Training Programme
for Public Health Nurses and Doctors
in Child Health Screening, Surveillance and Health Promotion

Unit 1
Health Promotion
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Child Health Promotion: A Review of Evidence

Draft Document: 6th September 2004

Introduction

This review aims to introduce the evidence base for the Child Health Promotion Module for the Child Health Surveillance and Screening Training Programme. This is a first draft to be updated on a regular basis.

Material was selected for inclusion in the review using criteria recommended by the Cochrane Collaboration (see www.hrb.ie) and the Health Development Agency (www.hda-online.org.uk).

The review is presented in line with the Programme of Action for Children’s commitment to support improvements in the quality and standards in Children's Health Services through the promotion of evidence based practice.

Further reports and resources will be added to our website on a regular basis: www.pacirl.ie

Prepared by:
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Rationale - draft

The World Health Organisation (WHO) definition holds an important expansion of the view of health, which is not only understood by somatic indicators, but also comprises how a person feels, psychologically and physically and how she or he manages with other persons and copes with every day life (WHO, 1948). The National Health Strategy adopts the broader definition of ‘health’ used by the World Health Organisation and recognises the value of identifying and responding to the needs of individuals within the health system (DoHC, 2001).

The Health of Our Children 2001 reports on children’s health in Ireland and argues for greater emphasis on prevention and health promotion in our approach to children’s health (DoHC, 2000).

Best Health for Children works to facilitate a co-ordinated partnership approach by the health boards to assist each child to reach his or her best health and well-being potential (Denyer et al. 1999). The Adolescent Health Strategy, 2001 recommends a refocus of attention from health-related lifestyle behaviour and the concept of risk to a ‘whole-child perspective’ and the need for an adolescent-friendly health service highlighting accessibility of services, flexibility in service delivery, ensuring staff have appropriate skills and training, providing quality information on health issues and partnership working involving adolescents, parents and service providers.

Evidence favours a move towards a more holistic approach to child and family health (Hall, D. & Elliman, D., 2003 Pg. 30). Some health surveillance activities have a strong evidence base (eg immunisation, breast feeding); for others there are some limited data suggesting they are likely to be effective in facilitating improved outcomes (eg early literacy, injury prevention programs); some appear to be intuitive yet at present there is no compelling evidence as to their effectiveness in improving outcomes (anticipatory guidance, the provision of information to parents) (NHMRC, 2002. Pg. 221). However, there appears to be little consensus as to which preventive and health promotion activities should be systematically incorporated into child health programs and how their outcomes should be judged. To date, with the notable exception of immunisation, such activities have tended to be ad hoc and time-limited, and to occur outside a quality framework (NHMRC, 2002. Pg. 221).

The goals of child health surveillance programme are twofold: that all children have the opportunity to realise their full potential in terms of good health, well-being and development; that remediable disorders are identified and acted upon as early as possible (Denyer, S. et al. 1999. Pg.9; O’Flanagan & O Nuallain 2001).

Inequalities

People who have low incomes or live in areas of deprivation are more likely to suffer depression and to have poor health and unhealthy lifestyles; their babies are more likely to be of low birth weight; their children are at higher risk of illness, sudden unexpected death, neglect, abuse, dental decay, injuries, and educational problems (Hall, D. & Elliman, D., 2003 Pg. 30). As the children grow older they are more likely to have unplanned teenage pregnancies, engage in substance misuse, leave school with no qualifications, and develop mental health problems (Hall, D. & Elliman, D., 2003 Pg. 30). An increasing body of research and experience suggests that relationships and community-wide issues must be addressed if real progress is to be made (Hall, D. & Elliman, D., 2003 Pg. 31).

Aspects of community social capital are determinants of both perceived health and mortality in adults (Waterson et al. 2004). Social capital includes for eg. the area in which you live, civic engagement, reciprocity and trust, social networks, and social support. High levels of social capital predict developmental and behavioural scores in children in low income areas, and low social capital increases the chances of dropping out of high school (Waterson et al. 2004). Ample evidence that environmental and linguistic deprivation of a degree commonly found in the population does contribute to social class differences in language development and literacy (Hall, D. & Elliman, D., 2003 Pg. 64). Poverty, stress, poor diet, and sometimes substance abuse affect the health and growth of the fetus (Hall, D. & Elliman, D., 2003 Pg. 63). Mortality, including infant mortality, have been shown to be strongly associated with perceptions of lack of helpfulness, lack of fairness, and social mistrust in a community.

Paediatricians, GPs, and health visitors (or public health nurses in an Irish context) all have a potential role to play in the development of social capital. They can work with patients and their parents in an empowering way and they can support the development of parenting programmes. Well facilitated group based programmes have the effect of developing mutual support and connectedness between
families in local communities. They also have beneficial impact on antisocial behaviour and criminality, and relationships with peers (Waterson et al. 2004).

Evidence has shown that initiatives including Sure Start (UK), Families First Initiative (NSW), Schools as Community programmes (NSW), Community Access to Child Health (USA) have all aimed to improve social capital through community development (Waterson et al. 2004).

Parents
Parents, with the help of relatives or friends, are very often the first to recognise that their child has a disability (O Flanagan & O Nuallain 2001; Polnay, L. 1989). It is of paramount importance to respect and respond to any concerns parents or careers might have and to recognize their role in the overall surveillance of their children (O Flanagan & O Nuallain 2001; Polnay, L. 1989). To strengthen and equip parents, parents should be provided with educational material containing basic guidelines on normal developmental patterns in infants and children (O Flanagan & O Nuallain 2001; Pugh G. et al. 1994 cited in Hall, D. & Elliman, D., 2003 Pg. 57).

Research demonstrates the important links between the quality of caregiver-child interactions and the child’s subsequent intellectual, language and emotional development (Mischenko et al. 2004). There is some evidence that parents who have difficulties with attachment can be helped to respond more appropriately and many parents who have participated in such programmes report both short- and long-term benefits (Hall, D. & Elliman, D., 2003 Pg. 59). Increasing self-confidence and self-esteem, widening social networks, and initiating new experiences contribute in the long run to improving parents’ health and this may have benefits for children (Hall, D. & Elliman, D., 2003 Pg. 63). Need to assist parents with personal support, information, advice and material resources as appropriate (Hall, D. & Elliman, D., 2003 Pg. 27). Growing evidence that support networks and social capital do influence outcomes (Hall, D. & Elliman, D., 2003 Pg. 28). E.g. Sure Start – aim to close the gap in outcomes between children growing up in poverty and the wider child population. (Hall, D. & Elliman, D., 2003 Pg. 54).
Nutrition in the first 2 years of life also provides a critical window of opportunity to influence health and well being in later life. Breastfeeding capitalises on this opportunity and the advantages that accrue from breastfeeding can make a significant contribution to addressing the health inequalities in low income and marginalized communities (Singhal et al; Lancet 2004 vol. 363: 1571-78).

NCAST tools are evidence-based standardised assessment tools developed in the US by Kathryn Barnard, which provide a systematic means of assessing the quality of parent-child interaction (Mischenko et al. 2004). These tools have immediate ‘face value’ for health visiting practice (public health nursing practice, in the Irish context), with the emphasis on the importance of early caregiver/child interaction and potential for early intervention work with families eg. Sure Start programmes (Mischenko et al. 2004).

Training
Parenting programmes in general are more favoured by parents if: they allow parents to share experiences; they make everyone feel included; they are easily accessible; they focus on educating parents so that they can make their own choices and decisions; they are offered before the child is 3 years old; the programme is led by a parent (Grimshaw, R. & McGuire, C. 1998 cited in Hall, D. & Elliman, D., 2003 Pg. 57). Delivery should include: collaborative approach acknowledging parents’ feelings and beliefs; difficulties normalized, humour and fun encouraged; parents supported to practise new approaches during session and through homework; parent and child seen together in individual family work; just parents in some group programmes; crèche, good-quality refreshments, and transport provided if necessary; therapists supervised regularly to ensure adherence and to develop skills (Scott, S. 2003 cited in Hall, D. & Elliman, D., 2003 Pg. 57).

Parent training programmes effectiveness include: structured sequence of topics, introduced in set order over 8-12 weeks; subjects include play, praise, incentives, setting limits, and discipline; emphasis on promoting sociable self-reliant child behaviour and calm parenting; constant reference to parent’s own experience and predicament; theoretical basis informed by extensive empirical research and made explicit; detailed manual available to enable replicability (Scott, S. 2003 cited in Hall, D. & Elliman, D., 2003 Pg. 57; Scott 1998).
Home visiting is not a single or uniform intervention – it is a mechanism for the delivery of a variety of interventions directed at different outcomes. Home visiting programmes are diverse in their goals, target recipients, mode and timing of their delivery and their theory and content. They may provide parent training/education, psycho-social support to parents, infant stimulation, and infant and maternal health surveillance. The programmes may be provided by nurses, midwives or lay people within different professional bases. Home visiting may vary in when it begins, how long it lasts and how many times within this period it occurs. A programme may be provided to all families with a new baby, to families in disadvantaged circumstances, to parents or children with particular problems, or parents of children defined as ‘at risk’ (Bull et al. 2004).

