



Children's Rights

The status of children in society and the degree to which they should have individual rights have become political issues in the 1990s. While voluntary groups and children themselves are keen to see their rights acknowledged, others see the promotion of such rights as a threat to authority.

THE UN CONVENTION ON THE RIGHTS OF THE CHILD

In 1989 the United Nations produced the Convention, the most far-reaching international document ever produced on children's rights. It specified 42 articles which established the basic rights of all children under eighteen years of age to life, survival and development.

Article 6

- 1 States Parties recognise that every child has the inherent right to life.
- 2 States Parties shall ensure to the maximum extent possible the survival and development of the child

It also specified the actions required by governments to ensure and promote these rights. The UK government ratified the treaty in 1991. Ratifying nations are obliged to report to the UN Committee on the Rights of the Child on the developments their governments have made in implementing the articles. The UK government did so in

February 1994 and the report was commented on by the UN Committee in 1995. The Committee expressed concern about a number of issues surrounding child welfare such as the impact of poverty and ethnicity on children's health, the levels of physical punishment of children and the erosion of the rights of gypsy and traveller children.

ARTICLE 12

The child's right to hold an opinion and to expect that opinion to be taken into account in any incident affecting his welfare is incorporated into Article 12.

- 1 States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

In November 1996, on the anniversary of the UK government's signing of the Convention, an organisation known as Article 12 was formed. It is run by children and young people and intends to publicise knowledge of the rights of the child, to represent the views of children and to establish closer communication between children and adults so that decisions based on co-operation can be made. Article 12 represents a new movement of political thought which seeks to incorporate the views of a disenfranchised group into the political process.



POLITICAL REPRESENTATION

To coincide with the last three general elections, the Children's Legal Centre has proposed a manifesto for children which recommends legislative and policy changes which would help UK law to come into line with the UN Convention. The Children's Legal Centre recognises that while there is considerable legislation focusing on children's welfare there is limited acknowledgement of children's wishes within the legal framework.

A 1996 report from the Calouste Gulbenkian Foundation urged the creation of a minister for children to be responsible for a children's unit within the Cabinet Office. It is envisaged that the Minister would develop overall governmental strategy for children in the UK, co-ordinate child-related policy across government departments, promote the active participation of children in society and ensure that government ministers were aware of the true state of children's lives in contemporary Britain. Policy would be a result of consultation and evaluation. An annual report on the position of British children in society would be expected. It is not suggested that the minister be responsible for overall family policy because, while obviously related to children's welfare, the family is not always the best place for a child. The essence of the Gulbenkian report is to make children the focal point of decision making.

LETTING CHILDREN MAKE DECISIONS

Some adults are fearful of children being given too much control in the decision-making process and in society generally. Children need to learn how to make appropriate, considered decisions as part of their general development and they need to be given the confidence to do so. Adults must encourage the development of this learning process and seek to build on children's strengths. Some children do not enjoy decision-making and are happier allowing adult control. For others, gradual

empowerment is important to their self-esteem and developing maturity. This has implications for health care professionals.

CHILDREN'S RIGHTS IN HEALTH CARE

The UN Convention on the Rights of the Child encompasses three main themes - participation, provision and protection.

Article 24 is specific about health rights:

1. States Parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

However, in the real world rights have to be balanced with resources. The 1996 Services for Children and Young People (The Children's Charter) concentrates on expectations rather than rights. While recent legislation such as the Children Act 1989 and the implementation of Children's Services Plans show greater consideration for the child in policy making and indicate a shift in focus from parental rights to parental responsibility, the prevailing mood still gives parents greater control in decisions taken about children's health. Technically, an individual has only one right in medical law - to refuse or consent to medical treatment. In the case of minors, the decision of the responsible adult can overrule the child's wishes particularly in life and death cases.

The case of Gillick V West Norfolk and Wisbech Area Health Authority in 1985 marked a shift in the legal attitude to children's health rights. It acknowledged a level of competence attributable to the child defined as a sufficient understanding of the situation to make an informed decision. Parental rights became less important than parental responsibility. While consideration of children's views is becoming more important in





the decision-making process, a child's refusal to consent to treatment can still be overridden by parents. The attitude of health professionals to the importance of children's views varies enormously. For parents, the ultimate responsibility of deciding on treatment is fraught with conflicting obligations.

Priscilla Alderson and Jonathan Montgomery have taken a radical view that a child is capable of making an informed decision about his health care from the age of five years old. This is obviously dependent upon his emotional maturity.

RIGHTS OF CHILDREN IN HOSPITAL

In 1984 Action for Sick Children (then known as NAWCH) produced its charter for children in hospital. Based on many of the recommendations in the 1959 Platt Report it outlined ten principles upon which hospital care of children should be based. It received widespread endorsement by leading health care organisations and has been influential in the implementation of health authority contracts.

In 1988 the European Association for Children in Hospital (EACH), the umbrella organisation for member associations involved in the welfare of children before, during or after a hospital stay, developed its own charter based on NAWCH's principles. There are currently fourteen national associations involved in EACH and its influence is beginning to be felt in eastern and central European countries.

Both the NAWCH charter and the EACH charter acknowledge the right of the child and his parents to informed participation in decisions about health care in accordance with Article 12.1 of the UN Convention. In practice this should mean serious consideration of the child's views and the parent's interpretations of her child's behaviour and responses. It also means health professionals need to discard some of their views about the age-related

abilities of children. For example, very young children can understand explanations about their treatment while adolescents may require more parental input than one might initially expect.

The Children's Charter has been criticised for not acknowledging the child as the consumer. Instead, it is written for parents and does not mention the importance of including children and young people themselves in decision making and the information process. The Department of Health Charter Unit did consult with children but the resulting document does not appear to reflect these discussions to any great degree. Most of the standards are described as expectations ie. standards of service which the NHS is aiming to achieve, rather than as rights ie. standards which all patients will receive all the time. However, it is another step forward in acknowledging that improvements in child health care need to be made and that certain principles should provide the basis for acceptable levels of care.





