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Highlights from this issue

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UK CHILD SURVIVAL IN A EUROPEAN CONTEXT

Child mortality in the UK has decreased over the past 40 years although UK child mortality trends and excess death figures compare unfavourably with many European countries. In their leading article, Wolfe and colleagues discuss this in detail—trends in mortality, potential reasons for the excess child and adolescent mortality in the UK and what can be done to strengthen conditions for children in Britain to survive and thrive. UK mortality is compared with EU15+ countries. These countries are the 15 member states of the European Union in 2004 (excluding the UK) together with Australia, Norway and Canada. Figures one and two in their paper show data that falls in UK mortality over time have been less impressive than in these other countries. The reasons for this difference are complex and the authors discuss different potential factors including poverty and social inequality (figure three) and deaths that are preventable through health care systems policy and health care practice. There are around 5000 deaths per year (60% in infancy, 18% in adolescence). If we want to improve on this and impact on our international ranking government, society, public health and health care need to work together to improve the health and well being of our children and young people. The authors recommend an independent UK Countdown collaboration should be established across disciplines and institutions, providing a bridge between the technical and the political, identifying gaps in knowledge and practice, reporting annually on progress, and proposing new actions to promote child survival. *See page 907*

WHY DO YOUNG CHILDREN DIE IN THE UK: A COMPARISON WITH SWEDEN

The UK has a higher child mortality rate than Sweden. Tambe and colleagues compare causes of death in children aged <5 years. Overall mortality rates were 614 per 100000 (UK) compared with 328 per 100000 (Sweden). The three main causes of death were prematurity, congenital malformations and infections—mortality rates across these and all other

conditions were striking with excess mortality in the UK—138.5, 112.1, 63.9 versus 10.1, 88.6, 34.8 ($p < 0.001$). Treatable infections had a significantly higher mortality in the UK than Sweden ($p < 0.001$). The gap is striking and as priority we need to explore the aetiology and factors that may impact on it. *See page 928*

WHY THE DIFFERENCE BETWEEN UK AND SWEDEN

In a letter Zylbersztejn and colleagues compare the mortality rates by birth weight and age at death with mortality rate by birth weight in Sweden. This reduces significantly the number of excess deaths and reflects the higher pre term birth rate in the UK which is likely to be a factor impacting on the mortality rate difference between the UK and Sweden. Many potential explanations include differences in live birth and stillbirth registration, policies relating to late termination of congenital malformations, thresholds for resuscitation, prenatal and neonatal care. *See page 1007*

SUDDEN UNEXPECTED DEATH IN INFANCY

Despite the fall in numbers sudden unexpected death in infancy remains one of the commonest causes of death outside the neonatal period. Fleming and colleagues provide an authoritative update—the terminology is difficult with a progressive reluctance to use the term sudden infant death syndrome. The paper reviews the recent epidemiology and aetiology, current hypothesis regarding the pathophysiology, different interventions that have been adopted and new approaches that offer the possibility of prevention in the future. The triple risk hypothesis is discussed whereby unexpected infant deaths might arise as a consequence of the combination of three factors coming together: a vulnerable infant, a vulnerable phase of development and a final insult occurring in this window of vulnerability. Reducing risk is discussed by considering infants at ‘increased risk’ and interventions that might impact. The dramatic fall in SIDS that followed ‘Back to Sleep’ campaigns in the UK and subsequently in many other countries reflects the

effectiveness of avoiding the prone sleeping position. The issue of co-sleeping (which is a risk factor) is more complex and discussed in the paper—with the recommendation that a ‘safe’ sleeping and night feeding arrangement is encouraged. Excess alcohol, drugs and cigarette smoking are discussed. The real challenge is to identify and target vulnerable infants with realistic interventions which will be acceptable and implemented. *See page 984*

THE VOICES OF CHILDREN AND YOUNG PEOPLE IN HEALTH

‘Make decisions about us, with us. Let us have our say.’ Royal College of Paediatrics and Child Health Youth Advisory Panel Member.

In a leading article Weil and colleagues explore the rights of children and young people to participate in decisions about their healthcare, and the benefits of doing so by reflecting on progress in the last 25 years, identifying ongoing areas of concern and calling for a change of culture through innovation and training. The article is important to read and reflect on with respect to your own practice. The authors discuss different national and international initiatives including article 12 of the United Nations Convention on the Rights of the Child (1989) ‘the views of the child being given due weight in accordance with the age and maturity of the child’ and article 24, section 2 (e) which is ‘to ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breast feeding, hygiene and environmental sanitation and the prevention of accidents’. The authors discuss progress in the UK—The National Service Framework for Children, the Children Commissioner for England, the 2010 white paper and the Chief Medical Officer Report (2012). Four positive concrete steps are proposed—greater dissemination of guidance and examples of good practice, greater evaluation of the participatory process, appropriate training and procedures to support participation and increased involvement of children and young people in improving their own health. *See page 915*