Evidence suggests that home-visiting interventions that are restricted to the pursuit of only a narrow range of outcomes are less effective than those with a more comprehensive approach in which the multiple needs of families are addressed. There is some evidence to suggest that more intensive programmes of home visiting have greater impact than others, but there is no clear answer to the exact prescription for the intensity and duration of home visiting programmes to be found within existing evidence.

Current evidence is not clear on the issue of whether home visiting is more effective when professionals rather than lay people provide it (Bull et al. 2004). Structured home visiting programmes using non-qualified or paraprofessional staff show small improvements (Hall, D. & Elliman, D., 2003 Pg. 71).

Note: Community Mothers Peer Support Programme has been evaluated. Brenda Molloy, director of this Programme can be contacted at – tel. 01 8387122]

Evidence suggests that home-visiting programmes to parents of young children can be associated with: improvements in parenting; reported improvements in some child behavioural problems; improved cognitive development, especially among some sub-groups of children such as those born prematurely or born with low birth weight; a reduction in accidental injury among children; improved detection and management of post-natal depression. There is either no evidence or inconclusive evidence for the impact of home visiting on other outcomes, including child abuse, increased uptake of immunisation, reduced hospital admissions or maternal participation in education or in the workforce. Given the potential importance of the contribution of home visiting to tackling child health inequalities, there is an urgent need to further develop the evidence base in this area (Bull et al. 2004; Hall, D. & Elliman, D., 2003 Pg. 70/1; Kendrick et al 2000).

Child Protection
With increasing understanding of child abuse, lists of ‘risk factors’ have been developed, but targeting at-risk factors is an unsatisfactory way of targeting resources (Hall, D. & Elliman, D., 2003 Pg. 67).

Low income, in combination with low levels of perceived social support, has been associated with a higher probability of punitive behaviour by the parent towards the child. Unemployment and low income are strongly associated with child abuse referrals (Taylor et al. 2000).

Primary prevention programmes could accomplish a great deal through parent support, community development, and early intervention for emerging problems (Hall, D. & Elliman, D., 2003 Pg. 70).

Increasing immunization uptake
Familiarity with the diseases immunization is designed to prevent, a knowledge of what the evidence actually shows with regard to effectiveness, risks, and contraindications, firm commitment to immunization among all primary care staff, and honest acknowledgment of areas of uncertainty are essential in child health promotion (Hall, D. & Elliman, D., 2003 Pg. 77).

Immunizations if carried out on the same occasion as other preventive care activities can improve organization and reduce costs. Immunization status of the child should be checked and any outstanding immunizations given (Hall, D. & Elliman, D., 2003 Pg. 79).

A study into travellers’ health provide evidence of a low uptake of infant health services by the travelling community, in particular immunisation uptake overall and attendance at developmental screening, both of which are less than 50% (Fitzpatrick et al. 1997).
Tuberculosis, BCG vaccine should be given to high-risk infants and children (Hall, D. & Elliman, D., 2003 Pg. 80). High-risk includes: close relative or contact of the family receiving treatment for TB; within the last 10 years; stay in a country where TB is endemic; who’s parents are from countries with a high prevalence of TB. (Hall, D. & Elliman, D., 2003 Pg. 80). Note: BCG vaccine is routinely given to all babies in Ireland after birth.

Hepatitis B vaccine, (4 doses) universal antenatal screening of mothers is recommended. (In Ireland currently all clients from at-risk groups are routinely screened for Hep B & C eg. kown or suspected drug abusers and people recently arrived from sub-Saharan Africa -screening for HIV is universal). If Hepatitis B infection in pregnant women is relatively uncommon, then universal neonatal hepatitis B immunization if not recommended. To reduce poor uptake, provide information in the personal child health record (Hall, D. & Elliman, D., 2003 Pg. 81).

Meningococcal C vaccine has been successful (Hall, D. & Elliman, D., 2003 Pg. 81). Meningococcal B vaccine is needed (Hall, D. & Elliman, D., 2003 Pg. 81). Pneumococcal conjugate vaccine is not recommended for general use (Hall, D. & Elliman, D., 2003 Pg. 81).

SIDS and sudden unexpected death in infancy
Incidence of SIDS in the UK has fallen and is largely attributable to the change in sleeping position from prone (face down) to supine (face up) (Hall, D. & Elliman, D., 2003 Pg. 82).

Risk factors include: Infant sleeping position, exposure to tobacco smoke, social class, age of mother, birth interval, infection in pregnancy, maternal drug addiction, male sex of infant, maternal depression, prematurity or low birth weight, multiple births, congenital defects, previous SID (Hall, D. & Elliman, D., 2003 Pg. 83). The social groups at highest risk of SIDS are generally also those who are hardest to reach through conventional health service approaches (Hall, D. & Elliman, D., 2003 Pg. 84).

Smoking
A reduction in smoking during pregnancy would, inter alia, make a major contribution to reducing the incidence of low birth weight. The aim of reducing smoking should not be pursued in isolation, but rather in the context of more wide-ranging efforts at health promotion within particular families by creating a good relationship with the parents and promoting self-confidence and self-esteem (Hall, D. & Elliman, D., 2003 Pg. 86).

A review by Dolan-Mullen P. et al 1994, examined the effectiveness of smoking cessation programmes aimed at pregnant women, those receiving advice were almost twice as likely to stop smoking that those not receiving advice. The review also found that the increased rates of smoking cessation obtained were associated with lower risk of low birth weight (EHPE, 2000 Pg. 125).

Smoking is the major modifiable risk factor contributing to low birth weight (Hall, D. & Elliman, D., 2003; Bull et al. 2003). Babies born to women who smoke weigh on average 200g less than babies born to non-smokers. The incidence of low birth weight is twice as high among smokers as non-smokers (Messeccar, 2001 cited in Bull et al 2003). Smoking cessation in pregnancy is strongly affected by socio-economic status, with women of lower education, income and employment status far more likely to continue smoking than women from higher SES groups (Graham and Der, 1999 cited in Bull et al 2003).

There is systematic review evidence that formal smoking cessation interventions, provided by specialists as part of antenatal care, are effective at increasing smoking cessation rates among pregnant women (Lumley et al., 2001 cited in Bull et al 2003). The exact content of smoking cessation programmes in pregnancy and how well these transfer from experimental to real-life settings are factors which, when better understood, are likely to moderate the general findings of effectiveness to emerge from the scientific review-level literature. There is evidence that effective smoking cessation interventions reduce the prevalence of low birth weight and increase birth weight among pregnant women who quit as a result of intervention (Lumley et al., 2001 cited in Bull et al 2003). There is insufficient evidence to draw conclusions about the potential benefit or harm resulting from the use of

High rates of relapse are known to exist among pregnant women who quit smoking. There is a consensus that the transition from pregnancy to the post-partum period is a critical stage for intervention to maintain smoking cessation, yet most interventions are targeted only at the prenatal period. The pregnant smoker needs to be reached as early as possible and those at most risk of smoking should be carefully targeted, encourage cessation before pregnancy is also recommended as a way of bringing forward quit attempts and reducing the likelihood of low birth weight (DiClemente et al., 2000; Messecar, 2001 cited in Bull et al 2003).

A large randomised controlled trial conducted in the UK (Moore et al., 2002) found that an intervention using self-help booklets targeted at pregnant women was no more effective than normal antenatal care.

High quality review-level evidence suggests that those involved in implementing interventions need to be trained in order to improve adherence to protocols and maximise effectiveness (Dolan-Mullen, 1999 cited in Bull et al 2003).

A randomised control trial of anti-smoking advice by Rose, G. & Colwell, L. in 1992 found that over a 20 year period, those offered advice were 7% less likely to die from any cause, 13% less likely to die from coronary heart disease, and 11% less likely to die from lung cancer (EHPE, 2000 Pg. 125). A Cochrane Review by Silagy, C. & Ketteridge, S. in 1998 found that for every 37 patients given brief advice by a physician to stop smoking, one more would quit than would be the case if advice was not given (EHPE, 2000 Pg. 124).

**Passive Smoking**

Passive smoking has adverse effects on children’s health e.g. risks of SIDs, middle-ear disease, meningitis, and admission to hospital for respiratory illnesses are increased (Hall, D. & Elliman, D., 2003 Pg. 85).

**Alcohol**

Evidence supports the use of brief interventions in patients with drinking problems, there is a need for further research (EHPE, 2000 Pg. 125).

**Unintentional injury prevention**

The World Health Organization suggests that by 2020 injury will account for the largest single reason for loss of healthy human life years (see Towner et al., 2001 cited in Millward 2003).

Unintentional injuries are the most common cause of death and a cause of considerable morbidity in children between the ages of 1 and 14 years (Hall, D. & Elliman, D., 2003 Pg. 86). Reducing the absolute number of injuries and deaths from accidents and the social class gradient are important objectives, which need multi-agency collaboration and investment. Social class gradient shows differences in the environment and in social patterns and attitudes (Hall, D. & Elliman, D., 2003 Pg. 87).

Evidence for effectiveness of interventions for reducing injury or changing behaviour has been assessed in the three main environments where child accidental injury occurs: on the road, at home and during leisure pursuits1 (Millward et al 2003).

