



Department of
**Health, Social Services
and Public Safety**

An Roinn

**Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí**

www.dhsspsni.gov.uk

The
health
of the **public**
in Northern Ireland



**Report of the
Chief Medical Officer**

2004



The
health
of the public
in Northern Ireland



**Report of the
Chief Medical Officer**

2004



Contents

	Page
Introduction	9
Chapter 1 The Health of the Public – Some Facts and Figures	11
Chapter 2 Lifestyle	19
Chapter 3 Maternal and Child Health	29
Chapter 4 Screening	39
Chapter 5 Cancer	51
Chapter 6 Mental Health	61
Chapter 7 Protecting the Public from Infection	71
Chapter 8 Quality Improvements in Health	79
Appendix 1 Tables	89
Appendix 2 List of Notifiable Diseases	115



List of figures and tables incorporated within the text

Figure

- 1(i) Age and sex distribution of the population, Northern Ireland – 2003
- 1(ii) Life expectancy at birth in Northern Ireland 1997 - 2003
- 1(iii) Percentage of women having babies by age group – 1993 and 2003
- 1(iv) Perinatal, neonatal and infant mortality rates in Northern Ireland
- 1(v) Main causes of death in Northern Ireland – 2003
- 1(vi) Percentage of deaths by age group in Northern Ireland – 2003
- 1(vii) The impact of health related behaviour on HPSS spending
- 2(i) The Balance of Good Health
- 3(i) Live births to mothers aged under 17 and under 20 – 1993 to 2003
- 3(ii) Live birth rate to mothers aged under 17 and under 20 – 1993 to 2003
- 4(i) Uptake rate for breast screening for Northern Ireland and by Health Board 2002/03
- 4(ii) Coverage rate for cervical screening for Northern Ireland and by Health Board 2002/03

Report of the Chief Medical Officer

- 5(i) Numbers and projected numbers of cancer deaths 1993-2025
- 5(ii) Predicted percentage change in cancers in Northern Ireland by 2025
- 6(i) Suicides – total, all males and males 15-34 – Northern Ireland 1991-2003

Table

- 1(i) Number of people by age group – 1993, 2003 and projected for 2013
- 6(i) Factors affecting mental and emotional health
- 6(ii) Estimated spending on Mental Health Services in Northern Ireland 2002/03
- 7(i) Routine childhood immunization programme.



Lists of tables in Appendix 1

- 1A Northern Ireland: Sex and Age Distribution of Population and Percentage of Total Population in each Group 2003
- 1B Northern Ireland: Mid Year Population Estimate 2003 by Board
- 2A, 2B and 2C Population Projections for Northern Ireland – Males, Females and Total
- 3 Births (Live, Still and Total) and Birth Rates in Northern Ireland 1988-2003
- 4A Births (Live, Still and Total) and Birth Rates by Health and Social Services Board in Northern Ireland 2003
- 4B Northern Ireland Births (Live, Still and Total) by District Council of Residence of Mother - 2003
- 5A Fertility Rates 1995-2003 (Women aged 15-49) – Northern Ireland
- 5B Age Specific Fertility Rates 2003 for Women in Northern Ireland by Health and Social Services Board
- 6A Notified Live Births by Weight at Birth in Northern Ireland 1997-2003
- 6B Notified Still Births by Weight at Birth in Northern Ireland 1997-2003
- 7A Perinatal Mortality in Northern Ireland 1988-2003
- 7B Neonatal Mortality in Northern Ireland 1988-2003

Report of the Chief Medical Officer

- 7C Post-neonatal Mortality in Northern Ireland 1988-2003
- 7D Infant Mortality in Northern Ireland 1988-2003
- 8 Childhood Mortality (Age 1-14) for each Health and Social Services Board 1999-2003 (expressed as a Standardised Mortality Ratio)
- 9A Standardised Death Rates (Age 15-74) Northern Ireland – 1994-2003
- 9B European Standardised Death Rates (Age 15-74) Northern Ireland 1994-2003
- 9C Standardised Death Rates (Age 15-74) for each Health and Social Services Board and Northern Ireland 2003
- 9D European Standardised Death Rates (Aged 15-74) for each Health and Social Services Board and Northern Ireland 2003
- 10. Potential Year of Life Lost (PYLL) – Northern Ireland 2003 Males and Females
- 11. Northern Ireland: Expectation of Life at Birth, at one year of age and at 65 years of age for certain periods between 1900-2003
- 12. Notifiable Diseases 1989-2003 for Northern Ireland
- 13A Percentage Uptake Rates for Immunisations (1994-2003) Northern Ireland
- 13B Immunisation Uptake Rates by Health and Social Services Board in Northern Ireland 2003



- 14A Coverage Rates for Cervical Screening in Northern Ireland 2002/03
- 14B Uptake Rates for Breast Screening in Northern Ireland 2002/2003
- 15A Notifications of Congenital Malformations: Number and Rates per 1,000 Total Registered Births to Mothers Resident in Northern Ireland 1991-2003
- 15B Incidence of Down's Syndrome per 1,000 Total Registered Births to mothers resident in Northern Ireland for a 5-Year Period 1999-2003 by Maternal Age

Report of the Chief Medical Officer



The importance of maintaining and improving the health of the public remains a priority. Although health indicators show that men and women are living longer and death rates for heart disease, stroke and certain cancers are falling there are worrying trends in lifestyles factors.

Levels of obesity in children and adults are increasing and people are becoming less active. The establishment of an interdepartmental taskforce to tackle the underlying causes of obesity is welcomed. Smoking continues to be the largest preventable cause of ill health. There is a need to ensure that non smokers, including children, are protected from the harmful effects of environmental tobacco smoke. The introduction of no smoking policies in the Northern Ireland Civil Service is a welcome development.



The state of our mental health impacts significantly on every aspect of our lives. Fortunately the majority of us experience good mental health though, at any one time, a significant number of us will be experiencing a mental health problem. Poor mental health is the leading cause of absence from work. There is much that can be done to improve the mental and emotional health of our population both in the workplace and in the community.

Screening programmes are now in place in Northern Ireland for many conditions. It is important that people respond positively to the offer of screening. Early detection will result in early treatment and an improved outcome for the person.

Report of the Chief Medical Officer

Although the benefits of screening for breast and cervical cancer are well established it is disappointing that just over 70% of eligible women attend these screening programmes. Sadly the majority of women who develop cervical cancer have never had a smear test.

In recent times there has been a growing emphasis on ensuring the quality of healthcare that patients receive. Quality of care is now at the core of a number of initiatives, including the skill mix of the workforce, their training and their ability to work together in effective teams. Managed Clinical Networks are a new concept which facilitates health professionals and organisations to work in partnership to ensure high quality clinically effective services.

This report addresses many of the challenges we face in health and health services in Northern Ireland. The facts and figures will serve as a future reference for the state of health of the people of Northern Ireland. My thanks are due to my friends and colleagues in Medical Branch in the DHSSPS who worked to produce this document.

