IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

IMO Position Paper on
Child Health

October 2012

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Ceardchumann Dochtúirí na hÉireann

Mission Statement

The role of the IMO is to **represent** doctors

in Ireland and to **provide** them with all relevant services.

It is committed to the **development** of a caring,

efficient and effective Health Service.

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IMO Position Paper on Child Health

The health of our children is vital to the social and economic growth of our country. There are many reasons for investing in the health of our children from antenatal health through to teenage years.

Many lifelong illnesses and disabilities originate in early childhood, and sometimes as early as prenatally[1]. Ensuring that children have the healthiest start in life provides the basis for good health in adulthood. Investment in early childhood health and development also increases the likelihood that children will attend school, earn higher income as adults, and be less dependent on welfare support. Giving children the opportunity to realise their maximum potential is key to addressing inequalities in health and ensuring a healthier more productive workforce.

Obesity is one of the most serious public health challenges affecting children of all ages with major implications for health and health services into the future. An urgent multidisciplinary programme is needed to tackle childhood obesity.

As young people reach adolescence they are exposed to new risks and choices affecting their health including, tobacco, alcohol consumption and illicit drug use as well as unsafe sexual behaviour. It is important that strategies to reduce harmful lifestyle choices are implemented and that young people are not deterred from seeking appropriate advice from their physicians.

Suicide and self harm is a major issue among young people today and a range of population measures and targeted interventions are required to improve mental health and help-seeking among adolescents.

With approximately one quarter of the population under 18, Ireland has the youngest population in the EU.[2] Ireland also has the highest fertility rate in the 27 EU states, and the number of births per year has increased by 37.1% since 1998. 2008 saw the second highest number of births for any year since 1892. Despite many advances and improvements in the health and well being in children, particularly in relation to immunisation, Ireland is at the wrong end of many health indicators relating to children. Here are some indicators from current known information[3]:

- Breast feeding rates remain one of the worst in the EU;
- The average age for detection of severe hearing loss is over 3 years of age, way above acceptable international standards;
- More than half of the total hospital discharges among children were children under 5 years of age;
- Almost one-quarter of 7 year old children are either overweight or obese;
- One in every 8 primary school children and one in every 6 post-primary school children miss 20 days or more in the school year;
- Nearly 10% of children aged 9-17 reported smoking cigarettes every day;
- Over 20% of children aged 10-17 reported that they had been drunk at least once in the last 30 days;
- There were 21 suicides of children aged 10-17 in 2009.

1 Center on the Developing Child,– The Foundations of Lifelong health are Built in Early Childhood, Harvard University July 2010

2 Office of the Minister for Children and Youth Affairs, State of the Nation's Children 2010 The Stationery Office, Dublin 2010

3 Ibid

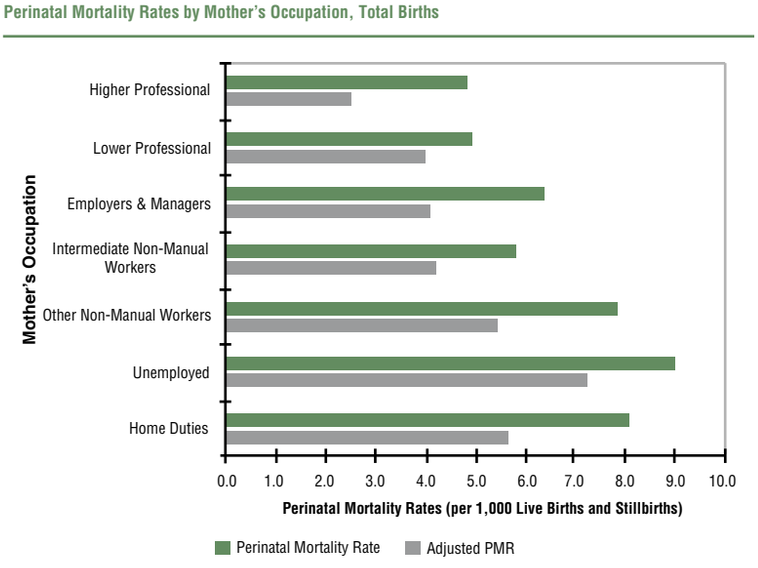
With the appointment of the Minister for Children and Youth Affairs and the establishment of a separate Department the Government is showing its commitment to delivering policy and legislation to improve the lives and rights of children. The Irish Medical Organisation (IMO) are calling for renewed focus on child health promotion and services and have a number of recommendations to make under the following headings:

1. EARLY CHILDHOOD DEVELOPMENT

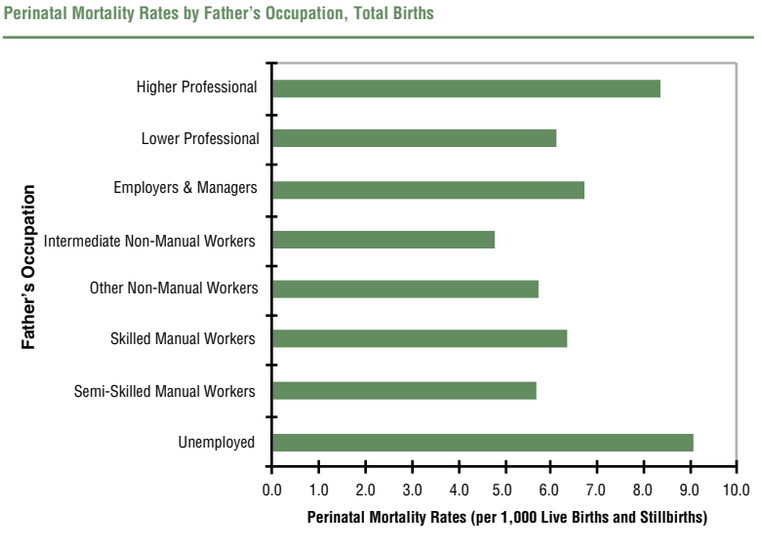
a) Antenatal Health

Perinatal statistics provide robust, comparable data allowing us to analyse the quality of our antenatal and perinatal care. Some of the key findings from the Perinatal Statistics Report 2010[4] are:

- The perinatal mortality rate (PNMR) has fallen from 8.6 per 1,000 births and stillbirths in 2001 to 6.5 per 1,000 singleton births in 2010. In comparison with other European countries, France had the highest PNMR at 12.1 per 1,000 live births and stillbirths and Finland had the lowest at 3.2 per 1,000 live births and stillbirths. There was a difference in the PNMR between socioeconomic groups; the PNMR was higher for those mothers and fathers classified as unemployed compared to those in higher socioeconomic groups. The PNMR was highest for mothers aged 40 to 44 years (at 11.4 per 1,000 live births and stillbirths).
- There was an upward trend in delivery by Caesarian section, being 27% of total live births in 2010 and 22% in 2002.
- The average age of mothers increased from 30.3 year in 2001 to 31.5 years in 2010.
- 46% of mothers exclusively breastfed at discharge from hospital in 2010, compared to 31% in 2001. Artificial feeding was most common amongst the unemployed group with a rate of 62.3%, whilst the lowest rate was amongst higher professionals at 27.9%.
- There were 177 domiciliary births in 2010 representing 0.2% of all births.



4 ESRI, Perinatal Statistics Report 2010, Health Research and Information Division, 2012



Source: ESRI, Perinatal Statistics Report 2010, Health Research and Information Division, 2012

Antenatal care in Ireland is well managed in large part through the shared care of obstetricians and GPs, via the Mother and Infant Scheme. In total 80% of maternities are managed by combined hospital and GP care[5]. Examples of where the current system succeeds include:

- The screening for infections in pregnancy that can cause congenital and neonatal infection (e.g. HIV, Rubella, Streptococcus Group B).
- The screening of clinical problems, which affect the foetus and mother (gestational diabetes, pre-eclampsia, placenta praevia).
- Assessment of foetal growth.
- The management of common symptoms of pregnancy.

However many lifestyle considerations in antenatal care are less well managed. Promotion of healthy lifestyles in pregnancy, through public health mechanisms, has not had success, often reflecting the assumption that these lifestyle factors may not directly affect foetal and child health.

Pre-conceptual health

Child health promotion does not only comprise the antenatal period to teenage years, but overlaps considerably with the public health policy of the entire Irish health service. For example, childhood immunization of rubella is reflected a generation later when the rubella status of pregnant women is assessed at the booking visit; of total maternities in 2010, over 92% were rubella immune. Similarly, promotion of breastfeeding cannot just begin during the antenatal period, but must begin preconceptually and be targeted at society as a whole. Also, by reducing socioeconomic and health inequalities, the poor outcomes in lower socioeconomic groups (in terms of prenatal statistics) can be improved.

