



EDITORIAL

Responding to structural symptoms: social pediatrics towards 2030



Respondiendo a los síntomas estructurales: pediatría social hacia 2030

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The health of children and adolescents is conditioned by structural factors such as poverty, housing insecurity, violence of any kind, environmental pollution, unregulated digitalization or migration. These circumstances commonly give rise to clinical manifestations that reflect a preventable burden of disease. Many such manifestations are related to adverse childhood experiences (ACEs), defined as cumulative life experiences that, from an early age, generate toxic stress with an impact on overall health that carries high social and economic costs. Social pediatrics, a field of medicine and public health, conceives of social, environmental, commercial and cultural determinants as an integral part of pediatrics practice. From this perspective, we propose eight high-priority challenges to reposition the field as a transformative response in the 2030 Agenda.

Child poverty and structural malnutrition

Twenty-eight percent of children and adolescents in Spain live at risk of poverty¹ in the form of material deprivation, low household work intensity and economic insecurity that translate to food insecurity, resource deprivation and limited access to healthy environments. Structural malnutrition—sustained imbalanced nutrition associated with inequality—stems from obesogenic environments characterized by economic barriers, low health literacy levels and overexposure to marketing of unhealthy food products. Social pediatrics proposes screening for social and commercial determinants of health, prescribing community resources and advocating for active environments appropriate for each stage. At the structural level, this requires policies such as taxing ultraprocessed foods and sugary drinks, facilitating access to fresh, locally-sourced foods and reinforcing school cafeterias as an equity strategy.

Mental health and silent suffering

Suicide is the leading cause of unnatural death among the young.² The frequency of mood disorders, sleep distur-

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bances and self-injury increases in the context of digital hyperconnectivity, precarious living and academic pressure. Many hyperadapted adolescents, who hide their pain to meet external expectations, present different forms of silent suffering. In addition, digital phenomena such as “doomscrolling” (the compulsive search for negative news), “FOMO” (fear of missing out) or “digital snacking” impede attention restoration and erode close relationships. A personalized assessment of the psychosocial environment must be performed, in addition to offering alternatives to excessive screen use by providing public spaces appropriate for healthy leisure, play, physical activity and social interaction. All of this must be accompanied by the provision of emotional education and strengthening rapport.

Violence against children and adolescents

In 2023, more than 27 000 cases of suspected violence against children were reported in Spain, many of them of severe abuse. The most frequent forms were neglect and emotional, physical and sexual abuse.³ However, the under-detection of violence continues to pose a challenge in the health care system, despite it being among the adverse experiences with the greatest deleterious impact on health throughout the lifespan. The Organic Law on the Integral Protection of Children and Adolescents Against Violence (known as LOPIVI³) recognizes new forms of violence and establishes the ethical and legal duty to prevent, report and intervene, guaranteeing protection to reporters. In this framework, health care professionals are responsible for safeguarding rights and should be supported by consistent laws and systems that prioritize the best interests of the child. Exploring circumstances associated with risk and identifying invisible forms of violence are key strategies in primary prevention, in addition to collaborative work and promoting a culture of treating children well. Delayed detection compromises protection, precludes early intervention and diminishes the chances of recovery. It is important to reinforce the right of minors to be listened to and guarantee institutional support to allow reporters to meet their legal obligation safely and with professional support.

School setting, learning and participation

The school is a key setting for development and should guarantee safety, respect and a sense of belonging. Its role in fostering kindness and empathy (treating others well),³ promoting learning and the prevention of violence, is essential to ensure the comprehensive wellbeing of children.

Schools face significant challenges in managing diversity² (disability, neurodivergence, migration) and emotional suffering with limited resources. Cultivating an empathic and collaborative relationship with schools is essential to engage them as key allies in the construction and protection of inclusive environments. In this context, schools and social pediatrics specialists share the responsibility to prevent overdiagnosis from being exploited to access resources and support.

Disability, neurodiversity and institutional protection

Neurodivergent and disabled children and adolescents face structural inequities. The increase in the diagnosis of autism spectrum disorder or attention-deficit hyperactivity disorder has brought to light geographical inequalities, a lack of intersectoral coordination and significant burdens on families.¹

Disability³ must be approached as an expression of human diversity, avoiding neuronormativity, medicalization and stigmatization. Practitioners must promote progressive autonomy, family participation and integrated care pathways and prepare pediatric patients for the transition to adult life, when many families experience peak levels of uncertainty.

Impact of migration and uprooting processes

Migrant children can experience multiple losses,² stigmatization, language barriers and housing instability. The emotional impact² of migration can be relevant, independently of geographical origin, reason for migration or socioeconomic status. Guaranteeing care and support with an individualized approach is of the essence.

The most vulnerable families face a triple burden¹: economic precariousness, legal barriers and difficulties accessing health care, all exacerbated by a lack of interpreters and community advocates.

Social pediatrics incorporates migration justice as a principle of equity, integrating cultural assessment, cross-cultural mediation and coordination with community-based support networks.

Environmental health and environmental justice

Climate change amplifies inequalities.⁴ Heat waves, air pollution, floods and exposure to plastics or pesticides increase the risk of asthma exacerbations, preterm labor or neurodevelopmental disorders.

While the entire population is exposed, the consequences are more severe, from an early age, among those living in vulnerable situations,¹ in which environmental risks accumulate. Starting in pregnancy, the potential exposure to toxins needs to be assessed with tools such as the “hoja verde” (green sheet), which includes screening for substance use as a form of prenatal child abuse.

Clinical practice must be sustainable and mindful of the environmental impact of the health care system. Reducing its carbon footprint is part of the field’s commitment to planetary health.

From this perspective, it is important to promote clean and safe urban environments that foster autonomy in children through active travel.

Vaccine coverage and social trust

Although vaccination rates are high in Spain, there are significant gaps in immigrant children or those who move

frequently. In parallel, there has been an increase in selective vaccine refusal, motivated by, among other factors, the spread of misinformation online, pseudoscientific discourses or institutional mistrust.

Social vaccinology⁵ calls for cultural accessibility, community mediation and informed participation. Promoting trust requires understanding the social and cultural determinants that shape decisions about vaccination.

Conclusion

These eight challenges are structural symptoms of a persistent reality that directly impacts child and adolescent health. Social pediatrics provides a rigorous, interdisciplinary and rights-based approach that is key to understanding and addressing this clinical complexity.

Redirecting pediatric practice toward care requires the implementation of an expanded history-taking that includes vulnerability and risk situations as part of primary prevention. Clinicians also need to recognize less visible forms of violence, such as institutional violence, which manifests when systems fail to protect minors or to support those who care for them.

This perspective does not only humanize care, but also improves its efficacy in diagnosis, management and at the community level. To address these challenges, it is

essential to reinforce training in social pediatrics within medical undergraduate and residency curricula, as well as to institute advisory and healthcare structures with specific competencies in relation to violence, structural determinants, and interdisciplinarity, capable of acting collaboratively in response to diseases currently associated with social determinants of health.

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