4 Establishing a healthy start in life

4.1. The importance of a healthy start

There is overwhelming evidence that what happens in childhood has a huge impact on health in later life. The building blocks for good health and development are laid in early childhood, starting in the womb. This includes physical health – obesity, heart disease and mental health are all affected by early childhood experiences. It also includes mental development and life expectations that determine educational achievement and income, which themselves have a direct impact on health.

We know from the data that children from many Black and Minority Ethnic communities and migrant families have poorer childhood outcomes using a range of indicators. This chapter examines this data.

4.2. The link between education and health

A well-proven link

Education has a significant impact on the health and well-being of children and young people throughout childhood, adolescence and into adulthood. A broad-based education and positive experience of school equips young people with the skills, knowledge and aspiration they need to achieve a healthy and happy life. Low educational attainment is a key determinant of inequalities in health because it influences socio-economic status, employment, income, housing and other psycho-social factors.

Education in Haringey

Schools in Haringey experience high mobility, with a large number of new arrivals that include refugees, asylum seekers and economic migrants from overseas, internal migrants (those from within the UK, including, for example, Roma, Gypsy and Traveller children) and unaccompanied asylum seeking children. New arrivals have varying needs depending on their previous schooling and individual circumstances. While many experience a smooth integration into the UK schooling system, some have greater needs and challenges to overcome. Some new arrivals have a fractured educational history or no previous schooling and experience cultural disorientation and feelings of loss and isolation. They may also be recovering from shock or trauma, be living with parents experiencing emotional difficulties or be experiencing changes in their family situation, including separation from one or both parents.[21]

Many new arrivals have English as an Additional Language (EAL) or are new to the English language when they arrive in the UK. This presents interesting challenges and opportunities for Haringey schools, which are embracing the multi-cultural and diverse populations that they serve. The number of different languages spoken by children in Haringey schools has been estimated at 175.

Haringey holds very limited information on the educational performance of new arrivals because it is difficult to collect this data. The school census information on pupils enrolled in Haringey schools records ethnicity only and does not distinguish refugee or asylum seeking status or length of time in the UK. Data is held on Roma, Gypsy and Traveller children. However, this does not always provide an accurate picture because parents/carers may not disclose this information.

There is often considerable school mobility among migrants arriving in the UK, as well as among internal migrants. There is evidence that school mobility influences educational performance in Haringey as there was a substantial difference in attainment for reading, writing and mathematics at Key Stage One between pupils who had been at their school for more than two years and those who had been there less than two years.[22] At the end of primary school, 20% of pupils had been in their school for less than three years prior to taking their School Attainment Tests (SATs). The attainment of these pupils was significantly below that of other pupils.[23]

In terms of ethnicity, there continues to be differences in attainment between White British pupils and pupils from other large ethnic groups in Haringey primary schools. In 2007, Haringey African pupils were 1% below their national peers, Caribbean pupils were 3% below and White UK pupils were 8% above their national peers. The educational performance of most minority ethnic pupils for the older age groups has improved considerably and the gap in attainment of five or more A* to C grades at GCSE has decreased.

Key messages:

- Experiences in early childhood are crucial to health outcomes in later life.
- There is a strong link between educational achievement and health. Pupils from certain Black and Minority Ethnic groups have lower educational attainment than White British pupils.
- The number of low birth weight babies, a proxy indicator for infant mortality, is higher in the deprived wards in the east of the borough.
- Antenatal care is important for the health of the mother and child. Some Black and Minority Ethnic groups are more likely to present late for antenatal care.
- National data indicates that rates of teenage motherhood are significantly higher among women of Mixed White and Black Caribbean, Other Black and Black Caribbean ethnicity.
- Black African and Caribbean and Other Black groups, mixed race White and Black groups and Bangladeshi, Pakistani, White Other and White Irish groups are more at risk of childhood obesity. However, this may be due to deprivation rather than ethnicity.
- New integrated service models, such as children's centres, are proving effective at offering services to hard-to-reach communities.

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Figure 9 shows that although there has been an improvement in educational attainment across the board and that this improvement has been significant among the major ethnic groups in Haringey, it is still clear that those from minority ethnic groups continue to have lower educational attainment than White British pupils.

Haringey Children and Young People's Service is committed to providing excellence in education for all their learners and overcoming any barriers to learning. Haringey participates in government strategies and schemes to improve achievement of diverse groups, including Making a Big Difference, New Arrivals Excellence Programme, Ethnic Minority Achievement Programme and Gypsy, Roma and Traveller support programmes.