BIBLIOGRAPHY

1. Action for Sick Children, What do Children Think About Their Rights in Hospital and at Home?, Cascade, September 1995, pp6-7
2. Alderson P, Children's Consent to Surgery, Paediatric Nursing, December 1991, pp10-13
3. Alderson P, European Charter of Children's Rights, Bulletin of Medical Ethics, October 1993, pp13-15
4. Alderson P, Teenagers in Hospital, Cascade, July 1993, p4-5
5. Alderson P, What right to health care? Cascade, September 1995, pp4-5
6. Alderson P and Montgomery J, Health Care Choices: Making decisions with children, Bulletin of Medical Ethics, April 1996, pp8-11 (Summary)
7. Alderson P and Montgomery J, Health Care Choices: Making decisions with children, IPPR, 1996
8. Alderson P and Nicholson R, Deciding when to withhold or withdraw life-sustaining treatment for children, Bulletin of Medical Ethics, April 1997, pp13-20
9. Belson P, A New NHS Charter for Children, Cascade, Issue 18, February 1996, p4
10. British Association of Child and Community Health, Child Health Rights: Implementing the U.N. Convention on the Rights of the Child within the National Health Service. A Practitioners' Guide, 1995
11. Burr S, Thirty Years On, Nursing Standard, Vol 10, No 26, 20 March 1996, pp22-23
12. Children's Legal Centre, A Manifesto for Children, 1997
13. Children's Rights Development Unit, UK Agenda for Children, 1994
14. Children's Rights Office, Making the Convention Work for Children, 1995
15. Fulton Y, Children's Rights and the Role of the Nurse, Paediatric Nursing, Vol 8, No 10, December 1996, pp29-31
16. Glasper, A, The Challenge of the Children's Charter; Rhetoric vs Reality, British Journal of Nursing, Vol 5, No1, 1996, pp26-29
17. Hodgkin R, A Minister for Children?, Children UK, Spring 1997, pp4-5
18. Hodgkin R and Newell P, Effective Government Structures for Children: Report of a Gulbenkian Foundation Inquiry, 1996
19. Korganonkar G and Tribe D, Children and Consent to Medical Treatment, British Journal of Nursing, Vol 2, No 7, 1993, pp383-384
20. Kurtz Z, Children's Rights and Health Care, Children and Society, 8:2, 1994, pp114-131
21. Lansdown F et al, Opinion, Children UK, Spring 1997, p6 (Explanation of Article 12)
22. Lansdown G, UN Convention on the Rights of the Child - monitoring its implementation in health care, Cascade, September 1996, pp10-11
23. Miller J, Helping Children Make Decisions, Co-ordinate, January 1997, pp4-5
24. Moores Y, What's new for Children?, Nursing Standard, Vol 10, No 26, 1996, pp20-21
25. Newell P, The UN Convention and Children's Rights in the UK London: National Children's Bureau, 1991
26. NAWCH Charter, Action for Sick Children, 1984
27. NHS, The Patient's Charter: Services for Children and Young People Department of Health, 1996 (Copies available from 0800 555777)
28. Ross-Trevor J, Informed Consent and the Treatment of Children, Nursing Standard, Vol 10, No 50, 4 September 1996
29. Royal College of Paediatrics and Child Health, Withholding or Withdrawing Life Saving Treatment in Children, 1997
30. Shelley P, Working with a New Generation, Cascade, Issue 1, November 1991, pp4-5
31. Shield J and Baum D, Children's consent to treatment: Listen to the children - they will have to live with the decision, British Medical Journal, Vol 308, 7 May 1994, pp1182-1183
32. Unicef, The Convention on the Rights of the Child, September 1995





Special Care Babies

HISTORY

The first special care baby unit was opened in Paris in 1890 by Pierre Budin, an advocate of maternal involvement in the care of babies in hospital. The Sorrento Maternity Hospital in Birmingham was the first British hospital to open a similar unit in 1931.

A government circular (1) in 1944 recommended that premature infants nursed at home should receive extra services and that premature baby wards in hospital should be supervised by a paediatrician and should provide accommodation for nursing mothers. However, real development in provision did not occur until the 1960s when a government report (2) recommended a comprehensive programme of care for pre-term babies. It stipulated six special care cots per 1000 live births per annum to be centred in larger hospitals under the supervision of a paediatrician. By the mid 1960s 62 babies per 1000 babies born were being admitted to special care units. This figure had reached 185 per 1000 babies born annually by 1975. The introduction of intensive care methods at London's University College Hospital, in 1966 saw a dramatic fall in the death rate of premature babies.

The 1971 Sheldon Report (3) recommended that up to 23% of babies born annually should be nursed in special care units and that neonatal training courses should be provided for nursing staff. The Court Report (4) in 1976 recognised that the number of deaths among infants weighing 2.5kg or less at birth had dropped significantly in the previous twenty years. The risk of severe physical and mental disability for those surviving babies had also decreased due to 'expert intensive newborn care' (Vol 1, p.47)

'In recent years it has been shown that intensive care of the immature and very ill infant not only succeeds in saving life but also in reducing the damage sequelae of neonatal illness'

(The Court Report, Vol 1, p122)

The beneficial effects of family involvement in the neonatal unit were initially acknowledged in the 1970s.

CARE OF THE BABY

A baby's birthweight is low because it has either been born too early (preterm) or because it has failed to grow adequately in the womb. Any baby born before the 37th week of pregnancy is considered preterm.

Babies with minor conditions should be left with their mothers at all times. Only seriously ill babies will be placed in intensive care cots.





INTENSIVE CARE AND SPECIAL CARE

Very sick babies will probably need ventilation either because their lungs are not fully developed due to their prematurity or because they have a lung disease or infection. The development of a premature baby's lungs varies with each individual so the decision to stop ventilation will depend on the development of each baby. Babies who cannot feed by mouth will also require intensive care. Total parenteral nutrition, an intravenous feeding method, is a highly specialised task. Babies may also need intensive care before and after surgery or other procedures such as transfusion or dialysis. Very premature babies will generally be placed in intensive care as a precaution until medical staff are assured of their stability. Most maternity hospitals will have an intermediate or transitional ward where babies requiring special care but not intensive care can be nursed with their mothers. The high special care unit admission rates witnessed during the 1970s have been reduced because health professionals have acknowledged the long term effects of poor maternal bonding and the increased risks of healthy babies acquiring an infection. Transfer to a special care baby unit is likely to be for the following reasons:-

1. Birth weight under 1700g or gestational age less than 32 weeks
2. Birth asphyxia
3. Aspiration including meconium aspiration with respiratory symptoms and signs.
4. Rhesus haemolytic disease
5. Respiratory signs such as transient tachypnoea or respiratory distress syndrome
6. Congenital malformation with symptoms such as congenital heart disease
7. Convulsions
8. Major infections (meningitis, pneumonia, septicaemia)
9. Persistent vomiting
10. Jaundice
11. Fetal haemorrhage

Such units provide extra monitoring, special equipment and a controlled and stable environment which provides the right levels of warmth, oxygen and food and fluids.

Length of stay will vary according to the baby's condition. Very premature babies will generally need more care but if there are no other problems, the baby should progress steadily.

In general babies born before 24 weeks gestation are unlikely to survive. More than half of the babies born at 24-28 weeks gestation do survive. Although birth weights less than 1000g are considered extremely low, babies under 750g can survive. Between 1978 and 1994 the stillbirth and infant mortality rates for England and Wales halved. However, about 1 in 5 deaths occurring in those under 15 years of age occurs within the first 24 hours after birth. There are about 7500 perinatal deaths annually in the UK. 70% of perinatal deaths occur in the 7% of low birthweight babies born annually in the Britain.

There is a high risk of complications with premature babies, most commonly associated with lack of oxygen before or during birth, resulting in brain damage. Lung damage can also be a side effect of early ventilation.