It is easy to envisage that the promotion of healthy antenatal lifestyles will affect child health positively, and accordingly improve adult health. However it is also long established that the pre-conceptual health status of the mother will directly influence the health of her children. Initially, Barker and colleagues showed that birth weight was

5 ESRI, Perinatal Statistics Report 2010, Health Research and Information Division, 2012

inversely associated with increased early death secondary to coronary heart disease[6] . It is increasingly recognised that adult-onset conditions, such as coronary disease, Type 2 diabetes mellitus, stroke and hypertension, may all have a component of their aetiology associated with abnormal birth weight[7]. In essence health passes through generations.

Antenatal health promotion

Many maternal lifestyle factors affect foetal development and child health directly. Each antenatal visit, especially the initial visit with the GP, is of paramount importance in educating women on healthy lifestyle behaviours. However if the woman is already pregnant, some of this advice comes too late. Moreover, Ireland is not succeeding when it comes to addressing some unhealthy lifestyle factors.

Smoking

Smoking in pregnancy is associated with a doubling of miscarriage, pre-term delivery, low birth rate, and increased perinatal mortality. Once the baby is delivered, smoking is associated with an increased risk of cot death and an increased risk of respiratory tract infections. Figures from Growing Up in Ireland[8], studying 11,000 children and their families, have shown that 18% of mothers smoke during pregnancy.

Alcohol

Fetal Alcohol Syndrome is rare and the effect of moderate alcohol consumption in pregnancy has been debated. Nevertheless, Growing up in Ireland[9] showed that 20% of women have taken alcohol at some stage in their pregnancy.

Obesity, Diet and Exercise

Obesity in pregnancy has been associated with an increase in congential anomalies (such as neural tube defects and spina bifida), intra-uterine growth retardation and also large babies. Almost half of pregnant women in Ireland are overweight (43%), with 31% of these women obese and 2% morbidly obese[10].

Folic Acid Intake

Folate supplementation: We know that folic acid supplementation is recommended to prevent neural tube defects, reducing its risk by 72%. A recent study showed that periconceptual intake of folic acid did not rise above 24% between 1996 and 2002.

Illicit Drugs

In one Dublin hospital up to 1.1% of expectant mothers had taken an illicit drug during their pregnancy.

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6 Barker DJ, Winter PD, Osmond C, Margetts B, Simmonds SJ. Weight in infancy and death from ischaemic heart disease. Lancet. 1989 Sep 9;2(8663):577-80. http://www.ncbi.nlm.nih.gov/pubmed/2570282

7 The Barker Hypothesis: Dover G.J. How Pediatricans Will Diagnose and Prevent Common Adult-Onset Diseases Trans Am Clin Climatol Assoc. 2009; 120: 199–207. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2744561/

8 ESRI, TCD, Growing Up in Ireland- National Longitudinal Study of Children, Key Findings: Infant Cohort (at 9 months) No. 1 Pregnancy and Birth, 2012 Department of Children and Youth Affairs

9 Ibid

10 UCD News, High Percentage of Pregnant Women Overweight and Obese, Research Finds 7 July 2010 http://www.ucd.ie/news/2010/07JUL10/300710_high_precentage_of_pregnant_women_overweight_and_obese_research.html

IMO Recommendations

Novel mechanisms at addressing these lifestyle factors must be found to prevent maternal and child ill health, and their subsequent economic costs. Education by GPs, obstetricians and nurses at each antenatal visit, though important, is not enough. A comprehensive public health programme, educating all young women, not just expectant mothers that unhealthy lifestyle measures will harm to their future child must be a priority.

- Moderate exercise is healthy in pregnancy and needs to be actively promoted and a normal healthy diet encouraged (avoiding paté, unpasturised dairy products, raw meat and eggs, liver products, some types of fish, caffeine and alcohol);
- Urgent legislation is required for the fortification of certain foods with folic acid;
- Introduce mandatory health warning labelling of alcohol products in respect of pregnancy and Foetal Alcohol Syndrome and Foetal Alcohol Spectrum Disorder.
- Ensure adequate funding of hospital and community obstetric care.

b) Child Health Surveillance

We know from advances in neuroscience that early development of children is much more 'plastic' than once thought and there is a considerable ability for trajectories for children to be shifted into a more positive direction even given very poor starting circumstances. Ensuring optimal health and well being in the early years has benefits which accrue throughout the life cycle and are as important as early education in securing a level playing field for children in terms of opportunities to achieve their potential. In Ireland, there is a need to ensure that Child Health services delivered into the future are of the highest quality. It is vital to ensure that a system is in place that guarantees all children the best possible start in life, and ensures that they all receive appropriate early intervention so as to mitigate the impact of a delay or abnormality as early as possible. If this doesn't happen, the costs to the HSE and society are considerable.

Child Health Surveillance is a programme of care initiated and provided by professionals, with the aim of preventing illness and promoting good health and development. Child Health Surveillance (CHS) is that part of a more general programme of child health promotion that relates to secondary prevention by early detection. CHS is the systematic and ongoing collection, analysis, and interpretation of indices of child health growth, and development in order to identify, investigate and, where appropriate, correct deviations from predetermined norms. In terms of professional input, these services are the main route by which parents receive information, and are one of the few services which connect with all families in the state. There has been a lack of clarity in relation to who is responsible for child health in an operational sense, and though there have been excellent reports and guides produced on standards and training programmes implemented, there has sometimes been a disconnect with these, and the development of a national approach to implementing them[11].

Primary and Community Care services play a crucial role in child health development. Primary Care has received limited funding through the Mother and Infant Scheme to provide some early infant screening and surveillance but without national standards applied to this work, or information as to the outcomes of it. Funding cuts and the moratorium on recruitment are seriously hampering Community Child Health services in some parts of the country. Galway Child Health Services have been particularly badly affected, where serious backlogs have arisen in BCG vaccination and development checks for babies. In general, the introduction of Community Paediatricians has been limited, and their focus has been from the hospital and out to the community, rather than from the community and into the hospital.

11 Brennan D. (2002). Report of the Public Health Review Group, Department of Health

IMO General Practitioners and Community Paediatricians are seeking a mandate to deliver Child Health Services into the future in a high quality diagnostic/surveillance Child Health Service. It is proposed that a model of service provision that will reflect the respective groups' specific training and expertise in delivering Child Health Services should be developed and by which the service can be identified nationally[12].

The IMO Recommend:

The Child Health Screening and Surveillance programme as set out in the Best Health for Children (BHFC) documents needs to be re-affirmed as the agreed national screening programme, and its delivery needs to be standardised across all areas of the country. BHFC highlighted the fact that evidence continues to emerge in relation to screening and this needs to be reviewed on an ongoing basis with changes to the screening programme, if necessary

The HSE should put in place a system to ensure that responsibility and accountability for the Child Health Screening & Surveillance Programme is established. The system needs to ensure that:

- All children at different ages receive the appropriate developmental checks and physical examinations.
- The scope of practice and competencies of health professionals are commensurate with professional, legal and ethical codes/guidance for practice.
- Clear written guidelines are provided to support the screening process and referral pathways.
- Appropriate education and supervised practice is available for the designated health care professionals in line with national recommendations and guidance.
- The process is standardised and evidence-based information is readily available to support decision-making.
- That standards, outcomes and monitoring comply with those determined nationally covering:
  - Staff training requirements
  - Fail-safe mechanisms to ensure that all babies are invited for screening, including those who may move in and out of an area
  - Appropriate diagnostics, referral and follow-up.
- Clear quality indicators for process and outcomes of screening are established nationally.

Governance arrangements (by suitable clinicians) need to be put in place to ensure that all components of the Child Health Service are delivered to the highest quality, evidence based standards by appropriately qualified health professional(s).

Appropriate financial and manpower resources must be made available for all services.

12 Submission to the Public Service Benchmarking Body (2006), Irish Medical Organisation

Services for Pre-School children:

- All newborn babies should receive a comprehensive medical examination, ideally within the first 24 hours of birth[13], and certainly within 72 hours by appropriately trained and competent health professionals. Quality standards for this examination will be agreed nationally in consultation with hospital paediatricians/neonatologists who should take responsibility for the ongoing training and supervision of junior staff to whom delivery of the actual examination may be delegated. There will need to be strong linkages with the Newborn Bloodspot Screening and Universal Neonatal Hearing screening programmes to ensure that there are fail-safe systems to ensure that all babies are offered these very important checks.

- All babies should be offered a six week check for which a standard set of data will be recorded, comprising a full physical examination including hips, testicular descent, vision and behaviour.

- All babies should receive, as a minimum, the agreed core child health visits by public health nurses in accordance with the recommendations of BHFC - within 48 hours of discharge from hospital, at 3 months, 7-9 months, 18 months-2 years and finally at 3.25-3.5 years. Mothers/infants identified as having additional needs will be offered further visits and support services as deemed appropriate and necessary. They will screen for possible developmental delay or growth abnormalities and arrange referral to specialised services which should be appropriately resourced in accordance with agreed referral policies and procedures.