Dr Henrietta Campbell
Chief Medical Officer

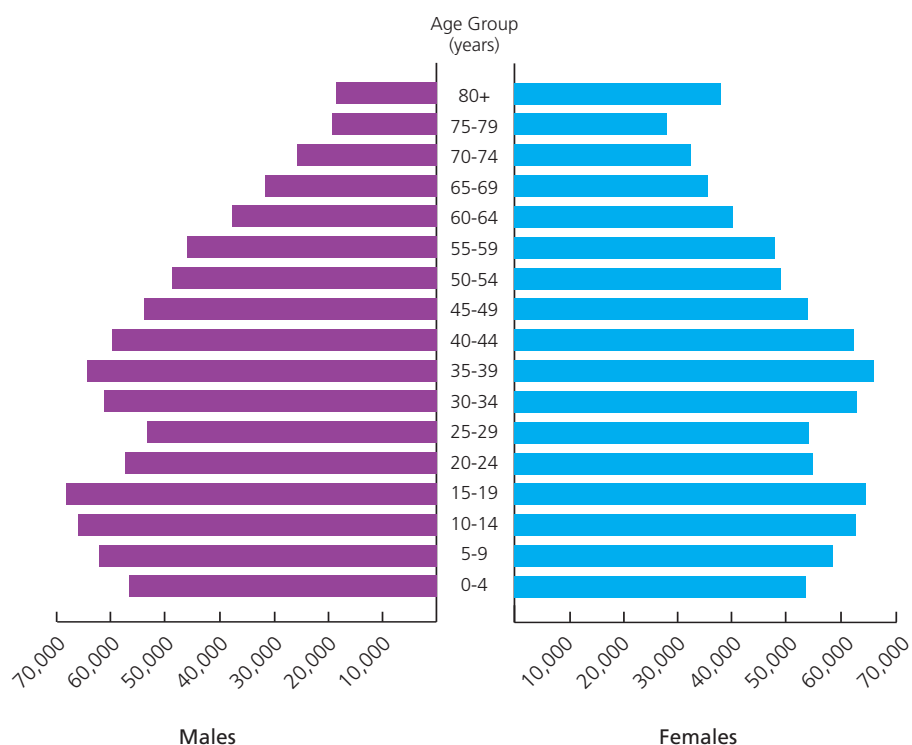
Chapter 1 The Health of the Public - Some Facts and Figures

Our Population

On 30 June 2003 the Northern Ireland population was estimated to be 1,702,600. It is based on the 2001 census and takes account of births, deaths and migrations in the subsequent years. A breakdown of the population by age and sex is presented in Figure 1(i). This shows an increasing number of older people with a relative predominance of females to males.

Figure 1(i)

Age and sex distributions of population - Northern Ireland 2003



Source: NISRA

Northern Ireland continues to have a relatively young population with 21.2% aged under 15 years. However in 10 years this proportion has fallen by 3% (33,000). Table (i) shows how the number of people, by age group, have changed over the last 10 years and the projected changes for the next 10 years.

Table 1(i)

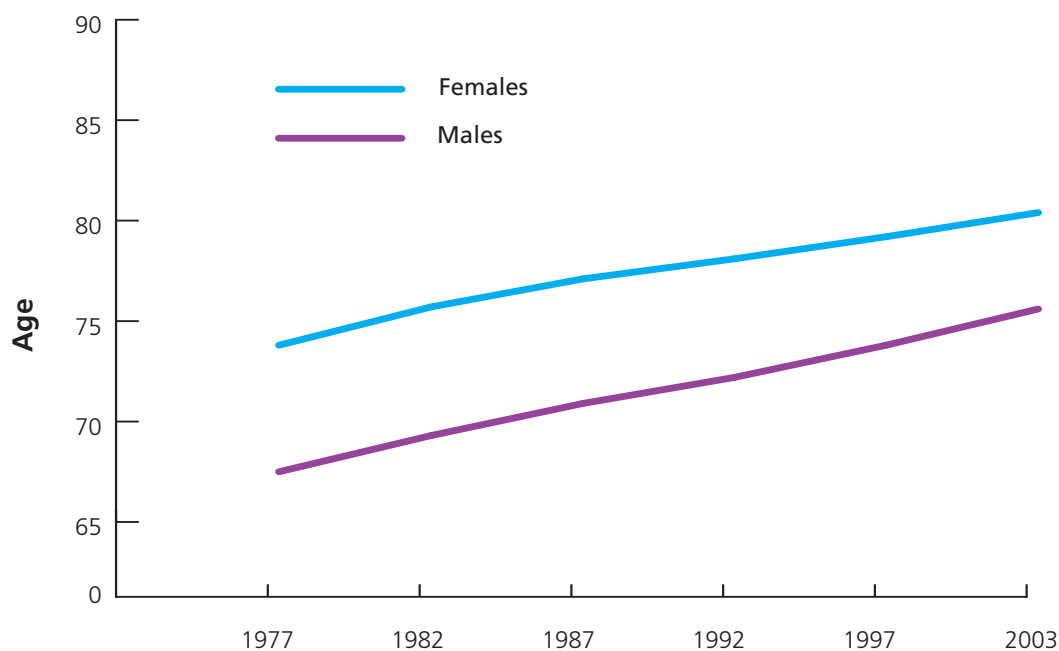
Number of people by age group - 1993, 2003 and projected for 2013

Age Group	1993	2003	2013
0-14	394,500 (24.2%)	361,200 (21.2%)	325,000 (18.4%)
15-64	1,029,200 (63.1%)	1,111,300 (65.3%)	1,162,000 (65.9%)
65+	208,100 (12.8%)	230,100 (13.5%)	277,000 (15.7%)

Life Expectancy

The age to which men and women can expect to live continues to increase steadily. This is the main reason for the increase in the number of older people. At birth Northern Ireland males can expect to live 75.6 years and females 80.4 years (Table 11). This is a considerable increase compared to 25 years ago when men could expect to live to 67.5 years and women to 73.8 years (Figure 1(ii)). Although this is good news for everyone, when compared to other European countries there is still much room for improvement.