NURSING CARE AND THE ENVIRONMENT

Babies in special units are likely to find the experience traumatic. Invasive procedures are common and the neonatal nurse needs to be particularly sensitive to the baby's expression of discomfort and pain. Preterm babies of less than 34 weeks gestation often display difficulties in feeding. Their sucking and swallowing reflexes are underdeveloped. Feeding may take a long time. It may be necessary to aspirate feeds into the trachea. Preterm babies lose their body heat rapidly. Careful monitoring of the unit's temperature is





essential and special care should be taken during baths, clinical examinations and procedures such as radiographic procedures and surgery. If the baby is kept at the correct temperature, he will use the least possible oxygen and energy to keep warm.

Preterm babies are more susceptible to infections than full term babies because their immunity systems are underdeveloped. Particular care must be taken to maintain hygiene levels in the special care unit.

Handling of the neonate in intensive care should be kept to a minimum by nursing staff. Excessive handling can lead to problems with oxygen levels and does not allow the baby to rest properly. However, babies need tactile stimulation to develop the parent-child relationship and to promote emotional and physiological development. Although baby massage and kangaroo care, where the baby is held directly against the parent's skin, are becoming more widespread, it is good practice to assess the need for handling at every stage.

To encourage a restful environment, care should be taken to minimise excessive noise and light. Very sick babies use up precious reserves to cope with environmental stimuli and can find prolonged exposure to noise and light stressful.

Newborn babies indicate levels of pain by certain types of cry, facial expressions and body movements. Pre-term infants are unable to use these physical changes to express pain. Stress levels indicating pain can be monitored by changes in the heart rate, respiration, blood pressure, skin and toe temperatures and blood oxygenation. Crying, grimacing, axial stiffening, head extension and odd positioning of the limbs can indicate extreme pain but alternatively, a baby suffering from chronic pain may respond by appearing inert and detached from the outside world. Pain can be alleviated by good techniques in the

administration of invasive procedures and by cuddling. In the case of painful illness, the appropriate levels of analgesia should be applied.

PARENTAL INVOLVEMENT

The acknowledgement of the importance of parent/child bonding has meant significant changes in the level of parental involvement in the care of the sick newborn. The arrival of a small and/or very sick infant after the hopeful period of pregnancy is bound to be very stressful for the parents. Some parents display signs of anticipatory grief which means they dare not fully acknowledge their feelings for the child in case the child dies. Parents of a sick or low weight baby find themselves in a new role as parents but they are not able to fully enjoy or participate in the parenting role as expected.

It is important that the needs of the family as a whole, including siblings, are recognised. In the past, visiting was severely restricted in neonatal units because of the risk of infection. However, visiting is widely accepted to be beneficial to all concerned and not a significant factor in infection control. The parents of the baby are likely to need support from their wider family and it is important that nursing staff include these family members in their information giving and support. Some parents are frightened of handling their delicate baby and will need constant reassurance from nursing staff. The amount and type of medical equipment in a neonatal unit can appear bewildering and frightening. Nursing staff should take time to explain procedures. However, the intensive care required by such babies inevitably means that nurses have limited time. Parents should be consulted, where possible, about stages in the baby's development so that they do not feel excluded from their baby's well-being and to encourage a feeling of involvement. It is widely recognised that separation at this early stage can lead to long term problems of poor bonding between mother and child. Feeding is an



important area in which parents can be involved in childcare. This applies whether the baby is breastfed or by expressed milk from the mother.

NEONATAL PRACTITIONERS

The care of sick newborns has become more complex and intensive in the last two decades. The nursing role has expanded, leading to the development of the neonatal nurse practitioner. The concept of the advanced neonatal nurse practitioners was developed in the United

States in the 1960s. This highly trained member of staff is capable of assessing, diagnosing and treating babies within agreed protocols and can take on some of the workload previously associated with doctors. The practitioner, having undertaken advanced training to degree level, is capable of undertaking all practical procedures. The role does not include traditional nursing duties but is expected to lead to less disruption of the nursing care and a decline in the levels of trauma witnessed in both baby and parents.

BIBLIOGRAPHY

1. Alderson P, Special Care for Babies in Hospital, Action for Sick Children (NAWCH), 1983
2. Dillon A and George S, Advanced Neonatal Nurse Practitioners in the United Kingdom: where are they and what do they do?, *Journal of Advanced Nursing*, 25, 1997, pp257-264
3. Fraser R, Breast-feeding support in a neonatal surgical unit, *Nursing Times*, Vol 93, No 47, 19 November 1996, pp54-55
4. Greenslade J, Very Special Care, *Nursery World*, 30 January 1992, pp15-17
5. Horsley A, The Neonatal Environment, *Paediatric Nursing*, February 1990, pp17-19
6. Hughes B and E, Extra Special Care: A parent's eye view of a neonatal unit, *Child Health*, June/July 1993, pp29-32
7. Kelnar C et al, *The Sick Newborn Baby*, Balliere Tindall, 1995, 3rd ed.
8. Marot F, A Bridge from Hospital to Home, *Professional Nurse*, April 1993, pp469-472
9. Orford T, Crisis and Crisis Intervention: Psychological support for parents whose children require neonatal intensive care, *Journal of Neonatal Nursing*, January 1996, pp11-13
10. Redman C, Handling With Care: Neonatal handling procedures, *Child Health*, February/March 1994, pp177-180
11. Redshaw M et al, A Home from Home?: Regard for parents in policy and practice in neonatal care, *Child Health*, August/September 1994, pp79-86
12. Redshaw M et al, Parental Perspectives on Neonatal Care, *Cascade*, January 1995, pp4-5
13. Scott R and Stratton D, A New Role for Nurses, *Family Medicine*, September 1997, pp6-9
14. Sparshott M, The Human Touch, *Paediatric Nursing*, June 1990, pp8-10
15. Sparshott M, Pain, Distress and the Newborn Baby, Blackwell Science, 1997
16. Sparshott M, Special Care for Special Babies, *Nursing Standard*, Vol 7, No 25, 10 March 1993, p14, (Managing Pain in Children Supplement)
17. Standfield G, Special Care Babies, *Cascade*, July 1992, p3
18. Yellott G, Promoting parent-infant bonding: Parental involvement in SCBU, *Professional Nurse*, June 1991, pp519-523

REFERENCES

- (1) Health circular 20: Care of premature infants, Ministry of Health, 1944
- (2) Prevention of prematurity and care of premature infants, Ministry of Health/Department of Social Security, 1961
- (3) Report of expert group on special care for babies, Sheldon Report, Ministry of Health Department of Social Security, 1971
- (4) Fit for the Future, Court Report, Ministry of Health/Department of Social Security, 1976





Immunisation

and childhood diseases

The mass immunisation of children is undoubtedly a cost effective method of disease prevention. According to government statistics there were 6 confirmed cases of measles in 1995, compared with an annual average of 400,000 before the immunisation programme began in 1968. In 1923, 6638 deaths from measles were recorded, the majority of them children. Immediately after the introduction of the measles vaccine in 1968 the number of deaths fell to thirteen per annum.

