

NEWSLETTER

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1

EDITORIAL: DESTINATION EUROPE

Over the last few years, and particularly during the recent past months, several countries of the European Union (EU) have dealt with increasing numbers of unaccompanied minor migrants, mainly originating from countries experiencing armed conflicts and oppression, or abuses of human rights.

These children, also defined as “separated children,” are under 18 years of age, are outside their home country, apart from their parents or their previous legal or customary primary caregiver, and are traveling to Europe typically to escape conditions of serious deprivation or exploitation.

The recent extraordinary migration's waves typically point to the northern European countries, using two main routes. The sea route, entering Europe mainly through Greece, Malta and Italy, and the land route through the Balkans.

These children are fragile, whether physically, intellectually, or socially. They lack the care and protection of their caregivers, and may be easily exposed to abuse and neglect. Because of their particular helpless condition, the unaccompanied minor migrants are at serious risk to be further deprived of their rights, and to become de facto “invisible” to the authorities, to the public health services, and in general to the public opinion. Furthermore, when they arrive at a destination, or more frequently during their journey through Europe, many children often vanish.

This important issue has been addressed by an article published in February issue of the Journal of Pediatrics (J Pediatr.2016 Feb;169:332-333.e1-
[http://www.jpeds.com/article/S0022-3476\(15\)01299-8/pdf](http://www.jpeds.com/article/S0022-3476(15)01299-8/pdf)).

In this article, the EPA-UNEPSA members Italian Federation of Pediatricians (Federazione Italiana Medici Pediatri – FIMP) and the Italian Society of Pediatrics (SIP) in collaboration with EPA-UNEPSA raise the awareness of the pediatric community on this matter, and emphasize the significant role that the national European societies of pediatrics may play in helping to contain the negative outcomes of these phenomena by activating dedicated task forces.

MASSIMO PETTOELLO MANTOVANI



LEARNING ACROSS BORDERS

7th Europaediatrics

Florence - Fortezza da Basso
13-16th May, 2015



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HIGHLIGHTS FROM THE 7TH EUROPAEDIATRICS CONGRESS IN FLORENCE: THE PAST-PRESIDENT RUBINO'S WELCOME ADDRESS

PROF. ARMIDO RUBINO
PAST-PRESIDENT EPA-UNEPSA

Ladies and Gentlemen, Colleagues and Friends,

It is with great pleasure that I welcome you to the Seventh “Europediatrics” Meeting – an event that confirms and reinforces the close ties existing between the EPA, Italy and the Italian paediatricians.

Indeed it was in the Congress held in Rome in the year 2000 that the name “Europediatrics” was coined.

I would like to focus my brief welcome address on two words: appreciation and cooperation.

Appreciation to the President of the European Paediatric Association Professor Leyla Namazova, to the President of the Congress and President of the Italian Society of Pediatrics Professor Giovanni Corsello, to my Italian colleagues who served on the Organizing Committee, to the EPA Council members, and last but not least, a special warm appreciation of Professor Terence Stephenson, Chairman of the Scientific Committee for his extraordinary and not easy work that resulted in this all inclusive, stimulative Scientific Programme. Warm greetings also to the President of the International Paediatric Association, Professor Andreas Constantopoulos, Past President of the European Paediatric Association and a promoter of the return of Europediatrics to Italy.

Turning to the other word: cooperation. This Congress is the result of collaboration between the National Paediatric Societies and the EPA Council; collaboration between different academic disciplines; collaboration between paediatricians and other professionals devoted to the care of infants, children and adolescents; collaboration between paediatricians and family associations. And, last but not least: collaboration between the European Paediatric Association and the many European Associations of Paediatric specialties who have actively participated in formulating the scientific programme.

At the base of the foundation and activity of the European Paediatric Association is the conviction that the professional figure of General Paediatrician is essential for the health needs of the paediatric population. We are convinced that this professional figure must be sustained, not as an alternative to paediatric specialties, but, on the contrary, in the logic of reciprocal strengthening.

On the other hand, the explosive and marvellous development of scientific knowledge that occurred during the second half of the 20th century brought about an extraordinary enrichment of paediatric culture and this has led to the establishment of the paediatric specialty associations, which are an essential tool for the development of scientific knowledge and for the health of infants, children and adolescents.

Thus was generated the idea that animates this Congress: keep together these two cultures, in order to promote activity devoted to the protection of health in the paediatric age, in a spirit of synergy, cooperation and positive interaction, and on the basis of shared values. Through this cooperation, Europediatrics addresses the objectives of the national and European Paediatric societies, namely:

- looking at the differences still existing between Regions, Countries and social classes, a major priority being to reduce or abolish these differences, but also to take advantage of the challenges provided by cross-border healthcare;
- maintaining a high standard of knowledge about the ever-changing health problems of children and adolescents;
- maintaining a cultural level such that scientific progress can be applied to the changing needs of children and adolescents;
- promoting, organizing and practicing an excellent system of continuous paediatric education;
- and lastly maintaining a strong link between research, teaching and healthcare.

However, I must also say that all is not well in the vast European territory: unfortunately there are still too many delays in the adoption of interventions to promote the health of children and adolescents. Therefore, let's hope that also this Congress will help to alert governments and public opinion to the need for urgent new interventions and initiatives aimed at promoting the health of children and adolescents in Europe.

In this precise moment, I cannot but recall the drama affecting children and adolescents in relation to the immigration from the south towards Europe. Not only for this reason, but also for this reason, there is a need for a new, extraordinary commitment to improve the medical, social and psychological care of infants, children and adolescents in Europe. A major effort is required to know more, and by knowing more, to act appropriately. There is an urgent need to promote and to invest more in scientific research, in paediatric training and in enhanced initiatives to improve health conditions for infants and adolescents, in both the EU and Non-EU Countries. For such studies and interventions, implementation of a special task force is called for. I strongly believe that the European paediatricians are poised to collaborate in these initiatives.

I would like to conclude this welcome address with words that sound to me like a motto for this Congress:

TOGETHER FOR CHILDREN

PROF. ARMIDO RUBINO

PAST-PRESIDENT EPA-UNEPSA

8th Europaediatrics Congress

jointly held with

The 13 National Congress of Romanian Pediatrics Society



7-11 June, 2017

Bucharest

Romania



More information available soon at:

www.epa-unepssa.org;

www.europaediatrics2017.org

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BUCHAREST: 8TH
EUROPEDIATRICS
CONGRESS & 13
NATIONAL CONGRESS
OF ROMANIAN
PEDIATRICS SOCIETY.
LOOKING FORWARD
TO 2017

Dear colleagues ,

It is a great pleasure to invite the Pediatricians from all over Europe and outside of Europe to the 8-th Europediatrics Congress & The 13 National Congress of Romanian Pediatrics Society , held in Bucharest, Romania, on 7-11 June 2017

Europediatrics , the flagship event of EPA/UNEPSA will be jointly held in 2017 with the 13-th National Congress of the Romanian Society of Pediatrics.

Figure 1
Eurpaediatrics
Congress Venue – the
Palace of Parliament in
Bucharest

The Romanian Society of Pediatrics was part of Romanian Medical Association since its formation in 1926 until 2001 when the society acquired its own legal status.



Figure 2
Eurpaediatrics
Congress Venue – the
Palace of Parliament in
Bucharest



Figure 3
The epa-unepsa council members:

Massimo Pettoello
Marin Burlea
Leyla Namazova-Baranova
Julije Mestrovic

Visiting the congress venue in Bucharest

Since 2010, the Society is a member of EPA – UNEPSA (The European Paediatric Association and the Union of National European Paediatric Societies and Associations) and also member of EAP (European Academy of Pediatrics).

The Society represents over 4000 pediatricians and 8,000 associate members and family doctors

The Romanian Pediatric School has a high academic and practical tradition; there are prestigious schools in 10 Universities- among which are Universities from Iasi, Cluj, Bucuresti, Tg. Mures, Timisoara, Craiova, Sibiu;

In the last 20 years, the Romanian pediatric system has been reorganized and rejuvenated. It now includes self-governing structures in some hospitals: Gastroenterology, Nefrology, Neurology, Allergology and Immunology, Diabetes and Nutrition, Respiratory medicine and more.

Besides International Courses and workshops in pediatrics, The Romanian Society of Pediatrics organizes national conferences and congresses with international participation.

The last National Congress of the Romanian Society of Pediatrics in 2015 at Timisoara was a tremendous success: over 1200 participants, 145 Romanian and 25 International Speakers, 180 topics on different sessions, 240 posters, 40 Sponsors

The 8th Europaediatrics Congress in 2017 is offering a tremendous Venue - The Palace of Parliament, Bucharest, Romania.

Built by Communist Party leader, Nicolae Ceausescu, the colossal Parliament Palace (formerly known as the People's Palace) It took 20,000 workers and 700 architects to build.

The Palace measures 275 m by 235 m, 86 m high, and 92 m underground. It has 1,100 rooms, 2 underground parking garages and is 12 stories high, with four additional underground levels including an enormous nuclear bunker. Total area of 365,000 sqm

The Palace of Parliament it is the world's second-largest office building in surface (after the Pentagon) and the third largest in volume (after Cape Canaveral in the U.S. and the Great Pyramid in Egypt).

When construction started in 1984, the dictator intended it to be the headquarters of his government. Today, it houses Romania's Parliament and serves as an international conference centre. Built and furnished exclusively with Romanian materials, the building reflects the work of the country's best artisans.