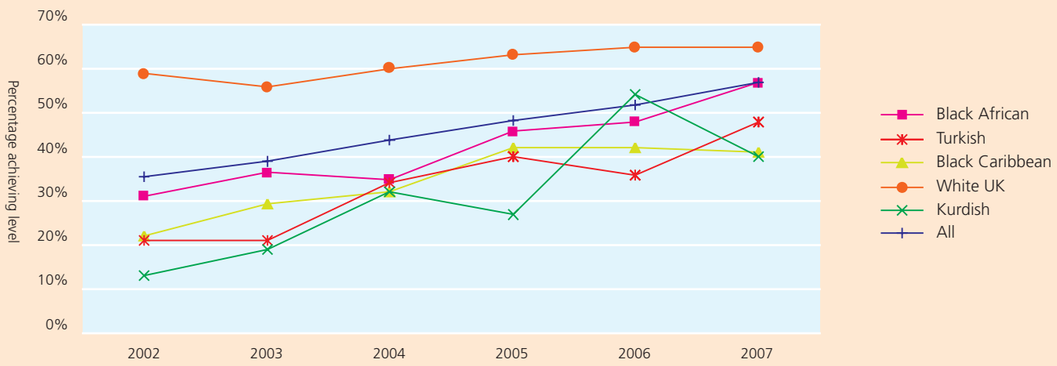
4.3. Infant and child mortality

An important indicator of health inequalities

Infant mortality, defined as deaths in children under one year old, is a sensitive measure of the overall health of a population. It reflects the apparent association between the causes of infant mortality and other factors that are likely to influence the health status of whole populations, such as their economic development, general living conditions, social well-being, rates of illness and the quality of the environment. The government has made infant mortality a priority in its tackling health inequalities strategy. The infant mortality element of the target is:

Starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between the routine and manual group and the population as a whole.*

Figure 9: Percentage of children obtaining 5 Grade A to Cs at GCSE, 2007



Source: Office for National Statistics

* The routine and manual group includes those in lower supervisory and technical, semi-routine and routine occupations. Typical examples might be porters, cleaners, bar staff, waiters/waitresses, sales assistants, catering assistants, train drivers, people working in call centres, electricians and sewing machinists.

Infant and child mortality in Haringey

While the infant mortality rate (IMR) for England is at an all-time low, rates in Haringey are significantly higher than those for England and London. Table 5 compares the infant mortality rate in Haringey with those for England and London.

Table 5: Infant mortality rates, 2005–2007

	England	London	Haringey (Rate and number)
Under 1 year	4.9	4.8	6.1 (75)
Neonatal (infant deaths under 28 days per 1,000 live births)	3.4	3.3	4.5 (55)
Deaths under 7 days (per 1,000 total births)	2.6	2.5	3.3 (41)
Stillbirths	5.3	6.2	6.1 (76)

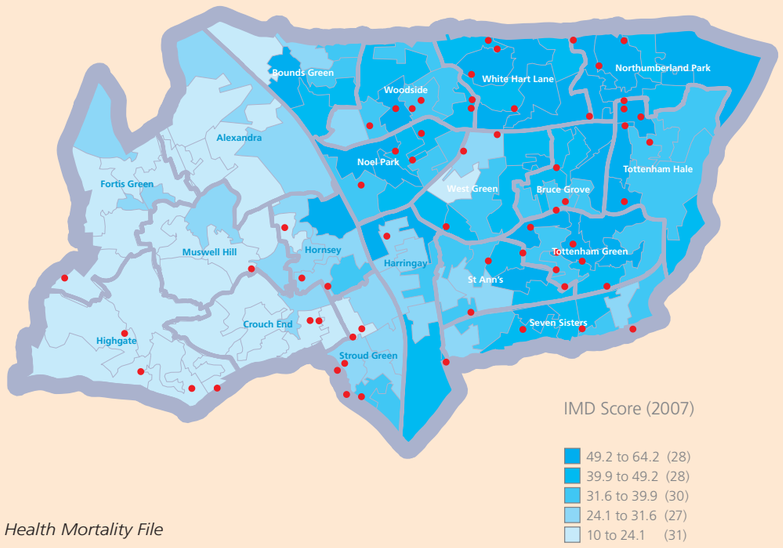
Source: National Centre for Health Outcomes Development (NCHOD)

The Department of Health Review of Health Inequalities in Infant Mortality highlighted inequalities in infant deaths among women in Black and Minority Ethnic groups.[24] This is because some Black and Minority Ethnic groups, including Pakistani, Bangladeshi, Black Caribbean and Black African families, are at particular risk of poverty and socio-economic disadvantage.

Clearly, ethnicity may be an important factor in infant mortality. However, numbers are too small at a local level to enable meaningful analysis. Nationally, the IMR in babies of mothers born in Pakistan was 10.2 per 1,000 live births in 2002–2004, double the overall IMR (4.9 per 1,000 live births in 2002–2004) for all babies born in England and Wales. The IMR in babies of mothers born in the Caribbean was 8.3 per 1,000 live births in 2002–2004, 63% higher than the national average. In London, deaths in the first year of life are more common among infants born to mothers who were born outside England and Wales, a rate of 5.9 per 1,000 in London, and as high as 10.9 in births to mothers born in West Africa.[25]

In Haringey between 2005 and 2007, local records based on Public Health Mortality Files identified 70 deaths, which are described in Figure 10.

Figure 10: Distribution of infant deaths in Haringey (under one year), 2005–2007



Source: Public Health Mortality File

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The highest numbers of deaths were in Tottenham Green (10) and White Hart Lane (8). There were no reported deaths in Alexandra or Bounds Green wards. Analysis over a three-year period shows that the infant mortality rate is higher in wards in the east of Haringey. However, as the numbers are small it is not possible to ascertain a clear pattern across the borough. There was a higher proportion of male deaths, 61% (43), which is consistent with national figures. Prematurity-related conditions (57%) and congenital anomalies (16%) account for the highest numbers of deaths.