Roads are the leading cause of fatalities in children. There is good evidence for: 20mph zones (leading to injury reduction); Cycle helmet education campaigns; Cycle helmet legislation; Child restraint loan schemes; Child restraint legislation all of which lead to behavior change (Millward et al 2003; Hall, D. & Elliman, D., 2003 Pg. 88). There is reasonable evidence for: Area-wide urban safety measures; Cycle helmet legislation; Child restraint legislation which are leading to injury reduction and education aimed at parents about pedestrian injuries; Cycle training; Child restraint education campaigns; Seat

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1 Evidence here has been gathered mainly by Towner et al., 2001 (Millward et al 2003).
Significant fatalities and injuries are sustained in the home through: Suffocation and foreign bodies; Fire and flames; Drowning and submersion; Falls; Poisoning. House fires are more common in Social Class V than Social Class I (Hall, D. & Elliman, D., 2003 Pg. 89). Scalds, standards for gas and electricity recommend 60 C maximum for thermostats. The use of thermostatic mixer taps for the bath set at 43 C is good practice but expensive (Hall, D. & Elliman, D., 2003 Pg. 90). Poisoning, medicines (low/intermediate/high/non toxicity); child-resistant containers and packaging prevent childhood poisoning (Hall, D. & Elliman, D., 2003 Pg. 91). Poison control number (Margolis, P 2001).

There is good evidence for: Smoke detector programmes (leading to injury reduction and behaviour change); Poisoning – child resistant packaging (leading to injury reduction) (Millward et al 2003). There is reasonable evidence for: product design and General safety devices leading to injury reduction; and window bars and parent education on hazard reduction leading to behaviour change (Millward et al 2003). There is no good or reasonable evidence of effective interventions, although there is some evidence for interventions targeted at drowning, and play and leisure injuries (Millward et al 2003).

- Baby-walker injuries, baby walkers have no demonstrable benefit to babies but are associated with unsafe practices (Hall, D. & Elliman, D., 2003 Pg. 91).
- Stair gates and fireguards, little evidence of benefit (Hall, D. & Elliman, D., 2003 Pg. 91).
- Glass injuries (doors, windows), safety glass
- Dog attacks, never leave a child unsupervised with a dog (Hall, D. & Elliman, D., 2003 Pg. 92).
- Sunburn and heat stroke, parent education/sunscreens (Hall, D. & Elliman, D., 2003 Pg. 92).
- Playground injuries, consider surface and equipment, injuries are uncommon (Hall, D. & Elliman, D., 2003 Pg. 92).

There are some general community prevention initiatives targeting a range of injury types in different groups. Reasonable evidence was found for both injury reduction and behaviour change. In addition, there are several mass media and training interventions that are rated as ‘reasonable/weak’ in effectiveness, although they are not specified by either injury reduction or behaviour change (Millward et al 2003).

Evidence suggests that residential areas with higher ratios of lower socioeconomic groups have higher accident rates, especially for children (Raine et al., 2000 cited in Millward et al 2003). However, very few injury prevention strategies have been designed to meet the needs of the most disadvantaged communities (BMA, 2001 cited in Millward et al 2003).

Despite clear evidence that social gradients exist in relation to childhood injury mortality, particularly concerning fire and flames, falls, poisoning, submersion, suffocation and foreign bodies, very few studies explicitly investigated accidental injury in relation to inequalities (Ward and Christie, 2000; Dowswell and Towner, 2002 cited in Millward et al 2003).

Training
A checklist giving examples of hazards and safety checks based on a developmental perspective might enable health professionals to raise the subject with parents more easily (Hall, D. & Elliman, D., 2003 Pg. 95). CF HSE Midlands Safety Awareness Programme.

Nutrition
Retrospective and prospective evidence that poor maternal nutritional status at conception and inadequate maternal nutrition during pregnancy can result in low birth weight. Kramer, 1987 cited in Bull et al 2003 reported that a number of nutritional factors had an influence on low birth weight, including pre-pregnancy maternal weight, gestational weight gain, energy intake, iron and anaemia (Bull et al 2003; Taylor et al. 2000).

Low birth weight is defined by the World Health Organization as a birth weight less than 2,500 grammes (g), since below this value birth weight-specific infant mortality begins to rise rapidly (Kramer, 1987 cited in Bull et al. 2003). It is caused by either a short gestation period or retarded
intrauterine growth (or a combination of both). Low birth weight is a major cause of infant mortality in developed countries including the UK (Stevens-Simon and Orleans, 1999 cited in Bull et al. 2003) and can cast long shadows into adult health status (Bull et al. 2003).

**Breastfeeding**

For optimal infant feeding WHO recommend exclusive breastfeeding (ie. no other food or fluid apart from breast milk) until 6 months of age (Nutrient Adequacy of Exclusive Breastfeeding for the Term Infant During the First Six Months of Life, WHO, Geneva, 2002). This recommendation is based on evidence that breast milk alone is nutritionally adequate up to 6 months for otherwise healthy infants born at full term (Hall, D. & Elliman, D., 2003 Pg. 96; Bull et al. 2003).

As well as providing a perfect source of complete nutrition for the optimal development of healthy infants, human breastmilk has an important role to play in protection against gastroenteritis and respiratory infection. There are also strong indications that breastfeeding plays an important role in preventing otitis media, urinary tract infection, atopic disease if a family history of atopy is present, juvenile onset insulin-dependent diabetes mellitus and obesity (cited in Protheroe et al, 2003). Data from a cross sectional study in Bavaria suggest that the risk of obesity in children at the time of school entry can be reduced by breast feeding: a 35% reduction occurs if children are breastfed for 3 to 5 months (von Kreis, R. 1999).

Breastfed babies may also have improved cognitive and psychological development, and there is a reduced risk of maternal breast and ovarian cancers and osteoporotic hip fractures (Hall, D. & Elliman, D., 2003 Pg. 96). WHO/UNICEF also recommends that breastfeeding should continue after the first 6 months (of exclusive breastfeeding) in combination with suitably nutritious and safe complementary foods for up to 2 years or beyond. In this way the health and nutritional advantages of breastfeeding can be maximised (Global Strategy on Infant and Young Child Feeding, WHO/UNICEF, 2003).

If a mother makes an informed decision not to breastfeed, then infant formula milks should be substituted. Breast or infant formula milks should constitute the main drink for the first year. Unmodified Cow’s milk should not be given before one year of age (Bull et al. 2003).

Breastfeeding is also beneficial to the mother’s health. Women who do not breastfeed are significantly more likely to develop epithelial ovarian cancer and premenopausal breast cancer than women who breastfeed. Other benefits for the breastfeeding mother include the increased likelihood that she will use up the body fat deposited in pregnancy (cited in Protheroe et al, 2003). Social limitations, lack of partner and family support, ambivalent attitudes to sexuality and nudity, societal attitudes, lack of privacy or facilities, a need to return to work, distaste, low levels of vitamin K in breast milk are reasons cited for not breastfeeding (Hall, D. & Elliman, D., 2003 Pg. 97). Prolonged bottle feeding beyond the age of 1 year is thought to increase the risk of tooth decay (Bull et al. 2003).

In general, pre-natal breastfeeding promotions in Bull et al. (2003) review were aimed at low income or minority ethnic groups, and based in hospital or clinic settings. This review found that Pre-natal interventions to promote breastfeeding were successful at increasing breastfeeding knowledge and initiation, with the exception of one intervention, which required attendance at a series of lectures where attendance rates were high. In this setting, one-to-one education sessions were more successful than group education at persuading women to breastfeed who had initially intended to feed their babies infant formula. Group sessions were better at increasing duration of breastfeeding, and the effectiveness of pre-natal education sessions in terms of initiation of breastfeeding was enhanced by contact with peer counsellors (Bull et al. 2003).

Breastfeeding promotions which spanned both the pre- and post-natal period were primarily aimed at low-income groups and set in the hospital or clinic and at home. The evidence for effectiveness of such interventions was mixed, with USA-based interventions achieving greater success than UK or Australian interventions. When programmes were personalised or ‘needs-focused’, they were successful at increasing breastfeeding initiation but not duration with three exceptions: One of these
interventions offered prizes and included partners, another evaluated the effect of contact with a breastfeeding specialist, and a third examined a peer counsellor support group (Bull et al. 2003).

Post-natal breastfeeding promotions were aimed at women who had already initiated breastfeeding, and were based in the hospital or home setting. In general, they comprised visits by a lactation consultant, telephone support services, a breastfeeding advice booklet, and training sessions aimed at improving midwife awareness of the needs of breastfeeding women. One of these interventions, which modified the contents of a commercial discharge pack given to mothers on leaving hospital, significantly increased breastfeeding duration. One USA-based evaluation of contact with a single lactation specialist provided evidence of an improvement in overall breastfeeding outcome. One cultural and language specific intervention that was implemented in conjunction with clinic visits was successful at increasing breastfeeding prevalence up to four weeks post-partum (Bull et al. 2003).