HISTORY

The beginnings of immunisation date back to the 18th century when Edward Jenner, a country doctor, noticed that milkmaids rarely suffered from smallpox although cowpox rash was common amongst them. Dr Jenner injected fluid from the cowpox rash into a patient who had not yet fallen ill with smallpox. This highly risky strategy appeared to prevent the onset of the disease.

HOW IMMUNISATION WORKS

Immunisation can be either a natural or an artificial process and is the means by which someone becomes immune to specific diseases.

Natural immunisation occurs when a person suffering from an infectious disease produces antibodies to the microbes causing the infection. Artificial immunity occurs when an

individual is made immune by vaccination without suffering from the disease itself. This can be either passive (injection of immunoglobins containing antibodies to specific diseases) or active (injection of inactivated or weakened live organisms or their products).

Types of vaccine

Live vaccines include the following:-

Measles, mumps, rubella, poliomyelitis, BCG

Toxoid (Inactivated toxin) vaccines include the following:-

Diphtheria, tetanus

Pertussis (whooping cough) is an activated organism.

Live vaccines vary in the antibody response. The measles, mumps and rubella vaccine requires one dose to achieve full, long-term antibody response, while polio, whooping cough, tetanus and diphtheria require three doses each. No vaccine is 100% effective. Between 5-10% of individuals being immunised will remain susceptible to the disease because they do not produce the necessary antibodies. High levels of immunisation up-take will normally protect these people but up-take must reach 95% to provide such protection.





THE NATIONAL VACCINATION PROGRAMME

Eight diseases are included in the childhood vaccination programme. The Department of Health recommended the following schedule in 1992:-

Vaccine	Age
Diphtheria, Tetanus, Pertussis, Hib, Polio	First dose 2 months, second dose, 3 months, third dose 4 months
Measles, Mumps and Rubella	12-15 months
Booster Diphtheria, Tetanus and Polio and second dose of Measles, Mumps and Rubella	3-5 years (usually before child starts school)
BCG	10-14 years (sometimes shortly after birth)
Booster Tetanus, Diphtheria and Polio	13-18 years (before child leaves school)

Routine childhood immunisations before children start school are usually given by GPs or practice nurses at surgeries or clinics. BCG and school leaving boosters are usually given in schools by appropriately trained school nurses.

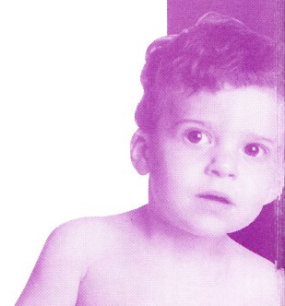
Timing is important and the schedule has been designed to give the baby full protection at the earliest possible stage.

INFECTIOUS DISEASES

MEASLES:

This is a potentially dangerous and highly infectious viral illness characterised by a rash and a fever. In general, young children are affected but it can strike at any age. The sufferer will feel generally unwell and will have a fever, runny nose, sore eyes and a cough. A red rash appears after 3-4 days, usually starting on the head and neck and then moving down the body. The spots can join to produce large red blotchy areas. The lymph glands may be enlarged. The rash and symptoms will usually subside after three days. Common complications include ear and chest infections. Diarrhoea, vomiting and abdominal pain may also occur. Febrile convulsions are common although tend not to be serious. In about 1 in 1000 cases, inflammation of the brain (encephalitis) occurs causing drowsiness,

vomiting and headaches approximately 7-10 days after the appearance of the rash. In extreme cases this can be followed by seizures and coma leading to permanent mental retardation and death. In very rare cases, about 1 in a 1000,000, a progressive brain disorder (subacute sclerosing panencephalitis) develops years after the measles attack. Although there is no evidence of measles causing birth defects, measles contracted during pregnancy leads to foetal death in 20% of cases. Children who are weak or undernourished are particularly susceptible to the disease, hence its prevalence in the third world. One attack of measles means lifelong immunity for the sufferer. Treatment should include plenty of fluids and paracetamol for the fever.





MUMPS

This viral illness occurs mainly in childhood and is characterised by inflammation and swelling of one or both of the parotid glands which are found inside the angle of the jaw. Although an acute viral illness, serious complications are uncommon in young children. However, in adolescent and adult males the virus can cause inflammation of the testes which can affect fertility. Infected children may display no symptoms but will feel slightly unwell due to the glandular swelling. In more serious cases, the child may complain of pain and difficulty in swallowing. He is likely to experience headaches and fever. The swelling will reduce after 7 to 10 days. The temperature should only last 2-3 days. Meningitis is a rare complication although mumps meningitis usually causes no long-term side effects. Pancreatitis, causing abdominal pain and vomiting, is an even rarer complication. There is no specific treatment. Painkillers may be required and the child should be given plenty to drink. The child may have to stay in bed for several days.

RUBELLA

A viral infection, rubella usually occurs in children aged 6-12 years. A rash appears firstly on the face and then spreads to the rest of the body, lasting a few days. The child may suffer a slight fever and some enlargement of lymph nodes at the back of the neck. It is possible for the infection to pass without being noticed and is nearly always mild. Symptoms may be more marked in adolescents and adults. The affected person will be contagious for several days before the symptoms appear and until one day after they disappear. Inflammation of the joints can occur once the rash has faded. Although generally a mild illness in children, rubella is particularly dangerous when it attacks the foetus in the womb. It can lead to devastating disability in the affected new-born child including blindness, deafness, heart abnormalities and learning difficulties. There is no specific treatment for rubella.

POLIOMYELITIS

In most cases the polio virus causes only mild illness. However, in more serious cases it attacks the brain and spinal cord and can lead to extensive paralysis and even death. The paralysis can affect the muscles used for breathing. About 85% of children display no symptoms at all. For others the incubation period will be followed by fever, sore throat, headache and vomiting lasting a few days. In serious cases, inflammation of the membranes covering the brain and spinal cord causes fever, severe headache, stiffness in the neck and back and muscle pain. In cases of paralysis the legs and lower trunk are most commonly affected. There is no effective drug treatment. Recovery from nonparalytic polio is complete but of those who suffer paralysis more than a quarter suffer minor permanent muscle weakness and less than a quarter suffer severe disability. Less than 1 in 10 dies. Postpolio deterioration can occur years after the initial paralysis, bringing new weakness and pain in the recovered muscle. During the period of paralysis, physiotherapy is essential to prevent long-term muscle damage.

PERTUSSIS (WHOOPIING COUGH)

Paroxysms of coughing, often ending in a 'whoop' noise as breath is rapidly drawn in are the main symptoms of this infectious disease which mainly affects infants and young children. In the early very infectious stage, the child will have a mild cough, sneezing, nasal discharge, fever and sore eyes. The cough gradually becomes worse and more persistent, especially at night. Coughing may make the child vomit. There is a risk of babies' breathing stopping following a coughing attack. The illness can last up to 10 weeks and can have an exhausting effect on the whole family. If an early diagnosis is made, antibiotics are effective in shortening the duration of the illness. Once severe coughing has started, antibiotics have little effect. A child should be kept warm and given small, frequent meals and lots to drink. The effects of smoking and



draughts should be minimised. Hospital admission is necessary if the child turns blue or persistently vomits after coughing.