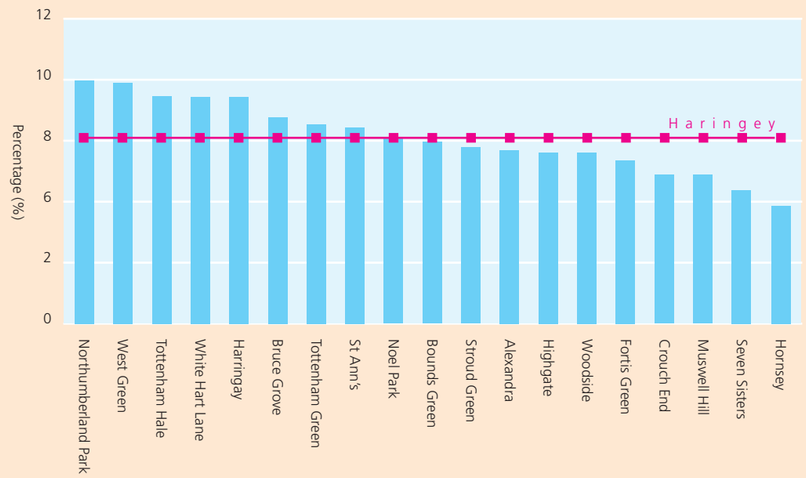
The main cause of death for neonates (under 7 days) is prematurity-related conditions (68%) and congenital anomalies (15%). National data suggests that 75% of deaths among neonates are caused by prematurity-related conditions and congenital anomalies, suggesting that Haringey has a higher number of deaths from these causes than expected.

The main causes of death for those aged between 7 and 28 days is prematurity (62%). In those over 28 days, prematurity and infection are the main causes, both 29%.

Between 2005 and 2007, there were 40 deaths in neonates (children under 7 days old) in Haringey, 13 between 7 and 28 days and 17 over 28 days. Compared to figures for England, Haringey has a slightly higher proportion of deaths under 7 days and between 7 and 28 days, but a lower proportion over 28 days.

It has been a legal requirement since April 2008 for the circumstances surrounding the death of any child resident in the borough to be reviewed. Haringey's Local Safeguarding Children Board established a Child Death Overview Panel in March 2008. The Child Death Overview Panel also considers the outcome of post-mortems and information gathered in Confidential Enquiry into Maternal and Child Health reports, in coming to a collective view as to whether or not a child's death might have been preventable.

Figure 11: Low birth weight by ward, 2005–2007



Source: Public Health Birth Files

The Annual Report of the Child Death Overview Panel identified that 25 Haringey children died between April 2008 and March 2009.[26] Of these, 19 were less than one year old and only six were older. Nine were less than one week old, 10 less than 28 days (40%). The overwhelming number of deaths were related to perinatal or congenital factors.

In the 2001 census, of the 0 to 15-year-olds in Haringey, 51.5% were White, 10.3% were Black Caribbean and 15.4% were Black African. This contrasts with the deaths reported, of which 8 out of 21 (38%) were Black African, 4 out of 21 (19%) were Black Caribbean and only 8 out of 21 (38%) were White.

Low birth weight

As numbers of infant deaths are small, there are fluctuations in the rate year on year which make it difficult to see longer-term patterns. Birth weight is, therefore, often used as a proxy measure for infant mortality. The graph given in Figure 11 describes the difference in low birth weight rates between wards. All of the wards in the east of the borough, with the exception of Seven Sisters, had the highest proportion of low birth weight babies born between 2005 and 2007.

4.4. Antenatal care

The importance of antenatal care

As more is known about foetal and infant development, the importance of booking early for antenatal care as an early intervention and prevention tool has become very clear. In addition, maternity services acknowledge the importance of addressing the needs of women and their partners before the woman becomes pregnant, as well as throughout pregnancy and childbirth.[28] Good maternal health and high quality maternity care throughout pregnancy and after birth can have a marked effect on the health and life chances of newborn babies and on their future development.

However, around 16% of all pregnant women, including many of those under 18 years of age, delay seeking maternity care until they are five or more months pregnant, thus missing the crucial early days of maternity care. These women and their babies have worse outcomes than those who access maternity care at an earlier stage of their pregnancy.[29]

A new approach to health and well-being

In Haringey, wards with the highest numbers of low birth weight babies are being prioritised for local workshops for professionals who work directly with families. These meetings aim to raise awareness of the causes and risk factors for infant mortality and to develop practical strategies to address some of these issues with local families. This is in line with the Department of Health recommendation that local areas should raise awareness of the infant mortality target with local professionals.[27]

Haringey has also developed a local Infant Mortality Action Plan, which details specific actions to reduce infant mortality under the following headings:

- Strengthening local delivery.
- Teenage pregnancy.
- Smoking cessation.
- Antenatal care.
- Postnatal care.
- Improving housing quality and reducing overcrowding.
- Reducing child poverty.