Health education interventions aim to provide factual information about breastfeeding. There is some evidence that distributing breastfeeding literature alone among the general population is not effective in promoting breastfeeding among women of different income and ethnic groups in the UK, Republic of Ireland and USA. Breastfeeding literature and formal education delivered to low income groups in the USA were not effective at promoting the initiation of breastfeeding. Group health education can be effective among women from different ethnic and low income groups in westernised countries. One-to-one educational programmes were more effective for women who planned to bottle-feed whereas group programmes were more effective for women who planned to breastfeed. This evidence is based on studies of low income black Americans. In a coordinated three-step approach to health education for women in Sweden, advice, leaflets and routine health education plus intensive staff training had significant effects on initiation rates (Protheroe et al, 2003).

Breastfeeding promotions delivered over both the ante- and postnatal period were most likely to have a positive effect on breastfeeding. The interventions involved were intensive, involving multiple contacts with a professional promoter or peer counselor (HDA 2004; Protheroe et al, 2003). Antenatal educational sessions were more effective when enhanced by contact with peer counsellors. Weaker evidence suggests promotion efforts may be assisted by including partners, providing incentives and changing the content of commercial hospital packs given to women upon discharge from hospital. The least successful interventions were those where breastfeeding promotion was only one part of a multiple health promotion programme, and involved special visits to the hospital/clinic or took place by telephone (Protheroe et al, 2003; HDA 2004).

Initiatives in the health sector aim to change the organisation of health services and care received by women in favour of the promotion of breastfeeding. These interventions are mostly conducted in the hospital sector and have included evaluations of the training of health professionals, ‘rooming-in’ (a home-like, private room), the reduced use of artificial milk, health education activities and studies conducted by the WIC programme (US Department of Agriculture’s Program for Women, Infants and Children – www.fns.usda.gov/wic). In a combined approach, training of staff, employment of a breastfeeding counsellor, written information and rooming-in were effective for both initiation and duration in the USA among low income women. However, this evidence is based on a poor quality trial.

(CF WHO/UNICEF Baby Friendly Hospital Initiative based on the 10 Steps to Successful Breastfeeding? The steps have been evaluated separately and there is also evidence for their cumulative effectiveness (see www. babyfriendly.org.uk)

Training health professionals as a standalone intervention did not produce statistically significant increases in initiation rates. Women’s knowledge and attitudes about breastfeeding were significantly improved by the training of health professionals as part of a health sector initiative. A five-year programme, which included training of health professionals, reported small increases in initiation but these were not proved to be statistically significant. There is limited evidence to show that intensive lactation training courses for health professionals alone can have an effect on breastfeeding initiation rates. A package of interventions including training, however, may be more likely to influence attitudes and encourage uptake of breastfeeding.
Only one UK-based randomized controlled trial (RCT) was found (Oakley, 1990 cited in (Protheroe et al, 2003), which evaluated the effect of social support for socially disadvantaged women. Support was provided in the form of home visits and telephone calls by a midwife on hospital discharge. No significant difference was reported in initiation rates between the intervention and control groups. However, this finding may have been influenced by the support received by some of the control group as 'standard care'. Feedback given by women regarding the intervention was very positive and suggested that a midwife listening to them was important.

Qualitative research exploring why some women on low incomes do not want to breastfeed concluded that breastfeeding is a practical skill. The confidence and commitment to breastfeed successfully are best achieved by exposure to breastfeeding rather than talking or reading about it. Local media campaigns (in one case TV) can be effective in improving attitudes towards breastfeeding (Protheroe et al, 2003).

Peer support programmes as standalone interventions have been shown to be effective in both the antenatal and postnatal periods for women who expressed a wish to breastfeed, but not for women who had decided to bottlefeed. Three out of five effective WIC interventions with women on low incomes included a peer support programme (Protheroe et al, 2003).

Multi-faceted interventions have been shown to increase initiation rates. Five out of six effective multifaceted interventions included a media campaign, in combination with health education programmes, training of health professionals and/or changes in government and hospital policies. Four out of six effective multi-faceted interventions included a peer support programme in combination with health education programmes, media programmes and/or legislative and structural changes to the healthcare sector (Protheroe et al, 2003).

In Scandinavia, where breastfeeding rates have remained at around 98%, multi-faceted interventions have been implemented at a national level over the last 20 years. Four types of intervention, which follow, have contributed to the high level of breastfeeding in Scandinavia. However, no evaluation has been undertaken to examine which, if any, of these aspects were more effective, or if the combined package was necessary: An increase in problem-based information about breastfeeding, written mostly for and often by mothers, but read also by health workers. Consequently, more health workers also succeeded in their own breastfeeding. Increased availability of mother-to-mother support groups, health workers with better management skills and sometimes personal experience, and the rise in collective breastfeeding experience as more women successfully breastfeed. Increase in paid maternity leave with guaranteed return to previous employment. Maternity ward practices changed substantially towards mother-infant contact and autonomy (Protheroe et al, 2003).

Few studies aimed to support women who had initiated breastfeeding to sustain breastfeeding. Most interventions were educational in design, and based on pre-determined issues. Very few interventions were tailored to address the specific needs of their participants, and none were targeted at the carers of new mothers alone (such as hospital or community health workers), women prior to pregnancy or men alone (Bull et al. 2003).

**Weaning**

The evidence for the effectiveness of interventions designed to promote good practice in weaning and infant feeding is limited, one intervention reported delayed introduction of solid foods following a lactation counselling programme, the other showed improved diet resulting from a peer support programme (Bull et al 2003).

The stage at which complementary foods are introduced should not begin before four months and for breastfed babies not before six months. The 6 month recommendation to start complementary foods has been extended to all infants in the UK and is currently being debated at CODEX. The complementary food should meet nutritional requirements for infants in terms of macro- and micro-nutrients, and provide all nutrients in the correct proportions. Non-wheat cereals, vegetables and some fruit to which no salt or sugar has been added are suitable first solid foods (Bull et al. 2003).
Between six and nine months of age dietary variety should increase to include meat, fish, eggs and all cereals and pulses, while the number of milk feeds is reduced. For infants on a vegetarian diet, care should be taken to ensure a variety of foods at each meal and protein sources should be mixed. Each meal should include a good source of vitamin C (Bull et al. 2003).

Intake of non-milk extrinsic sugars should be limited to 11% of energy intake, therefore weaning foods and additional drinks should be free from, or low in, non-milk extrinsic sugars. Fats should not be restricted as they are an important source of energy for this age group and restriction may affect growth. Provided energy intake is adequate, the proportion of dietary energy derived from starchy foods should increase as the proportion derived from fat decreases, with adult dietary recommendations becoming applicable to children over 5 years old (Bull et al. 2003).

A varied diet and moderate exposure to sunlight are encouraged to ensure adequate vitamin and mineral status, and from six months infants who are solely breastfed should receive vitamin supplements (Bull et al. 2003).

Review-level evidence on the effectiveness of nutritional interventions for the prevention of low birth weight (Bull et al. 2003):

<table>
<thead>
<tr>
<th>Evidence of effectiveness</th>
<th>Current lack of evidence of effectiveness</th>
<th>Conflicting evidence of effectiveness</th>
<th>Use not recommended; evidence of potential harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calcium supplementation (to reduce preterm birth and LBW, especially those at risk of hypertensive disorders)</td>
<td>Magnesium supplementation (to reduce LBW)</td>
<td>Balanced protein-energy supplementation (to reduce preterm birth)</td>
<td>Niacin: balanced protein supplementation (to prevent LBW)</td>
</tr>
<tr>
<td>Balanced protein-energy supplementation (to reduce preterm birth)</td>
<td>Iron and folic acid supplementation (to prevent LBW)</td>
<td>Nutritional advice in pregnancy (to prevent LBW)</td>
<td>High-protein supplementation (to prevent LBW)</td>
</tr>
<tr>
<td>Iron supplementation (to prevent LBW)</td>
<td>Zinc supplementation (to prevent LBW)</td>
<td>Folic acid supplementation (to prevent LBW)</td>
<td></td>
</tr>
<tr>
<td>Zinc supplementation (to prevent LBW)</td>
<td>Folic acid supplementation (to prevent LBW)</td>
<td>Vitamin D (to prevent LBW)</td>
<td></td>
</tr>
<tr>
<td>Folic acid supplementation (to prevent LBW)</td>
<td>Vitamin D (to prevent LBW)</td>
<td>Fish oil supplementation (to prevent LBW)</td>
<td></td>
</tr>
<tr>
<td>Fish oil supplementation (to prevent LBW)</td>
<td>Vitamin D (to prevent LBW)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Lower quality review-level evidence is based on weaker quality evidence which did not meet the criteria of the MRC Evidence Base, or did not meet the criteria of systematic, transparent, and rigorous evidence as measured by the critical appraisal form, but are relevant to low birth weight.

All babies should receive one dose of vitamin K prophylaxis at birth. Babies who are entirely or mainly breastfed should receive effective long-term prophylaxis. Roche Konakion MM is licensed for oral and parenteral use. Staff must record the formulation, dose, route, and date of all vitamin K administration; multiple policies in one district should not be tolerated (Hall, D. & Elliman, D., 2003 Pg. 99).