We invite you to discover yourself the beauty of this place and we are looking forward to welcome all of you in Bucharest in 2017

Leyla Namazova-Baranova,

President of EPA/UNEPSA

Marin Burlea,

President of 8th Europaediatrics





**BRIGITTE BRANDS, DR. RER
BIOL.HUM., DIPL.BIOL., MBE**

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PAEDIATRIC E-LEARNING

The E-Learning in Paediatric Medical Continuing Education (CME)

E-learning is of growing importance in the medical and life science education fields. Due to ever-growing globalization and the increased need for flexibility, even in the medical arena, new and innovative methods of education and life-long learning are burning issues. Moreover, time, travel and cost constraints make flexible access to education ne-

cessary. Also in the CME for paediatricians, there is a need for up-to-date scientific based contents with direct reference to practical application. Still, e-learning courses in CME are often unregulated, with biased content and run by non-academic, non-public providers. Moreover, their contents are of narrow width and depths, incomplete and without regular updates. Thus, there is an urgent need for CME e-learning of unbiased, up-to-date and high quality contents which offer easy and mobile access to allow for self-paced, interactive learning.

The Early Nutrition eAcademy (ENeA, <http://www.early-nutrition.org/en/enea/>) is a free of charge e-learning co-operation initiated by the Early Nutrition Academy (ENA) and the Dr. von Hauner Children's Hospital at the LMU Medical Center Munich, Germany. Current international recommendations, meta-analysis, systematic reviews and latest scientific findings are consolidated and translated into practical application. The contents of the e-modules are written and reviewed by leading international experts in the field who are part of international research collaborations such as the EU-funded EarlyNutrition project (www.project-earlynutrition.eu). ENeA provides accredited e-learning modules for CME on topics in the area of early nutrition and lifestyle.

The e-modules target healthcare professionals (HCP) and new investigators worldwide who aim to deepen their knowledge and improve healthcare services in the area of early nutrition.



BAYERISCHE
LANDESÄRZTEKAMMER

CME

— Continuing Medical Education —



Certificate of Completion

Module IV: Complementary Feeding in Infancy – Unit 1: Current Recommendations and Practices (VNR: 2760909005749120018)
made available at www.enea.moodle.elearning.lmu.de and organized by the Early Nutrition eAcademy,
is accredited by the

European Accreditation Council for Continuing Medical Education (EACCME)
with 2 European CME credits (ECMEC, equivalent to 100 minutes)
and by the German Medical Association
with 2 CME credits
to provide the above mentioned CME activity for medical specialists.

This is to confirm successful completion by

Euro Pediatrics
Main Street, 12345 Firenze, Italy

on May 13th, 2015
with 2 European CME credits (ECMEC) and 2 German CME credits.

Professor Borthold Koletzko, Dr. med. Dr. med. habil. (MD PhD)
(Early Nutrition Academy)



The EACCME is an institution of the European Union of Medical Specialists (UEMS).
Only those e-learning materials that are displayed on the UEMS-EACCME website have formally been accredited.
Each medical specialist should claim only those credits that he/she actually spent in the educational activity.

Unit 3 Composition and Preparation of Complementary Feeding

Contents of this Unit

- Nutritional Requirements of Complementary Foods
- Meal Frequency and Energy Density of Complementary Foods
- Types and Consistency of Complementary Foods During Infancy
- Vegetarian and Vegan Diets During Infancy
- Safe preparation and Storage of Complementary Foods
- Feeding Advice During and After Illness

Learning Aims of this Unit

Upon successful completion of this Unit the user will be able to:

- Provide an outline of the nutrient and energy content of complementary foods and their importance for infant growth and development
- Outline the appropriate number of meals required during infancy and the appropriate energy density of the food provided
- Provide an outline of the types and consistency of complementary foods to introduce to infants during the complementary feeding period
- Comment on the key facts and issues of vegetarian and vegan diets during infancy
- Describe the practice of good hygiene and proper food handling to prevent gastrointestinal illness in infancy
- Understand the importance of continued feeding during and after illness



BERTHOLD KOLETZKO, DR MED DR MED HABIL (MD PHD), UNIV.- PROFESSOR OF PAEDIATRICS

The ENeA platform is run in close collaboration with the European Society for Gastroenterology, Hepatology and Nutrition (ESPGHAN) and embedded in the ESPGHAN e-learning programme, offering the nutrition training part for health care professionals.

The ENeA e-learning platform consists of different Modules, each focusing on one defined topic within the field of early nutrition. To date the following modules are available online:

Further Focus Modules will be available soon; amongst them modules on Nutrition and Epigenetics, Anthropometry in Infants, Critical Nutrients during Pregnancy and Lactation, and Early Nutrition and Life in Low Income Countries.

Each module is divided into an introductory section, followed by three to five Units addressing different aspects of the main topic and concluding with Case-based Training.

Each unit is then subdivided into several parts. At the beginning of each unit, a graphical overview outlines the content and learning aims of each unit. Before starting with the lessons, a Self-As-



assessment test provides the user with feedback on their level of prior knowledge regarding a specific topic. Each unit is then sub-divided into smaller, clearly designated Lessons which encompass the most important and relevant aspects of the main topic. Wherever possible, lessons contain expert statements, videos or interactive graphics to support and clarify the written content. In addition, reference lists on selected topics provides users with sources for further and more detailed information. The final section of each unit - entitled Key Statements - gives a short summary of all lessons covered in each unit. At the conclusion of each unit a CME Test is available. Having worked through all lessons the user should be familiar with the contents of the unit and able to successfully complete the CME test at the end of each unit.

Each module ends with a Case-based Training. The purpose of this virtual situation training is to give users the possibility to apply their newly acquired knowledge to practical case studies. The case-based training is purely for the users' additional benefit and is not connected to the CME certificate.

Additionally, users have the opportunity to communicate with each other or with the ENeA team via a Discussion Forum. For ease of use, abbreviations are linked to provide the user with an immediate relevant explanation and all references in the modules are linked to the reference list. A comprehensive list of all references used in the modules can be downloaded

An e-Learning Module on “Complementary Feeding”

One of the available modules on the platform is on the specific theoretical and practical aspects

of complementary feeding. The module addresses timely and appropriate complementary feeding practices for infants and young children and their importance for healthy growth and development. Current, international recommendations for the timing of introduction of complementary foods are provided along with the current scientific recommendations addressing the health effects of both early and late introduction of complementary foods. Detailed recommendations on the food types, amounts and frequency of meals to provide to infants and young children is discussed along with practical examples of complementary foods to provide in different regions of the world. The biological and developmental aspects during the complementary feeding period are explained which help to deepen understanding as to why complementary feeding is so important. This module focuses especially on the nutrition needs of normal healthy infants while also addressing special nutrition needs of infants during illness and some specific issues associated with complementary feeding in developing countries.

In the first unit, current recommendations and practices are presented and discussed. Adequate nutrition during infancy and early childhood is crucial for normal, healthy growth and development. This first unit presents an overview of complementary feeding during infancy and provides an outline of the various definitions of complementary feeding by international organizations. Based on a short summary of the history of infant feeding, significant changes and advances which have occurred throughout the 20th and 21st century are highlighted. The importance of complementary feeding, as well as the nutritional inadequacy of prolonged exclusive breastfeeding is discussed, with a focus on the “criti-

cal period” of development and the nutritional deficiencies which can occur without appropriate complementary feeding practices. The learner is given a comprehensive insight into the current international recommendations of complementary feeding along with an outline of the current complementary feeding practices in different regions of the world.

In the second unit of this module, the health effects of complementary feeding are addressed. Based on current studies reporting the age at which complementary foods are introduced, this unit outlines how the timing of complementary foods can have immediate or later health consequences. Both too early and too late introduction of complementary foods can have undesirable health effects. Divided into several lessons, the user will learn about health outcomes such as obesity, atopic diseases and cardiovascular disease, as well as some other health effects associated with complementary feeding such as the risk of dental caries, and the risk of infections. This unit presents the learner with some specific issues associated with complementary feeding in developing countries including the health impacts of inadequate provision of complementary foods, addressing specific nutritional deficiencies and stunting.

The third unit presents practical aspects of complementary feeding: composition and preparation. Current, scientifically based recommendations on the practical aspects including the preparation and composition of complementary foods are subject of this unit. The aim is to give the user an overview of appropriate complementary feeding in infants, such as the types and consistency of complementary foods during infancy, the nutrient and energy content and the

amount and meal frequency of complementary foods. In addition, the unit provides evidence for the recommendations on vegetarian and vegan diets during the complementary feeding period. Moreover, the learner gains an overview on the safe preparation and storage of complementary foods as well as feeding advice during and after illness.

The last unit is on physiological aspects during the complementary feeding period. During the first years of life, the infant’s diet undergoes its biggest change from an exclusively liquid diet to a diet with an increasing variety of complementary foods in addition to milk. During this transition, the infant is likely to encounter a variety of foods and textures for which adequate oral motor skills and a mature digestive, renal and immune system are needed. This unit addresses the biological and developmental aspects during the complementary feeding period. The physiological maturation of renal and gastrointestinal function that is required for non-milk foods as well as the neuro-developmental changes necessary for safe and effective transition to family foods are explained to the learner. Moreover, the development of taste and food preferences is discussed as well as growth patterns during the complementary feeding period.

ENeA goes Regional - Adaptations for Paediatric e-Learning in specific settings

The English language umbrella platform ENeA Global is currently being diversified to regional and country specific requirements through dedicated sub-projects such as ENeA China, ENeA Turkey and ENeA SEA (South East Asia). Based on the collaboration with renowned experts in these regions, the e-learning programme will be

adapted to the specific settings and needs of health care professionals in those countries in order to offer customised continuing medical education in the field of early nutrition and life, in both, high and low income country settings.