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The NHS has developed a target for early antenatal booking. This aims to have 80% of women presenting to maternity services receiving a full assessment by 12 weeks 6 days of pregnancy by the end of 2009/10 and 90% in 2010/11. Latest quarterly figures (January to March 2009) show that 53% of women in Haringey booked for antenatal care before 12 weeks 6 days. Achieving 80% by the end of 2009/10 is, therefore, a challenging target for Haringey.

Which groups tend to present late for antenatal care?

The London Health Observatory analysed the distribution of risk factors for infant mortality across North East London in 2004/05, identifying ethnic groups at higher risk of late booking. For North East London, the ethnic groups with the highest proportion of deliveries coded with gestational age who booked early (less than 12 weeks gestation at first antenatal booking) in 2004/05 were Bangladeshi, Irish White and White and Asian (mixed). The ethnic groups with the highest proportion of late booking (over 20 weeks) are predominately the Black ethnic groups, White and Black African (mixed) and African and Other Black, as well as the 'not known' category.

There is a much higher risk of infant death among babies born to women who were themselves born in high risk countries. In London, this means that women born in East or West Africa and the Caribbean make up the groups that tend to present late for antenatal care.[30] Therefore, influencing early access to effective antenatal care for these groups is vital.

In addition to the London Health Observatory analysis, national surveys indicate that, as a whole, women from Black and Minority Ethnic groups are more likely to book late for antenatal care, less likely to receive antenatal care regularly and therefore receive fewer antenatal check-ups. Evidence also suggests that some women from minority ethnic groups are less likely to have dating or anomaly scans and to be offered or to undertake screening.

Issues of mobility also impact on accessing antenatal care. In particular, Gypsy and Traveller women and recent migrants are often forced to move home during pregnancy or shortly after delivery, with potentially serious implications for their own and their babies' health.

The Confidential Enquiry into Maternal and Child Health Report[31] highlights that women who have recently arrived in the UK, whatever their immigration status, bring new challenges for maternity services. The key issues include poor overall health status and underlying and possible unrecognised medical conditions. Some women have also suffered the consequences of genital mutilation, while others experience the trauma of fleeing war-torn countries and pregnancy as a result of rape. Services therefore need to be flexible and sensitive to meet the needs of a mobile and potentially traumatised population.

Why some groups tend to present late for antenatal care

In order to understand the reasons why women book late for antenatal care, NHS Haringey commissioned a social marketing project to gather the evidence on this issue. The key barriers to early booking identified among local women are:

- A lack of understanding as to why early access to maternity services is important.
- Women not finding out they were pregnant until after 12 weeks 6 days.
- Limited capacity of services, resulting in booking in after 12 weeks 6 days.
- Communication difficulties between services – for example, between GP and hospital – resulting in delays.
- Previous negative views of health services.
- Language barriers.
- Transience of population – that is, moving between boroughs during pregnancy.

An action plan to address these barriers is in development. NHS Haringey has also recently recruited a Consultant Midwife in Public Health based at the North Middlesex Hospital to lead on promoting early access to maternity services.

Female genital cutting or mutilation

Women who have undergone female genital mutilation are significantly more likely to experience difficulties during childbirth and their babies are more likely to die as a result of the practice.[32] Complications include the need to have a caesarean section, dangerously heavy bleeding after the birth of the baby and prolonged hospitalisation following the birth.

According to the World Health Organization, female genital mutilation is a common practice in a number of countries around the world, and over 100 million women and girls are estimated to have experienced female genital mutilation. It is illegal to perform female genital mutilation in the UK. However, due to increasing migration from countries where this practice is common, it is likely that the prevalence of female genital mutilation among the pregnant population in the UK is increasing. As female genital mutilation can affect women's pregnancies in a number of ways, it is important that maternity services respond with appropriate education and training for staff.

4.5. Childhood immunisation

A very effective medical intervention

Mass immunisation is widely acknowledged as being one of the most effective medical interventions to minimise infectious diseases.

A new approach to health and well-being

Developing maternity services in easily accessible and visible community facilities, such as Sure Start Children's Centres, is one way to engage with the most vulnerable families, especially in disadvantaged areas. By linking maternity services to the other types of care provided in children's centres, families will be able to access a whole range of other services that provide the valuable support and advice which both parents may need before and after their baby is born. Antenatal care is provided from most children's centres in Haringey ensuring easier access for vulnerable populations. Children's centre outreach workers are the key to reaching families that would not normally access mainstream services. Haringey is currently producing an outreach strategy that will embed outreach support in children's centres.