Dental and oral disease

Despite hundreds of studies involving thousands of individuals, we have little evidence about how to promote oral health effectively. Sustained use of fluoride reduces caries and good oral hygiene promotes gingival health. Evidence concerning the effectiveness of the use of fluoride2 (whether in the form of toothpaste, tablets, drops, or rinses) in reducing caries is strong. Thus, health promotion interventions which incorporate the regular use of one or other of these items are effective as long as

2 Fluoride in water at 1 part per million has been shown to be the most effective method of reducing tooth decay. Dentists can identify those individuals who would most benefit from fluoride and offer it on prescription (Hall, D. & Elliman, D., 2003 Pg. 102).
compliance is achieved. Daily brushing with a fluoride toothpaste is easier to achieve than regular use of other fluoride supplements. There is no evidence in the literature that oral health promotion per se effects caries rates, even if changes in behaviour are achieved, unless fluoride is being used (HDA, 1997).

There is a 40% reduction in dental malocclusions if infants are breastfed for 1 year.

Oral health promotion on an individual level is effective for reducing plaque levels. However, there is strong evidence that the changes achieved are short term and are not sustained. Interventions designed to improve oral hygiene are effective even when very simple direct instruction is used. Cognitive-behavioural techniques are not required in order to achieve changes in plaque levels. School-based toothbrushing campaigns aimed at improving oral hygiene have not been shown to be effective (HDA, 1997).

Reduction in plaque levels almost always, but not invariably, leads to reductions in inflammation and bleeding of the gingivae. The lack of specificity of this relationship and the unknown long term health consequences of gingivitis make evaluation of oral health promotion in this field very difficult (HDA, 1997).

Improving individuals’ knowledge of dental health matters can be achieved through oral health promotion and oral health education. The clinical, behavioural and health significance of these shifts in knowledge are unknown and there is some evidence that there are no consequences from improvements in knowledge.

Since very few studies measure behaviour directly, it is difficult to evaluate the effect of oral health promotion on behaviour. Reported behaviour and behavioural intention can be altered and oral hygiene behaviour can be improved in the short term by simple educative interventions (HDA, 1997).

Nutritional advice, sugars are the most important dietary factor in the cause of dental caries. Children taking frequent or regular sugar-based medicines are shown to have increased levels of dental decay. Tooth erosion is related to increased consumption of acidic drinks either as pure fruit juices or as carbonated beverages (Hall, D. & Elliman, D., 2003 Pg. 102). Wean children onto food and drink which are free from non-milk extrinsic sugars (Hall, D. & Elliman, D., 2003 Pg. 102). There are remarkably few evaluations of the effect of oral health promotion on sugar consumption, and those which are available frequently use reported behaviour as the measurement instrument. Thus, evaluations of health promotion aimed at altering sugar consumption often describe changes in knowledge levels rather than altered habits or lifestyles (HDA, 1997).

Although little evaluative research has been published, the available evidence indicates that mass media campaigns are ineffective for promoting either knowledge or behaviour change. However, they may have some value in raising awareness and agenda setting as part of an overall oral health promotion strategy (HDA, 1997).

Effective cleaning of teeth and gums using a should commence once teeth appear. Daily thorough brushing with children’s fluoride toothpaste from two years of age is an oral health promoting behaviour and is an achievable goal A small pea-sized blob of paste is all that is required for children up to 6 years of age, children require parental assistance with brushing until at least 6 years of age (Hall, D. & Elliman, D., 2003 Pg. 103).

School-based toothbrushing instruction aimed at improving oral hygiene has not been shown to be effective. Oral health promotion is effective for increasing knowledge levels. However, there is no evidence that changes in knowledge are causally related to changes in behaviour. There is no convincing evidence of the effectiveness of mass media programmes designed to promote oral health (HDA, 1997).

Dental, ophthalmic and aural treatment. Health boards are required under section 67 of the Health Act 1970, to make dental, ophthalmic and aural treatment available without charge to preschool and national school children referred from child health examinations (Denyer, S. et al. 1999. Pg.26)
Indicators of maternal wellbeing - Postnatal depression

Depression and mood disorders (Baby blues; Acute puerperal psychosis; post-natal depression) are common among the mothers of young children and occur in all social classes (Hall, D. & Elliman, D., 2003 Pg. 60). Preliminary evidence that women at risk can be identified antenatally and that intervention at this stage can reduce the incidence of post-natal depression (Hall, D. & Elliman, D., 2003 Pg. 61). Postnatal depression can have adverse consequences for the emotional and physical well-being of the baby (Elliman, D. et al 2004).

The Edinburgh Postnatal Depression Scale (EPDS) is used to facilitate detection of depression. The Edinburgh Postnatal Depression Scale has not been fully validated for routine use as a screening tool in primary care (Murray, L. et al 2004 cited in Elliman, D. et al 2004). On the basis of current evidence the National Screening Committee (UK) do not recommend the use of the EPDS as a screening tool (Elliman, D. et al 2004; Hall, D. & Elliman, D., 2003 Pg. 62).

Behaviour Problems

Evidence that particular parenting styles are harmful for children and are particularly associated with antisocial child behaviour (Scott S. 1998; Kendrick et al 2000). These are: a persistently hostile, rejecting emotional tone; harsh or erratic discipline; poor supervision; parental conflict; and low involvement in the child’s activities (Scott S. 1998). As every family is different, a thorough assessment is essential of the parenting and of the child (Scott S. 1998).

The evidence suggests that, to be effective, prevention and intervention should encourage positive relationships as well as address misbehaviour (Hall, D. & Elliman, D., 2003 Pg. 55). Targeted approach to behavioural and emotional disorder needs to be accompanied by a total population education programme to raise the knowledge and skills of all parents. Evaluation using randomised controlled trials has shown that behaviourally based parenting programmes considerably improve both the quality of parenting and the outcome for the child. Effective programmes address both the moment to moment minutiae of parents’ handling of children, and the wider context of their lives that can get in the way of good enough parenting (Scott, 1998).

Behavioural problems and difficulties with speech and language acquisition often coexist and are associated with learning difficulties in school (Hall, D. & Elliman, D., 2003 Pg. 55).

Training

There is a need for more resources for primary prevention and the opportunities for health education which could be given by doctors at various stages of the life cycle, beginning in pregnancy (Stone D, & Campbell H, 1997). Health staff should have an aide memoire of topics to discuss with parents at the time of each screening test (Colver, A 1990). Training in health surveillance is essential (Colver, A 1990). Curriculum developers must work together to teach these health promotion skills at undergraduate and postgraduate medical education (Stone D, & Campbell H, 1997). Training should be standardised across the country, the surveillance of children who moved to another health district would not be affected nor would primary health care teams have to vary their programme (Colver, A 1990).

Successful programmes and projects (Hall, D. & Elliman, D., 2003 Pg. 50).

- Services - broad spectrum and comprehensive, crossing traditional professional boundaries, and are coherent and easy to use.
- Structure and staff are flexible in their ability to respond to unexpected demands.
- Staff have time and the skill to establish a relationship of respect and trust with families.
- Child seen as a member of the family, and the family a part of the community.
- Projects have enthusiastic committed leadership, clearly specified measurable aims, and focus on families with high levels of need.
- Sustained high quality and quantity of input and sufficient continuity of input to develop a relationship with the individual client.

Service provision and support are often poor for children affected by the illness or disability of a parent (Hall, D. & Elliman, D., 2003 Pg. 40). The primary care team is well placed to recognize the impact of the adult illness on the rest of the family (Hall, D. & Elliman, D., 2003 Pg. 41). Children of parents
with learning disability, depending on severity, may have a number of problems (Hall, D. & Elliman, D., 2003 Pg. 43). Children with physical disabilities may have problems with attendance at clinics, school and out-of-school activities, and in caring for the parent (Hall, D. & Elliman, D., 2003 Pg. 44). Young carers may experience impaired psycho-social development, including poor educational attendance and performance, and restricted peer networks, friendships, and opportunities (Hall, D. & Elliman, D., 2003 Pg. 43).

Service provision for all ethnic groups is important if the needs of all children are to be met (Webb, E. 2000 cited in Hall, D. & Elliman, D., 2003 Pg. 38).
PRINCIPLES OF HEALTH PROMOTION

The World Health Organisation (1998) has identified seven key principles that should guide all our efforts to enhance the health of the population.

Empowerment
Health promotion initiatives should enable individuals and communities to assume more power over the personal, socio-economic and environmental factors that affect their health.

Participative
Health promotion initiatives should involve those concerned in all stages of planning, implementation and evaluation.

Holistic
Health promotion initiatives should foster physical, mental, social and spiritual health.

Intersectoral
Health promotion initiatives involve the collaboration of agencies from relevant sectors.

Equitable
Health promotion initiatives should be guided by a concern for equity and social justice.

Sustainable
Health promotion initiatives should bring about changes that individuals and communities can maintain once initial funding has ended.