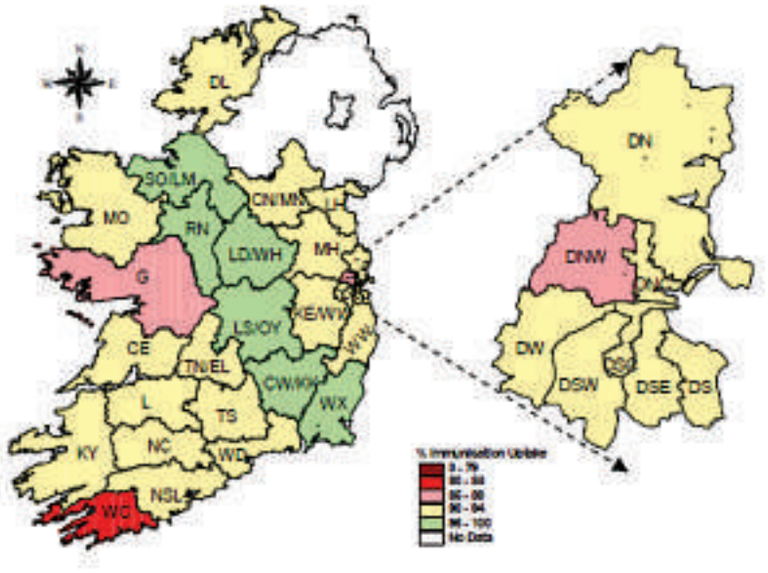
Services for School Age Children:

- A standardised school health service should be provided in primary schools in all areas of the country.
- There should be an agreed school health screening programme, delivered primarily by dedicated school nurses. Clear standards and guidelines should be developed in relation to all aspects of the screening programme, including referral for assessment, diagnosis and treatment where necessary.
- As recommended by Best Health for Children Revisited (2005), a national standardised health screening questionnaire should be developed for use at agreed ages in the school cycle, its purpose being to identify:
  - Children who have missed out on primary care in the pre-school years
  - Health problems that are of relevance to school (including immunisation status and any chronic health needs); and
  - Any problems in relation to the children's health and well-being that are worrying the parents.
- Systems should be put in place to identify particularly at risk children who might require extra support in order for them to benefit fully from the school system e.g.:
  - Children with chronic illness or complex or long-term health needs
  - Children with special educational needs
  - Children whose family background puts them at higher risk e.g. parents with mental health, drug/alcohol problems
  - Children in care
  - Refugee and asylum seeker children
  - Traveller children

13 Hall DMB & Elliman D (2006). Health for all Children Revised Fourth Edition London:Oxford University Press

c) Childhood Immunisation

"Immunisation is one of the most cost-effective health interventions available, saving millions of people from illness, disability and death worldwide each year. A well-functioning immunisation programme is essential to reducing child mortality and morbidity from vaccine preventable disease. "[14]



MMR1 immunisation uptake rates (%) by LHO, in those 24 months of age in Quarter 1-2012,
Source: HSE _ Health Protection Surveillance Centre, Immunisation Uptake Report for Ireland, Q1 2012

While national immunisation uptake rates have improved over the last 10 years, uptake rates vary between LHOs, and between vaccines and many areas are not able to provide accurate data. Of children 24 months of age in Quarter 1-2012, the target rate of uptake (≥95%) was reached in 25 LHOs for D3, P3, T3, Hib3 and Polio3, while the target rate for uptake of MMR1 was reached in just 6 LHOs.[15] Of children 72 months of age, there is insufficient data on uptake rates of MMR2, but of the reporting areas uptake of the booster vaccine is just 51.1%.[16] In 2010 Measle and mumps cases continued. There were 403 cases of measles notified to the HPSC of which 108 were hospitalised and 293 cases of mumps.[17]

A number of factors contribute to poor immunisation uptake. Poverty and factors related to poverty are recognised as being among the more persistent barriers to immunisation.[1819] The significance of this for children living in poorer households is increased by such households also being places where exposure to vaccine-preventable disease is increased.[20]

14 HSE, Driving change in Immunisation, The Role of the National Immunisation Office

15 HSE _ Health Protection Surveillance Centre, Immunisation Uptake Report for Ireland, Q1 2012

16 HSE _ Health Protection Surveillance Centre, Immunisation Uptake in Children at 72 months of age, March 2012

17 HSE _ Health Protection Surveillance Centre, Annual Report 2010

18 Strategies to sustain success in childhood immunizations. The National Vaccine Advisory Committee. JAMA. 1999;282(4):363–370.

19 Lynch M. Effect of practice and patient population characteristics on the uptake of childhood immunizations. Br J Gen Pract. 1995;45(393):205–208.

20 Singleton R, Holve S, Groom A, et al. Impact of immunizations on the disease burden of American Indian and Alaska native children. Arch Pediatr Adolesc Med. 2009;163(5):446–453.

The relationship between socioeconomic deprivation and practice immunisation delivery appears to be specific rather than a more general feature across all indicators of quality of primary care.[21] This is probably a reflection of immunisation-specific issues. Examples of such issues include the necessity for multiple appointments to receive the complete immunisation series, and the contribution of missed immunisation opportunities that occur at acute illness visits.[22] [23] Children living in more socially deprived households have more frequent episodes of acute illness. Healthcare visits for such illnesses account for the majority of missed immunisation opportunities.[24]

In the last number of years, measles outbreaks attributed to poor herd immunisation rates have occurred. There is a dearth of Irish research data in regard to new initiatives that could improve rates of immunisation including measles. Accurate research is dependent on validity of data. The absence of a single national computer record of vaccinations remains an obstacle.

IMO Recommendations

- Introduce as a matter of urgency the new National Immunisation Information System;
- All babies and children in the pre- school age group should be immunised in accordance with the agreed national Childhood Immunisation Schedule;
- A standardised School Immunisation Programme should be delivered in all areas of the country. The School Immunisation information system will have appropriate linkages with the Child/School Health information system;
- Incentives are required to increase immunisation rates in areas of socio-economic deprivation;
- Devise a national strategy for the elimination of Measles & Rubella (in line with the WHO agreed programme) as a matter of urgency and to ensure that implementation plans are adequately resourced.

2. CHILDHOOD OBESITY

The World Health Organization describes Childhood Obesity as *"one of the most serious public health challenges of the 21st century".*[25] Prevalence of obesity among children has increased at an alarming rate worldwide with over 42 million children under five estimated to be overweight in 2010. Recent data from the National Longitudinal Study of Children shows that 1 in 4 children in Ireland are overweight or obese. Of the infant cohort, 19% of 3-year olds are overweight a 6% are obese.[26] Of the child cohort, 19% of 9-year olds are overweight and 7% are obese, with rates of overweight and obesity higher among children, particularly girls, from less socio-economically advantaged households.[27]

21 Ashworth M, Seed P, Armstrong D, et al. The relationship between social deprivation and the quality of primary care: a national survey using indicators from the UK Quality and Outcomes Framework. Br J Gen Pract. 2007;57(539):441–448

22 Cohen NJ, Lauderdale DS, Shete PB, et al. Physician knowledge of catch-up regimens and contraindications for childhood immunizations. Pediatrics. 2003;111(5 Pt 1):925–932.

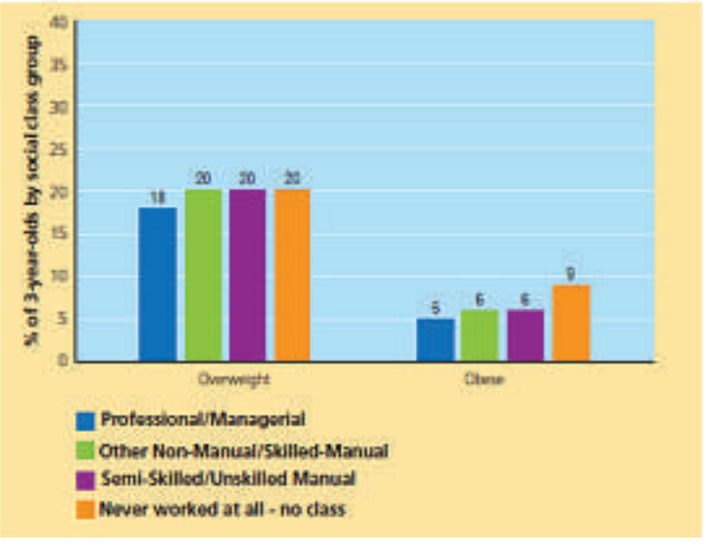
23 Turner N, Grant C, Goodyear-Smith F, Petousis-Harris H. Seize the moments: missed opportunities to immunize at the family practice level. Fam Pract. 2009;26(4):275–278.