Northern Ireland males can expect to live 75.6 years and females 80.4 years

Figure 1(ii)**Life expectancy at birth in Northern Ireland 1977-2003**

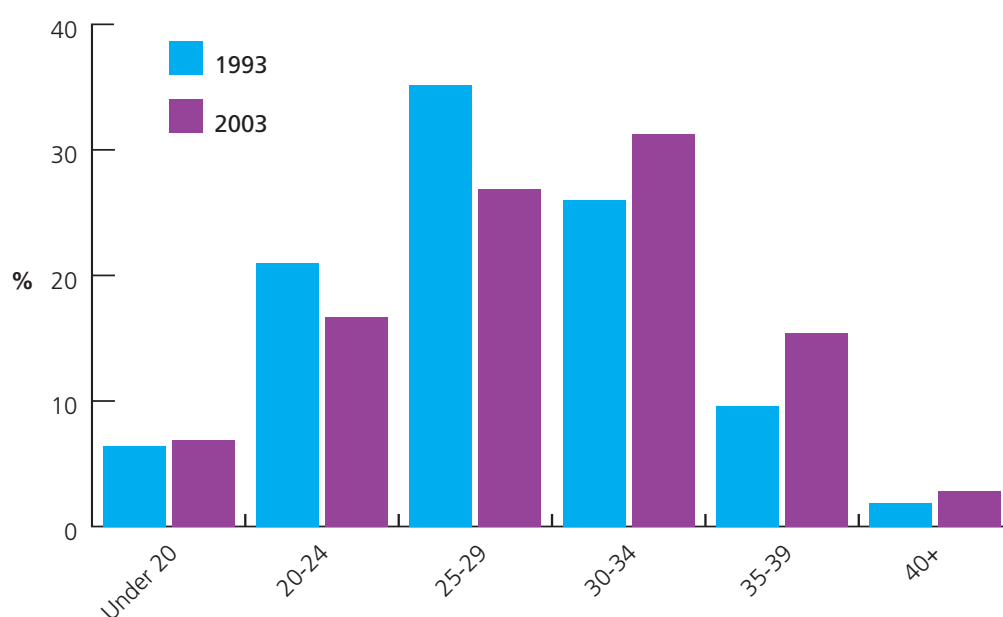
Source: NISRA

Birth Rates

The total number of births in Northern Ireland has been falling steadily for many years (Table 3). Although there were 600 more babies born in 2003 than in 2002, the number of births per year has fallen by 6,000 in the last 15 years. In the same period the crude birth rate (the number of births per 1,000 population), fell from 17.4 in 1988 to 12.8 in 2003. This reduction can be attributed to people choosing to have smaller families and also to females delaying the age at which they have their family. In 1993 the most popular age to have a baby was 25-29 whereas in 2003 the most popular age was 30-34. The proportion of births to women aged between 35 and 39 increased by over 50% in the last 10 years (Figure 1(iii)).

Figure 1(iii)

Percentage of women having babies by age group – 1993 and 2003



Source: NISRA

Deaths in Children

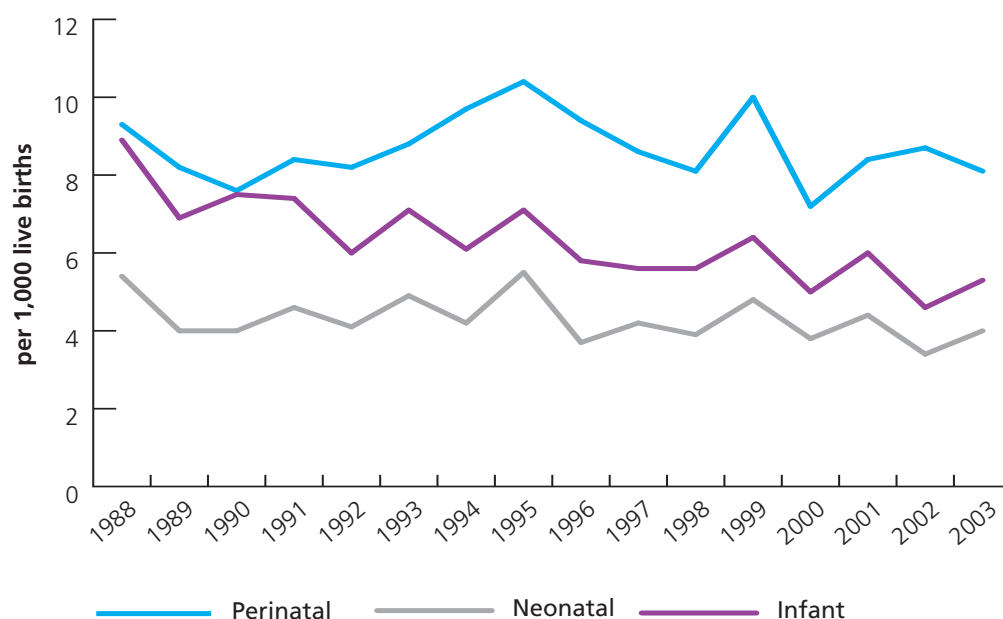
Infant mortality (the number of deaths in the first year of life) has always been recognised as a good indicator of the health of the population. Between 1988 and 2003 the infant mortality rate in Northern Ireland fell from 8.9 per 1,000 live births to 5.3 though the 2003 rate showed a slight increase from the 2002 rate (Table 7D). When infant death rates are low a relatively small fluctuation in the actual number of deaths can alter the death rate considerably, however, it is the longer term trend which is of particular importance.

Deaths occurring in the first year of life are normally subdivided into still births and deaths in the first week (perinatal), first month (neonatal) and first year (infant). The changes in death rates for perinatal, neonatal and infant deaths over the last 15 years are shown in Figure 1(iv). Although there appears to be little change in the perinatal

death rate, it is masked by the fact that in October 1992 all still births from 24 weeks (previously 28 weeks) are included in the perinatal death rate.

Figure 1(iv)

Perinatal, Neonatal and Infant mortality rates in Northern Ireland 1988-2003



Source: NISRA/DHSSPS

Death in Adults

In 2003 there were 14,462 deaths in Northern Ireland, 6,920 occurred in men and 7,542 in women. Cancer has now overtaken coronary heart disease as the main cause of death in both men and women. Respiratory disease and stroke are also important causes of death (Figure 1(v)). Although relatively fewer die from accidents and suicides, they are nonetheless very important causes of death particularly as the majority of them occur at a relatively young age.

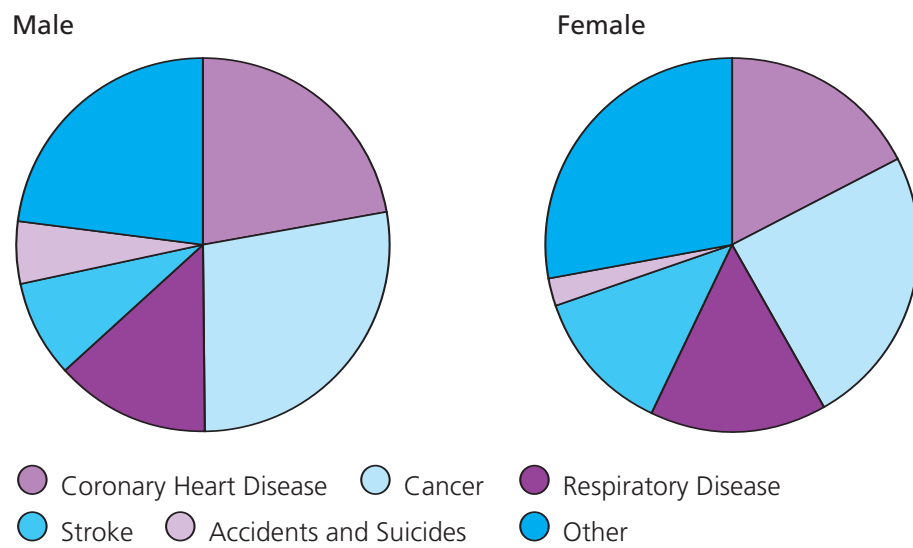
In addition to cause of death, age of death is also of interest. Women generally die at an older age than men. In 2003, 70% of women were 75 years or older when they died, this

Report of the Chief Medical Officer

compares with 52% of men. Between the ages of 15 and 44 there were almost twice as many deaths in men and women. Many of these deaths particularly in men would have been the result of an accident or suicide (Figure 1(vi)).