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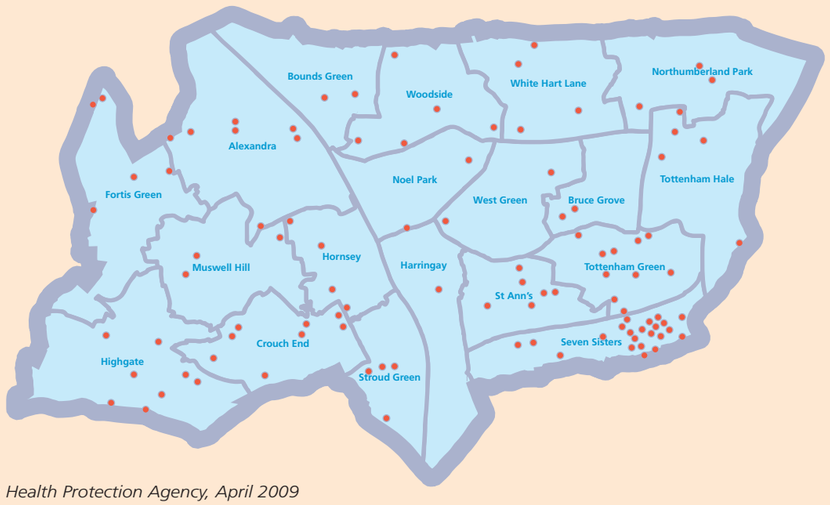
Immunisation works at two levels. Firstly, on the individual level the vaccine helps protects the person from the specific disease. Secondly, and possibly of more significance to public health, it reduces the incidence of the disease in the community. The latter relies on a high coverage of vaccine uptake across the population. The percentage of coverage required depends on the relative infectiousness of the particular disease and population mixing, but in general requires at least 90% or more of the population to receive the vaccine. Because of the importance of high coverage, every effort is made at the national and local level to ensure that the uptake is high and that immunisation services are equally accessible to all segments of the community.

But one that is not always used

There is some evidence to show that immunisation rates are lower in disadvantaged groups,[33] although the reasons for this are complex and due to a range of factors including large family size, cultural and religious beliefs and single parenthood.[34] However, children whose mothers are older and more highly educated have also been shown to be more likely to be unimmunised in comparison.[35]

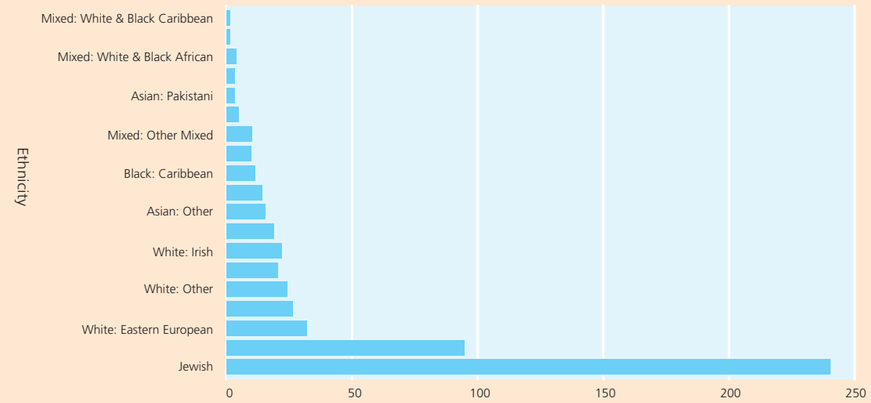
The relationship between ethnicity and vaccine uptake is complex in some cultures. It is possible that, where there are language barriers and therefore minimal access to mass media controversies, parents are more likely to trust health professionals and not be unduly influenced by outside pressure.[36] For other groups, media controversy can exacerbate fears, language barriers may mean that messages from health professionals are not fully understood and any beliefs about immunisation can prove difficult to change. The evidence suggests that different approaches are required to tackle immunisation uptake and ensure that services are provided to meet a wide range of needs.

Figure 12: Haringey measles cases from 21 May 2007 to 27 March 2009, by ward



Source: Health Protection Agency, April 2009

Figure 13: Measles cases in NE London from 21 May 2007 to 14 December 2008, by ethnicity



Source: Health Protection Agency, April 2009

In Haringey there have been ongoing problems collating data on immunisations due to the child health computer system that is currently being updated. Extensive work is underway to address this issue and preliminary immunisation data will be available for 2009/2010.

Measles vaccination

The number of measles cases is an indicator of whether vaccine coverage is sufficiently high. The rates of measles cases are fairly evenly spread across the borough as the map showing cases as red dots in Figure 12 indicates.

A small cluster of measles cases in the Seven Sisters area was predominantly within the orthodox Jewish community where there are well-recognised problems with access to services due to a range of cultural factors, large family size and close communities, with some distrust of wider healthcare provision.[37] This would mimic wider North East London data indicated in Figure 13, which shows that the Jewish communities have the highest incidence of measles cases that are most likely to be a result of low immunisation uptake.

Human Papilloma Virus vaccination

The new Human Papilloma Virus (HPV) vaccine was introduced in September 2008 to prevent development of cervical cancer. It has been offered in all Haringey schools to girls aged 12–13 years. Clinics were also held during evenings to offer immunisation to those who were not in school. For the routine cohort of girls aged 12–13 years, in school Year 8, the uptake is around 81%. This high uptake was achieved primarily due to the hard work of the school nursing service and the support of all the schools. The uptake of HPV immunisation has been examined according to the ethnic mix in each local school that participated in the programme. This suggests a slightly higher uptake among the White British population. However, the breakdown of the uptake figures for each school involves relatively small numbers and, therefore, does not allow for a robust analysis.