24 Ibid.

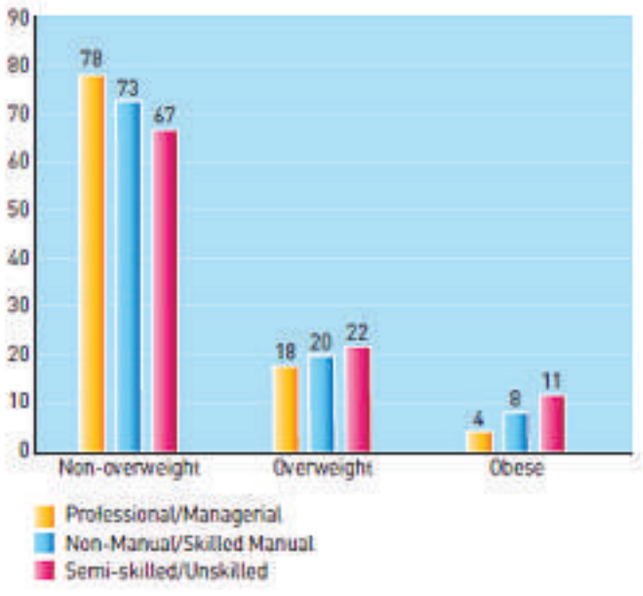
25 WHO, Childhood Overweight and Obesity, downloaded from http://www.who.int/dietphysicalactivity/childhood/en/

26 ESRI, TCD, Growing Up in Ireland- National Longitudinal Study of Children, Key Findings: Infant Cohort (at 3 years) No. 1 The Health of 3-year olds, 2011 Department of Children and Youth Affairs

27 ESRI, TCD, Growing Up in Ireland- National Longitudinal Study of Children, Key Findings: 9 year olds No. 4 The Health of 9-year olds 2009 Department of Children and Youth Affairs



Percentage of 3-year-old children classified as overweight or obese, by household social class
Source: ESRI, TCD, Growing Up in Ireland- National Longitudinal Study of Children, Key Findings: Infant Cohort (at 3 years) No. 1 The Health of 3-year olds, 2011



Percentage of 9 year old children within each BMI category by household social class
Source: ESRI, TCD, Growing Up in Ireland- National Longitudinal Study of Children, Key Findings: 9 year olds No. 4 The Health of 9-year olds 2009

Childhood obesity is associated with a higher chance of obesity in adulthood[28] and consequent heath problems including premature death, type II diabetes, cardio vascular disease, stroke, osteoarthritis, colon and endometrial cancers and mental health problems including depression and low self-esteem. Obese children also experience breathing difficulties, increased risk of fractures, hypertension, early markers of cardiovascular disease, insulin resistance and psychological effects.

28 WHO, Obesity and Overweight Fact Sheet No. 311, Updated March 2011 downloaded from http://www.who.int/mediacentre/factsheets/fs311/en/

In 2005 the National Task Force on Obesity estimated that 2,000 premature deaths annually are attributed to obesity, at an estimated cost, in economic terms, of €4bn to the State with the direct and indirect costs of treating obesity estimated at €0.4bn.[29]

Poor nutrition and lack of exercise is the principal cause of obesity[30] and children are more likely to be overweight or obese if their parents are obese. In addition a wide range of environmental and social factors influence individual energy intake and expenditure and can be considered obesogenic. These include affordability of healthy food and one's level of disposable income, family practices, school policies and procedures, transport and urban planning policies, policies on food supply and agriculture and commercial marketing activities.[31]

The most effective way to reduce excessive weight in the long-term is to ensure children consume a healthy, nutritionally balanced diet and increase levels of exercise. While GPs have an important role in the recognition of and intervention to prevent childhood obesity[32], the behavioural and environmental factors that contribute to obesity and overweight provide opportunities for actions and interventions designed for prevention and treatment.[33]

IMO Recommendations

The IMO is calling on the HSE to work with the Department of Health and the Department of Children and Youth Affairs to put in place a comprehensive multidisciplinary programme to tackle childhood obesity including:

Population measures to improve nutrition and encourage physical exercise

- Introduce legislation to ban Transfatty Acids from foods produced and sold in the Republic of Ireland;
- Place a ban on advertising of unhealthy foods to children including TV advertising of processed foods before 9pm;
- Introduce a pricing structure to discourage the consumption of food with high sugar, high fat and high salt content and encourage the consumption of healthier food and drink;
- Support the development of swimming pools and alternative outdoor sporting pursuits, such as the construction of Coillte supported mountain bike circuits;
- Provide funding for more playgrounds, cycle lanes and other measures to promote improved physical activity in all ages and especially schoolchildren.

Education to increase understanding of the problem of obesity and what constitutes a balanced diet and healthy lifestyle

- The implementation of a parental education campaign to highlight the dangers of childhood obesity;
- Introduce compulsory health education up to the end of the senior cycle;
- More extensive use of the media, including children's programming, to promote healthy lifestyle messages;

29 Department of Health and Children. Obesity: The Policy Changes. The Report of the National Taskforce on Obesity, 2005.

30 European Commission Directorate-General for Health and Consumer Protection (EC DGSanCo) 2006, Nutrition and Obesity Prevention Factsheet downloaded from http://ec.europa.eu/health/ph_determinants/life_style/nutrition/documents/nut_obe_prevention.pdf

31 WHO 2007

32 White A et al, Childhood Obesity; Parents Fail to Recognise. General Practitioners Fail to Act,IMJ 2012: 105: 1 10-13

33 U.S. Department of Health and Human Services, The Surgeon-General's Call to Action to Prevent and Decrease Overweight and Obesity, 2001.

Measures to improve nutrition and encourage physical exercise in schools

- The introduction of common standards relating to nutrition, hydration and physical exercise in all school and pre-school facilities;
- The removal of vending machines selling unhealthy snacks and drinks in schools;
- Adequate and safe sporting facilities should be provided for children in all schools;
- Address the issue of school insurance which is limiting exercise opportunity for children and ensure that Physical Education takes place on a daily basis in schools.

3. ADOLESCENT HEALTH

a) Tobacco

Approximately 7,000 people die each year in Ireland from a smoking related disease such as lung cancer, heart disease, stroke and emphysema. Some 90% of lung cancers and 30% of all cancers are caused by smoking.[34] One quarter of deaths from coronary heart disease and 11% of all stroke deaths are attributable to smoking. Smokers are two to three times more likely to suffer a heart attack compared to non-smokers.[35] Second-hand smoke also increases the risk of coronary heart disease among non-smokers by 25-35%[36] and is a risk factor for asthma in children.

While few young people die from smoking related diseases, smoking is an addiction that begins in adolescence. According to a survey commissioned by the Office of Tobacco Control, 78% of smokers started smoking before they reached the age of 18, and 53% before they reached the age of 15.[37] While smoking rates among young people are declining, approximately 19% of boys and 22% of girls in the 15-17 years age group report that they are current smokers.[38]

IMO recommendations

Children need protection from smoking and second-hand smoke and the IMO recommends:

- Support for the initiative taken by ASH Ireland and calls on local authorities to ban smoking in children's playgrounds and call on all local authorities to introduce bye-laws or whatever arrangements are necessary to ban smoking in such playgrounds;
- Extend the legislation on protecting people from passive smoking to include children in cars.
- Ensure that all sports arenas/stadia are smoke free;
- A further €1 increase in the price of a packet of 20 cigarettes in the next Budget;
- Bring forward the introduction of graphic warning labels on all tobacco product;

34 ASH Ireland, Key facts downloaded from http://www.ash.ie/Resources/Resources/Navigation.html

35 OTC 2007, Annual Report 2006

36 OTC 2004, Second-hand Smoke: the facts

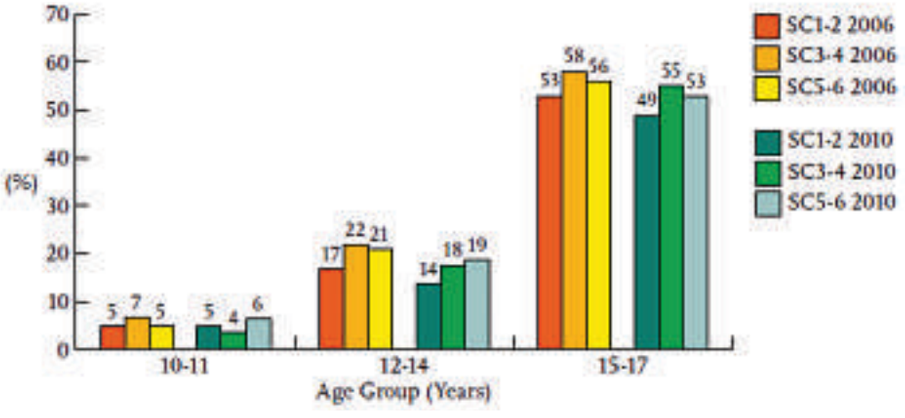
37 OTC 2006, Children, Youth and Tobacco: Behaviour, Perceptions and Public Attitudes