Up to date, a total of more than 5,000 health care professionals from 142 countries in the world are actively taking part in the ENeA programme – so feel free to join in as well under [http://www.early-nutrition.org/en/enea/!](http://www.early-nutrition.org/en/enea/)

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EARLY NUTRITION FOR THE PUBLIC

<http://www.project-earlynutrition.eu/eneu/?typ=public>



INTERNATIONAL CONTRIBUTIONS:
AMERICAN ACADEMY OF PEDIATRICS (AAP) IN
COLLABORATION WITH THE EUROPEAN PAEDIATRICS
ASSOCIATION (EPA UNEPSA)

American Academy of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

5

ADDRESSING ANTIMICROBIAL

Rana Hamdy, MD, MPH, FAAP, J. Michael Klatte,
MD, FAAP and Zach Willis, MD, FAAP

THE VALUE OF ANTIMICROBIAL STEWARDSHIP

Antimicrobial resistance is a significant and rising threat to global health, threatening the effective treatment of infections caused by bacteria, fungi, parasites, and viruses. Antimicrobial resistance is

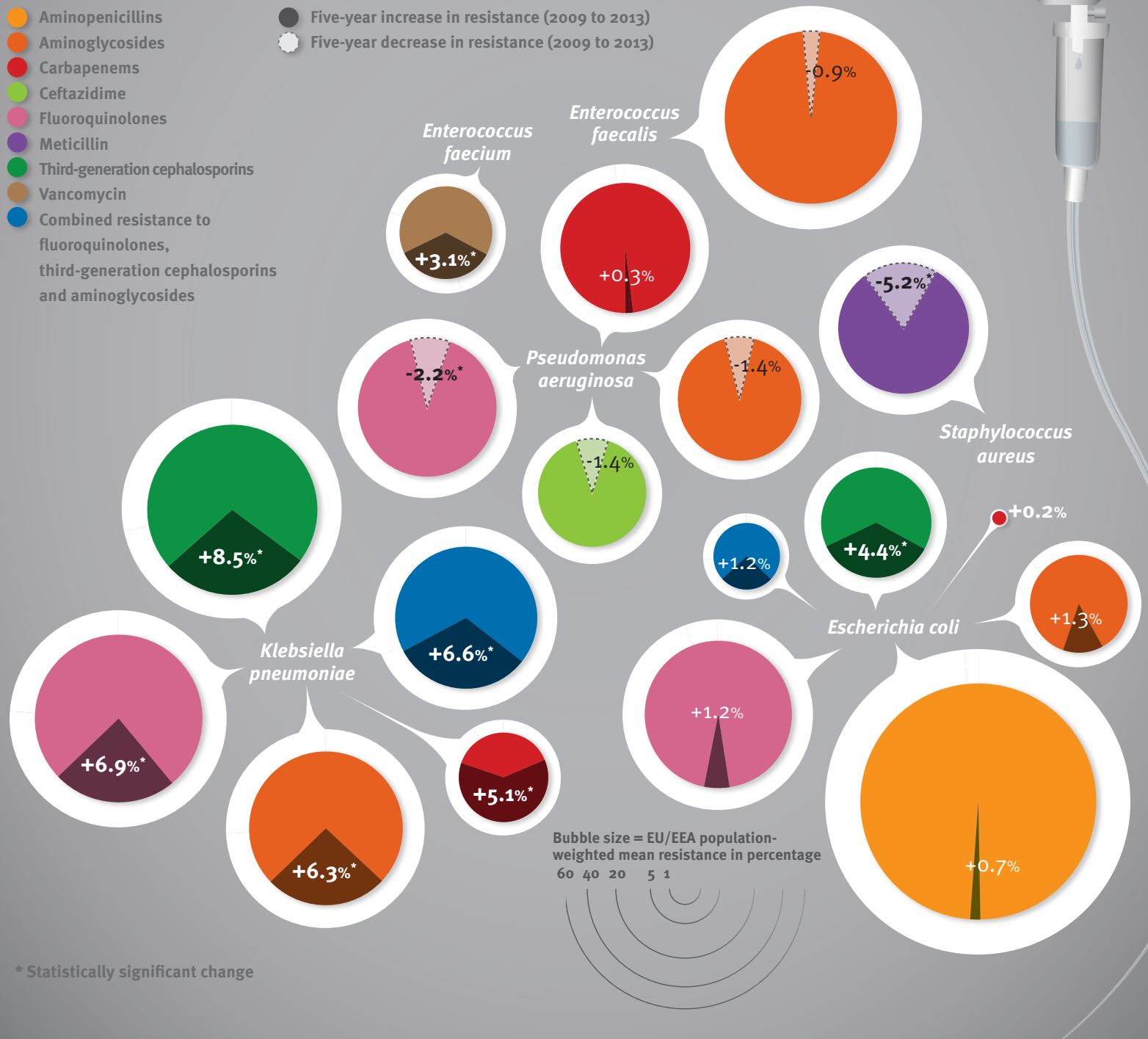
Antimicrobial resistance in Europe



Each year, 30 EU/EEA countries report data on antimicrobial resistance to the European Antimicrobial Resistance Surveillance Network (EARS-Net), hosted at ECDC.

- Aminopenicillins
- Aminoglycosides
- Carbapenems
- Ceftazidime
- Fluoroquinolones
- Meticillin
- Third-generation cephalosporins
- Vancomycin
- Combined resistance to fluoroquinolones, third-generation cephalosporins and aminoglycosides

- Five-year increase in resistance (2009 to 2013)
- Five-year decrease in resistance (2009 to 2013)



present in all regions of the world, and new mechanisms of resistance continue to emerge and spread globally. Overuse of antimicrobials drives antimicrobial resistance.

In the United States there has been increasing national attention to antibiotic resistance and in interventions to reduce its spread, including antimicrobial stewardship. Antimicrobial stewardship is a multifaceted effort to ensure the optimal selection, dosage, and duration of antimicrobial treatment that results in the best clinical outcome for the treatment of infection, while minimizing toxicity to the patient and impact on subsequent resistance. Antimicrobial stewardship programs (ASPs) have been

ANTIBIOTIC STEWARDSHIP IN YOUR FACILITY WILL



DECREASE

- ANTIBIOTIC RESISTANCE
- C. DIFFICILE INFECTIONS
- COSTS

INCREASE

- GOOD PATIENT OUTCOMES



shown to prevent medication errors, reduce healthcare costs, and reduce rates of infections caused by *Clostridium difficile* and multidrug-resistant bacterial pathogens. In March of 2015, The White House endorsed the value of antimicrobial stewardship with the National Action Plan for Combating Antibiotic-Resistant Bacteria. Among other recommendations, this plan directs the Centers for Medicare and Medicaid Services (CMS) to include formal antimicrobial stewardship activities as a condition of participation for all participating acute care U.S. hospitals by 2018.

ANTIMICROBIAL STEWARDSHIP IN PEDIATRICS

The antimicrobial stewardship movement in the United States began in adult acute care facilities, but the past decade has witnessed a surge of stewardship initiatives in children's hospitals as well. One 2011 survey found that 42% of 38 freestanding children's hospitals in the U.S. had a formal antimicrobial stewardship program in place, while an additional 37% were in the process of developing a program. Of those existing programs, 81% had been established after 2007.¹ Since that survey included only freestanding children's hospitals, little is known about the status of stewardship in other pediatric inpatient settings.

Recent research has demonstrated the tremendous need to optimize antimicrobial use in the am



Accelerating Antimicrobial



STEWARDSHIP PROGRAMS

bulatory pediatrics setting. Antibiotics are among the most commonly prescribed class of medications in children. Of the approximately 25 million antibiotic prescriptions given for pediatric acute respiratory tract infections on an annual basis in the U.S., nearly half (11.4 million) are estimated to be unnecessary.² One survey of outpatient pediatric providers from 21 European Union countries found that nearly half of the respondents overestimated risks associated with not prescribing antibiotics for acute upper respiratory tract infections, therefore implying significant unnecessary antibiotic utilization.³

While there is a clear need for antimicrobial stewardship in the ambulatory pediatrics setting, data necessary to guide ASP implementation for outpatient pediatric practitioners are currently scarce. Research interest in this area continues to grow. A recent clinical trial in a large network of pediatric offices found that using a combination of clinician education and prospective audit with feedback significantly reduced prescriptions for both broad-spectrum antibiotics and off-guideline prescribing for pneumonia and sinusitis.⁴ After the prospective audit ceased, these beneficial effects were not sustained.⁵ These findings suggest that an outpatient ASP can be highly successful, and interventions must remain in place in order to achieve sustained positive impact.

CHALLENGES IN ASP IMPLEMENTATION

While stewardship programs are known to be beneficial, there can be numerous barriers to successful implementation. Many barriers are common to both the inpatient and outpatient settings. Most inpatient programs include an infectious diseases physician and a clinical pharmacist, who must both be compensated for their time. The necessary members of an outpatient ASP are less clearly de-

fined, but time commitment is nevertheless required. The growing body of literature demonstrating the cost-effectiveness of stewardship programs provides justification for the costs of ASP implementation to hospital/practice administration.⁶

Restriction and/or timely monitoring of antimicrobial prescribing practices requires information technology resources, and may depend on a facility's existing ordering, billing, and record-keeping systems. Finally, ASP initiatives must be acceptable to clinicians, who may be sensitive to perceived intrusions on their autonomy. As many stewardship activities are 'unenforceable' recommendations, a program's success invariably rests on establishment of productive relationships with one's fellow clinician colleagues.

COLLABORATIVE EFFORTS IN-PROCESS

Experts from the AAP Committee on Infectious Diseases, the Section on Infectious Diseases and the Pediatric Infectious Diseases Society (PIDS) convened a meeting in October, 2015 to discuss the barriers to ASP implementation and to develop a strategy to address them. Key elements of the strategic plan included education, policy, advocacy, practice and research.