Multi-strategy
Health promotion initiatives should use a variety of approaches, including policy development, organisational change, community development, legislation, advocacy, education, and communication, in combination with one another.
3.6 Health Promotion

Working Group Membership
Ms Carmel Cummins, (chair), Training & Development Officer, PAC
Ms Eileen Maguire, Training & Development Officer, NEHB
Mr Bernard McDonald, Reg Child & Adolesol Health Dev Officer, NEHB
Ms Grace O’Neill. Training & Development Officer, SEHB
Ms Teresa Cawley, Training & Development Officer, NWHB
Ms Mary Roche, Project Manager, Adolescent Health, PAC

Rationale
• Each child has a right to realise his/her potential in terms of good health, well-being and development.
• There is a need to work in partnership with parents and other primary carers.
• There is a need to develop a holistic health service for children and their families in which psychosocial well-being and development are as important as physical well-being.

Recommendations
• Increased emphasis on affirming and promoting bonding, parenting skills and age appropriate play
• Early identification of families in need of additional supports
• Health promotion literature, and its use, needs to meet criteria set out in Good practice guidelines for using health promotion information materials as established by the National Health Promotion Information Project (2004)

Equipment
• Personal Health Record (PHR) developed by MWHB
• Health Promotion Literature e.g. Child Health Information Services Project (CHISP) materials developed by SEHB
• Child Safety Awareness Manual developed by MHB
• Mechanisms to support multidisciplinary and interagency working

Personnel
Health promotion and education is the responsibility of all child health professionals, who require knowledge of the key determinants of child health and the skills for health promoting, reflective and responsive practice.
## Health Promotion

<table>
<thead>
<tr>
<th>Timing</th>
<th>History</th>
<th>Equipment</th>
<th>Health Education and Promotion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth</td>
<td>Parental concerns</td>
<td>Skills to work in partnership with parents on all issues related to their baby’s health and well being.</td>
<td>Parental health and well-being&lt;br&gt;Prevention of SIDS&lt;br&gt;Transport in cars&lt;br&gt;Feeding practice&lt;br&gt;Sibling management&lt;br&gt;Parent–infant interactions&lt;br&gt;Child development&lt;br&gt;Accident prevention&lt;br&gt;Information about local support networks and contacts for additional advice and support when needed.&lt;br&gt;Identification of parents who may be in need of additional supports.</td>
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<td>Motivational mechanism to support multidisciplinary and interagency working</td>
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<tr>
<td>Postnatal visit</td>
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<td>As above</td>
<td>As above</td>
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<tr>
<td></td>
<td></td>
<td>PHR – MWHB</td>
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<td></td>
<td></td>
<td>Caring for your child – Health Promotion Unit, DoHC</td>
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<td></td>
<td></td>
<td>Child Safety Awareness Manual - MHB</td>
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<td></td>
<td></td>
<td>Caring for your Baby – (CHISP) SEHB</td>
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<tr>
<td></td>
<td></td>
<td>Breastfed is bestfed - NWHB</td>
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<tr>
<td>6 to 8 weeks</td>
<td>As above</td>
<td>As above</td>
<td>As above</td>
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<td></td>
<td></td>
<td></td>
<td>Family planning</td>
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<tr>
<td>3 months</td>
<td>As above</td>
<td>As above</td>
<td>As above</td>
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<tr>
<td></td>
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<td></td>
<td>Oral health promotion&lt;br&gt;Age appropriate play&lt;br&gt;Return to work&lt;br&gt;Child care&lt;br&gt;Family planning</td>
</tr>
<tr>
<td>7 to 9 months</td>
<td>Parental concerns</td>
<td>As above</td>
<td>As above</td>
</tr>
<tr>
<td>18 to 24 months</td>
<td>Parental concerns</td>
<td>As per post natal visit</td>
<td>As above</td>
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<td></td>
<td></td>
<td></td>
<td>Management of challenging behaviour&lt;br&gt;Toilet training</td>
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<tr>
<td></td>
<td></td>
<td>Mother and toddler groups</td>
<td></td>
</tr>
<tr>
<td>3 to 4 years</td>
<td>Parental concerns</td>
<td>As per post natal visit</td>
<td>As above</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Access to information on local playschools/ pre-school/schools</td>
</tr>
<tr>
<td>School entry (Junior Infants)</td>
<td>Parental and teacher concerns</td>
<td>Skills to work in partnership with parents on all issues related to their child’s health and well being.&lt;br&gt;Mechanisms to support multidisciplinary and interagency working</td>
<td>As per SPHE programme&lt;br&gt;Advisory and supporting role to teacher in SPHE</td>
</tr>
<tr>
<td>School exit (5th or 6th class)</td>
<td>As per school entry</td>
<td>As per school entry</td>
<td>As per school entry</td>
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</tbody>
</table>
Health Promotion Training Module

Overall Aims: Setting the context for developments in child health promotion in Ireland as part of the core screening and surveillance programme.

Duration: 1 day

Tutor Expertise: Regional Training and Development Officer
Possible co-tutors/presenters – clinical colleague who participated in training/CAHDO/researcher PH Dept/Health Promotion Officer

Training Aides / Materials:

Flipchart and markers

Pp presentations
Introduction
Determinants of Child Health – the evidence
Effectiveness of interventions – the evidence(1) and Implications (2)
Standards in Child Health Promotion
Partnership with Parents

Resources
Information on and copies of materials, where possible, of best practice demonstration projects re partnership with parents – e.g. CHISP, PHR, Child Safety Awareness Manual, immunisation booklet, breastfeeding booklet

Handouts: 1 Tasks and skills in promoting children’s health
2 Strengths and development needs
3 Evaluation sheet
Specific Objectives:
By the end of the session participants
- Will have identified the major determinants of child health and well-being.
- Will have considered the evidence in relation to effective interventions in promoting children’s health
- Will have identified how local practice links with evidence-based best practice and the recommendations of BHFC Report and its review
- Will have identified the core competencies in developing a partnership with parents.
- Will have identified useful resources in developing a partnership with parents.
- Will have considered the implications for own practice and personal development.
## Lesson Plan

<table>
<thead>
<tr>
<th>Timing</th>
<th>Content – Session 1</th>
<th>Method</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>9.30</strong></td>
<td>Welcome Agenda Setting Context setting</td>
<td>Tutor welcomes, introduces self and co-facilitator PP Agenda and context of training</td>
<td>PP presentation See Appendix 1</td>
</tr>
<tr>
<td></td>
<td>Introductions</td>
<td>Paired introductions in group Full group introductions re expectations and concerns Record on FC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Group contract</td>
<td>Facilitate group agreement on a way of working for 6 days or give update on the context of developments in training programme since group met.</td>
<td></td>
</tr>
<tr>
<td><strong>10.00</strong></td>
<td>Identifying determinants of CH</td>
<td>The life of Pat Groups of 4-5 work on the life story of a child 0-4 in this area. (Prompts could be from whole child perspective, school readiness or tutor gives an example)</td>
<td>Materials FC sheet/markers for each group</td>
</tr>
<tr>
<td><strong>10.15</strong></td>
<td>Process/feedback</td>
<td>Presentation from each group on Pat’s story – max. 5 mins each Process in full group re what this group thinks determines a child’s health and well-being? Record Protective factors and Risk factors on FC Conclude by asking group to prioritise in terms of the major determinants – number on FC lists</td>
<td></td>
</tr>
<tr>
<td>Timing</td>
<td>Content - Session 2</td>
<td>Method</td>
<td>Comments</td>
</tr>
<tr>
<td>--------</td>
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</tr>
<tr>
<td>10.35</td>
<td>What’s the evidence?</td>
<td>Presentation on determinants of children’s health</td>
<td>PP presentation – See Appendix 2</td>
</tr>
<tr>
<td>10.55</td>
<td>Break</td>
<td></td>
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</tr>
<tr>
<td>11.00</td>
<td>Break</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.15</td>
<td>Promoting children’s health- what’s the evidence on interventions?</td>
<td>National and international evidence. Refer to sections on evidence in relation to specific interventions to address specific determinants e.g. socio-economic, relational early interventions (manual to have been disseminated to group before hand or summary pp presentation to group on the day)</td>
<td>Manual ps 3-20 PP presentation – See Appendix 3</td>
</tr>
<tr>
<td>11.20</td>
<td>Group discussion</td>
<td>Group discuss in relation to - What determinants of child health were the intervention designed to influence positively? - the core skills health professionals used in each intervention.</td>
<td>Reference sources Plus Irish evidence – Health in Ireland - an unequal state Websites for accessing evidence</td>
</tr>
<tr>
<td>11.35</td>
<td>Group feedback</td>
<td>Brief feedback from each group on the nature of the intervention they have discussed under both headings above.</td>
<td>Examples of local best practice – demonstration projects - PHR, CHISP, CSAP, parenting programmes, community</td>
</tr>
<tr>
<td>11.50</td>
<td>Regional best practice</td>
<td>The local story – how are we doing? What interventions are in place? Opportunity for input by local project leaders</td>
<td></td>
</tr>
</tbody>
</table>
### Health Promotion Guidelines as part of CHSSP


