Highlights from this issue

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REDUCING CHILD HEALTH INEQUALITY

Health inequalities are defined as the gap in outcomes between different groups in society. Hargreaves and colleagues investigate trends in health inequality among children and young people in England using data from health surveys over the last decade. Four outcomes were considered; self/parent reported general health, presence of a longstanding illness, obesity and smoking. Changes in the absolute and relative risks of the four outcomes were considered using occupation of the head of household as a marker of socio-economic status. No indicator showed a reduction in relative or absolute health inequality between 1999 and 2009. All four outcomes showed an increase in inequality at some point during the period. The findings are disappointing and challenging. The challenge of reducing child health inequality is discussed in detail by the authors and in an accompanying editorial by Nick Spencer—Reducing Child Health Inequalities; what's the problem? ***See pages 850 and 836***

WEANING TUBE FEEDS

Many children with chronic conditions require tube feeding, often started infancy with obvious benefit in terms of nutrition, growth and development. The long term switch to oral feeding (where possible) is not always straightforward. Many children develop oral aversion. Wilken and colleagues report their experience of a rapid home based tube-weaning programme in 39 children (median age 16 months, median duration of tube feeding 15 months). All were offered intensive support prior to and during the weaning period. Oral feeding was established in 90% with reasonable preservation of growth. Charlotte Wright in an accompanying editorial discusses the UK experience including the need to wean tube feeds in order to promote oral feeding emphasising the need for multidisciplinary services to be available to support families during this period and the importance of agreeing a potential exit strategy whenever tube feeding is started. ***See pages 856 and 838***

SHOULD ALL CHILDREN BE IMMUNISED AGAINST INFLUENZA?

Influenza is an important cause of morbidity and mortality, especially in combination with secondary bacterial infections. Annual influenza vaccination is recommended for everyone at risk including the elderly, health care workers and children over the age of 6 months in high risk groups. This is with the inactivated vaccine made from Influenza A and B viruses produced in hen's eggs and given by intramuscular injection. This year all children in the UK aged 2 and 3 years will be offered the Live Attenuated Influenza Vaccine as part of an evolving strategy to offer to all children aged 2–17. Adam Finn's group discuss the background to, practicalities of and opportunities offered by this change including the potential to improve understanding of the epidemiology of influenza epidemics and thereby impact on them longer term. ***See page 846***

DEATHS FROM UNINTENTIONAL INJURY IN PAKISTAN

Globally 825 000 children die due to injury every year with the death rate being very significantly higher in lower income countries. Razzak and colleagues investigate the injury mortality burden in children under 5 years in Pakistan (39.5 per 100 000 per year, 9800 deaths, 2.5% of deaths) using data from the Pakistan Demographic and Health Survey from 2007. In children aged 1–4 years (ie, who survived to their first birthday) injury was the 3rd most common cause of death (11%) after diarrhoeal illness (18%) and pneumonia (17%). Drowning (22%), road traffic accidents (12%), burns (11%) and falls (10%) were the commonest injuries with mortality two fold greater in rural compared to urban areas. The authors put the data in context with other studies. In Bangladesh for example the injury rate is significantly higher with deaths predominantly due to drowning. This high mortality burden highlights the need to include injury prevention in global health strategies to achieve the Millennium development goal of reducing child mortality by two thirds. ***See page 867***

OPPORTUNITIES FOR INJURY PREVENTION

In a second paper from the same group an 'in home' unintentional injury hazard assessment tool is used to quantify potential injury risks for young children in a low-income urban setting in Pakistan. The detail is in the paper. The authors identified a significant risk burden with multiple hazards present across all household areas and outside. Common risks identified included stoves within easy reach of the child (>50%), presence of open buckets of water within easy reach of the child (48%) and pedestal fans accessible to the child (48%). Very few households had simple safety equipment, for example a fire extinguisher. The authors highlight the opportunities for injury prevention through application of this tool as part of a wider strategy for injury prevention. The findings are of relevance to the global child health agenda to reduce morbidity and mortality in children. ***See page 881***

GLOBAL CHILD HEALTH TRAINING

Many UK paediatricians in training benefit from experience of child health in low-resource settings (and institutions in low-resource settings benefit from hosting trainees). Goenka and colleagues explore pathways to develop experience including preparation, timing and practicalities. The article provides essential guidance for interested trainees. In an accompanying editorial Elizabeth Molyneux discussed the importance of including global health in the training of health professionals. The data in the article is challenging—1 billion of the world's 2.2 billion children live in poverty, 640 million are without shelter, 400 million with no safe water and 270 million with no access to health. The importance of global child health, the benefit of training to the trainee and the future of global child health training in the UK are discussed in detail. ***See pages 898 and 840***

IN *F&N* THIS MONTH

The challenges trainees face in delivering end of life care in the neonatal unit are reported in a qualitative study from Toronto in which fellows underwent semi-structured interviews. The six themes identified that reflected these challenges were: (1) withdrawal of life-sustaining treatment based on poor outcome, (2) explaining 'no resuscitation options' to parents, (3) clarifying 'do not resuscitate' orders, (4) empowering families with knowledge and shared decision-making, (5) dealing with different cultures and (6) managing personal internal conflict. The authors suggest that these can serve as focal points for improving end of life care educational programmes for neonatal fellows training.

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