38 Kelly C, Gavin G, Molcho M and Nic Gabhainn S. The Irish Health Behaviour in School-aged Children (HBSC) Study 2010 Health Promotion Research Centre NUIG and DOHC 2012

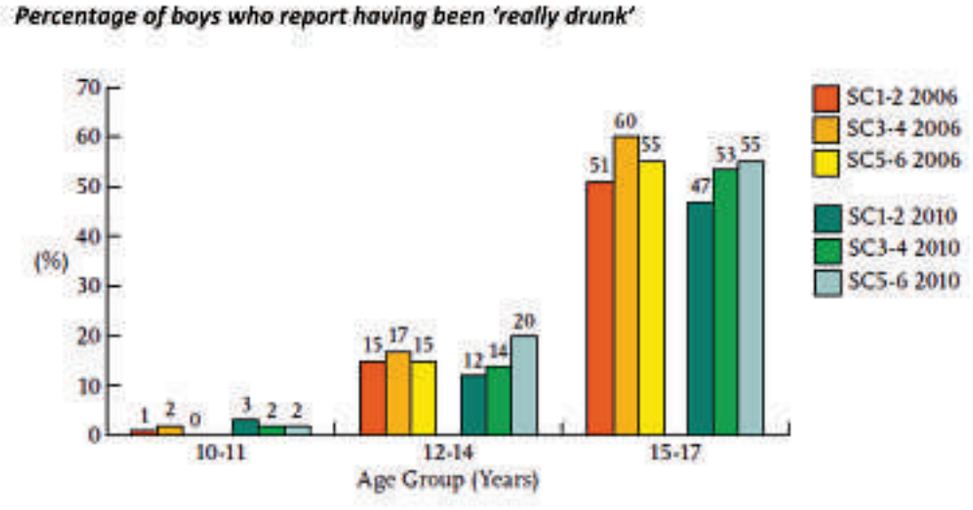
- Reinstate the penalties for those in breach of the Public Health (Tobacco) Acts 2002-2004 so that those who are found guilty of selling tobacco products to children will lose their licence to sell tobacco products for at least three months.

b) Alcohol

Alcohol is associated with more than 60 acute and chronic health disorders ranging from accidents and assaults to mental health problems, cardiovascular disease, liver cirrhosis and certain cancers. While chronic conditions more often affect older people, acute conditions are more prevalent amongst younger people.[39] Alcohol is considered to be a contributory factor in accidental death and suicide and is also related to unsafe sex, drunkenness, public disorder and interpersonal problems.



Percentage of boys who report having been 'really drunk'



Percentage of girls who report having been 'really drunk'
Source: Kelly C, Gavin G, Molcho M and Nic Gabhainn S. The Irish Health Behaviour in School-aged Children (HBSC) Study 2010 Health Promotion Research Centre NUIG and DOHC 2012

39 Mongan D, Reynolds S, Fanagan S and Long J 2007, *Health-related consequences of problem alcohol use. Overview 6* Dublin: Health Research Board pp45-46

Ireland ranks among the highest consumers of alcohol in Europe and according to the HBSC, 52% of 15-17 year olds, 16% of 12-14 year olds and 4% of 10-11 year olds report having been "really drunk" while over a third of 15-17 year olds reported being drunk in the last 30 days.[40]

In Ireland the drinks industry spends approximately €50m on advertising[41] and are the major sponsors of festivals and sporting events.[42] Young people are particularly susceptible to alcohol promotion. Mass media advertising, sports and events sponsorship, merchandising, internet presence, electronic communications and point-of-sale marketing, "all combine to embed the young-person in a network of pro-drinking stimuli".[43]

IMO Recommendations

The IMO congratulates the Government for launching the National Substance Misuse Strategy and urges that an implementation structure with defined accountability be put in place.

Specifically the IMO recommends:

Alcohol Promotion

- The introduction of legislation to prohibit below cost selling of alcohol;
- A minimum pricing structure for alcohol products including products sold for consumption off the premises in which it is purchased;
- Bring in a sliding scale of alcohol taxes with the lowest tax on low alcohol beer and the highest tax on spirits;
- Commence Section 9 of the Intoxicating Liquor Act 2008 (structural separation of licensed and non-licensed businesses on a premises);
- Introduce and commence the regulations developed under Section 16 (1) (b) and Section 16 (1) (c) of the Intoxicating Liquor Act (regulations relating to the promotion and consumption of alcohol);
- Impose a levy on the alcohol industry to be used to cover the cost of treating alcohol related harm.

Promotion of alcohol to Young People

- Prohibit alcohol sponsorship of sporting activities and sporting organisations;
- Ban the promotion or sponsorship of concerts by alcohol companies where the attendance will include people under 18 years of age;
- Legislate so that a pre 9pm watershed ban on alcohol advertising on Irish television is brought in;
- Abolish all advertisement for alcohol in cinemas other than when a film with an 18 plus cert is shown and at other events where under-18 year olds attend;
- Introduce a traceability mechanism to be put in place so that alcohol sold in off-licences to underage persons can be traced.

40 Kelly et al 2012

41 Foley A. 2007, Purchase of Inputs by the Drinks Industry - A Report Commissioned by the Drinks Industry Group of Ireland, Dublin : DIGI ..p14

42 Foley A. 2008 The Economic Contribution of the Drinks Industry - Commissioned by the Drinks Industry Group of Ireland, Dublin : DIGI ..p44

43 BMA Board of Science 2009 Under the Influence – The Damaging Effect of Alcohol Marketing on Young People p 21

The IMO also urges the Government to make moves to harmonise alcohol policy in the Republic of Ireland and Northern Ireland to include the introduction of a minimum price structure for alcohol products on an all island basis.

c) Illegal Drug use

The most recent survey of Drug use in Ireland carried out by the NACD and the PHIRB[44] shows that drug use among young people is rising and that people aged between 15-24years reported the highest last-year use of any illegal drug (15%) and the highest use of cannabis (13%), new psychoactive substances (10%), amphetamines (1.5%), ecstasy (1.1%) magic mushrooms (1%) and many other drugs. The HBSC 2010 report shows that 17% of 15-17 year olds reported using cannabis in the last 12 months.[45]

The dangers of drugs depend on the substance and the setting:

Sedatives such as alcohol, heroin and tranquilisers can be fatal if an overdose is taken. They can also affect co-ordination, making accidents more likely. Use of sedatives can also lead to physical dependence and withdrawal symptoms. Injecting drugs, particularly heroin, can lead to the spread of blood borne diseases such as HIV and Hepatitis B and C.

Stimulants such as amphetamines, cocaine, crack and ecstasy can produce anxiety or panic attacks particularly if taken in large quantities. They can also be dangerous for people who have heart or blood pressure problems.

Hallucinogens such as LSD and magic mushrooms and to a lesser extent cannabis and ecstasy can sometimes produce very disturbing experiences and may lead to erratic or dangerous behaviour particularly if the user is already unstable.[46]

IMO Recommendations

- The IMO calls on the Department of Children and Youth Affairs and its agents to get involved at all levels of the National Drugs Strategy.

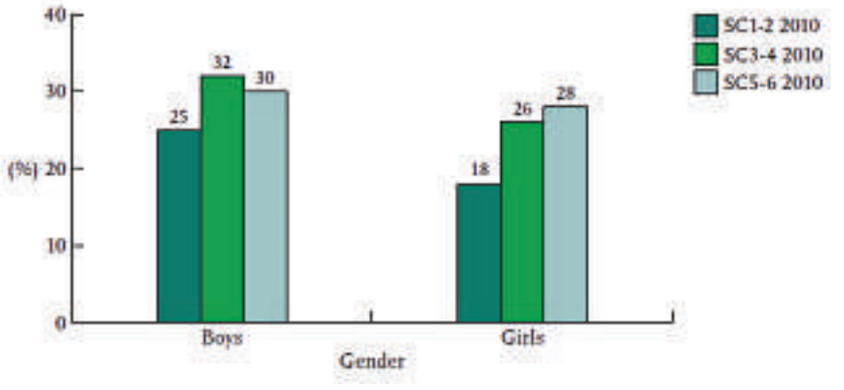
44 National Advisory Committee on Drugs (NACD) & Public Health Information and Research Branch (PHIRB), Drug Use in Ireland and Northern Ireland First Results from the 2010/11 Drug Prevalence Survey Bulletin 1

45 Kelly et al, 2012

46 Drugscope 2008 Drug Dangers downloaded from http://www.drugscope.org.uk/resources/mediaguide/drugdangers.htm

d) Sexual Health

According to *The Irish Health Behaviour in School-Aged Children (HBSC) Study 2010,* 27% of 15-17 year olds report having had sex of which 59% reported having used the birth control pill as a form of contraceptive.[47] Minors frequently seek advice from their GP in relation to contraception or the treatment of sexual transmitted infection. Under the *Non-Fatal Offences Against the Persons Act 1997,* under 16 year olds cannot consent to medical treatment, ever. However GPs often continue with a consultation with a minor, employing Gillick competence and the Fraser guidelines from the UK.