**Group response**
- Invite group comments on
  - what is welcomed in what was presented
  - Questions/concerns arising.

### Principles of Health Promotion

**Summary**

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<table>
<thead>
<tr>
<th>Timing</th>
<th>Content – Session 3</th>
<th>Method</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.00</td>
<td>Partnership with Parents</td>
<td>Energiser – Working with parents is like… Working with health professionals is like…invite participants to give a word or image that comes to mind when they think of working with parents or as parents working with health professionals (in pairs for 2 minutes, if possible, or brainstorm in full group)</td>
<td>Tutor may want to record key words on FC to focus on spectrum of words used.</td>
</tr>
<tr>
<td>Timing</td>
<td>Content</td>
<td>Method</td>
<td>Comment</td>
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<td>--------</td>
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</tr>
<tr>
<td>2.15</td>
<td>Processing</td>
<td>If in pairs, hear back in full group – words, images – process the full spectrum of words, which reflect the complexity of the work and the range of competencies/ skills required.</td>
<td>PP presentation – see Appendix 5</td>
</tr>
<tr>
<td>2.30</td>
<td>What do parents want?</td>
<td>PP summary presentation on &quot;Supporting Parenting: a study of parents' support needs&quot; by Sinead Riordan, CHISP consultations with parents and PHR evaluation findings.</td>
<td>Handouts See Appendix 6</td>
</tr>
<tr>
<td>2.50</td>
<td>Key roles of the health professional – working groups</td>
<td>On thing that can help in such complex work is to reflect in a structured way on our role. Present 6 headings on these key roles: ▪ Direct action ▪ coaching/educating ▪ Advocacy ▪ Changes in the system ▪ Giving feedback ▪ Counselling</td>
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</tr>
<tr>
<td></td>
<td>Processing in full group</td>
<td>Divide group into three – each group focuses on two key roles – the tasks and skills required. What core competencies are needed in our partnership role? Record on FC the list of group’s suggested best strategies and core competencies used</td>
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</tr>
<tr>
<td>3.20</td>
<td>Implications for individual participant’s practice</td>
<td>Individual worksheet exercise Each participant identifies strengths and developmental needs in relation to core competencies</td>
<td>Worksheet See Appendix 7</td>
</tr>
<tr>
<td>Time</td>
<td>Task Description</td>
<td>Notes</td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>----------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td></td>
</tr>
</tbody>
</table>
| 3.30  | **How training needs can be met**  
Summary – brief input on learning opportunities in HSE area. | Paired discussions  
CF opportunities in the other training days, other corporate, professional and academic learning opportunities |
| 4.15  | Closing round                                                                    | HSE area T&D Calendar etc.                                             |
| 4.20  | Evaluation                                                                       | See Appendix 8                                                        |
| 4.30  | Thanks/Close                                                                     |                                                                      |

Appendices 1-5 are available on request from carmel.cummins@pacirl.ie
## Working in partnership with parents

<table>
<thead>
<tr>
<th>Tasks</th>
<th>Skills used</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 Direct action e.g.</strong></td>
<td>• First post-natal home visit</td>
</tr>
<tr>
<td>• Carrying out a developmental check</td>
<td>• Giving vaccination</td>
</tr>
<tr>
<td><strong>2 Coaching/teaching e.g.</strong></td>
<td>• Breast feeding</td>
</tr>
<tr>
<td>• Safety in the home</td>
<td>• Access to a playgroup</td>
</tr>
<tr>
<td><strong>3 Advocacy e.g.</strong></td>
<td>• When there is need for referral</td>
</tr>
<tr>
<td></td>
<td>• Access to a playgroup</td>
</tr>
</tbody>
</table>
### Tasks

<table>
<thead>
<tr>
<th></th>
<th>Skills used</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Changes in the system e.g.</td>
</tr>
<tr>
<td></td>
<td>• Unmet need identified</td>
</tr>
<tr>
<td></td>
<td>• Data collection</td>
</tr>
<tr>
<td>5</td>
<td>Giving feedback e.g.</td>
</tr>
<tr>
<td></td>
<td>• To child</td>
</tr>
<tr>
<td></td>
<td>• To parent</td>
</tr>
<tr>
<td></td>
<td>• To manager</td>
</tr>
<tr>
<td></td>
<td>• To peers</td>
</tr>
<tr>
<td>6</td>
<td>Counselling e.g.</td>
</tr>
<tr>
<td></td>
<td>• Post-natal depression</td>
</tr>
<tr>
<td></td>
<td>• When a child has been diagnosed with a condition needing continuing care</td>
</tr>
</tbody>
</table>

Adapted from Murgatroyd (1988) Psychology in Action: Counselling and Helping, British Psychological Society and Methuen: London
<table>
<thead>
<tr>
<th>Competencies</th>
<th>My developmental need/s</th>
<th>How need/s can be met</th>
</tr>
</thead>
</table>

Working in partnership with parents to promote the health of their children
**Evaluation Sheet**

Training of doctors and public health nurses in Child Health Screening, Surveillance and Health Promotion

Introductory Module   Date____________________

Child Health Promotion and Partnership with parents

1. Three words to describe your experience of this training day

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

2. Please rate by circling a number on a scale of 1 to 5, where
1 = inadequate, 2 = poor, 3 = satisfactory, 4 = very good, 5 = excellent

<table>
<thead>
<tr>
<th>a. Content</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>A reason for your rating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>b. Tutoring/ facilitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>A reason for your rating</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

3. Please list two things you learned today that you intend to use in your practice

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

4. What was most relevant/useful?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

5. What was least relevant/useful?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

6. A question/concern/comment arising from this day’s work.

Signature (optional) ________________________________

Thank you for your help in evaluating the work.
Appendix 9

Good practice guidelines for using health promotion information materials.

Produced by:
National Health Promotion Information Project 2004
The National Health Promotion Information Project aims to facilitate the provision of quality health promotion information materials nationally. These guidelines have been developed to support health professionals when using health promotion information materials. “Writing effective health information materials”, published by the Health Promotion Unit in 2003, provides good practice guidelines for writing and designing health information materials.

Contact details:
National Health Promotion Information Project
St. Catherine’s Hall
Waterside
Waterford
Phone: 051 842815
Email: obriens@sehb.ie
Finding good quality leaflets and booklets

Health promotion leaflets and booklets are available from a number of places.

The National Health Promotion Information Project maintains a database of leaflets, booklets, posters and other resources available from Health Promotion Departments and voluntary organisations throughout Ireland. To search the database visit the Health Promotion Unit website www.healthpromotion.ie.

Your local Health Promotion Department will have a variety of leaflets and booklets. In general they will have all Health Promotion Unit leaflets and booklets and those produced by your local health board. The Communications Department in your organisation is useful contact for finding out where leaflets and booklets published by the board are available from.

Many of the voluntary organisations that focus on specific health issues publish leaflets and booklets. The following table lists national or Dublin contact details for a range of organisations. To get details of local services contact the numbers listed or check in your local phonebook.

---

### Health Promotion Leaflets - Useful addresses and telephone numbers

<table>
<thead>
<tr>
<th>Contact details of your local Health Promotion Department</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Other organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name</strong></td>
</tr>
<tr>
<td>Alzheimer Society of Ireland</td>
</tr>
<tr>
<td>Arthritis Foundation of Ireland</td>
</tr>
<tr>
<td>Asthma Society of Ireland</td>
</tr>
<tr>
<td>Barnardos</td>
</tr>
<tr>
<td>Bodywhys (Eating disorders helpline)</td>
</tr>
<tr>
<td>Organization</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>Bord Bia</td>
</tr>
<tr>
<td>Brainwave - Irish Epilepsy Association</td>
</tr>
<tr>
<td>Crisis Pregnancy Agency</td>
</tr>
<tr>
<td>Cystic Fibrosis Association of Ireland</td>
</tr>
<tr>
<td>Dental Health Association</td>
</tr>
<tr>
<td>Diabetes Association of Ireland</td>
</tr>
<tr>
<td>Down's Syndrome Association</td>
</tr>
<tr>
<td>Drug/HIV Helpline (National)</td>
</tr>
<tr>
<td>Enable Ireland (Children with special needs)</td>
</tr>
<tr>
<td>Health and Safety Authority</td>
</tr>
<tr>
<td>Irish Cancer Society</td>
</tr>
<tr>
<td>Irish Heart Foundation</td>
</tr>
<tr>
<td>Irish Sudden Infant Death Association</td>
</tr>
<tr>
<td>Meningitis Research Foundation</td>
</tr>
<tr>
<td>Mental Health Association of Ireland</td>
</tr>
<tr>
<td>National Council for Ageing and Older People</td>
</tr>
<tr>
<td>National Council for the Blind</td>
</tr>
<tr>
<td>National Dairy Council</td>
</tr>
<tr>
<td>National Safety Council</td>
</tr>
<tr>
<td>Osteoporosis Society of Ireland</td>
</tr>
<tr>
<td>Parkinsons Association of Ireland</td>
</tr>
</tbody>
</table>
Checklist for choosing good quality leaflets

What makes a good leaflet?

What do you look for when choosing leaflets or booklets to display in your clinic or to use when talking with clients? How do you decide which leaflet is the best and which you should bin?

A checklist like this one is a good starting point. It highlights the key points that ensure a leaflet keeps the readers attention and is easily understood. It also allows you to assess how well the leaflet has been written, designed and illustrated. And it can provide a good framework for developing new written materials for your practice.

The Health Promotion Unit booklet “Writing effective health information material – guidelines for writing and design” gives more detailed guidelines.