Although we know there are a number of factors that influence immunisation uptake, there is not much research analysing the uptake for HPV vaccine specifically. However, the initial trial for the vaccine implementation in Manchester suggested a lower uptake in schools with a higher proportion of girls from minority ethnic backgrounds.[38] Other factors, such as socio-demographic factors were also found to be important, as well as parents' beliefs on the safety, or otherwise, of the vaccine. Anecdotal reports from the local campaign would agree with this. It is therefore not possible to assume that the variation in the uptake is due to ethnicity alone.

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Over 2009/10 and 2010/11 all those eligible under the national catch-up are being offered the vaccine either in school or at community clinics. Across London and nationally there is a drive to improve the data we have on immunisation and to ensure that we adopt a comprehensive approach to data collection. As part of this drive, NHS Haringey is moving all records to the new Rio system, which will greatly improve the way in which we can collect and analyse our immunisation uptake and the service we provide. This system may enable us to collect data systematically on ethnicity and other socio-demographic details.

4.6. Teenage pregnancy

Why teenage pregnancy rates matter

While individual young people can be good and competent parents, the evidence suggests that, generally, children born to teenagers are much more likely to experience a range of negative outcomes in later life. Having children at a young age can damage young women's health and well-being and severely limit their education and career prospects. Children born to teenage parents are also much more likely to become teenage parents themselves.

Women from some ethnic groups are more likely to become teenage mothers

There is evidence that suggests that young people from some ethnic groups are much more or less likely than others to experience teenage pregnancy, even after taking account of the effects of deprivation. For example, teenage pregnancy rates vary dramatically between London boroughs with a similar level of deprivation, but a different ethnic composition. In some instances, a borough's rate is double that of a similarly deprived borough with a different ethnic make-up.[39]

Data on mothers giving birth under the age of 19, identified from the 2001 census, show that rates of teenage motherhood are significantly higher among mothers of Mixed White and Black Caribbean, Other Black and Black Caribbean ethnicity. White British mothers are also over-represented among teenage mothers, while all Asian ethnic groups are under-represented.

Girls and young women of Black and Black British ethnicity are also over-represented among women aged under 18 undergoing abortions. In 2004, Black ethnic groups (which represent around 3% of all females aged 15–17) accounted for 9% of women aged under 18 undergoing abortions, and in London, which has high rates of repeat abortion, 43% of all women aged under 18 undergoing abortions following a previous pregnancy were young women from Black ethnic groups.

Variations between ethnic groups in sexual activity and contraceptive use suggest that the higher rates of teenage pregnancy among some ethnic groups are at least partly attributable to differences in behaviours and attitudes, and not simply a result of deprivation. A survey of adolescents in East London[40] showed the proportion having first sex aged under 16 was far higher among Black Caribbean men (56%), compared to 30% for Black African, 28% for White and 11% for Indian and Pakistani men. For women, around 30% of both White and Black Caribbean groups had sex aged under 16, compared to 12% for Black African and less than 3% for Indian and Pakistani women.

Teenage pregnancies in Haringey

The conception rate among women aged under 18 in Haringey fell from 80.2 per 1,000 in 2002 to 63.7 per 1,000 in 2005. The annual rates for 2005 and 2006 were the same, with a small decrease in actual numbers of conceptions. The provisional annual rate for 2007 has seen a rise to 70 per 1,000 (an increase of 12 actual conceptions), but the most recent Office for National Statistics data for the first quarter of 2008 has shown a significant decrease to 52 per 1,000, with the lowest actual numbers of conceptions (45) since the national Teenage Pregnancy Strategy was published in 1999. The rolling quarterly average is now 67.8 per 1,000. Our 2007 rate also shows that 65% of conceptions among women aged under 18 led to abortion.

Teenage Pregnancy Monitoring

A teenage pregnancy conception data monitoring scorecard is being developed to support analysis using age, ethnicity, ward, etc. Initial analysis suggests 'hotspot' wards/postcodes, notably N17, N15 and N22. Ethnicity data sets suggest more clarity/breakdown is needed.

4.7. Childhood obesity

A growing health problem

There has been a steady rise in obesity rates among adults and children over the last two decades, with now one-third of children being either overweight or obese in England. Children who are obese are at greater risk of developing health problems in childhood as well as becoming obese adults, who are at greater risk of a lower life expectancy.

Obesity is associated with an increased risk of cardiovascular disease, diabetes, stroke and cancer, as well as psychological problems such as low self-esteem, lack of confidence, depression, stigma and discrimination. Causes of childhood overweight and obesity are linked to over-consumption of energy-dense food and drinks and reduced levels of physical activity.[41]

A new approach to health and well-being

NHS Haringey is working in partnership with other local organisations and young people themselves to undertake awareness-raising initiatives targeted at specific groups. These include:

- A Sex and Relationships Education (SRE) booklet for Turkish-speaking young men and women.
- A targeted publication made with and for Leaving Care and Asylum Team clients.
- A targeted fortnightly 4YP Nurse session at the Leaving Care and Asylum Team Compton Road Site, providing advice and guidance on sexual health and the full range of contraception and referrals to other relevant services. Targeted 4YP Youth Worker-led group sessions have also been run on sex and relationships for Afghani, Albanian and Turkish Sorani male clients.
- Accredited SRE/Speakeasy training has been provided for the Leaving Care and Asylum Team. This training is aimed at equipping parents and professionals with the skills to talk to young people about sex and relationships.