Figure 1(v)

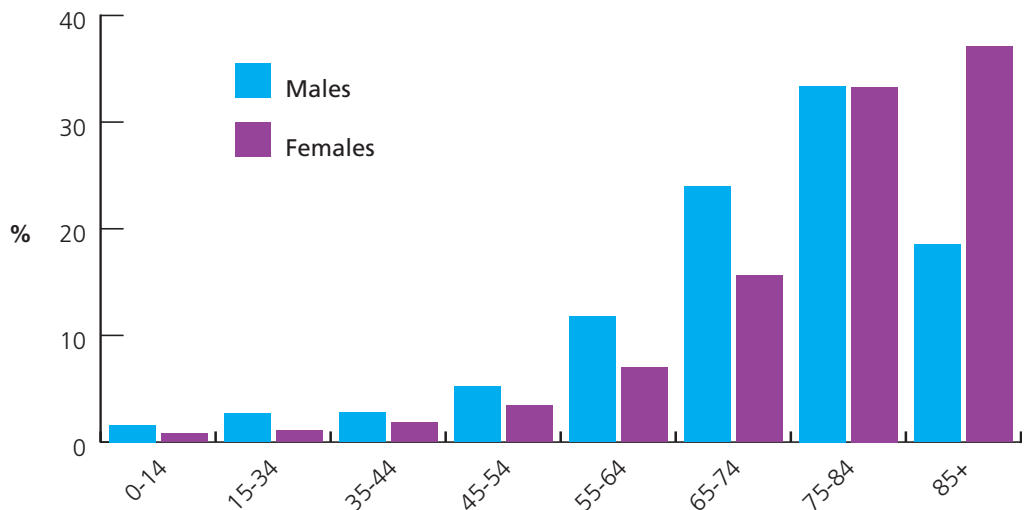
Main causes of death in Northern Ireland - 2003



Source: NISRA

Figure 1(vi)

Percentage of deaths by age group in Northern Ireland - 2003



Source: NISRA



The Impact of Health Related Behaviours

Health related behaviour and lifestyle can have a significant impact on our long-term health status, quality of life and life expectancy. It is important that public health interventions are put in place to reduce poor health as a result of largely preventable causes.

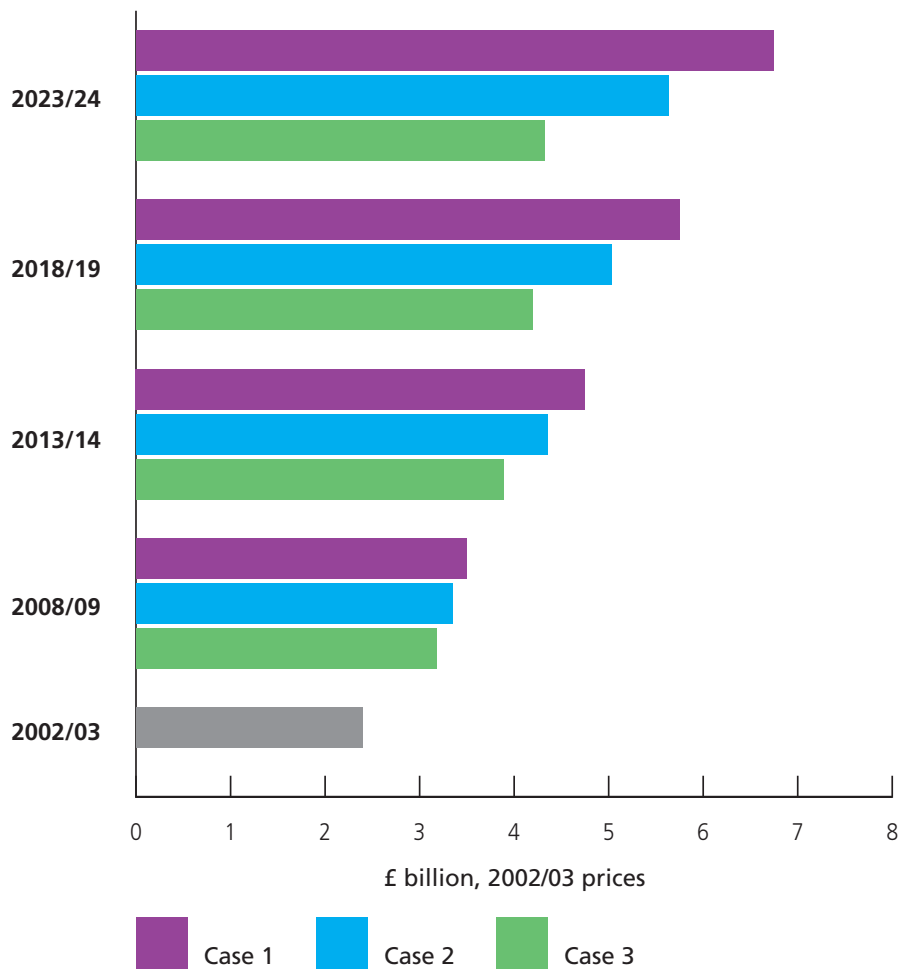
Investing for Health, launched in March 2002, seeks to shift the emphasis from treatment to prevention. It supports individuals, communities, government and social partners to work together in a concerted effort to improve health and reduce health inequalities. It advocates engagement with communities on their local health and well-being needs, the development and nurturing of multi-sectoral Investing for Health Partnerships and increased cross-Departmental working. It has the potential to improve all our health, and in particular that of those groups at greatest risk. The underlying idea is that if we invest relatively small amounts of time, money and effort now, we can make substantial future gains in health and a reduction in health inequalities. Figure 1(vii) demonstrates the impact on health and social services expenditure for three scenarios depending on our ability to tackle the causes of poor health.

A number of major assumptions are built into this analysis and there are other factors which may undermine the projected figures, however it does illustrate two important points:

- Health and social care needs and associated costs are likely to increase significantly over the next 20 years for demographic and other reasons.
- Depending on our ability to engage with the public in managing their health and wellbeing, the impact of these costs could be substantially mitigated.

Figure 1(vii)

The impact of health related behaviours - estimated total HPSS spending (£ billion)



Source: DHSSPS

Case 1: Progress against Investing for Health targets would be achieved but at a slow pace with full achievement of 2010 targets by 2025.

Case 2: Investing for Health targets achieved by 2010 but no further progress in improving public health behaviours.

Case 3: Current Investing for Health targets would be achieved by 2010 and progress would continue steadily over the next 20 years.

A purple-tinted illustration of three people riding bicycles. In the foreground, a man in a light-colored shirt and dark shorts is riding. Behind him, a woman in a dark tank top and shorts is riding. In the background, a child in a striped shirt and shorts is riding. The bicycles are also purple-tinted. The text 'Chapter 2 Lifestyle' is overlaid on the image.

Chapter 2 Lifestyle

Introduction

The lifestyle we choose has a major impact on our health. What we eat, what we drink and if we smoke, all effect our health and well being. The importance of healthy eating has been promoted for many years though people still need clear consistent messages about what constitutes a balanced diet. The harmful patterns of drinking are well recognized in our society. Although binge drinking is a particular problem, the long-term health effects of alcohol consumption, above the recommended levels, are being increasingly recognized. The effects of smoking have been known for years. Now there is increasing awareness of the effect of passive smoking on health and, as a result, many countries are taking measures to ensure that people are protected from its harmful consequences. These lifestyle issues are considered in more detail in this chapter.

Diet

It is well established that good nutrition is essential for good health. A healthy diet protects against a number of diseases, including heart disease, stroke, diabetes, cancer, dental caries and osteoporosis.

A diet high in fat, cholesterol and salt is a major risk factor for heart disease and stroke. The rise in the number of people who are overweight or obese is strongly linked to the increasing number of people being diagnosed with diabetes. Being overweight or obese has also been linked to the

development of cancer, in particular cancer of the oesophagus, bowel, breast and kidney. Obesity is now regarded as the greatest avoidable cause of cancer after tobacco. Diet has been linked to the development of one-third of all cancers: diets high in fruit and vegetables may reduce the risk of various types of cancer, while eating high levels of preserved and/or red meat are associated with increased cancer risk.