Percentage of 15-17 year olds who report having ever had sex, by gender
Source: Kelly C, Gavin G, Molcho M and Nic Gabhainn S. The Irish Health Behaviour in School-aged Children (HBSC) Study 2010 Health Promotion Research Centre NUIG and DOHC 2012

While underage sex is not to be encouraged, it is important that young people are not discouraged from seeking medical advice on contraception and sexually transmitted infection. Under current legislation children under the age of 15 may not consent to any sexual activity while those between the age of 15 and 17 may consent to sexual activity but not to sexual intercourse. In addition females below the age of 17 cannot be charged with statutory rape, but males under the age of 17 can. Child protection is of paramount importance to doctors, however the IMO are concerned that an obligation to report consensual sexual activity among minors, either to the Gardai or the HSE, under the Criminal Justice (Withholding of Information on Offences Against Children and Vulnerable Persons) Act 2012 or the Children First Bill will deter minors from seeking advice on sexual health. As the Minister for Justice, Equality and Defence has indicated, this issue is best addressed in an amendment to the Criminal Law (Sexual Offences) Act.[48]

IMO Recommendations

- The issue of criminalising and reporting consensual sex among minors should be urgently addressed;
- The IMO calls on the Department of Health and Children to develop a comprehensive strategy for the promotion of sexual health in Ireland.

47 Kelly C. Gavin A. Molcho M. And Nic Gabhainn S. The Irish Health Behaviour in School-Aged Children (HBSC) Study 2010, Health Promotion Research Centre, National University of Ireland Galway 2012

48 See IMO Presentation to the Oireachtas Committeee on Health and Children on the Children First Heads of Bill June 2012

4. SUICIDE AND SELF HARM IN ADOLESCENTS

Suicide and self-harm in adolescents are major public health problems with devastating impact on individuals, families and communities. While suicide is a rare event in young people, it ranks as a major cause of death because very few young people die from other causes. In Ireland suicide rates are highest among young men and rates of self-reported harm are highest among young females.[49] Provisional data from 2011 show 95 young people between the age of 15-24 died by suicide (approximately one fifth of total deaths by suicide), of which 80 were male.[50] In 2010 there were 1,089 recorded presentations of self harm by young people aged 10-17 years (representing 10% of all cases of self-harm) of which two-thirds were made by females.

The risk factors for suicide and self-harm in adolescents are:

Sociodemographic and educational factors

- Sex (female for self-harm and male for suicide) — most countries*
- Low socioeconomic status*
- Lesbian, gay, bisexual, or transgender sexual orientation
- Restricted educational achievement*

Individual negative life events and family adversity

- Parental separation or divorce*
- Parental death*
- Adverse childhood experiences*
- History of physical or sexual abuse
- Parental mental disorder*
- Family history of suicidal behaviour*
- Marital or family discord
- Bullying
- Interpersonal difficulties*

Psychiatric and psychological factors

- Mental disorder*, especially depression, anxiety, attention deficit hyperactivity disorder
- Drug and alcohol misuse*
- Impulsivity
- Low self-esteem
- Poor social problem-solving
- Perfectionism
- Hopelessness*

(All the factors in the panel have been shown to be related to self-harm. *Shown to be related to suicide.)

Source: Hawton K. Saunders K.E.A. O'Connor R.C, Self-harm and Suicide in Adolescents, Lancet 2012 : 379: 2373-82

Hawton et al have identified a number of socio-demographic and educational factors, individual negative life events and psychiatric and psychological factors associated with suicide and self-harm in adolescents[51]. There is also some evidence to suggest that media treatment of suicide can affect suicide rates.

49 National Office for Suicide Prevention Annual Report 2010

50 CSO Vital Statistics – Yearly Summary 2011

51 Hawton K. Saunders K.E.A. O'Connor R.C, Self-harm and Suicide in Adolescents, Lancet 2012 : 379: 2373-82

A range of population measures and targeted interventions can impact positively on mental health and help-seeking among young people.

Approaches to prevent self-harm and suicide in adolescents

Population measures

- School-based psychological well-being and skills training programmes
- Gatekeeper training (eg, school teachers, peers)
- Screening to identify those who might be at risk
- Restriction of access to means used for self-harm and suicide
- Improved media reporting and portrayal of suicidal behaviour
- Encouragement of help-seeking behaviour
- Public awareness campaigns
- Help-lines
- Internet sources of help
- Reduction of stigma associated with mental health problems and help seeking

Measures for at-risk populations

- Psychosocial interventions for adolescents at risk of self-harm or suicide (eg, depressed adolescents, abused individuals, runaway children)
- Screening of those at risk (eg, young offenders)
- Psychosocial interventions for adolescents who have self-harmed
- Pharmacotherapeutic interventions for adolescents at risk of self-harm or suicide

Source: Hawton K. Saunders K.E.A. O'Connor R.C, Self-harm and Suicide in Adolescents, Lancet 2012 : 379: 2373-82

In addition a recent study on mental health services in England and Wales found that the provision of adequate community mental health services, in particular the provision of 24-hour crisis care, is associated with a reduction in suicide rates, with the biggest falls in deprived catchment areas.[52]

IMO Recommendations

- Implement in full the recommendations outlined in *Reach Out: The National Strategy for Action on Suicide Prevention 2005-2014* and the recommendations detailed in the report of the Joint Oireachtas Sub-Committee on the *High Level of Suicide in Irish Society;*
- All national and local newspapers in Ireland should publically adopt and comply with the National Guidelines on the Reporting of Suicide (published by the Irish Association of Suicidology and the Samaritans) in all publications;
- Suicide Intervention Teams should be provided in all hospitals on a 24 hour 7 days a week basis;
- Pilot the development of community based 24 our crisis mental health provision throughout Ireland.

52 While D et al, Implementation of mental health service recommendations in England and Wales and suicide rates, 1997—2006: a cross-sectional and before-and-after observational study, Lancet 2012 : 379: 1005-12

5. HEALTH AND SOCIAL SERVICES FOR CHILDREN AND ADOLESCENTS

a) Access to Primary Care

Primary Care has an important role to play in the prevention and management of chronic disease. Asthma is the most common chronic disease in children in Ireland. 18.9% of 13-15 year olds have asthma, of which approximately a third miss 10 days of school on average per year[53]. With appropriate management in Primary Care significant reductions can be made in hospital admissions and Emergency department visits.

Rising levels of obesity and its long-term consequences on health also highlight the importance of strengthening the prevention and management of chronic disease in primary care. Just 40% of children have access to GP care under the Medical Card and GP card scheme. Patients who have to pay the full cost of Primary care may be deterred from seeking medical care, increasing the risk of delayed detection of medical problems.

The IMO recommends:

- Urgent consultation and negotiation on the funding and provision of universal access to Primary Care Services including resources for the prevention and management of chronic illnesses in children.

b) Paediatric Hospital Services

The 2001 National Health Strategy Quality and Fairness: A System for You committed to a review of paediatric services and in 2006, the McKinsey Report[54] recommended that in line with international best practice the delivery of quality integrated tertiary paediatric services required" a single tertiary centre of sufficient critical mass to offer the required breadth of services" and that it should be co-located with a leading adult academic hospital. The Report of the Joint HSE/DOHC Task Group on the optimum location of the new national paediatric hospital[55] further recommended a review of the configuration of maternity services and that the site selected for the paediatric hospital should accommodate a full secondary and tertiary care maternity hospital. Six years on and numerous set-backs and reviews later, there is still no site for the new national children's hospital. Meanwhile accommodation at many of the country's children's hospitals and maternity hospitals is outdated and in need of serious capital investment.

IMO Recommendations:

- An urgent decision is needed on the site of the new national children's hospital;
- In the meantime urgent investment is required to maintain paediatric and maternity hospital services.

c) Child and Adolescent Mental Health Services

"Mental health is a prerequisite for normal growth and development. Most children and adolescents have good mental health, but studies have shown that 1 in 10 children and adolescents suffer from mental health disorders severe enough to cause impairment. Mental health disorders in children and young people can damage self-esteem and relationships with their peers, undermine school performance, and reduce quality of life, not only for the child or young person, but also for their parents or carers and families. The majority of illness burden in childhood and more so in adolescence, is caused by mental health disorders. Mental health disorders in childhood are the most powerful predictor of mental health disorders in adulthood."[56]

53 Asthma Society of Ireland, Asthma in Ireland downloaded from http://asthmasociety.ie/asthma-information/asthma-in-ireland

54 McKinsey & Co. Childrens Health First 2006

55 Report of the Joint Health Service Executive / Department of Health and Children Task Group to advise on the optimum location of the new national paediatric hospital 2006

56 HSE, Third Annual Child & Adolescent Mental Health Service Report 2010-2011, HSE 2011

Good outcomes are most likely if children and young people have timely access to advice, assessment and evidence, however the latest Annual Child & Adolescent Mental Health Service Report from the HSE[57] shows that CAMHS are still far below the level of services recommended in *A Vision for Change.*[58] Just 56 community mental health teams and just 3 Hospital Liaison teams are in place out of a recommended 85 community mental health and 14 Hospital Liaison teams. Just 39 inpatient beds are in place, which is less than half of the 100 beds which were required "as a matter of urgency" in 2006. And overall, just half the recommended number of staff are in place.