HAEMOPHILUS INFLUENZA TYPE B (HIB)

Hib is the most common cause of meningitis and is prevalent in babies of about 10 months. 71% of cases occur in children under two years of age. It can result in deafness, convulsions and intellectual impairment or even death. It can also cause septicaemia, epiglottitis, pneumonia, arthritis and cellulitis. The bacterium can be present in the nose, mouth and throat of healthy 'carriers'. In the United Kingdom there are an estimated 1400 cases of invasive Hib disease annually. 900 of these cases are Hib meningitis. This results in 65 child deaths and 150 cases of permanent neurological damage annually.

UPTAKE

According to government figures published in 1997, childhood immunisation levels reached their highest levels in 1995/96.

96% uptake of 3 doses of diphtheria, tetanus and polio immunisation

94% uptake of 3 doses of pertussis and haemophilus influenza B (Hib) immunisation

92% uptake of measles, mumps and rubella immunisation

Source: Department of Health Press Release 97/014, 23 January 1997

The uptake of childhood vaccination is noticeably affected by publicity about the safety of the vaccines themselves. In the mid 1970s fears about the safety of the whooping cough vaccine following reports linking it with brain damage, led to uptake rates falling from 79% in 1973 to 31% in 1978. Rates as low as 9% were recorded in some parts of the

country. As a result, epidemics occurred in 1977/79 and 1981/83. There were over 100,000 notifications of the disease during each epidemic and a total of 51 deaths occurred.

SIDE EFFECTS

Despite the high uptake, levels of concern about the risks of immunisation remain high among parents. Key concerns centre on the possibility of severe reactions, links with sudden infant death syndrome (SIDS) and damage to the immune system. There is no scientific evidence to suggest a causal link between vaccination and outcomes such as neurological damage, SIDS and auto-immune diseases although circumstantial evidence does exist. Parental identification of such links may be purely coincidental.

However, parent support group, JABS (Justice Awareness and Basic Support), has identified certain commonalities amongst its 450 members. Family histories have denoted a tendency towards common allergic reactions such as asthma, eczema, hayfever, antibiotic allergy, epilepsy or fits. JABS is concerned that general practitioners are not taking sufficient care to find out about patients' medical histories before going ahead with immunisations. The organisation is also concerned that notification of side effects is not being made so that official statistics do not reflect the true numbers of adverse reactions. Suspected reactions to all vaccines should be reported to the Committee on the Safety of Medicines by GPs via the 'yellowcard' system. JABS would like an explanation of the reporting system to be made to all parents taking their child for immunisation.

JABS would also like to see each child treated as an individual before immunisation is undertaken. Children should be tested for immunity and allergic reaction before vaccination. The organisation believes mass





vaccination programmes to be unethical. It is not against immunisation in theory but believes more care should be taken.

Amongst its members, the most common post-vaccination problems are fits, ME, Guillain Barre Syndrome and limb and joint problems. Seven children are reported to have died.

MMR (MEASLES, MUMPS AND RUBELLA) - SIDE EFFECTS

This vaccine was introduced to the United Kingdom in 1988 and achieved a high uptake rate quickly because parents welcomed the chance to immunise their children for three diseases in one go. However, in September 1992, two of the three brands of MMR vaccine were withdrawn because of an association with virus meningitis. Japan and Canada withdrew the MMR vaccine in 1990 and 1991 respectively following research into frequent adverse reactions. Despite their replacement, JABS remains unconvinced about the safety of the triple vaccine and would like to see the three constituent parts given separately until more research has been undertaken. In Japan, the vaccine is only available in its single virus form.

There has also been controversy about the link between vaccination, and the MMR vaccination in particular, and the increasing incidence of Crohn's disease in the UK. Dr Andy Wakefield and Professor Roy Pounder of the Royal Free Hospital reported evidence of a link between measles vaccine and later development of ulcerative colitis and Crohn's disease. Although Crohn's disease was very rare prior to the Second World War, its incidence has increased significantly over the last thirty years, and appears to coincide with the introduction of the measles vaccine in the 1960s. Crohn's causes abdominal pain, diarrhoea, constipation, fatigue, anaemia, weight loss and fistulas. A causal link has not yet been established but the Royal Free researchers would like to see more research being undertaken.

DISSENT

There have been protests about immunisation since the first small pox injections. Compulsory smallpox immunisation, introduced in Britain in 1853, caused widespread rioting and many parents opted for imprisonment rather than have their child vaccinated. Although national uptake is high, there is still significant concern amongst parents. While non-compliance is often associated with lack of information, in the case of immunisation it is more generally associated with well-educated, professional parents. Health professionals acknowledge real difficulties in winning over the last 5-10% of parents who currently refuse consent for vaccination.

Many parents feel that they are not given sufficient information about possible side effects. In the 1994 Operation Safeguard national measles immunisation programme, the government leaflet aimed at parents focused heavily on the dangers of the diseases themselves and minimised the possibility of serious side effects. Children taking part were not asked their views and although parents had to sign a consent form, there has been some suggestion that information on consent forms was ignored by health professionals.

THE LEGAL SITUATION

In extreme cases in Britain, children have been forcibly vaccinated against their parents' wishes, following a court order. There is further evidence of health visitors and GPs threatening parents, particularly socially disadvantaged parents, with care orders if they refuse their consent. 1992 Department of Health guidelines state that parental consent should always be obtained before vaccination takes place but some parents have found that their children have been vaccinated without their knowledge, for example, while on an unrelated visit to hospital.



Section 1, subsection 1 of the 1989 Children Act declares children's interests to be paramount. This effectively gives the courts power to overrule a parental decision if it is felt the action or inaction of the parents threatens the well-being of the child. In extreme cases, the court is likely to bow to the expertise of the medical profession.

Homeopathy and religious beliefs are the most common reasons for refusal according to research.

COMPULSORY VACCINATION

The government is committed to a voluntary vaccination programme. Information promoting the benefits is widely available and Britain has a history of voluntary co-operation. Few countries have opted for compulsory vaccination. In the United States, parents must prove their child has natural immunity to target diseases or declare strong religious reasons for not having their child immunised before the child can start school. However, this has resulted in late uptake of immunisations and a high incidence of target diseases occurring in pre-school children. In 1989 and 1990 a measles epidemic in the USA resulted in 55,000 cases most of which occurred in unimmunised children aged three years.

Eradication of diseases can be attained without 100% uptake of vaccination. High immunisation coverage within the general population means the disease cannot establish itself. However, governments and parents should never be complacent.