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Consider joining the AAP Section on Infectious Diseases

The AAP Section on Infectious Diseases (SOID) aims to improve the care of infants, children, adolescents, and young adults with infectious conditions. The SOID contributes to the AAP mission by providing quality educational programs for both the general pediatrician and the pediatric subspecialist. The SOID offers its members a forum for education, networking, leadership and advocacy. View the many benefits of membership here. Membership in the SOID is affordable at \$25/year or less and is available for international physicians who are actively involved in some aspect of the study (or practice) of infectious diseases in fetuses, infants, children or adolescents and interested in contributing toward the objectives of the Section.





6

PEDIATRIC NEUROLOGY FOR THE PEDIATRICIAN: JOINT SESSIONS OF THE EPA AND THE EUROPEAN PEDIATRIC NEUROLOGY SOCIETY (EPNS) AT THE 7TH EUROPAEDIATRICS CONGRESS, FLORENCE 2015

Banu ANLAR, MD, Hacettepe University, Ankara, Turkey

EPNS Board Education and Training Committee

Neurological problems constitute an important part of pediatric practice. When questioned, developmental delays or concerns are found in 10-40% of children seen in outpatient clinics for unrelated





reasons. Timely diagnosis of developmental delays can only be made by pediatricians who are aware of this fact. Therefore practical, reliable, and inexpensive methods, such as standard developmental screening tests, are needed to assess the child's developmental level. Although particular attention should be given to early infancy and preschool periods, the role of the pediatrician in following neurological development clearly does not end after the child reaches school age. The pediatrician is practically also a family physician: working closely with the child, parents, and other health or educational professionals, he/she ascertains the child's developmental adaptation and social adjustment as well as parents' and teachers' understanding. The 7th EUROPAEDIATRICALS in Florence provided the opportunity of presenting these tools and emphasizing the particular time points and contexts where the pediatricians' role becomes crucial for the neurological and developmental outcome of the child.

An important group consists of babies at risk for neurological problems, whose majority consists of prematurely born babies in developed countries. They benefit from early intervention, increased parent-child interaction through stimulation and play, and families benefit from support and education. Close follow-up allows the pediatrician to detect motor or cognitive delays in time and refer the child for early treatment and special education.

A direct role for the pediatrician is related to the detection and management of systemic problems frequently accompanying and aggravating neurological conditions, such as malnutrition, iron deficiency, visual and hearing problems or subclinical seizures, which all contribute to the child's dysfunction and may benefit considerably from the pediatrician's intervention. Moreover, medication-related problems such as adverse effects on behaviour or general health can be best detected by the pediatrician who follows the child.

Neurological problems also constitute a considerable portion of the hospitalist's work. As an example, they form about one-fourth of pediatric intensive care unit admissions, and about one fifth of the pediatric consultations. Moreover, neurology patients have higher mortality. Neonatal and adolescent periods, the two extremes of the pediatric age group, are particular periods where collaboration between pediatric subspecialties is important. As examined in detail at the congress, transition of the adolescent with a chronic health problem to adult health services is being increasingly recognized as a vulnerable time for the

patient, when collaboration with adult neurology makes an important difference.

During the congress, common neurological symptoms of childhood were taken up in joint pediatrics-pediatric neurology sessions: headache, gait abnormalities, and developmental delays. Practical neurological examination was demonstrated with images and videos of normal and abnormal findings, providing the audience with important clues applicable in a busy daily practice. The difficulties of the examination of young children and possible solutions were discussed in real-world situations. The need to be creative in the examination of a non-cooperative toddler, the opportunistic examination of a scared infant or young child, the value of direct observation during a seemingly informal talk with the mother have been illustrated and supported by contributions from the audience. Pediatric neurology sessions were well-received and recommended for future European pediatric congresses.





7

RE-EVALUATION OF PALIVIZUMAB USAGE IN ISRAEL

The new recommendations of the American Academy of Pediatrics (AAP) calling for a more limited and narrower usage of palivzumab (synagis) for the prevention of RSV in high risk groups have caused some confusion among pediatricians in Israel.

For the last decade several professional associations in Israel especially the Neonatology and The Pediatric Pulmonology Associations have advocated for a gradual expansion of the populations eligible for this expensive technology. While 14 years ago synagis was recommended for 200 infants born \leq than 28 weeks and those with chronic lung diseases, the funding for the prophylaxis was consistently increased and recently includes all infants born \leq 34 week + 7 days and included 2750 eligible infants.

In response to this reaction, The Israeli Pediatric Association, has nominated an ad hoc committee that included the chairmen of the relevant associations and societies (Neonatology, Pediatric Pulmonology, Pediatric Intensive Care,, Public Health, Pediatric Infectious Diseases, and representative of the Ministry of Health (MOH).

The committee has reviewed the available data and reached the following conclusions:

1. Palivizumab has been proven effective in reducing hospitalizations following RSV infection at high risk groups.
2. Palivizumab has not been proven to reduce mortality associated with RSV infection.
3. While palivizumab prophylaxis reduces ICU hospitalizations due to RSV infections, it was not shown to reduce mechanical ventilation due to this infection.
4. The cost of prevention of 1 RSV hospitalization is different among different countries and could be quite high (\geq 250,000\$ in most models).
5. Palivizumab prophylaxis may decrease wheezing episodes among treated infants.
6. While palivizumab may reduce hospitalizations among high risk patients its usage is not supposed to significantly affect the total burden of RSV infection since the overwhelming part of RSV hospitalization affect otherwise healthy infants who are not eligible for RSV prophylaxis.

The committee's recommendations were as follows:

1. To continue during the present winter (2014-2015 season) with the same criteria.
2. To start with national data collection regarding the impact of RSV infection in Israel.
3. To establish immediately following the present winter a cost benefit analysis in order to determine whether the current criteria are cost effective. The analysis is supposed to be finished prior to the next season in order to define more correctly the population that is eligible for RSV prophylaxis.

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PROF. GIORGIO TAMBURLINI

8

NEW EVIDENCES ABOUT THE EFFECTS OF HOME READING ENVIRONMENT ON THE ACTIVATION OF SPECIFIC BRAIN REGIONS SUPPORTING EMERGENT LITERACY.

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Literacy is the ability to utilize written information to expand and share knowledge in order to optimally function in society. Literacy acquisition involves a complex interplay of genetic, neurobiological and environmental factors, only the latter of which are directly modifiable (1). Emergent literacy is defined as the



skills, knowledge, and attitudes supporting reading and writing that develop from infancy, when parents are often a child's first and most important teachers. Cognitively constructive home environments, especially prior to school entry, provide an essential foundation for emergent literacy. Parent-child reading exposes the child (and caregivers) to a larger variety of words than are otherwise spoken during everyday conversation, especially in low socio-economic status households (2,3) and has been described as 'the single most important activity for developing the knowledge required for eventual success

in reading' (4), explaining much of the variance in language, emergent literacy skills and achievement in children, independent of socio-economic status. Parent-child reading since early infancy is widely advocated to promote cognitive development, and is recommended by several pediatric associations worldwide.

Although parent-child reading has been shown in behavioral and intervention studies to improve oral language and print concepts, quantifiable effects on the brain have not been previously studied. Hutton et al. (5) found an association between parent-child reading exposure and activation of brain areas supporting mental imagery and narrative comprehension. Nineteen 3- to 5-year-old children were selected from a longitudinal study of normal brain development and completed blood oxygen level-dependent functional magnetic resonance imaging using an age-appropriate story listening task, where narrative alternated with tones. Higher reading exposure (using the validated StimQ-P Reading subscale score which measures frequency of reading and number and variety of children's books available at home) was positively correlated ($P < 0.05$, corrected) with neural activation in the left-sided parietal-temporal-occipital association cortex, a "hub" region supporting semantic language processing, controlling for household income. It should be emphasized that these children, although 7



of them were from low income families had on average over a hundred of children's books at home.

The study for the first time demonstrated an association between home reading environment and activation of specific brain regions supporting emergent literacy during the prekindergarten period and provides neurobiological confirmation of the benefits of home reading shown by behavioural studies and provide further support to programs, such as Reach out and Read in the Unites States, Bookstart in the UK and Nati per Leggere in Italy, where paediatrician and other child professionals encourage parents to read to their babies since the first year of life. These programs are aimed at maximizing caregiver-child engagement through dialogic reading, where the child is stimulated to apply and exercise a broad range of language and executive function abilities.

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9

TO ENCOURAGE KIDS' HEALTH, PEDIATRICIANS ADD READING TO ESSENTIAL CHECK- UP LIST

The nation's largest pediatricians group is now formally urging parents to read aloud to their children daily from infancy. The American Academy of Pe-

diatrics says doing so stimulates early brain development and helps build key language, literacy and social skills.

You may wonder about the benefits of reading to your baby. An infant won't understand everything you're doing or why. But you wouldn't wait until your child could understand what you were saying before you started speaking to him or her, right? Nor would you bypass lullabies until your baby could carry a tune or wait until he or she could shake a rattle before you offered any toys.

Reading aloud to your baby is a wonderful shared activity you can continue for years to come — and it's an important form of stimulation.

Reading aloud:

- teaches a baby about communication
- introduces concepts such as numbers, letters, colors, and shapes in a fun way
- builds listening, memory, and vocabulary skills
- gives babies information about the world around them

Believe it or not, by the time babies reach their first birthday they will have learned all the sounds needed to speak their native language. The more stories you read aloud, the more words your child will be exposed to and the better he or she will be able to talk.

Hearing words helps to build a rich network of words in a baby's brain. Kids whose parents frequently talk/read to them know more words by age 2 than children who have not been read to. And kids who are read to during their early years are more likely to learn to read at the right time.

When you read, your child hears you using many different emotions and expressive sounds, which fosters social and emotional development. Reading also invites your baby to look, point, touch, and answer questions — all of which promote social development and thinking skills. And your baby improves language skills by imitating sounds, recognizing pictures, and learning words.