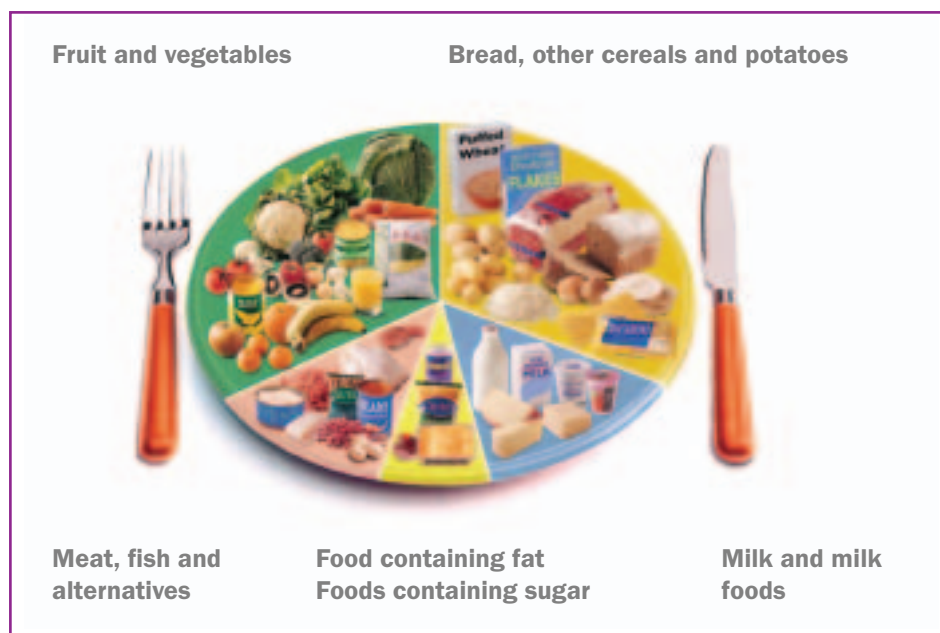
DIET AND ORAL HEALTH

The oral health of Northern Ireland's population is the worst in the UK. One in eight adults have no natural teeth and our children have the highest rates of tooth decay in Europe. Many of the risk factors for oral disease are also implicated in general health problems. A diet high in sugary foods and drinks predisposes to obesity and diabetes, but it is also the main cause of tooth decay.

An Oral Health Strategy for Northern Ireland is being developed. Its aims are to improve the oral health of our population and to reduce the inequalities in oral health within our society.

A Balanced Diet

A healthy diet is a balanced diet. The proportion and types of foods which are needed to make up a healthy balanced diet are illustrated in Figure 2(i). You should aim to eat food in these proportions. Also, the energy derived from food should be in balance with the energy expended through daily activity and exercise.

Figure 2(i)**The Balance of Good Health**

Source: British Nutrition Foundation

Food is divided into five groups: bread, cereals and potatoes; fruit and vegetables; milk and dairy foods; meat, fish and other alternatives; foods containing fat and foods containing sugar. Choosing a variety of foods from the first four groups every day will provide the body with the wide range of nutrients which it needs. Foods in the fifth group - foods containing fat and foods containing sugar - are not essential to a healthy diet but add extra variety, choice and palatability to meals. This group of foods should form the smallest part of the diet.

Eat five or more portions of fruit and vegetables per day as well as nuts and whole grains

REDUCE YOUR SALT INTAKE



There is strong evidence to support the link between salt and high blood pressure. The Scientific Advisory Committee on Nutrition concluded in their report on Salt and Health (April 2003), that a reduction in the average population salt intake would proportionally lower population average blood pressure levels and lead to significant public health benefits by contributing to a decrease in cardiovascular disease. The Food Standards Agency launched a major public health campaign in September 2004 aimed at raising awareness of excessive salt intake as a health issue and secondly, explaining how easy it is to consume too much salt because of its presence in so many foods. Sid the Slug is a sympathetic character who appears in all the TV, national poster and print advertising and on the dedicated campaign website, www.salt.gov.uk

Cut down on the amounts of fatty, salty and sugary foods in your diet.

Obesity

There have been significant changes in our dietary habits and level of physical activity over the last century and particularly in the last 30-40 years. Many people today consume too many foods that are high in calories, sugar and saturated fats and which are excessively salty. In addition levels of physical activity have dropped, thereby reducing the energy required by individuals. This has led to a significant increase in the number of people who are overweight or obese. Two thirds of men in Northern Ireland and half of all of women are overweight, with 17% of men and 20% of women clinically obese. Of particular concern are the worrying trends seen in children. Research by the Queen's University and the University of Ulster, carried out as part of the Young Hearts study, indicates that, among 12 and 15 year olds the percentage of children that are overweight or obese has increased by more than a quarter in the past decade.



Changes in diet have occurred for a number of reasons. The improved preservation techniques and availability of pre-packaged and prepared foods, as well as targeted advertising has led to people making less healthy food choices. People eat out more often and many more people are buying takeaways. Busier lifestyles also mean people have less time available to shop for ingredients and prepare food.

People have become less active due to the shift towards less physically demanding jobs, increased use of cars, technological advances in the home, increased parental concerns about child safety and more passive leisure pursuits such as watching television and computer games.

Two thirds
of men and
half of all
women are
overweight.

“Fit Futures”

The Ministerial Group on Public Health, which is chaired by the Minister for Health, Social Services and Public Safety, has responded to the rising levels of overweight and obesity by establishing an interdepartmental taskforce to examine options for preventing the development of overweight and obesity in children and young people. The taskforce initiative, which is known as *‘Fit Futures: focus on food, activity and young people’*, is concentrating on finding ways to tackle the underlying causes of obesity, namely inappropriate eating patterns, food intake and insufficient physical activity. The Fit Futures taskforce is expected to make recommendations on priorities for action to the Ministerial Group before summer 2005.

Changing behaviours such as dietary habits is very complex. Individuals need to be aware of what constitutes a healthy diet and the risks and benefits of eating certain foods to enable them to make healthier choices. However they also need the skills to enable them to put healthier choices into practice. For example, they need to understand food labels to ensure they are buying healthy produce and to develop practical cooking skills thus ensuring that they can cook a

healthy meal, using a variety of ingredients and in the time they have available. The availability, accessibility and cost of food will influence choices, as will advertising and marketing, particularly in relation to children.

Views on Healthy Eating from Young People aged 12-18

“Healthy food is too expensive and unhealthy food is very accessible. The sweets and chocolate are at the front of the shop and the fruit is at the back of the shop”.

“Parents work very long hours with no time to cook, so I usually put something in the microwave”.

“Teach young people in schools to cook ordinary homemade food. Have separate cookery classes, not home economics”.

Nutritional standards for schools

The Health Promotion Agency has been working with the Department of Education, the Education and Library Boards and the Health and Social Services Boards and Trusts to develop and implement a pilot of the proposed compulsory nutritional standards for school meals.

The nutritional standards are outlined in the document, *Catering for Healthier Lifestyles*, published by the Department of Education. Over 100 schools across Northern Ireland, representing primary, post-primary and special sectors, have agreed to participate in the pilot, which began in March 2004 and will last for three school terms.