BIBLIOGRAPHY

1. Anon, Parents May Raise Measles Paper, The Free Bulletin, No 22, June 1995, p2
2. Bedford H, Facts and Fiction, Health Visitor, Vol 66, No 9, September 1993, pp314-316
3. Bowen-Morris J, Protection against Hib: Study shows that immunisation policy is a success, Health Visitor, Vol 70, No 9, September 1997, pp344-346
4. Bower H, Crohn's Casts Cloud Over Measles Drive, Hospital Doctor, 1 June 1995, p25
5. Chandrakumar M and Saleh M, For What Reasons are Babies not given Whooping Cough Vaccination?, Maternal and Child Health, February 1994, pp52-58
6. Cook R, Paediatric Immunisation (Continuing Education), Nursing Standard, Vol 8, No 13-14, 15 December 1993, pp23-26
7. Crawford M, Winning the Fight Against Disease: A review of childhood immunisation, Child Health, Vol 2, No 5, 1995, pp187-191
8. Department of Health, Childhood Immunisation Reaches Highest Ever Levels, Press Release 97/014, 23 January 1997
9. Gilbert P, Immunisation: allaying fears, Nursery World, 14 October 1993, pp22-23
10. Gilbert P, What is Immunisation?, Nursery World, 7 October 1993, pp18-19
11. Gledhill E, New Developments in Paediatric Vaccines, Processional Care of Mother and Child, Vol 6, No 5, 1996, p117-118
12. Greenslade J, Immunisation Update, Nursery World, 1 October 1992, pp14-15
13. Gulland A, Jab that Packs a Punch, Vol 93, No 32, 6 August 1997, p18
14. Health Education Authority, Immunisation: compulsion or cooperation?, Healthlines, May 1997, pp17-19
15. Health Education Authority, Immunisation Issues, Healthlines, April 1993, p9
16. Hubbard B, Vaccines: The Holy War on the Family, AIMS Journal, Vol 8, No 2, Summer 1996, pp5-8
17. Leifer D, Shattered, Nursing Standard, Vol 10, No 51, 11 September 1996, pp26-27
18. Maceoin D, The Immunisation Debate, Childright, 83, Jan/Feb 1992, pp11-15
19. Nicholson R, Pawns in a political game, Vol 68, No 11, November 1995, p448
20. Smith S, Immunisations: Facts Pack, Community Outlook, March 1993, pp16-17
21. Thompson J, Facts, fictions and fears, Health Visitor, Vol 68, No 7, July 1995, pp292-292
22. Tyler A, Vaccination: The hidden facts, ES Magazine, September 1991, pp74-75
23. Whyte A, Adverse Reactions, Health Visitor, Vol 68, No 7, July 1995, pp269-270
24. Whyte A, Parents Sue over Vaccine Damage Claim, Health Visitor, Vol 8, No 11, November 1995, p447
25. Wiltsher A, Operation Safeguard: Learning the lessons, Health Visitor, Vol 68, No 2, February 1995, pp52-53

USEFUL ADDRESSES

The Informed Parent
19 Woodlands Road, Harrow
Middlesex HA1 2RT

JABS
1 Gawsworth Road, Golborne
Warrington WA3 3RF
Tel: 01942 713565

Campaign for Justice For All Vaccine
Damaged Children (UK)
Erins Cottage, Fussells Building
Whiteway Road, St George
Bristol BS5 7QY
Tel: 0117 955 7818

The Immunisation Project
Health Education Authority
Hamilton House, Mabelton Place
London WC1H 9TX
Tel: 0171 413 1947



Child Development

Child development is measured by physical, intellectual, emotional, linguistic and social progression. Levels of attainment at different ages will vary because of factors like environment and family background. However, certain levels of development are expected at particular ages.

A BASIC GUIDE TO STAGES OF DEVELOPMENT

1-3 months

Sucking is a primitive reflex action common to all newborn babies. By one month the baby will identify sucking with satisfaction and it will become a voluntary action. The baby will respond to touch on the cheek by moving his head. Early signs of grasping and random movements are noticeable. The grasp reflex, which is very strong at birth, is lost by three months. The baby will respond to light, movement and noise. Talking to the baby constantly provides stimulation. The baby will be responsive to a soothing voice. The relationship with the parent or primary care giver begins at this early stage.

3-6 months

The baby will be able to keep his head erect while sitting. He will use his mouth as an explorative sensory activity and will grasp objects with both hands. He will develop an interest in repetitive actions but he will forget the presence of objects once they are out of his

sight. He begins to understand that objects move. He recognises familiar sounds and voices. He will begin to link sounds together and will develop the power of imitation. He will respond to differences in tone of voice and will recognise the voice of his mother or main caregiver. He will develop feelings of trust and security accordingly. The baby will spend more time awake, will cry less and will smile. At six months the baby may display the first signs of distress and anxiety amongst strangers.

6-9 months

The baby can hold his head erect with a straight back. He may be able to sit up alone. Eye-hand co-ordination allows the baby to pull objects towards him. He will use his feet for grasping and as playthings themselves.

9 months

The baby will begin to crawl or to develop an alternative method of shuffling along. He can sit up unaided and manipulates objects as a means of exploration. He will stand when supported. He uses his finger and thumb like scissors to pick up objects and understands object permanence. He may develop a fear of strangers and become distressed when separated from his main caregiver.

9-12 months

He can pull himself to a standing position and let himself down while holding on to furniture. Some children will begin to walk. The baby can begin to experiment with feeding himself at this stage. He can build towers with bricks and may begin to show a preference for the





right or the left hand. He can clap hands and wave goodbye. The ability to crawl and walk leads to increased confidence. He may begin to realise he can manipulate adults for his own amusement. Repetitious activities strengthen the baby's sense of control. He begins to understand concepts. He will recognise his own name and will respond when called. He understands simple commands. He has a wide range of emotions but little control over them.

15-18 months

He can walk, run, go upstairs and feed himself. He will push and pull objects. Development of fine motor skills means he can hold a crayon and scribble, turn pages of a book and build brick towers. He can carry toys while walking and can walk backwards. He can imitate adult expressions. His preference for one particular hand will be more marked. He may talk continuously and is likely to have a vocabulary of twenty simple words but he will understand many more. He is still emotionally vulnerable and may become more clingy to his parent. He may develop fears such as fear of the dark. He will begin to develop social relationships.

18-24 months

Greater movement brings greater independence. Eye-hand co-ordination improves considerably. He will play ball games and is capable of balancing. His small muscle control is improving. His imagination is beginning to develop and he will indulge in imaginative play. He can undress himself and may be able to express the need to go to the toilet. Potty training can begin if the child appears ready. He begins to put words together and has a strong sense of curiosity. Between 18 and 36 months temper tantrums are common. He will express pleasure at his achievements.

30-36 months

He can jump, stand on tiptoe, climb and run well. He has developed fine muscle dexterity and can hold a pencil. He can dress himself when supervised. He begins to use prepositions

in his speech. He will enjoy domestic play, copying the adults in his environment. He will be jealous of adult attention and is likely to have a limited concept of sharing. By three years old, he will be constructing proper sentences and will be able to talk about past and future.