But perhaps the most important reason to read aloud is that it makes a connection between the things your baby loves the most — your voice and closeness to you — and books. Spending time reading to your baby shows that reading is a skill worth learning. And, if infants and children are read to often with joy, excitement, and closeness, they begin to associate books with happiness — and budding readers are created.



Listen. Different Ages, Different Stages

Young babies may not know what the pictures in a book mean, but they can focus on them, especially faces, bright colors, and contrasting patterns. When you read or sing lullabies and nursery rhymes, you can entertain and soothe your infant.

Between 4 and 6 months, your baby may begin to show more interest in books. He or she will grab and hold books, but will mouth, chew, and drop them as well. Choose sturdy vinyl or cloth books with bright colors and repetitive or rhyming text.

Between 6 and 12 months, your child is beginning to understand that pictures represent objects, and most likely will develop preferences for certain pictures, pages, or even entire stories. Your baby will respond while you read, grabbing for the book and making sounds, and by 12 months will turn pages (with some help from you), pat or start to point to objects on a page, and repeat your sounds.

When and How to Read

Here's a great thing about reading aloud: It doesn't take special skills or equipment, just you, your baby, and some books. Read aloud for a few minutes at a time, but do it often. Don't worry about finishing entire books — focus on pages that you and your baby enjoy.

Try to set aside time to read every day — perhaps before naptime and bedtime. In addition to the pleasure that cuddling your baby before bed gives both of you, you'll also be making life easier by establishing a routine. This will help to calm your baby and set expectations about when it's time to sleep.

It's also good to read at other points in the day. Choose times when your baby is dry, fed, and alert. Books also come in handy when you're stuck waiting, so have some in the diaper bag to fill time sitting at the doctor's office or standing in line at the grocery store.

Here are some additional reading tips:

- Cuddling while you read helps your baby feel safe, warm, and connected to you.
- Read with expression, pitching your voice higher or lower where it's appropriate or using different voices for different characters.
- Don't worry about following the text exactly. Stop once in a while and ask questions or make comments on the pictures or text. ("Where's the kitty? There he is! What a cute black kitty.") Your child might not be able to respond yet, but this lays the groundwork for doing so later on.
- Sing nursery rhymes, make funny animal sounds, or bounce your baby on your knee — anything that shows that reading is fun.
- Babies love — and learn from — repetition, so don't be afraid of reading the same books over and over. When you do so, repeat the same emphasis each time as you would with a familiar song.
- As your baby gets older, encourage him or her to touch the book or hold sturdier vinyl, cloth, or board books. You don't want to encourage chewing on books, but by putting them in his or her mouth, your baby is learning about them, finding out how books feel and taste — and discovering that they're not edible!
- Listen
- What to Read
- Books for babies should have simple, repetitive text and clear pictures. During the first few months of life, your child just likes to hear your voice, so you can read almost anything, especially books with a sing-song or rhyming text. As your baby gets more interested in looking at things, choose books with simple pictures against solid backgrounds.
- Once your baby begins to grab, you can read vinyl or cloth books that have faces, bright colors, and shapes. When your baby begins to respond to what's inside of books, add board books with pictures of babies or familiar objects like toys. When your child begins to do things like sit up in

the bathtub or eat finger foods, find simple stories about daily routines like bedtime or bathtime. When your child starts talking, choose books that invite babies to repeat simple words or phrases.

- Books with mirrors and different textures (crinkly, soft, scratchy) are also great for this age group, as are fold-out books that can be propped up, or books with flaps that open for a surprise. Board books make page turning easier for infants and vinyl or cloth books can go everywhere — even the tub. Babies of any age like photo albums with pictures of people they know and love. And every baby should have a collection of nursery rhymes!
- One of the best ways you can ensure that your little one grows up to be a reader is to have books around your house. When your baby is old enough to crawl over to a basket of toys and pick one out, make sure some books are included in the mix.
- In addition to the books you own, take advantage of those you can borrow from the library. Many libraries have storytime just for babies, too. Don't forget to pick up a book for yourself while you're there. Reading for pleasure is another way you can be your baby's reading role model.
- Reviewed by: Carol A. Quick, EdD. May 2013

During the first weeks of life your newborn may seem to do little more than eat, sleep, cry, and generate dirty diapers. But in reality, all senses are functioning as your infant takes in the sights, sounds, and smells of this new world.

It's hard for us to know exactly what a newborn is feeling — but if you pay close attention to your baby's responses to light, noise, and touch, you can see complex senses coming alive.

Sight

Your newborn can see best at a distance of only 8 to 12 inches, and focus when gazing up from the arms of mom or dad. Your newborn can see things farther away, but it is harder to focus on distant objects. Newborns are very sensitive to bright light and are more likely to open their eyes in low light.

After human faces, bright colors, contrasting patterns, and movement are the things a newborn likes to look at best. Black-and-white pictures or toys will attract and keep your baby's interest far longer than objects or pictures with lots of similar colors. Even a crude line drawing of two eyes, a nose, and a mouth may keep your infant's attention if held close within range.

Your baby, when quiet and alert, should be able to follow the slow movement of your face or an interesting object.

Although your baby's sight is functioning, it still needs some fine tuning, especially when it comes to focusing far off. Your baby's eyes may even seem to cross or diverge (go "wall-eyed") briefly. This is normal, and your newborn's eye muscles will strengthen and mature during the next few months.

Give your infant lots of interesting sights to look at. Introduce new objects to keep your baby's interest, but don't overdo it. And don't forget to move your infant around a bit during the day to provide a needed change of scenery.

Hearing

Most newborns have a hearing screening before being discharged from the hospital (most states require this). If your baby didn't have it, or was born at home or a birthing center, it's important to have a hearing screening within the first month of life. Most kids born with a hearing loss can be diagnosed through a hearing screening.

Genetics, infections, trauma, and damaging noise levels may result in a hearing problem so it's important to have kids' hearing evaluated regularly as they get older. Even if your child passed the newborn hearing screen, talk to your doctor if you have concerns about your baby's hearing.

Your newborn has been hearing sounds since way back in the womb. Mother's heartbeat, the gurgles of her digestive system, and even the external sounds of her voice and the voices of other family members were part of a baby's world before birth.

Once your baby is born, the sounds of the outside world come in loud and clear. Your baby may startle at the unexpected bark of a dog nearby or seem soothed by the gentle whirring of the clothes dryer or the hum of the vacuum cleaner.

Try to pay attention to how your newborn responds to your voice. Human voices, especially Mom's and Dad's, are a baby's favorite "music." Your infant already knows that this is where food, warmth, and touch come from. If your infant is crying in the bassinet, see how quickly your approaching voice quiets him or her down. See how closely your baby listens when you are talking in loving tones.

Your infant may not yet coordinate looking and listening, but even while staring into the distance, your little one is probably paying close attention to your voice when you speak.

Taste and Smell

Taste and smell are the two most closely related of the senses. Research shows that new babies prefer sweet tastes from birth and will choose to suck on bottles of sweetened water but will turn away or cry if given something bitter or sour to taste. Likewise, newborns will turn toward smells they prefer and turn away from unpleasant odors.

Though sweetness is preferred, taste preferences will continue to develop during the first year of life. For now, breast milk or formula will satisfy your newborn completely!

Touch

As it is to most humans, touch is extremely important to a newborn. Through touch, babies learn a lot about surroundings. At first, your baby is looking only for comfort. Having come from a warm and enveloping fluid before birth, babies are faced with feeling cold for the first time, brushing up against the hardness of the crib, or feeling the stiff edge of a seam inside clothes.

Babies look to parents to provide the soft touches: silky blankets, comforting hugs, and loving caresses. With almost every touch a newborn is learning about life, so provide lots of tender kisses and your infant will find the world is a soothing place to be.

Should I Be Concerned?

If you just want a little reassurance that your baby's senses are working well, you can do some unscientific testing for yourself. When quiet and alert without other distractions, will your baby focus and follow your face or favorite toy?

If your baby's eyes seem to cross more than just briefly, be sure to tell your doctor. In some instances, medical correction may be required. Also tell the doctor if your baby's eyes appear cloudy or filmy, or if they appear to wander in circles as they attempt to focus.

Most newborns will startle if surprised by a loud noise nearby. Other ways to rest assured your baby is hearing well: Does your baby calm down when he or she hears your voice. Does your baby turn to the sound of a rattle? Does your baby respond to soft lullabies or other music? Do sounds made out of sight capture your baby's attention?

If you have any concerns about your newborn's ability to see or hear, talk to your doctor. Even newborns can be tested using sophisticated equipment, if necessary. The sooner a potential problem is caught, the better it can be treated.

Reviewed by: Mary L. Gavin, MD September 2011





10

STARTING THE DEBATE ON THE ROLE OF CHILDREN IN PHILOSOPHY



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Introduction

Curiosity, imagination, fantasy, and continuous questioning: the child seems to be a natural philosopher until the age of eight to ten years, when the initial spirit of inquiry mysteriously seems to fade. What happens to them?

Innovative ideas, dreams and endless speculations: adolescents and young people start creating and planning their own new world. Have they reached the level of becoming experienced philosophers?

Rational decisions, pragmatism, disillusion, lack of time for thinking, and poisonous competition seem to rule the life of adults. Has the adult world missed the chance to practice philosophy and more importantly to understand the child as a philosopher?



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Philosophical Practice and Clinical Philosophy

Gareth Matthews takes up these concerns in *Philosophy and the young Child*. Trying to understand a philosophy that represents the range and depth of children's inquisitive minds, he explores both how children think and how adults think about them: "Adults discourage children from asking philosophical questions, first by being patronizing to them and then by directing their inquiring minds towards more 'useful' questions. Most adults aren't themselves interested in philosophical questions. They may be threatened by some of them. Moreover, it doesn't occur to most adults that there are questions that a child can ask that they can't provide a definitive answer to and that aren't answered in a standard dictionary or encyclopaedia either."