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In view of the serious negative impact of obesity on health and well-being, the government has set an ambitious target to reduce the proportion of overweight and obese children to 2000 levels by 2020.[42] Haringey has also identified childhood obesity as a local public health priority in its Local Area Agreement.

Trends in childhood obesity in Haringey

In Haringey, results of the 2008 annual National Child Measurement Programme show high rates of children at risk of obesity (23.2%) in the 10–11 age group (Year 6). This is above both the London average (21.6%) and the England average (18.3%). The prevalence of children at risk of obesity in the 4–5 age group (Reception Year) was 10%, which is comparable to the London and England average.

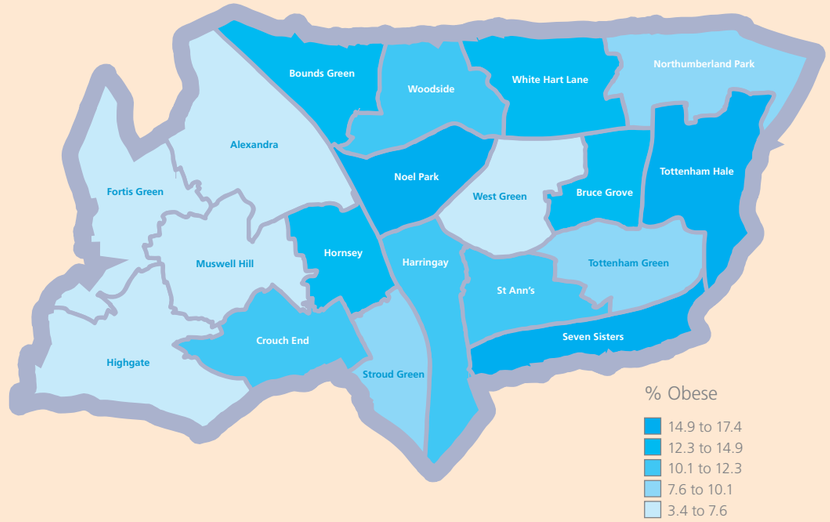
Further analysis of the child growth patterns across England and London revealed differences between ethnic groups. The largest prevalence of those at risk of obesity was found in the Black African and Caribbean and Other Black groups in addition to the mixed race White and Black groups. There was also a higher proportion of children at risk of obesity in the Bangladeshi, Pakistani, White Other and White Irish categories. Children in the White British, White and Asian, Indian and Chinese categories had significantly lower rates of risk of obesity.[43]

The overall prevalence of children at risk of obesity is significantly higher across London compared to England. This is linked to the far greater numbers of children of Black ethnic origin who were shown to have significantly higher Body Mass Index (BMI) than other ethnic groups. The reason for differences in child growth patterns between ethnic groups is unclear and may be due to biological differences or other confounding factors.[44] The weight status classifications of overweight and obese are based on the UK90 child growth reference chart, which in turn is based on a sample of White British children. Therefore, this does not account appropriately for differences in height and build in other ethnic groups. When accounting for other variables and differences in height between ethnic groups, it was found that children from Black African and Caribbean ethnic groups had no significant differences in the likelihood of being classified as overweight or obese from the White British group. Haringey has a high population of children of Black ethnic origin, which may disproportionately affect the rate of children defined as at risk of obesity. Further investigation of ethnicity as a factor in determination of child obesity is needed.

Deprivation is also strongly linked to prevalence of obesity. The risk of obesity in the most deprived group was almost double that of the least deprived group for reception age children in London, and for Year 6 children the risk was almost two-thirds greater in the most deprived compared to the least deprived groups. This relationship is also strongly linked to the high proportion of minority ethnic groups who live in areas of high deprivation. When these confounding influences were accounted for, it was revealed that deprivation is a stronger indicator of the risk of obesity, whereas ethnicity differences are more likely to do with body composition, in particular height.