In preparation for the pilot, Kitchen Unit Supervisors from all participating schools, received nutrition training and practical training on issues such as menu planning and healthier catering.

Smoking

Smoking is a serious public health problem. It is a major preventable cause of premature death and ill health. Thirty percent of all cancers and over 80% of lung cancers are due to smoking. It is also a significant risk factor for coronary heart disease and stroke. A lifetime non-smoker is 60% less likely than a current smoker to have coronary heart disease and 30% less likely to suffer a stroke.

A Five-Year Tobacco Action Plan 2003-2008

In 2003 the Department of Health, Social Services and Public Safety published its 5-year tobacco action plan. Its overall aim is to create a tobacco-free society. The key objectives are:

- to prevent people from starting to smoke;
- help smokers to quit; and
- protecting non-smokers from tobacco smoke.



Passive Smoking

Passive smoking, also known as environmental tobacco smoke and sometimes referred to as second-hand smoke, is a mixture of side stream smoke from the burning tip of a cigarette and the smoke exhaled by a smoker. In the UK an estimated 1.3 million workers are exposed to passive smoking for at least 75% of their working time. Passive smoking causes an estimated 1,000 deaths in the UK each year.

There is now strong evidence that non smokers, breathing in the smoke in the atmosphere, are exposed to many of the same health risks as the smoker. They are at increased risk of developing lung cancer, heart disease, stroke and asthma. Passive smoking can also aggravate existing asthma and bronchitis. Children are at even greater risk because of their smaller lungs and the fact that their bodies are still developing. For them passive smoking increases the risk of asthma, bronchitis and middle ear disease. Lung growth and development are also affected. The risk of cot death in babies is doubled. Passive smoking during pregnancy increases the risk of having a baby with a low birth weight. Small babies are at much greater risk of infections and other health problems. It is therefore important that the general public, particularly children, are protected from tobacco smoke.



Passive smoking causes an estimated 1,000 deaths in the UK each year.

Apart from the health effects of passive smoking many people find tobacco smoke unpleasant. It irritates the eyes, nose, throat and chest and many people do not like its smell. Some individuals can find it very uncomfortable and difficult to work in such an environment.

Smoke-free Workplaces

The introduction of no smoking policies in the workplace is a welcome development and makes an important contribution to improving the health of the public. In January 2005 the Northern Ireland Civil Service became smoke free. Workplace policies aim primarily to minimize risks to non-smokers from passive smoking. Such policies can also reduce the level of active smoking and thus contribute to an overall reduction in smoking prevalence.

People employed in the hospitality industry are at particular risk of the effects of passive smoke. For the UK, it is estimated that every week one hospitality worker dies from the health

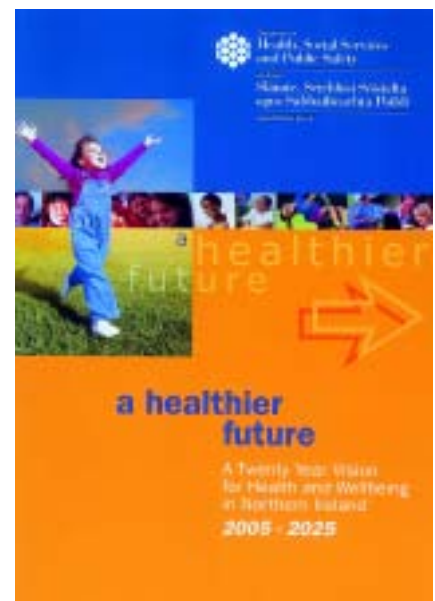
effects of passive smoking. On average, bar and restaurant staff are exposed to three times more smoke than a non smoker married to a smoker.

If all workplaces in Britain, which currently permit smoking, became smoke free it is estimated that each smoker would, on average, smoke three fewer cigarettes per day. In addition more than 300,000 people would quit smoking and in the longer term more than 150,000 lives would be saved. The effects of passive smoking would also be removed.

Tobacco Control – UK and International Developments

In March 2004, the Republic of Ireland introduced a ban on smoking in enclosed workplaces and public places. The Office of Tobacco Control in Ireland has reported that implementation has been relatively straightforward with very high levels of compliance. The United States has workplace bans in place in the States of California and New York. In continental Europe, Norway, and more recently Italy, have gone completely smoke free in public places.

Within the UK, Scotland plans to legislate for smoke free provision by 2006. England are proposing to prohibit smoking in most enclosed public places and workplaces, while still allowing smoking in some pubs and bars, other than those preparing and serving food. In Northern Ireland, DHSSPS began consultation on this vital public health issue in December 2004 with the publication of its Regional Strategy 'A Healthier Future – A Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005-2025'.



Alcohol

Alcohol related harm is a problem, which impacts on most of society either directly or indirectly. It can cause a range of health problems for the individual but can, and often will, affect family and friends and other people who come into contact with them, either at work or in a social context.

Whilst the most obvious consequences of excessive alcohol consumption are seen on our streets with groups of young adults binge drinking, often leading to violent confrontation, the effects on our health overall are potentially more serious and insidious.

In the UK alcohol consumption has increased by 50% since the 1970's.

It is often not appreciated that alcohol consumption is second only to tobacco as the main cause of preventable premature death in the UK. As alcohol becomes generally more affordable, consumption levels are rising with approximately one in three men and one in five women now exceeding the safe drinking limits. As a result, cirrhosis of the liver has increased by up to ten fold in the last thirty years.

The effects of excessive alcohol consumption are a major burden on health services, with up to 70% of night-time attendances at accident and emergency departments being alcohol related.

The impact of alcohol-related diseases is also evident in patterns seen among people admitted to hospital. As one Belfast physician commented recently;

'Compared to 10 or 20 years ago, there is little doubt that we are seeing many more patients with alcohol related problems admitted as medical emergencies. The trend suggests that people are presenting to us at a younger age, sometimes as young as 30-40 years of age, and that we are treating more women with serious alcohol related health problems. Some patients have no idea of the toll alcohol has taken on their body'.



Chapter 3 Maternal and Child Health

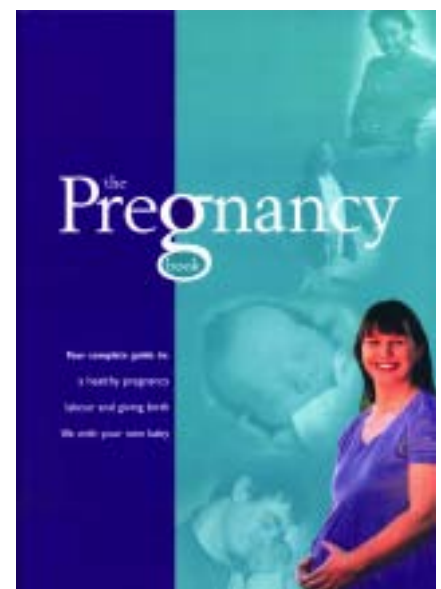
Introduction

The health of mothers and children is fundamental to the future of society. When women become pregnant it is important that they receive advice and guidance to ensure that they, and their baby, enjoy the best possible health.

Many organisations, such as those discussed in this chapter, and health professionals in Northern Ireland and in the UK work to improve mothers' health and give children the best start in life and to improve the care they receive should they become ill.