For Matthews, the impoverishment of the philosophical thinking of children and adolescents is regrettable insofar as it allows the potential for critical and creative thinking to fall by the wayside. This in itself would already be bad enough, but in the course of aforementioned impoverishment, further essential knowledge that philosophy offers to each single being is lost. The education of the practical ability to react rationally to critical developments in life and the application of the therapeutic potential of philosophy will be neglected. In the Socratic tradition, the central concern of philosophy is the education "of a single being to develop the ability to react to the world"; besides this, according to Socratic-Platonic self-understanding, concern for the soul is part of its main scope. Thus, philosophy aims at the health of the soul. Sadly, in

the process of its academic professionalization, the therapeutic dimension of philosophy has faded increasingly into the background. The rise of Philosophical Practices outside of universities beginning in 1980 was a reaction to this trend. In Philosophical Practice, particularly in Philosophical Counseling, in the conversation between the philosophical practitioner and his or her client, the focus is not only on the primal philosophical question, the question concerning the good life. A special challenge is certainly constituted by the problem of how you can live a good life even under difficult conditions. As a basic experience of life, which, at the same time, causes its troublesomeness, illness is an important topic of the Philosophical Practice. In Clinical Philosophy, a synthesis of philosophy and medicine finally takes place. The clinical philosopher Martin Poltrum advocates the employment of philosophers in clinics: "What would such a philosopher do? On the one hand he would be a contact person for patients who have a current metaphysical need caused by illness, sorrow, death, and other borderline situations, and are pressed by questions which are discussed traditionally in philosophy, and on the other hand he would be the counselor for the medical staff for medical-, psychotherapeutic- and care-ethical problems. An additional task of the clinical philosopher would be the institutionalization of lectures about the art of living [...] because especially in hospitals there is an increased interest in knowledge of life caused by the situation of being ill." This approach is worthy of applause. However, it doesn't consider the possibility of a specialized clinical philosopher for ill children and adolescents. The field of work for such a philosopher would be quite different to the one described above. Among other tasks, this philosopher would not only advise the medi-

cal staff and the patients but also the parents of the patients. Considering the fact that children can, as mentioned above, be seen as natural philosophers in a certain way, the clinical philosopher on the pediatric ward of a hospital would be a highly reasonable innovation. He or she would encourage the children to give their 'inner philosopher' full scope and would assist them caringly in orientating themselves in the world – especially under the preconditions of being ill.

The child as a philosopher

Basically all children in their capacity as newcomers to this world are disposed to orient themselves in the world. Admittedly, this is a task that essentially is never completed because humans, as existing creatures, are subject to permanent change, and the world is engaged in a constant transformation. Hence, not only children, but also grown-ups have to orient themselves in the world. It is beyond dispute that adults, in comparison with children, possess more experience with regard to this challenge. Therefore, adults are required to help children with their orientation in the world. Usually, children trust adults to do just that. More precisely, they believe that the grown-ups want to and can help them to find orientation in the world. The betrayal of this naïve basic trust is catastrophic.

Philosophy is orientation in thinking and at the same time orientation in the world through thinking. From this perspective, doing philosophy is an essential task for survival. However, doing philosophy is also, as we can see watching children discover the world, a fundamental human need. To a certain extent, everyone is doing philosophy. Humans as creatures with the capacity for language principally also possess the capacity for

doing philosophy. This alone, however, does not automatically make each human a philosopher. Philosophy in the advanced sense is a strict affair, which usually puts a strong emphasis on methodological as well as logical aspects. Philosophy can be practiced or trained. Now, if grown-ups practice philosophy with children, ideally both parties profit from the training because children are doing philosophy differently from adults. Adults possess greater experience in thinking, so that they can guide the children in the thought-process.

By contrast, childlike thinking is more naïve – innocent, as Nietzsche puts it. Infantile thinking distinguishes itself through a form of refreshing naivety, which adult thinking has lost in the course of years. This naivety can sometimes have an unmasking quality. Thinking does not blindly accept common truths. While adults are inclined to comfortably confine themselves in a shell of pre-established truths, children are not as quick to settle for common sense explanations. They especially do not accept explanations that are contrary to their worldly experience. Naively, children simply cling to what they have experienced or seen, no matter the parental assurance that, “actually,” such and such is the case. By this means the persistent asking child is able to help the grown up philosopher to get to the bottom of things by hindering him or her to come up with immediate answers which prevent a deep illumination of the matter in question.

Those who do philosophy with children should ask what children have seen and what answers they have given to serious questions. Adults should not patronize children. It is absolutely essential in education “to give children responsibility in accord with their level of development – also

for their thinking”. Patronizing, however, even if it is based on a nurturing intention, is the death of child philosophers, whose central organ is imagination.

A philosophical education for children emphasizes responsibility. Philosophical education is an invitation to think for oneself in a twofold manner: on the one hand through the practice of thinking, the “capacity to use ones own intelligence”, as Kant phrases it; and on the other hand through imparting a fundamental disposition of openness. Basically, everything can be questioned and put into different perspectives. To wonder in this context is not so much an expression of naivety, as it is the precondition of an incipient mode of thinking, which does not only operate logically, but also creatively.



SUSTAINABLE DEVELOPMENT GOALS

11

...AND CHILD HEALTH

In September, the focus of the ISSOP (International Society for Social Pediatrics and Child Health) annual meeting was the Sustainable Development Goals.

Developed by the UN to reply the Millennium Development Goals, the SDGs are more comprehensive but also rather 'clunky' – in other words, long winded and difficult to summarise effectively.

THE GLOBAL GOALS

For Sustainable Development



Sustainable Development Goals (1/2016 – 12/2030)

Goal 1. End poverty in all its forms everywhere

Goal 2. End hunger, achieve food security, improved nutrition, promote sustainable agriculture

Goal 3. Ensure healthy lives and promote well-being for all at all ages

Goal 4. Ensure inclusive and equitable quality education, promote lifelong learning opportunities for all

- Goal 5.** Achieve gender equality and empower all women and girls
- Goal 6.** Ensure availability and sustainable management of water and sanitation for all
- Goal 7.** Ensure access to affordable, reliable, sustainable and modern energy for all
- Goal 8.** Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all
- Goal 9.** Build resilient infrastructure, promote inclusive, sustainable industrialization & foster innovation
- Goal 10.** Reduce inequality within and among countries
- Goal 11.** Make cities and human settlements inclusive, safe, resilient and sustainable
- Goal 12.** Ensure sustainable consumption and production patterns
- Goal 13.** Take urgent action to combat climate change and its impacts*
- Goal 14.** Conserve and sustainably use the oceans, seas & marine resources for sustainable development
- Goal 15.** Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss
- Goal 16.** Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels
- Goal 17.** Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development

There are three reasons for the change:

- The MDGs were set to complete in 2015
- Many targets have not been met hence need revision
- There were felt to be omissions so the new goals cover a wider range of determinants

The goals are intended to cover social, economic and environmental priorities and there is intended to be integration between the various goals – see <https://sustainabledevelopment.un.org/topics>

Whilst there is much to praise in the new goals there are also a number of critical inconsistencies which I will review below.

Child health in the SDGs

Unlike the MDGs there is no single child health target in the SDGs. MDG 4 was clearcut – to reduce under fives mortality by 2/3 by 2015. Whilst there was a big reduction of UFM globally (from 12.7 million in 1990 to 6.3 million in 2013), in many low income countries (notably those in Africa) the target was far from being met. Also the target was limited and said little about nutrition, growth or development.

There are 17 sustainable development goals so room for much more detail.

In contrast the first three SDGs are more comprehensive –

Goal 1 - End poverty in all its forms everywhere

Goal 2 - End hunger, achieve food security and improved nutrition, promote sustainable agriculture

Goal 3 - Ensure healthy lives and promote well-being for all at all ages

Within Goal 3 there are nine targets, the following being those most relevant to children:

3.1 - By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births

3.2 - By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births

3.6 - By 2020, halve the number of global deaths and injuries from road traffic accidents

3.7 - By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

3.8 - Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

There are also further targets for child health within other goals for example :

16.2 End abuse, exploitation, trafficking and all forms of violence against and torture of children

Violence against girls is covered in Goal 5 –

5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation

These targets are challenging and we in ISSOP are planning to take up the question of violence against children, which is so pervasive and yet so highly preventable. Perhaps this is something we could collaborate on with EPA?

Inconsistencies in the SDGs

There are however certain inconsistencies and anomalies within the SDGs.

Goal 10 is to reduce inequality within and among countries. These inequalities are severely detrimental to child health. Yet many commentators see the origin of the growing inequalities as being in large part due to the neo-liberal economic policies of Western governments, and the lobbying by big business to promote such policies. See for example

<http://wer.worldeconomicsassociation.org/files/WEA-WER-4-Woodward.pdf>

which is a paper by an eminent economist that challenges the way the SDGs approach poverty. Woodward points out in this thoughtful paper (entitled *Incrementum ad Absurdum*) that if reducing poverty has to rely simply on economic growth, then it will take 100 years to reach the poverty line of \$1.25 a day. Only by seriously tackling inequality – meaning measures to curb the growth of wealth – can poverty be genuinely reduced.

The second inconsistency is in relation to climate change. Goal 13 is strong - 'Take urgent action to combat climate change and its impacts'. But this is not compatible with Goal 8: 'Promote sustained, inclusive and sustainable economic growth' – since economic growth (unless defined very clearly as not requiring more scarce resources) will inevitably increase CO2 emissions.

