge de Pédiatrie/Belgische Vereiniging voor Kindergeneeskunde

Bosnia and Herzegovina
Paediatric Society of Bosnia and Herzegovina

Bulgaria
Bulgarian Paediatric Association

Croatia
Croatian Paediatric Society

Cyprus
Cypriot Paediatric Society

Czech Republic
Czech National Paediatric Society

Denmark
Dansk Paediatrisk Selskab

Estonia
Estonian Paediatric Association

Finland
Finnish Paediatric Society

France
Société Française de Pédiatrie

Georgia
Georgian Paediatric Association

Germany
Deutsche Gesellschaft für Kinder- und Jugendmedizin (DGKJ)

Greece
Hellenic Paediatric Society

Hungary
Hungarian Paediatric Association

Ireland
Royal College of Physicians of Ireland/Faculty of Paediatrics

Israel
Israeli Paediatric Association

Italy
Società Italiana di Pediatria

Società Italiana di Ricerca Pediatria

Italian Federation of Primary Care Pediatricians

Kazakhstan
Pediatric Societies and Associations of Kazakhstan

Latvia
Latvijas Pediatru Asociacija

Lithuania
Lithuanian Paediatric Society

Luxembourg
Société Luxembourgeoise de Pédiatrie

Macedonia
Paediatric Society of Macedonia

Moldova
Moldovan Paediatric Society

Montenegro
Pediatric Societies and Associations of Montenegro

The Netherlands
Nederlandse Vereninging voor Kindergeneeskunde

Poland
Polskie Towarzystwo Pediatryczne

Portugal
Sociedade Portuguesa de Pediatria

Romania
Societatea Romana de Pediatrie

Societatea Romana de Pediatrie Sociala

Russia
The Union of Paediatricians of Russia

Public Academy of Pediatrics

Serbia and Montenegro
Paediatric Association of Serbia and Montenegro

Slovakia
Slovenska Paediatricka Spolocnost

Slovenia
Slovenian Paediatric Society

Spain
Asociación Española de Pediatría

Sweden
Svenska Barnläkarföreningen

Switzerland
Société Suisse de Pédiatrie/Schweizerische Gesellschaft für Padiatrie

Turkey
Türk Pediatri Kurumu

Turkmenistan
Pediatric Societies and Associations of Turkmenistan

Türkiye Milli Pediatri Derneği

Ukraine
Ukraine Paediatric Association

United Kingdom
Royal College of Paediatrics and Child Health

Uzbekistan
Pediatric Societies and Associations of Uzbekistan

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18

SAVE THE DATE

CALENDAR OF EVENTS: UPCOMING CONFERENCES

2015

2016

European Meeting by EPA/UNEPSA

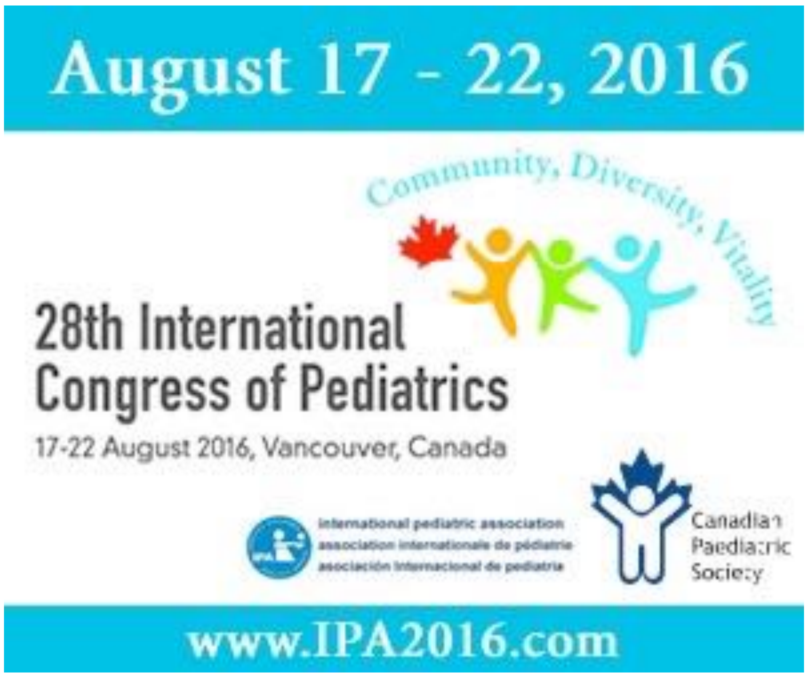
7th Europaediatrics
13-16 May 2015, Florence, Italy

Other Paediatric Meetings

European Paediatric Neurology Society Congress 2015
27-30 May 2015, Vienna, Austria

54th European Society for Paediatric Endocrinology (ESPE) Annual Meeting
1-3 October 2015, Barcelona, Spain

Epa-unepsa is the member for Europe of the International Paediatric Association and invites you to attend the 28 international congress in Vancouver, 17-22, August 2016



August 17 - 22, 2016

28th International Congress of Pediatrics

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