3-4 years

The child has co-ordinated movements. His vocabulary has extended to about 900 words. By four years old, he will know about 2000 words and have an understanding of many more. His language development will be rapid. He will constantly seek information about new experiences. He is moving towards an intuitive phase and will be forming concepts. He will begin to understand past and future tense and a sense of duration. By four years old, he may realise he can contradict adults' wishes and be cheeky. He will begin to learn to share and moves away from egocentrism. He will play in groups but will focus on the activity rather than on other children.

4-5 years

He can dress and undress alone. He can count on his fingers and carry out small tasks. He will begin to classify information. The child will be more protective towards younger children and animals. He will develop friendships with other children and will want to be part of a group. Peer groups become important. Group games become more competitive. A child will begin to develop an understanding of cultural and family differences.

THEORIES OF CHILD REARING

Although different societies have always had ideas about child-rearing, the concept of mothercraft did not evolve until the 1920s under the auspices of Scottish doctor, Frederick Truby King. He attempted to establish clear rules about child rearing in an attempt to improve the overall health of children.





However, his methods failed to take account of personality differences in both mother and child. The influence of Truby King coincided with greater government intervention in child health. The establishment of infant welfare clinics prompted greater interest in child health and the importance of hygiene. Truby King was an early professional adviser to these clinics.

Truby King believed in breast-feeding and a regular four hourly regime of feeding. He believed an established routine should not be altered even if the baby was crying. The mother was encouraged to give her baby as much fresh air and sunlight as possible and regular sleep. The mothercraft movement revived breast feeding and improved hygiene standards. In New Zealand the introduction of the movement saw infant mortality drop by 1000 deaths per annum. However, critics have condemned the strictness of the regime, particularly the refusal to feed babies on demand. Mothers felt confined by the regime but also pressured into doing what they had been told was the best for the baby. However, a study of child-rearing practices in Nottingham in 1963 showed that working mothers were ignoring the advice and were responding to their babies demands as they came.

In the 1950s a more relaxed approach to child rearing was introduced. The American Benjamin Spock published 'Spock's Common Sense Book of Baby and Child Care' which rejected adherence to a rigid regime and encouraged mothers to trust their instincts.

Psychologist, John Bowlby, developed his theory of maternal bonding in the 1950s. He believed that the long term mental health of children depended upon a close and continuous relationship with their mother. He later extended the caring role to include fathers or long term carers like nannies. He believed maternal deprivation was likely to lead to an

inability to form lasting emotional attachments in adult life and could lead to delinquency. However, the theory of maternal bonding did make working mothers feel guilty.

In recent years, the trend has been to focus on the needs of the child above all else.

PLAY - ITS ROLE IN CHILD DEVELOPMENT

Even young babies can play with each other and establish their own level of communication if the correct environment is established. Young babies learn their social skills from adults and transfer them to their relationships with other children. Babies in the setting of the nuclear family may not have the opportunity to develop friendships with other babies.

GENDER DIFFERENCES

There are undoubted differences in the style of play and the choice of toys based on gender. Although there will always be children who do not conform to stereotype, boys will be, in general, more adventurous, challenging and competitive than girls. Girls tend to be better at play which requires manual manipulation such as sewing and threading. Physical activities enjoyed by girls are more likely to involve co-operation, such as skipping, rather than competition. Some psychologists attribute these trends to physical differences in strength but other explanations focus on environmental influences and prejudices. Many parents feel uncomfortable if their child does not conform to gender stereotype. Parents often influence a child to play with certain gender appropriate toys unwittingly. Within the nursery or the domestic setting, children can be encouraged to play with a range of toys. Stories putting children in unusual settings are a good way of introducing new ideas.





PARENTAL PLAY

Mothers and fathers have different contributions to make to the play environment. Studies have found that fathers are far more likely to indulge in physical play with their children, especially with their sons. Physical play helps develop strength and co-ordination. Fathers' play is likely to be more unpredictable and less conventional than mothers' play. This can encourage cognitive development and an understanding of the unexpected, as well as encouraging imaginative play. Mothers, in general, will elect for quieter play based on role-playing. A father may be inclined to show greater concern than the mother if the child shows an interest in toys and games not considered gender appropriate. This concern is likely to be more apparent in the case of boys.

PLAY AS SOCIAL DEVELOPMENT

Play will encourage the child to share, to be aware of the needs of others and to be aware of the pleasure in communal activity. It is also important to learn about winning and losing and accepting the ideas of other children. Being with younger children allows the older child to develop caring skills, while also acting as a role model. The child will begin to develop an understanding of social responsibility. It is important that the adult carer reinforces issues of fairness, discipline and respect for others. Play will inevitably lead to conflict. A potentially difficult situation can be used to reinforce ideas of good behaviour and to help children find ways of problem solving.

CULTURAL DIFFERENCES IN CHILD REARING

Different cultures have varying expectations of how children should behave in particular situations. These may have an impact on the child's stages of development. For example, studies have found that Western middle class parents are likely to find night time waking of

babies more stressful than rural parents in Kenya. The stress of the Western parents could be transmitted to the baby. Differences in the care routine and the expectations of the baby to conform to such a routine are likely to manifest themselves in the baby's ability to adapt to different situations. Differences in attitude to the family unit will also impact on the parental view of child development and child rearing. Western cultures tend to value the individual more highly than in Eastern cultures where group needs dominate. It is important for the secondary child carer to be aware of the impact of the family environment on the child.

NURSING IMPLICATIONS

A preverbal infant will require a significant degree of tactile care to reassure him. Rocking, fondling and cuddling are important. He will respond to a gentle voice and a smile. When assessing pain, it is important to assess physiological indicators such as facial expressions and tone of any crying.

At the toddler stage a child will be exhibiting signs of independence but will obviously still be highly dependent. His only means of exerting control in a particular situation may be to express negativism. Stressful situations, like hospitalisation, may result in a period of regressive behaviour.

A preschooler will be able to communicate reasonably but may have exaggerated fears about unknown situations. Explaining the situation simply and honestly should encourage a mutual bond of trust. Allowing the child to make simple choices in a difficult situation should make him less fearful. His sense of time is still underdeveloped so the timing of events should be explained in relationship to a known event. The familiarity of favourite toys or comfort blankets will encourage a feeling of security.





The school age child (6-12 years) will need more careful explanation about any events related to illness and hospitalisation. The child should be included in the decision making process as much as possible. He may feel isolated and may hesitate to ask for help. The child's awareness of his body is emerging so a degree of privacy is required. A child at this stage may deal with pain in a passive way by clenching his fists or grinding his teeth. Praise should be given frequently.

For the adolescent, privacy is paramount. Hospitalisation may be seen as a threat to independence so particular attention should be paid to decision making. The adolescent may revert to childish behaviour to deal with painful or stressful situations.

It is important for nurses and carers to understand how children conceptualise illness so that they can communicate with the child on his own terms.