So, let's work with the goals which are clearcut and necessary and question the assumptions underlying those relating to social determinants and growth.

Tony Waterston, International Society for Social Pediatrics and Child Health

Paediatric Learnings from Gut Microbiota for Health World Summit

Barcelona 2015



12

GUT MICROBIOTA FOR HEALTH (GMFH) - E-BOOK

The Gut Microbiota for Health (GMfH) organisation, which forms part of the European Society of Neurogastroenterology and Motility (ESNM), is a

At this year's summit, key findings were presented in the field of gut microbiota, many of which are relevant to paediatrics now and in the future. There is currently a great deal of interest in the importance of early life factors shaping the gut microbiota, which may impact upon the development of an infant's immune system and potentially influence long-term health.



Click video to play

Prof Massimo Pettoello-Mantovani

The potential impact of the gut microbiota within the field of paediatrics is not recognised enough by general paediatricians due to a lack of transfer between the fields.

Prof Massimo Pettoello-Mantovani, Professor in Paediatrics, Italy, Secretary General of the European Paediatric Association (EPA)



Click video to play

Gemma Castillejo de Villasante

This area is of real interest to me as a paediatrician and will shape the treatment of child health in the future.

Gemma Castillejo de Villasante, Paediatric Gastroenterologist, University Hospital Sant Joan de Reus, Spain

body which facilitates scientific debate on topics relating to gut microbiota. As well as running an experts exchange programme, the GMfH formed a joint scientific committee alongside the American Gastroenterology (AGA), ESNM, European Society for Paediatric Gastroenterology (ESPGHAN), the European Crohn's and Colitis Organisation (ECCO), and the European Association for the Study of the Liver (EASL) to run the 4th GMfH World Summit which was held this year in Barcelona (14-15 March).

International speakers and delegates from all fields of gut microbiota research such as doctors, nutritionists, dieticians, pharmacists and biologists joined the summit, where a wide range of research was presented, covering topics such as obesity, breast feeding, bowel disease and liver cancer, amongst others. Many of the topics were of great interest to the paediatricians in attendance, therefore, we have selected highlights of the summit which are relevant to child health. Professor Massimo Pettoello-Mantovani, Secretary General of the European Paediatric Association (EPA) who attended the summit stated:

“The potential impact of gut microbiota within the field of paediatrics is not recognised enough by general paediatricians due to a lack of transfer between the fields.”

We very much hope you find this of interest.

Please click here www.paediatricgutmicrobiota.com to read about the key findings, relevant to paediatricians, from this year's Gut Microbiota for Health Summit.



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FROM THE INTERNATIONAL LITERATURE



THE ROLE OF PROBIOTICS IN THE ANTIBIOTIC ASSOCIATED DIARRHOEA IN CHILDREN

- The use and effectiveness of probiotics in children has been a long lasting important debate during the past years, which continues to raise the attention of pediatricians. In particular, several articles in the recent past have discussed the role of probiotics for the prevention of Antibiotic-Associated Diarrhea in children, focusing on advantages and disadvantages. A paper published by the ESPGHAN Working Group for Probiotics/Prebiotics in the Journal of Pediatric Gastroenterology and Nutrition in December 2015 (<http://www.ncbi.nlm.nih.gov/pubmed/26756877>) provides recommendations, developed by the Working Group (WG) on Probiotics of ESPGHAN, for the use of probiotics for the prevention of antibiotic-associated diarrhea (AAD) in children. The recommendations were based on a systematic review of previously completed systematic reviews and of randomized controlled trials (RCTs) published subsequently to these reviews. The recommendations were formulated only if at least 2 RCTs that used a given probiotic (with strain specification) were available. The quality of evidence (QoE) was assessed using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) guidelines. The use of probiotics for preventing AAD was considered in particular in the presence of risk factors such as class of antibiotic(s), duration of antibiotic treatment, age, need for hospitalization, comorbidities, or previous episodes of AAD diarrhea.

Szajewska H, Canani RB, Guarino A, Hojsak I, Indrio F, Kolacek S, Orel R, Shamir R, Vandeplass Y, van Goudoever JB, Weizman Z. Probiotics for the Prevention of Antibiotic-Associated Diarrhea in Children. J Pediatr Gastroenterol Nutr. Dec. 2015, Epub ahead of print (<http://www.ncbi.nlm.nih.gov/pubmed/26756877>)

- A further recent report from a working group of gastroenterologists and nutritionists from the Great Ormond Street Hospital (UK), the Guy's and St Thomas NHS Foundation Trust (UK), the University St Joan de Resus (Sp), and the University of Nottingham UK, discusses the role of antibiotic resistance, and the background and prevalence of Antibiotic Associated Diarrhoea (AAD). The working group emphasizes that following an increasing amount of interest in therapies that may influence changes to gut microbiota, an approach that has been adopted by many healthcare professionals for the management of AAD is the use of probiotics. The report discusses the evidences reported in several studies, that the use of specific probiotics effectively reduces the incidence of AAD in children, also reduce associated healthcare costs and aid antibiotic compliance.

Castillejo De Villasante G, Koglmair J, Lindley K, Hallows S and Avery A. Antibiotic Associated Diarrhoea and the use of probiotics in children. REPORT 2015 (<http://paediatricgutmicrobiota.com/aadeng/>)

Antibiotic Associated Diarrhoea and the use of probiotics in children

Given the documented overuse of antibiotics amongst children, it was considered that Antibiotic Associated Diarrhoea (AAD) may be a potential issue within the paediatric population. A group of paediatricians and dietitians was convened to discuss the management of AAD, specifically in regards to the use of probiotics as a preventative measure.

Authored by



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Please click here to read the full article

GENETIC ANALYSIS OF CHILDREN WITH CONGENITAL TUFTING ENTEROPATHY (CTE). A CLINICAL CONDITION CHARACTERIZED BY DIARRHEA

- Congenital tufting enteropathy (CTE), an inherited autosomal recessive rare disease, is a severe diarrhea of infancy which is clinically characterized by absence of inflammation and presence of intestinal villous atrophy. The importance of genetic analysis in the diagnosis of genetic diseases is a well consolidated notion. However, genetic analysis covering all the wide range of genetic diseases is not always available in all hospital centers. In fact, since histological analysis is still not decisive in predicting the outcome of CTE patients, the identification of new mutations contributes to the genotype-phenotype correlation and provides further information about the assessment of the clinical outcome of the patients.. A recent article published by D'Apolito et al in the World Journal of Pediatrics (D'Apolito et al. Genetic analysis of Italian patients with congenital tufting enteropathy, World J Pediatr. 2015 Dec 18.Epub ahead of print) emphasizes the importance of genetic analysis, in particular in the Congenital Tufting Enteropathy (CTE). The study underlines the important role of performing the molecular screening of both the typical EpCAM and SPINT2 genes in the diagnosis of various congenital diarrheal disorders. The identification of a novel EpCAM mutation increasing the mutational spectrum of allelic variants associated with this gene further contributes to better understanding the pathogenesis of disorders

LINK: <http://www.ncbi.nlm.nih.gov/pubmed/26684320>

Collaboration for genetic analysis offered to the community of Pediatrics:

The first author, Dr. Maria D'Apolito, responsible of the Pediatric Research Laboratory at UNIFG, reports that the Institute of Pediatrics of the University of Foggia (Italy) offers the pro bono scientific support of the Research Center of the University of Foggia, providing the molecular screening of both EpCAM and SPINT2 genes to those centers needing genetic analysis to perform final diagnosis in children with suspected Congenital Tufting Enteropathy and other genetic disorders.

EPA-UNEPSA thanks Dr. D'Apolito for her kind and generous offer.

For those that may be interested, Dr. D'Apolito can be contacted directly using the following information:

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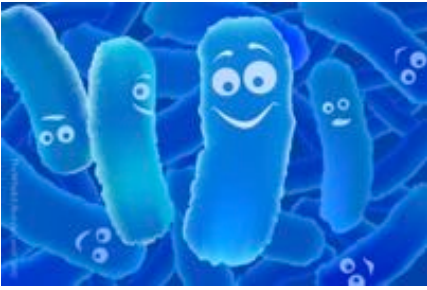
Tel: 0039.0881.588091



14

INTERNATIONAL COLLABORATIONS TO SCIENTIFIC RESEARCH IN PEDIATRICS





SURVEY:

THE UNDERSTANDING AND USE OF PROBIOTICS

EPA-UNEPSA has received a kind request of scientific collaboration from the UK by Dr. Zelda Wilson, who is doing a Master degree in Advanced Dietetics at the University of Nottingham. For her final research, she is studying the role of probiotics in the wellbeing of humans, and in the management of various clinical conditions. Dr. Wilson is interested in how healthcare professionals perceive and use probiotics. Therefore she has developed a short survey that may start providing some insight into this matter.

EPA-UNEPSA is glad propose the brief survey to the readers of the Newsletters. To participate in that will take 15 minutes of your time. Completion of the questionnaire implies consent to the use of anonymised quotations to be used in research outputs such as reports.

LINK TO THE SURVEY:

<http://www.dansurveys.com//index.php?sid=15447&lang=en>

The deadline is 30 March 2016.

In order to further emphasize the importance of appropriate medical care for children, and to encourage the completion of the questionnaire, after the deadline one winner will be picked at random to receive an educational grant of up to £500 which will be offered by EPA-UNEPSA to attend the scientific/educational meeting of your choice. No personal details will be used other than to notify on the allocated bursaries.

Thank you in advance for your participation. If you have any questions or would like to know more about the survey, please contact the Editorial Committee of the EPA-UNEPSA Newsletter (info@epa-unepsa.org).