Despite the recommendations of the Mental Health Commission that such practices should stop from 2009, 131 children were admitted to adult psychiatric units in 2011.[59] At the end of July 2012, almost 40% of referrals to CAMHS were waiting over 3 months for an appointment.[60]

IMO Recommendations

- Adequately resource Child and Adolescent Mental Health Services in line with the recommendations of A Vision for Change including the provision of 100 in-patient units;

d) Disability Services

Under the Disability Act 2005, children under 5 years old are entitled to an independent assessment of health and educational needs. Following the assessment, the HSE is obliged to provide a statement of the services that will be provided. Children with disabilities need a wide range of services that extend across the board from specific health interventions to community and hospital-based therapies to preschool and school education, yet substantial deficits in health services for children with disabilities continue.

In the emergency budget April 2009 the Government decided to defer the implementation of the remaining provisions of the Education for Persons with Special Education Needs (EPSEN) Act 2004 and the Disability Act 2005 which would provide a similar needs assessment for education and health and social care services for 5 to 18 year olds in 2010. By this the Government is reneging on its commitments to the most vulnerable children in our society, preventing 2% of under 18 year olds from reaching their potential.

Recommendations

- Multi-annual ring-fenced funding for disability services;
- Gaps and inadequacies in the assessment process must be addressed so that all children have a complete assessment within the statutory timeframe;
- Immediate recruitment of speech and language therapists, occupational therapists and physiotherapists to deliver urgent assessment and treatment to children who have been waiting;
- Increase the provision of respite services to meet demand;
- Full implementation of the Disability Act 2005 and the EPSEN Act 2004.

57 HSE, 2011

58 Expert Group on Mental Health Policy, A Vision for Change Report of Expert Group on Mental Health Policy Govt of Ireland 2006

59 HSE Performance Report December 2011

60 HSE Performance Report July 2012

e) Child Protection Services[61]

In Ireland social services as they relate to children are recognised as grossly deficient. Lack of funding and successive recruitment moratoriums has severely hampered services, including delays in intervention, inconsistencies in assessment procedures, regional variations in family support services and therapeutic services available, no 24-Hour Community Care Service, and few resources available for prevention and early intervention leading to a crisis-driven service. The screening and triage of reports is resource intensive. Even with the recent increase in funding for Child Protection Services, The IMO is concerned that unless adequately funded, mandatory reporting will further divert resources from services to protect children suffering abuse and neglect or to provide support services for those cases that fall below the threshold for intervention.

Currently four centres exist for the assessment of child sexual abuse. Both St Louise's in Crumlin and St. Clare's, Temple Street have no in-house Community Paediatrician - assessments are carried out on request. The Family Centre Cork has three Community Paediatricians available on an on-call basis and Waterford Community Child Centre has one ½ time equivalent Community Paediatrician. The rest of the country has no formal assessment centres in place. In 2011, the Community Paediatrician in Waterford saw almost 200 cases with each assessment taking on average a full working day.

The IMO recommends that:

- A provision is included in the Children First Bill to adequately fund Child Protection Services including a provision to resource services according to area of deprivation;
- The development of adequate assessment and supportive systems should be enacted prior to plans for mandatory reporting in order to foster confidence by service users and medical practitioners in optimum outcomes from reporting;
- Medical assessments require substantial resource provision and expertise and must be provided by Specialised Community Paediatric Services;
- Investment in prevention and early intervention approach to child protection in line with international evidence-based best practice which suggests that prevention and early intervention can lead to better outcomes.

f) Parent Education Programmes

It is argued that parent education programmes can help improve relationships in the family, school and community[62]. Recently, UK-based parenting companies have been included in a government-led rollout of free parent education (Parent Gym)[63]. The UK-based pilot classes are free for those that attend. Many of the parental education programmes have originated from the U.S. (FAST- Families and Schools Together) and Australia (Triple P- Positive Parenting Programme). It is highly commendable that the HSE Health Promotion Unit has offered the Triple P Parenting Programme[64] in Westmeath and Longford to volunteering parents, for free. It is noted that childhood emotional and behavioural problems are not deprivation linked and it is important that such educational measures are targeted at the entire population, as has been done in the midlands.

Parent education has understandably met criticism, both of nanny state intrusion into the family and also with a lack of robust evidence in terms of societal outcomes.

61 See IMO Presentation to the Oireachtas Committeee on Health and Children on the Children First Heads of Bill June 2012

62 http://www.triplep.net/files/pdf/Parenting_Research_and_Practice_Monograph_No.1.pdf

63 http://www.parentgym.com/what_we_do

64 http://www.nuigalway.ie/health_promotion/documents/Conference/Presentations/fergal_fox.pdf

- The IMO would welcome a feasibility study by the HSE Health Promotion Unit into widespread introduction of parenting classes, and the long-term societal gains and potential economic savings of rolling out such a programme.

6. CONCLUSION AND SUMMARY OF RECOMMENDATIONS

Children are exposed to a wide range of factors that will influence their health and well-being throughout their life. Investing in the health of our children from antenatal care through to adolescence is vital to addressing health inequalities and promoting the economic and social growth of our nation. Ensuring that all the programmes and services are in place will give our children the best chance of reaching their maximum potential.

1 Early Childhood Development

a) Antenatal Health

Novel mechanisms at addressing these lifestyle factors must be found to prevent maternal and child ill health, and their subsequent economic costs. Education by GPs, obstetricians and nurses at each antenatal visit, though important, is not enough. A comprehensive public health programme, educating all young women, not just expectant mothers that unhealthy lifestyle measures will harm to their future child must be a priority.

- Moderate exercise is healthy in pregnancy and needs to be actively promoted and a normal healthy diet encouraged (avoiding paté, unpasturised dairy products, raw meat and eggs, liver products, some types of fish, caffeine and alcohol);
- Urgent legislation is required for the fortification of certain foods with folic acid;
- Introduce mandatory health warning labelling of alcohol products in respect of pregnancy and Foetal Alcohol Syndrome and Foetal Alcohol Spectrum Disorder.
- Ensure adequate funding of hospital and community obstetric care.

b) Child Health Surveillance

The Child Health Screening and Surveillance programme as set out in the Best Health for Children (BHFC) documents needs to be re-affirmed as the agreed national screening programme, and its delivery needs to be standardised across all areas of the country. BHFC highlighted the fact that evidence continues to emerge in relation to screening and this needs to be reviewed on an ongoing basis with changes to the screening programme, if necessary

The HSE should put in place a system to ensure that responsibility and accountability for the Child Health Screening & Surveillance Programme is established. The system needs to ensure that[65]:

- All children at different ages receive the appropriate developmental checks and physical examinations.
- The scope of practice and competencies of health professionals are commensurate with professional, legal and ethical codes/guidance for practice.
- Clear written guidelines are provided to support the screening process and referral pathways.
- Appropriate education and supervised practice is available for the designated health care professionals in line with national recommendations and guidance.

65 Harvard University, Center on the Developing Child, 2010 The Foundations of Lifelong Health are Built in Early Childhood

- The process is standardised and evidence-based information is readily available to support decision-making.
- That standards, outcomes and monitoring comply with those determined nationally covering:
  - Staff training requirements
  - Fail-safe mechanisms to ensure that all babies are invited for screening, including those who may move in and out of an area.
  - Appropriate diagnostics, referral and follow-up.
- Clear quality indicators for process and outcomes of screening are established nationally.

Governance arrangements (by suitable clinicians) need to be put in place to ensure that all components of the Child Health Service are delivered to the highest quality, evidence based standards by appropriately qualified health professional(s).

Appropriate financial and manpower resources must be made available for all services.

Services for Pre-School children:

- All newborn babies should receive a comprehensive medical examination, ideally within the first 24 hours of birth[66], and certainly within 72 hours by appropriately trained and competent health professionals. Quality standards for this examination will be agreed nationally in consultation with hospital paediatricians/neonatologists who should take responsibility for the ongoing training and supervision of junior staff to whom delivery of the actual examination may be delegated. There will need to be strong linkages with the Newborn Bloodspot Screening and Universal Neonatal Hearing screening programmes to ensure that there are fail-safe systems to ensure that all babies are offered these very important checks.
- All babies should be offered a six week check for which a standard set of data will be recorded, comprising a full physical examination including hips, testicular descent, vision and behaviour.
- All babies should receive, as a minimum, the agreed core child health visits by public health nurses in accordance with the recommendations of BHFC - within 48 hours of discharge from hospital, at 3 months, 7-9 months, 18 months-2 years and finally at 3.25-3.5 years. Mothers/infants identified as having additional needs will be offered further visits and support services as deemed appropriate and necessary. They will screen for possible developmental delay or growth abnormalities and arrange referral to specialised services which should be appropriately resourced in accordance with agreed referral policies and procedures.