Antenatal Care

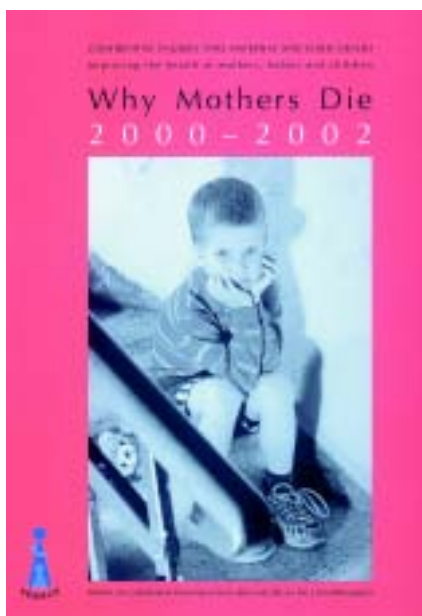
Preparing well for pregnancy is an important part of ensuring the good health of mothers and their babies. Prospective parents receive advice from many sources on topics such as diet, exercise, alcohol intake and reducing exposure to tobacco smoke. All of these are known to have an effect on mothers and their baby's health. A valuable source of information is the Pregnancy Book which mothers receive at an early stage of their first pregnancy. It is published by the Health Promotion Agency for Northern Ireland and based on the version published from the Department of Health in England. The book provides information to help mothers make decisions about pregnancy, to help them cope and also how to best enjoy both pregnancy and their baby.



The evidence behind many of these messages is highlighted by the National Institute of Clinical Excellence (NICE) guidance on good practice in antenatal care of women. The guidance covers the information that should be given to mothers and how their care should be organised and delivered throughout their pregnancy. The DHSSPS endorses this guidance and it is currently being implemented throughout our hospitals.

Caesarean Sections

The majority of women have normal uncomplicated deliveries, however an increasing number of women are having caesarean sections. Northern Ireland has one of the highest rates of caesarean section in the world. In 2000 the rate was 23.7% in Northern Ireland, compared to 19.3% in the USA in 1999 and 12.2% in Norway. The rate is continuing to rise locally and in 2002 it was 25.8%. During 2004, NICE produced guidance on best practice advice on the care of pregnant women who are making decisions about the birth of their baby and on care during and following caesarean section. This guidance is currently being considered locally.



Why Mothers Die

Tragically, very occasionally mothers die, during pregnancy or around the time of birth. It is important to ensure that any potentially preventable cause of such deaths is identified. To assist in identifying preventable causes, information is collected on all women who die in the UK during pregnancy or within one year of the birth. This anonymised information is reviewed by experts to see what lessons can be learned. This work is co-ordinated by the Confidential Enquiry into Maternal and Child Health office in London. The enquiry seeks to identify areas for improvement and make recommendations on good practice. It disseminates important messages to health



professionals so that all pregnant and recently delivered women receive the best possible care delivered in appropriate settings and taking account of their individual needs.

Every three years a UK maternal deaths report is produced and widely distributed to hospitals and to health care professionals. The 50th anniversary report "Why Mothers Die" was published in November 2004. It covers the three years 2000 -2002. The report highlights that pregnancy is now much safer for most women in the UK but risks are raised for certain women who, for whatever reason, find it difficult to attend for antenatal care and for those with lifestyle factors such as obesity.

'WHY MOTHERS DIE 2000-2002' – KEY FINDINGS

- Pregnancy is safer than ever. Deaths caused directly by pregnancy have reduced by over 90% since the 1950s.
- Very vulnerable and socially excluded women, including asylum seekers and women who cannot speak English, are at greater risk of suffering maternal death.
- The leading reason why women die is now suicide in the early post natal period.
- It is important not only for women to seek advice early in their pregnancy but that they are then provided with a flexible antenatal service that meets their needs and enables them to continue to attend throughout their pregnancy.

During the period 2000 - 2002 only 1 in 19,000 pregnancies resulted in the death of the mother, this compares with 1 in 1500 pregnancies in 1952 - 1954. This is an indication of how far clinical care has advanced in the last 50 years.

Implementation of the recommendations from the maternal deaths reports have contributed significantly to this reduction in maternal deaths.

However there is a need to continue to make improvements and to ensure that the recommendations in the report are acted upon.

Health of Children

Happily the vast majority of children born in Northern Ireland are bouncing healthy boys or girls. For those who do have some health problems there are opportunities to detect these early through newborn screening programmes (see chapter 4) and through ongoing health surveillance. However in the fourth edition of "Health for All Children" there is a greater emphasis on health promotion, primary prevention and active intervention for children at risk, whether for medical or social reasons rather than the medical model of screening.

The aim of the current programme is to work with families and communities to achieve optimum child health. Staff should get to know the family soon after the baby is born and identify those families and communities which need support and target them as appropriate. There should also be good links and close working with community development programmes and other initiatives aimed at reducing inequalities and social exclusion, eliminating poverty and improving educational outcomes.

Breastfeeding

Breastfeeding is the best form of nutrition for infants. It has proven health benefits for both mother and child. Babies who are breastfed have a lower risk of gastroenteritis and respiratory and ear infections. In mothers, the risk of pre-menopausal breast cancer is reduced the longer they breastfeed.

In 2002 the World Health Organisation issued new guidance recommending mothers exclusively breastfed their babies for

six months. The Department of Health, London, issued this recommendation to the public and professionals stating "Breastfeeding is the best form of nutrition for infants. Exclusive breastfeeding is recommended for the first six months (26 weeks) of an infant's life as it provides all the nutrients a baby needs." The Department of Health and Social Services and Public Safety has endorsed this guidance and issued a copy of it to relevant staff in 2004.

RECOMMENDATIONS ON INFANT FEEDING

- Breastmilk is the best form of nutrition for infants, it provides all the nutrients a baby needs;
- Exclusive breastfeeding is recommended for the first six months of an infant's life;
- Six months is the recommended age for the introduction of solid foods for both breast and formula fed infants;
- Breastfeeding (and/or breastmilk substitutes, if used) should continue beyond the first six months along with appropriate types and amounts of solid foods; and
- Mothers who are unable to, or choose not to, follow these recommendations should be supported to optimise their infant's nutrition.