EPA-UNEPSA has been informed that the survey was endorsed by the British Dietetic Association and the European Society for Primary Care Gastroenterology, and that Ethical approval has been obtained from School of Biosciences Research Ethics Committee (SB REC).

SURVEY:

The BRIDGE Health project

EPA-UNEPA has received a request of collaboration from Dr. Anthony Staines of the Department of Public Health, Ireland, to complete a Public Health SURVEY for the BRIDGE health Project supported by the European Union.

EPA-UNEPSA is glad to contribute to the study performed by the BRIDGE health Project and kindly ask to the EPA-UNEPSA Newsletter readers to complete the Survey, which link is reported below:

LINK TO THE SURVEY:

<https://www.surveymonkey.com/r/BridgeHealth-WP7>

BRIDGE Health stands for BRidging Information and Data Generation for Evidence-based Health policy and research. The BRIDGE Health project aims to prepare the transition towards a sustainable and integrated EU health information system for both public health and research purposes. The project was launched in May 2015 and will be running for 30 months. It includes 31 partners in 16 countries. The project bridges the best of EU projects in domains of population and health system monitoring, indicator development, health examination surveys, environment and health, population injury and disease registries, clinical and administrative health data collection systems and methods of health systems monitoring and evaluation. BRIDGE Health is supported under the EU action of the Public Health Programme implemented by the Consumers, Health and Food Executive Agency of the European Commission.

(<http://www.bridge-health.eu/#sthash.NowalhZO.dpuf>)



PROF DR FÜGEN ÇULLU ÇOKUĞRAŞ
EPA-UNEPSA COUNCIL MEMBER
IPA , STANDING COMMITTEE

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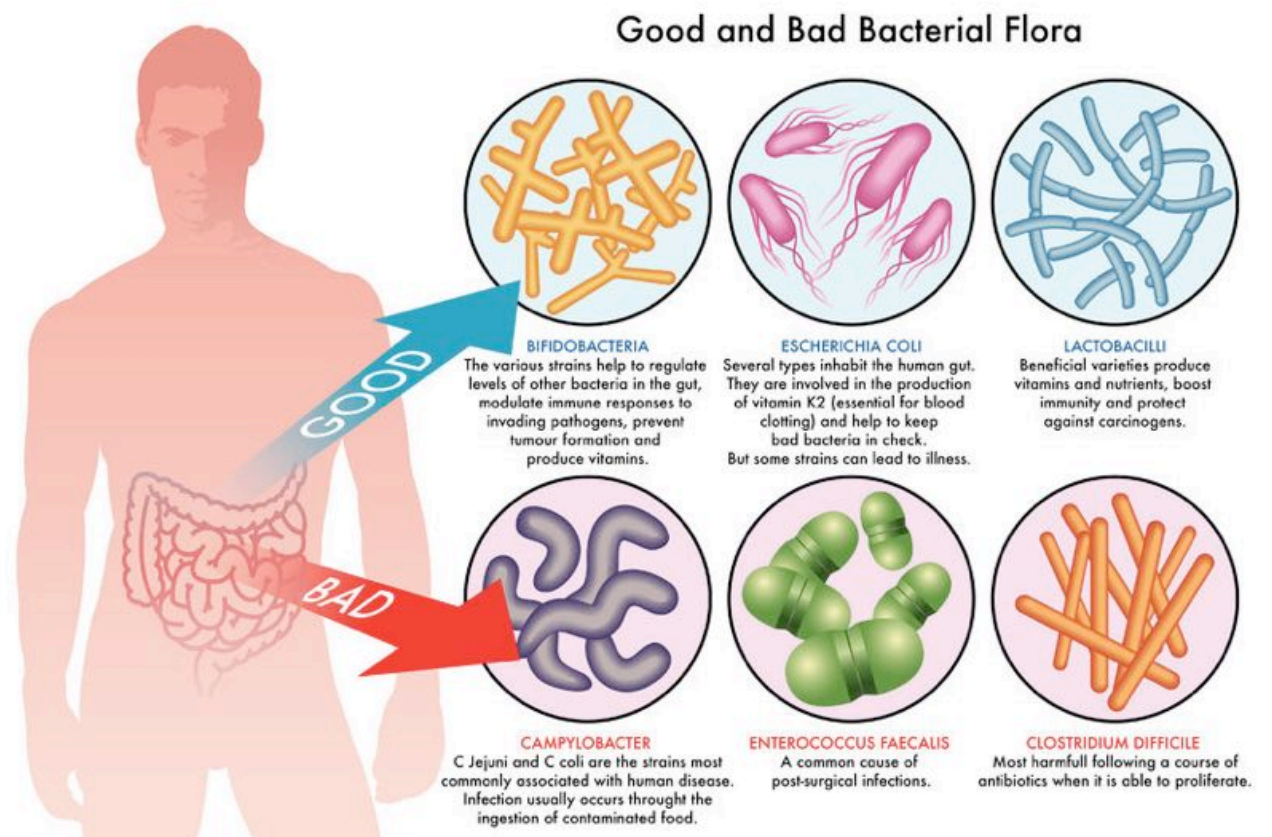
COMMENTARY: THE UNDERSTANDING AND USE OF PROBIOTICS

Probiotic bacteria are defined as nonpathogenic live microorganisms which when consumed in adequate amounts confer a health benefit on the host. These nonpathogenic bacterial species resi-

de in the gastrointestinal tract of normal healthy persons; their beneficial effect comes from competition with other microorganisms. They increase the production of anti-inflammatory cytokines, decrease pro-inflammatory cytokines, reduce intestinal permeability. Thus gut microbiota plays an important role on health; the disequilibrium between pathogenic and nonpathogenic bacteria is demonstrated in gastrointestinal, allergic diseases as well as in the outcome of certain diseases such as infectious diseases and oncologic diseases.

In some of these diseases such as antibiotic-associated diarrhea the use of probiotics is well defined; in some others therapeutic intervention of probiotic microorganisms is advised but not evidence-based.

The survey proposed by Dr. Wilson in the section of International Scientific Collaborations of this Newsletter (page 58-60) will help a better understanding of the probiotics and their use, and EPA-UNEPSA is glad to suggest the readers to take 15 minutes of their time to complete it.





EURYPA 2015



1st Congress of the European Young Paediatricians' Association

Notes from the Congress

- ✦ 563 participants from 10 different countries attended to the congress.
- ✦ Participants from England, Austria, Romania, Hungary, France, Belgium, Croatia, Albania and Moldavia were present.
- ✦ 47 of the participants were from outside of Turkey.
- ✦ 116 Turkish participants were from outside of Istanbul.
- ✦ The topic of the opening ceremony was a recent important subject: "War and Children".
- ✦ 31 sessions held on the recent topics of the pediatric clinics.
- ✦ In those sessions 40 different topics have been delivered by 87 speakers.
- ✦ Total of 278 poster presentations have been made.
- ✦ Our questionnaire showed 97% satisfaction rate at the end of the congress.



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EURYPA 2015

THE EUROPEAN
YOUNG
PAEDIATRICIANS
ASSOCIATION



You can download entire Newsletter from this link

[Download](#)



EPA/UNEPSA MEMBER AND AFFILIATED ASSOCIATIONS AND SOCIETIES 2016

Albania

Albanian Paediatric Society

Armenia

Armenian Association of Paediatrics

Austria

Oesterreichische Gesellschaft für Kinder- und Jugendheilkunde (OEGKJ)

Azerbaijan

Azerbaijan Pediatric Society

Belgium

Societe Belge de Pédiatrie/Belgische Vereniging 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 Vereniging voor Kindergeneeskunde

Uzbekistan

Pediatric Societies and Associations of Uzbekistan

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

Turkey

Türk Pediatri Kurumu

Türkiye Milli Pediatri Derneği

Turkmenistan

Pediatric Societies and Associations of Turkmenistan

Ukraine

Ukraine Paediatric Association

United Kingdom

Royal College of Paediatrics and Child Health

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NOTE:
THE PICTURE IN PAGE 2, WAS TAKEN FROM CLIPPARTS.CO:
CLIPPARTS.CO/KIDS-CLIP-ART-BLACK-AND-WHITE.

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SAVE THE DATE

CALENDAR OF EVENTS: UPCOMING CONFERENCES

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MAY

<http://icnc2016.org/>

14th International Child Neurology Congress ; May 1st – 5th, 2016 ; Amsterdam, the Netherlands

<http://espid2016.kenes.com/>

34th Annual Meeting (ESPID 2016) ; May 10-14 , 2016; Brighton, UK

<http://www.espghancongress.org/>

49th Annual Congress of ESPGHAN; 25-28 May 2016; Athens, Greece

CHILDREN. FIMP International Meeting
May 12-14, 2016 - Bari, Italy
(elodiaevent@gmail.com)

JUNE

<http://www.aepc2016.org/>

50th Annual Meeting of the Association for European Paediatric and Congenital Cardiology; Rome, Italy; 1st to 4th June 2016

<http://www.cipp-meeting.org/en/>

XV International Congress of Pediatric Pulmonology; Naples, Italy; June 23-26, 2016


AUGUST


August 17 - 22, 2016

Community, Diversity, Vitality

28th International
Congress of Pediatrics

17-22 August 2016, Vancouver, Canada

 International pediatric association
association internationale de pédiatrie
asociación internacional de pediatría

 Canadian
Paediatric
Society

www.IPA2016.com

SEPTEMBER

www.espe2016.org/

55th ESPE Annual Meeting; Paris, France; 10-12 September 2016.

<http://www.ipna2016.com/>

17th Congress of the International Pediatric Nephrology Association; Iguazu, Brazil; September 20-24, 2016

<http://www.paediatrics.kenes.com/>

6th Congress of the European Academy of Paediatric Societies (EAPS 2016) ;
21-25. September, 2016; Geneva; Switzerland



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