BIBLIOGRAPHY

1. Dosnajt J, Child-rearing Practices of Two Generations of Punjabi Parents, *Children and Society*, Vol 11, 1997, pp29-43
2. Frederick C and Reining K, Essential Components of Growth and Development, *Journal of Post Anesthesia Nursing*, Vol 10, No 1, February 1995, pp12-17
3. Goldstein J, Fathers as Play Partners, Under Five Contact, May 1997, pp10-11
4. Halstead M, Between Two Cultures? Muslim Children in a Western Liberal Society, *Children and Society*, 8:4, 1994, pp312-326
5. Henderson A, Physical Development 2: Fine Motor Skills, pp14-15
6. Henderson A, Social Development, Under Five Contact, June 1997, pp8-9
7. Kohner N, Birth to Five, Health Education Authority, 1994
8. O'Hagan M, Geraghty's Caring for Children, Balliere Tindall, 1997
9. Reid J, Bringing up Baby, *Nursery World*, 11 April 1996, pp12-13
10. Reid J, Different Schools of Thought, *Nursery World*, 31 October 1996, pp24-25
11. Schaffer H R, Family Structure or Interpersonal Relationships: the context for child development, *Children and Society*, 2, 1988, 2 pp1-11
12. Rushforth H, Nurses' Knowledge of How Children View Health and Illness, *Paediatric Nursing*, Vol 8, Vol 9, November 1996, pp23-27
13. Selleck D, Playmates, *Nursery World*, 17 July 1997, pp24-25
14. Swanwick M, Bringing up Baby, *Paediatric Nursing*, Vol 5, No 4, May 1993, pp20-24
15. Swanwick M, Earing Cultures. *Paediatric Nursing*, Vol 8, No 7, September 1996, pp13-17
16. Swanwick M, Knowledge and Control, *Paediatric Nursing*, June 1990, pp18-20
17. Williamson Dr G, And Another thing (language development), *Nursery World*, 8 August 1996, pp16-17
18. Williamson Dr G, One at a Time (language development) *Nursery World*, 25 July 1996, pp16-17
19. Williamson Dr G, Two by Two (language development), *Nursery World*, 1 August 1996, pp16-17
20. Woolfson Dr R, All Things Being Equal, (gender and play), *Nursery World*, 8 February 1996, pp12-13
21. Woolfson Dr R, A Co-ordinated Approach, (co-ordination skills) *Nursery World*, 18 April 1996, pp12-13
22. Woolfson Dr R, Home and Dry (potty training), *Nursery World*, 20 November 1997, pp12-13
23. Woolfson Dr R, Fingers and Thumbs (hand-eye co-ordination), *Nursery World*, 18 September 1997, pp10-11

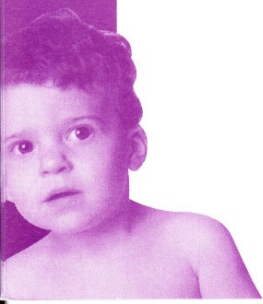




NAWCH Charter

for children in hospital

- 1 Children shall be admitted to hospital only if the care they require cannot be equally well provided at home or on a day basis.
- 2 Children in hospital shall have the right to have their parents with them at all times provided this is in the best interest of the child. Accommodation should therefore be offered to all parents, and they should be helped and encouraged to stay. In order to share in the care of their child, parents should be fully informed about ward routine and their active participation encouraged.
- 3 Children and their parents shall have the right to information appropriate to age and understanding.
- 4 Children and their parents shall have the right to informed participation in all decisions involving their health care. Every child shall be protected from unnecessary medical treatment, and steps taken to mitigate physical or emotional distress.
- 5 Children shall be treated with tact and understanding and at all times their privacy shall be respected.
- 6 Children shall enjoy the care of appropriately trained staff, fully aware of the physical and emotional needs of each age group.
- 7 Children shall be able to wear their own clothes and have their own personal possessions.
- 8 Children shall be cared for with other children of the same age group.
- 9 Children shall be in an environment furnished and equipped to meet their requirements and which conforms to recognised standards of safety and supervision.
- 10 Children shall have full opportunity for play, recreation and education suited to their age and condition.





Library and Information Service

Action for Sick Children aims to raise the standards of health care for all children whether in hospital or at home. The charity was founded in 1961 to improve conditions for hospitalised children and alleviate the distress suffered by the child separated from his or her mother. Since then, ASC has campaigned for child and family centred care. The library and information service has played a key role in the charity's work and success.

Subject coverage

The unique collection focuses on the emotional and psychological needs of sick children and their families. Key topics include: preparation for hospital admission, the effects of illness and hospitalisation, parental involvement and family centred care, pain, play therapy, nursing care of children both in hospital and in the community, symptoms of and treatments for specific illnesses

An historical collection of articles traces the developments in hospital care of children since the 1940s. The library also holds a collection of parents' self-help books and a collection of books written specifically for children about hospital admission and coping with illness.

Services

Literature searches on specific topics can be supplied on request. A charge of £5.00 is made to non-members (See library membership) A photocopying service is available subject to the Copyright Act 1988. A charge of £1.00 per article will be made.

Reading lists and Keypoint summaries on major topics are also available at a cost of £1.00 pence. A publications list can be supplied free of charge.

Library membership

£30.00 per annum (waged) £10.00 per annum (students). Membership offers an unlimited number of literature searches and full access to information services including a bi-monthly current awareness bulletin, copies of 'Cascade' magazine, our Annual Report and concessionary rates to conferences and seminars. It also includes new editions of Keypoints and Reading Lists as they are produced or updated.

Availability

The library and information service is open to all health care professionals, students and parents. The library is open Tuesday and Wednesday from 9.30am to 5pm. An appointment is required for a personal visit. Please enclose a stamped addressed envelope with all requests for information.





Library membership form

As a library member you can expect:

- Full use of the Library and Information Service
- A bi-monthly current awareness bulletin
- Our quarterly magazine 'Cascade' and Annual report
- Concessionary rates for conferences and seminars
- Keypoints and Reading Lists as they are published or updated

The library is open Tuesday and Wednesday 9.30am-5.00pm. Please telephone to arrange a visit. Inquiries can also be dealt with by letter or telephone

Fees: The cost of membership is

- £30.00 - persons in full employment/colleges etc
- £10.00 - students/unwaged

NAME _____

ADDRESS _____

TELEPHONE NUMBER _____

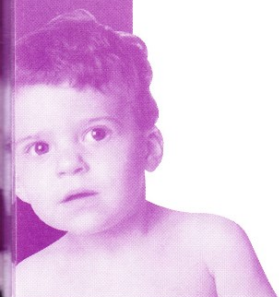
NAME OF INDIVIDUAL TO WHOM MAILINGS SHOULD BE SENT (if different from above)

_____ DATE _____

I enclose my library membership fee of £30.00/£10.00

Please make cheques payable to Action for Sick Children and send to:

The Librarian, Action for Sick Children, Argyle House, 29-31 Euston Road, London, NW1 2SD





Action for Sick Children

National Association for the Welfare of Children in Hospital Limited

Action for Sick Children

Argyle House
29-31 Euston Road
London NW1 2SD

Tel: 0171 833 2041

Fax: 0171 837 2110

Email: action_for_sick_children_edu@msn.com

Web site: <http://www.actionforsickchildren.org.uk>