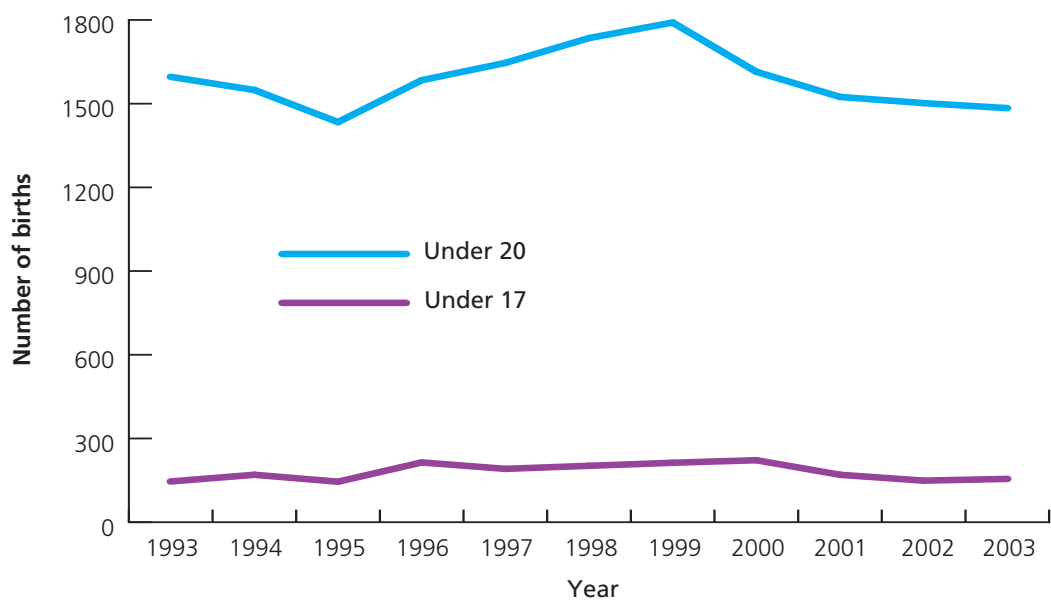
Teenage Parenthood

Northern Ireland has a history of one of the highest teenage pregnancy rates in Europe. In the late 1990s about 1,700 babies were born each year to women under 20. However recent years have seen a reduction in the numbers of births to teenage mothers as shown in Figures 3(i) and 3(ii). This change has occurred as a result of the work in developing a strategy and action plan on teenage pregnancy parenthood, which was published in 2002. This brought together the many Departments, Agencies and voluntary

bodies that work with young people and develop a multifaceted approach. Health seminars, information sources, education and community support all play a major role.

Figure 3(i)

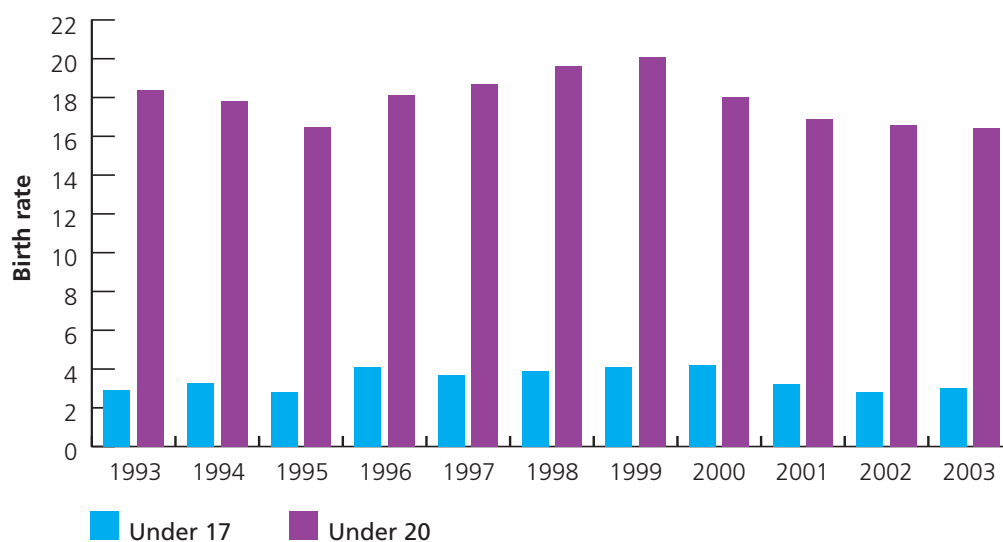
Live births to mothers aged under 17 and under 20 – 1993 to 2003



Source: NISRA/DHSSPS

Figure 3(ii)

**Live birth rate to mothers aged under 17 and under 20
– 1993 to 2003**



Source: NISRA/DHSSPS

Footnote: Figures refer to live births to Northern Ireland residents which were registered in each of the relevant years. Population refers to female population aged 13-19, derived from the mid-year population estimates each year. Rate per 1,000 population refers to the rate per 1,000 female population aged 13-19 years.

Teenage pregnancy and early motherhood can have negative consequences for both mother and baby and are often associated with poor educational achievement for the mother, poor physical and mental health, social isolation and poverty. The teenagers most at risk of becoming parents are those already disadvantaged with a history of poverty, low educational achievement, sexual abuse, mental problems or offending behaviour. Children in care are also at an increased risk, as are those who have low self-esteem. Within Northern Ireland there is regional variation in the rates of teenage pregnancy. Areas which experience higher rates of teenage pregnancy also demonstrate higher levels of deprivation.

Reducing Teenage Pregnancy

The challenge of reducing the number and the consequences of teenage pregnancies has several layers of complexity. For young teenagers, the challenge is to equip them with the knowledge and skills that will help them build self-esteem and strong relationships, while postponing sexual activity. For older teenagers, who are already sexually active, the challenge is to motivate them to practice safer sex and to ensure that sexual health services and advice centres are accessible, tailored to their needs, and welcoming. The major challenge, however, is to provide young people with opportunities for the future so that they avoid risk-taking behaviour today in the hope of a better tomorrow.

The success of the past few years in implementing the strategy is the result of a huge amount of commitment from those working in the area of teenage pregnancy and parenthood, both in the statutory and voluntary sector. Some of the specific initiatives that have contributed to the reduction in teenage pregnancy rates include:

- *Tailored Services*
Health and Social Services Boards have been developing local services tailored to the needs of all young people. They are looking critically at the sexual health services for young people and have sought their views. New sexual health services include pilot projects in a youth friendly environment, designed to be more accommodating to the needs of young people. Health and Social Services Boards have also explored ways of making local directories of services available to young people, for example through websites, information available at family planning services, and advertising in school magazines.
- *Community Based Programmes*
Community based teenage personal development programmes have been established. Many focus on



developing self esteem, confidence and services aimed at teenagers include innovative health promotion events in primary care practices and Sure Start initiatives.

Effective communication between young people and their parents and peers play an important role in both improving self-esteem and promoting the opportunity to discuss issues of sexuality. One programme on communication is *Speakeasy*, run by the Family Planning Association Northern Ireland. This programme is designed for parents of teenagers to help facilitate better communication, particularly on risk taking behaviours. It provides a good example of the potential benefits of improved communication skills between parents and young people.

- *Relationships and Sexuality Education (RSE)*
RSE guidelines have been developed by the Department of Education and these have now been introduced in all schools. Health and Social Services Boards have worked with Education and Library Boards to support the training of teachers in the delivery of RSE programmes in schools.
- *Confidentiality*
Young peoples' concerns about confidentiality can result in their reluctance to seek information and advice and to use contraceptive services. They may fear that if they consult a doctor or nurse their parents will be informed. The Implementation Group has developed a leaflet on confidentiality for use by health professionals. This will be published in Spring 2005 and will be followed by a leaflet on confidentiality for use by school staff and a leaflet specifically for young people outlining their rights to confidentiality.

Supporting Parenting Teenagers

For those teenagers who have children, it is vital that they are supported in their parenting role and in pursuing their education. A number of initiatives have been introduced to provide this support, for example:

- The Department of Education funds the School Age Mother's Support Service. Its aim is to facilitate and encourage school aged mothers to remain in formal education. Funding is now available for childcare for those parenting mothers who wish to remain in education.
- The Department of Education and Learning provides support for young single parents through New Deal for Lone Parents. One initiative is facilitating flexible training and employment opportunities for young parents.

The collaborative efforts outlined above will continue with the goal of providing young people with sound information and access to appropriate services, to ensure that they are equipped to make responsible decisions and choices in their lives.