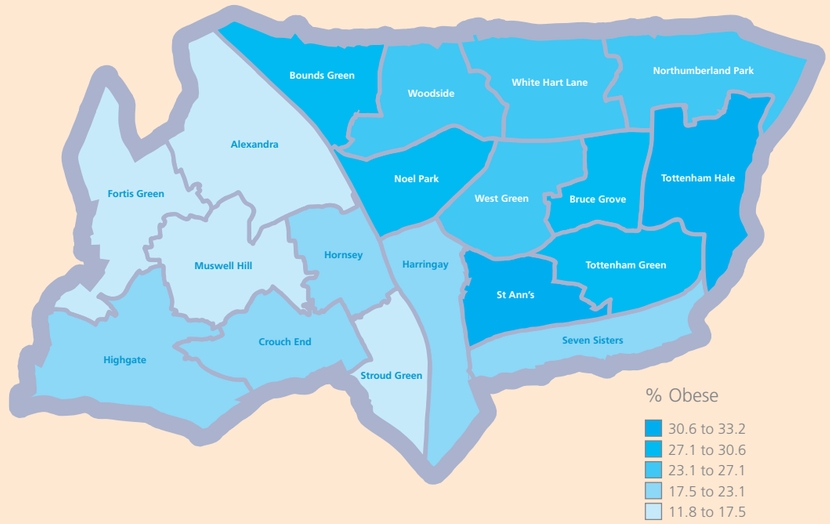
* The weight status classifications used in this data analysis are indicators only of the potential risk of obesity, overweight or underweight rather than a clinical defined diagnosis. The classification is based on calculation of BMI using the height and weight and then comparison against the UK90 child growth charts.

Figure 14: Obesity in Reception Year children, by ward, 2008



Source: National Child Measurement Programme

Figure 15: Obesity in Year 6 children, by ward, 2008



Source: National Child Measurement Programme

4 Establishing a healthy start in life

Therefore, for Haringey's migrant and Black and Minority Ethnic population there may be a greater risk of child obesity due to low socio-economic status and living in areas of deprivation. The maps given in Figures 14 and 15 show ward level data that reveals significantly higher rates of those at risk of obesity in the more deprived east of Haringey compared to the less deprived wards in the west.

NHS Haringey recently commissioned a social marketing research study, focusing on families in the east of Haringey, to provide insight into the social, psychological and environmental factors that may contribute to child obesity. The research revealed that families from minority ethnic groups tended to have more control over what their children ate and were generally more likely to prepare fresh home-cooked meals, although they had less awareness of dietary considerations, such as portion sizes and levels of fat, sugar and salt consumed. The assumption was that traditional home-cooking is always the healthy option regardless of amount and content of what is being eaten.

Some Black and Minority Ethnic families also placed less importance on sport and physical activity compared to study and religious practice, seeing it as an optional extra. Parents generally had low awareness of the need and importance of exercise for their children. Research also reveals that many parents/carers do not identify their children as being at risk of obesity or associate potential health problems of child overweight and obesity as applying to their children.[45]
There is a misconception, particularly among some minority ethnic groups, that parents perceive overweight as desirable, being an indication of health and prosperity.[46]

4.8. Children's centres

An integrated approach to service delivery

Children's centres provide multi-agency services that are flexible and meet the needs of young children and their families. Children's centres offer integrated early learning, care, family support, health services, outreach services to children and families not attending the centre and access to training and employment advice. High quality learning and childcare are central to the role of children's centres.

Children's centres play a crucial role in improving outcomes for all young children and in reducing inequalities in outcomes between the most disadvantaged children and the rest. Children's centres also have a key role in promoting social cohesion and fostering positive relationships within their community.

Parents from minority ethnic groups generally want the same range of services from children's centres as other parents, but may require a different model of support or delivery in order to access them.

Sure Start Children's Centre Practice Guidance[47] states that in order to ensure that services are responsive, the manner in which services are delivered in children's centres should be tailored to families' particular needs, in terms of timing, venue, language, faith and culture.
Play equipment, resources, books and activities should reflect the background of different communities, and positive images of minority ethnic groups should be displayed prominently.

Evaluations suggest that the greatest barrier towards inclusion in children's centre services for Black and Minority Ethnic and migrant communities is the lack of English proficiency. Children's centres try to overcome this by employing a greater number of multi-lingual staff or outreach workers, in order to enable effective targeting and to support initial contact with families.

Children's centres seek to build a relationship of trust with minority ethnic communities so that families feel that they know about and can access services. An outreach strategy is currently in development in Haringey, which will embed outreach provision within children's centres.

Where are we now?

There are 17 children's centres in Haringey, offering a range of services to families with young children, including stay and play sessions, workshops on parenting, healthcare support and information on childcare.
Further information for families can be found at www.haringey.gov.uk/fisd.

NHS Haringey

A new approach to health and well-being

Broadwater Farm Children's Centre runs a successful Polish Group. The group was initiated by the Polish family support worker. The Polish parents then asked whether they could continue to run the group by themselves with the help of Centre staff. The group started with six parents and has since doubled due to effective communication within the Polish community, many of whom are now accessing other Children's Centre services. The group meets to discuss particular topics, ranging from safety in the home to nutrition. For further information contact: Salma Douik, Information Officer, on 020 8885 8800.

Park Lane Children's Centre has, over the last two years, seen an increase in the number of Polish, Somalian and Romanian women accessing services. This increase is due largely to the provision of antenatal and postnatal services at the Centre, run by the Community Midwives from North Middlesex and Whittington Hospitals. For further information, contact Marlene D'Aguilar, Deputy Head of Centre, on 020 8489 4945.

Sonia Blake, Midwife Team Leader, North Middlesex Hospital, says:

"Working within Park Lane Children's Centre has made a difference in our approach and the means of delivering antenatal and postnatal care to our women. Our aim is to be able to reach families that we may not otherwise reach and reduce our waiting time at appointments."