The checklist (adapted from Health Promotion England)

Target group

→ Who is the leaflet aimed at?
Do the cover design and title clearly show whom the information is for?
Is a leaflet or booklet the most appropriate way to give information to your target audience? Literacy, disability and cultural issues may mean a leaflet or booklet is not appropriate.

Information quality

→ Is it accurate?
Can you spot any mistakes? Ask your colleagues if you are unsure.

→ Is it up-to-date?
Some information, such as contact details, for example, frequently changes.
Is there a publication and/or review date listed – this information can help you decide whether the information is up-to-date.

→ Are the important points covered in the right order?
The content of the leaflet should be non-judgemental and give the reader accurate and balanced facts.

Tone of voice

→ Is it patronising or scaremongering?
This is likely to put the reader off – and prevent the message from getting across.

→ Does it avoid discrimination?
Leaflets and booklets should avoid making assumptions or using clichés about issues such as race, sex, or age.
Motives

→ Is the information from a credible source?
Be aware of advertising. Are commercial interests influencing the messages given?
Do the messages given contradict other health promotion messages?

Clarity and comprehension

→ Is the language simple and direct?
Are sentences short? A maximum of 15 to 20 words is recommended.
Is jargon – in particular, medical jargon – avoided?
Does the language used address the reader in a friendly, ‘personal’ way?

→ Are meanings clear?
Abbreviations may not be obvious to all readers.

→ What about headings?
Most people scan a leaflet quickly by picking out the headings, so these should be
used to emphasise the most important points.

→ What is the readability score of the leaflet?
Most leaflets for the general public should have a readability score equivalent to 13
years of age (National Adult Literacy Agency 2000).
For materials already printed use the SMOG Test (p 18 Writing effective health
information materials).

→ Is there a summary of the most important information?
A good leaflet should summarise the key ‘take home’ messages.

Design and layout

→ Is it a convenient size?
For leaflets or booklets on display – would it fit easily into a pocket or handbag for example?

→ Does it have an eye-catching cover and title?
Does the leaflet or booklet stand out from other publications?
Does the cover and title give a positive message?

→ Does it use easy-to-read, sensible typefaces?
A minimum size of 12-point font is recommended for the general public. For readers
who may have poor eyesight, for example the older people, a minimum of 14-point
font is recommended.

→ Is there enough spacing between the lines?
Densely packed text is much more difficult to read.
→ Is there too much information? Large blocks of text may put off readers.

→ Have highlighting techniques such as bullet points and **bold font** been used effectively? They should be used to highlight key points and draw the reader’s eye to important information. Bullet points or numbered points should be used when listing information.

→ Is colour used to help you find your way around the text? A good contrast between the text and background colour make reading easier – for example dark colours for text and white or light colours for the background.

**Illustrations and photographs**

→ Do they support the text? Illustrations and captions can help to ‘tell the story’ and reinforce key messages.

→ Are photographs and illustrations relevant to and representative of the target group? If the information is for the general public, are people from different walks of life and communities visible.

**Bilingual versions**

→ Is the same tone used in both languages? If you are not fluent in both languages, it is worth asking someone who is to check through the text.

→ Is the design suited to different cultures? All languages and communities should be treated equally. Sensitivity to cultural differences is important.
Using information leaflets and booklets with clients

Information leaflets and booklets can be used to support verbal information given by you to the client. How you use the leaflets or booklets will impact on how useful clients find them.

**Relevance**

How clients use leaflets and booklets is influenced by the way they seek information and learn. Adults, in general, only seek information when they have identified a gap in their own knowledge. To accept the new information as correct, adults then need to be able to make sense of it and apply it to their own life (Dervin B, Nilan M 1986). It is important, therefore, that the leaflets and booklets used with clients contain information that is relevant to them, their lifestyle and age of their children.

Recent research carried out by the Child Health Information Services Project (CHISP) reinforces this. Parents involved in the research wanted relevant information given to them at the appropriate time

“….. I mean at the moment, you look up toddler, what should he be doing now” (Conway E 2003).

**Literacy**

When using written health information you need to be aware of literacy difficulties. Over 50% of the general population in Ireland may experience difficulties understanding written health information. People with literacy difficulties become very adept at hiding their difficulties. The literacy difficulties can include:

- being unable to read,
- not feeling confident in their own ability to read and understand health information,
- not being able to relate the examples given to their life,
- hidden disabilities such as sight problems, dyslexia.

If a client expresses a desire to address their literacy difficulties, you can help them make contact with their local Adult Literacy Scheme. The phone number will be in the Golden Pages.

**References:**

Conway E 2003 *Identifying the child health and related support service information needs of parents/carers from the ante-natal to pre-school years* South Eastern Health Board.

Dervin B, Nilan M 1986 *Information needs and uses* in Williams ME (Ed.) 1986 *Annual Review of Information Science and Technology (ARTIST)* Volume 21,

National Adult Literacy Agency (NALA) 2002 *Health and Literacy Report*
Guidelines for using information leaflets and booklets effectively

1. Read all leaflets or booklets before you use them with clients.

2. Choose leaflets or booklets that are written in a friendly, non-judgemental tone and an easy-to-read style.

3. Use leaflets and booklets that contain information relevant to the client, their lifestyle and the age of their children.

4. Make the leaflet or booklet relevant to the client. Say why you are giving them the leaflet and what information they will find in it and where they will find it - “This booklet has a lot of information about immunisation. It has information on all the vaccinations, how they work and answers some of the common questions parents have.”

5. Check with the client if they are comfortable reading the leaflet or booklet themselves – “Would you like to read it in your own time, or would you prefer me to read through it with you now?”

6. **When reading through the leaflet or booklet with the client, pick out the important information and discuss it with them. Check their understanding of the information.**

   “You mentioned that you are concerned about giving John the MMR vaccination because of what you have heard and read about a link with autism. Was the information on the safety of vaccines of any help?”
Translating health information into languages other than English.

Translation involves putting a message in one language into another language so that a user of the other language can understand the message. Translators deal with the written word, while interpreters deal with the spoken word.

The need for written health information in languages other than English or Irish has grown as Ireland becomes increasingly multi-cultural. The demand for health information in specific languages will vary, however, depending on local demographics.

Here are some practical guidelines to follow when translating written health information into languages other than English:

- Find out the specific language or languages your target audience can read.
- Make sure your original message is written in plain English and that the content is accurate.
- Use a translator specialising in the language required.
- Get quotes for the translation and proof reading. You will need someone to proof read (check) the printers draft before final printing.
- Get approval and funding before commissioning the work.
- Decide how you will produce the information. It is often more cost effective to arrange printing rather than to photocopy and the quality is better.
- Test the translated information with your target audience. You may need the assistance of an interpreter for this task.
- Proof read the printers draft before final printing.
- Review and update information regularly.

**Useful contacts:**

For translating information from English into Irish:
Your organisation may have an Irish Officer who will advise you.
Gaelgáras offer translation services – [www.gaelaras.ie](http://www.gaelaras.ie)

For translating information from English into languages other than Irish:
The Irish Translators Association is a useful information source with a listing of registered translators and information on fees - [http://homepage@tinet.ie/~translation](http://homepage@tinet.ie/~translation)
References:


Child and Youth Health Intergovernmental Partnership, Australia,(2002) *Child Health Screening and Surveillance: supplementary document – context and next steps*.

Clwydian Community Care NHS Trust (1999) *Child Health Promotion Programme for North Wales*


Cox JL, Holden JM, Sagovsky R. *Edinburgh Post Natal Depression Scale* (EPDS), Department of Psychiatry, University of Edinburgh


Laffoy, M Childhood Accidents at home. IMJ Vol.90 (1):26-27


McCain, M. & Mustard F(1999) *Reversing the Real Brain Drain Early Years*, UNICEF, Ontario, Canada,


Community Child Health Services
Maternity and Infant Care Scheme, under section 63 of the Health Act 1970, the health board shall make available without charge medical, surgical and nursing services for children up to the age of 6 weeks (Denyer, S. et al. 1999. Pg.25)

Preschool child, under section 66 of the Health Act 1970, the health board shall make available without charge at clinics, health centres etc a health examination and treatment service for children under the age of 6 years. Service is free of charge and children who are referred for further specialist out-patient attention or for admission to hospital are also treated free of charge (Denyer, S. et al. 1999. Pg.25)

School health service, under section 66 of the Health Act 1970, a health board shall make available without charge a health examination and treatment service for pupils attending a national school (or a school not a national school at the discretion of the health board). Children who are referred for further specialist out-patient attention or for admission to hospital are also treated free of charge (Denyer, S. et al. 1999. Pg.26)

Further information
Bristol Child Development Programme, emphasis on empowering parents to find their own solutions to their child-rearing concerns (www.ecdc.org.uk in Hall, D. & Elliman, D., 2003 Pg. 71).

Homestart aims to reduce the need for professional intervention (Hall, D. & Elliman, D., 2003 Pg. 72).

Newpin www.newpin.org.uk voluntary organization providing help for people with parenting difficulties.

Day Care www.copas.net.au/ccch

Sure Start

Triple P

UNICEF Baby Friendly Initiative; peer support.