Services for School Age Children:

- A standardised school health service should be provided in primary schools in all areas of the country.
- There should be an agreed school health screening programme, delivered primarily by dedicated school nurses. Clear standards and guidelines should be developed in relation to all aspects of the screening programme, including referral for assessment, diagnosis and treatment where necessary.
- As recommended by Best Health for Children Revisited (2005), a national standardised health screening questionnaire should be developed for use at agreed ages in the school cycle, its purpose being to identify:
  - Children who have missed out on primary care in the pre-school years
  - Health problems that are of relevance to school (including immunisation status and any chronic health needs); and
  - Any problems in relation to the children's health and well-being that are worrying the parents.

66 Hall DMB & Elliman D (2006). Health for all Children Revised Fourth Edition London:Oxford University Press

- Systems should be put in place to identify particularly at risk children who might require extra support in order for them to benefit fully from the school system e.g.:
  - Children with chronic illness or complex or long-term health needs
  - Children with special educational needs
  - Children whose family background puts them at higher risk e.g. parents with mental health, drug/alcohol problems
  - Children in care
  - Refugee and asylum seeker children
  - Traveller children

c) Childhood Immunisation

- Introduce as a matter of urgency the new National Immunisation Information System;
- All babies and children in the pre- school age group should be immunised in accordance with the agreed national Childhood Immunisation Schedule;
- A standardised School Immunisation Programme should be delivered in all areas of the country. The School Immunisation information system will have appropriate linkages with the Child/School Health information system;
- Incentives are required to increase immunisation rates in areas of socio-economic deprivation;
- Devise a national strategy for the elimination of Measles & Rubella (in line with the WHO agreed programme) as a matter of urgency and to ensure that implementation plans are adequately resourced.

2 Childhood Obesity

The IMO is calling on the HSE to work with the Department of Health and the Department of Children and Youth Affairs to put in place a comprehensive multidisciplinary programme to tackle childhood obesity including:

Population measures to improve nutrition and encourage physical exercise

- Introduce legislation to ban Transfatty Acids from foods produced and sold in the Republic of Ireland;
- Place a ban on advertising of unhealthy foods to children including TV advertising of processed foods before 9pm;
- Introduce a pricing structure to discourage the consumption of food with high sugar, high fat and high salt content and encourage the consumption of healthier food and drink;
- Support the development of swimming pools and alternative outdoor sporting pursuits, such as the construction of Coillte supported mountain bike circuits;
- Provide funding for more playgrounds, cycle lanes and other measures to promote improved physical activity in all ages and especially schoolchildren.

Education to increase understanding of the problem of obesity and what constitutes a balanced diet and healthy lifestyle

- The implementation of a parental education campaign to highlight the dangers of childhood obesity;
- Introduce compulsory health education up to the end of the senior cycle;
- More extensive use of the media, including children's programming, to promote healthy lifestyle messages;

Measures to improve nutrition and encourage physical exercise in schools

- The introduction of common standards relating to nutrition, hydration and physical exercise in all school and pre-school facilities;
- The removal of vending machines selling unhealthy snacks and drinks in schools;
- Adequate and safe sporting facilities should be provided for children in all schools;
- Address the issue of school insurance which is limiting exercise opportunity for children and ensure that Physical Education takes place on a daily basis in schools.

3 Adolescent Health

a) Tobacco

Children need protection from smoking and second-hand smoke and the IMO recommends:

- Support for the initiative taken by ASH Ireland and calls on local authorities to ban smoking in children's playgrounds and call on all local authorities to introduce bye-laws or whatever arrangements are necessary to ban smoking in such playgrounds;
- Extend the legislation on protecting people from passive smoking to include children in cars.
- Ensure that all sports arenas/stadia are smoke free;
- A further €1 increase in the price of a packet of 20 cigarettes in the next Budget;
- Bring forward the introduction of graphic warning labels on all tobacco product;
- Reinstate the penalties for those in breach of the Public Health (Tobacco) Acts 2002-2004 so that those who are found guilty of selling tobacco products to children will lose their licence to sell tobacco products for at least three months.

b) Alcohol

The IMO congratulates the Government for launching the National Substance Misuse Strategy and urges that an implementation structure with defined accountability be put in place.

Specifically the IMO recommends:

Alcohol Promotion

- The introduction of legislation to prohibit below cost selling of alcohol;
- a minimum pricing structure for alcohol products including products sold for consumption off the premises in which it is purchased;
- bring in a sliding scale of alcohol taxes with the lowest tax on low alcohol beer and the highest tax on spirits;
- commence Section 9 of the Intoxicating Liquor Act 2008 (structural separation of licensed and non-licensed businesses on a premises);
- introduce and commence the regulations developed under Section 16 (1) (b) and Section 16 (1) (c) of the Intoxicating Liquor Act (regulations relating to the promotion and consumption of alcohol);
- impose a levy on the alcohol industry to be used to cover the cost of treating alcohol related harm.

Promotion of alcohol to Young People

- Prohibit alcohol sponsorship of sporting activities and sporting organisations;
- Ban the promotion or sponsorship of concerts by alcohol companies where the attendance will include people under 18 years of age;
- Legislate so that a pre 9pm watershed ban on alcohol advertising on Irish television is brought in;
- Abolish all advertisement for alcohol in cinemas other than when a film with an 18 plus cert is shown and at other events where under-18 year olds attend;
- Introduce a traceability mechanism to be put in place so that alcohol sold in off-licences to underage persons can be traced.

The IMO also urges the Government to make moves to harmonise alcohol policy in the Republic of Ireland and Northern Ireland to include the introduction of a minimum price structure for alcohol products on an all island basis.

c) Illicit Drugs

- The IMO calls on the Department of Children and Youth Affairs and its agents to get involved at all levels of the National Drugs Strategy.

d) Sexual Health

- The issue of criminalising and reporting consensual sex among minors should be urgently addressed;
- The IMO calls on the Department of Health and Children to develop a comprehensive strategy for the promotion of sexual health in Ireland.

4 Suicide and Self Harm in Adolescents

- Implement in full the recommendations outlined in *Reach Out: The National Strategy for Action on Suicide Prevention 2005-2014* and the recommendations detailed in the report of the Joint Oireachtas Sub-Committee on the *High Level of Suicide in Irish Society;*
- All national and local newspapers in Ireland should publically adopt and comply with the National Guidelines on the Reporting of Suicide (published by the Irish Association of Suicidology and the Samaritans) in all publications;
- Suicide Intervention Teams should be provided in all hospitals on a 24 hour 7 days a week basis;
- Pilot the development of community based 24 our crisis mental health provision throughout Ireland.

5 Health and Social Services for Children and Adolescents

a) Primary and Community Child Health Services

- Urgent consultation and negotiation on the funding and provision of universal access to Primary Care Services including resources for the prevention and management of chronic illnesses in children.

b) Paediatric Hospital Services

- An urgent decision is needed on the site of the new national children's hospital;
- In the meantime urgent investment is required to maintain paediatric and maternity hospital services.

c) Child and Adolescent Mental Health Services

- Adequately resource Child and Adolescent Mental Health Services in line with the recommendations of A Vision for Change including the provision of 100 in-patient units;

d) Disability Services

- Multi-annual ring-fenced funding for disability services;
- Gaps and inadequacies in the assessment process must be addressed so that all children have a complete assessment within the statutory timeframe;
- Immediate recruitment of speech and language therapists, occupational therapists and physiotherapists to deliver urgent assessment and treatment to children who have been waiting;
- Increase the provision of respite services to meet demand;
- Full implementation of the Disability Act 2005 and the EPSEN Act 2004.

e) Child Protection Services

- A provision is included in the Children First Bill to adequately fund Child Protection Services including a provision to resource services according to area of deprivation;
- The development of adequate assessment and supportive systems should be enacted prior to plans for mandatory reporting in order to foster confidence by service users and medical practitioners in optimum outcomes from reporting;
- Medical assessments require substantial resource provision and expertise and must be provided by Specialised Community Paediatric Services;
- Investment in prevention and early intervention approach to child protection in line with international evidence-based best practice which suggests that prevention and early intervention can lead to better outcomes.

f) Parental Education Programmes

- The IMO would welcome a feasibility study by the HSE Health Promotion Unit into widespread introduction of parenting classes, and the long-term societal gains and potential economic savings of rolling out such a programme.

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