

STANDARD 9:

Enabling play and learning

‘Health care providers, organizations and individual health workers, share a responsibility to advocate for children and to reduce the fear, anxiety and suffering of children and their families by ensuring that they enable children to play and learn’.

Supporting criteria for play

1. Support for play that includes:
 - For all children who are well enough - encouraging and helping children to play when they are awake, ‘especially at the bedside’ when a child is too ill or unable to get to an area set aside for play.
 - In a hospital, a play service with a play worker/s who has been trained, or a lead health worker with the skills to set up and supervise play and the play materials
2. In a health facility, resources for play that include:
 - A separate, safe and clean place to play in each clinical area, providing there is space available, that can be used by all children who are well enough
 - Providing safe and culturally appropriate play materials. Alternatively, or in addition, encouraging parents to bring and use the child’s own toys
 - Secure storage for play materials so that they do not get stolen
3. Provision of advice to all children and families about safe and appropriate play materials (including toys) for use at home
4. The promotion and use of strategies involving play for:
 - Recreation and stimulation of development
 - Helping children to cope with their health problem (therapeutic play), for example play to distract, for procedure preparation, to help in the giving of information, for stress relief, for expression
 - Helping to manage pain and other distressing symptoms.

Discussion

‘State parties recognise the right of the child to rest and leisure, to engage in play and recreational activities appropriate to the age of the child....’ UNCRC: Article 31

‘Play is a natural part of childhood and a vital factor in the mental, social and emotional growth of children’ - National Association of Hospital Play Staff, UK.

Play is not just a way of passing time and entertaining children, but is an important way for well or ill children to make sense of the world around them. It also helps them cope with any special problems and difficulties and enables them to develop to their full potential. It is important to remember that an ill child is a normal child in an abnormal situation, so having sensory stimulation and the opportunity to play is even more important when a child is ill.



*Child patient playing
in a hospital corridor
in Pakistan*

Play and sensory stimulation within health care is often thought of as trivial or of little importance, despite its many benefits and the low cost involved. Many health workers (and sometimes parents) feel that an ill child has no need to play or be stimulated, and that this should wait until they are better. However, this underestimates the importance of play and its role in helping an ill child.



*Malnourished
children and their
mothers learning
how to play in a
Ugandan
Hospital.*



Some of the reasons why play and sensory stimulation are important enough to be given a higher priority by health workers include:

1. A faster recovery from illness

Research evidence shows that ill children who are given the opportunity to play get better faster than those that don't. Play is a normal part of every child's life, whether it is spontaneous ('free') or helped.

2. Better physical, mental, emotional and social development

The physical and mental stimulation of play is vital to help children develop to their full potential. Body growth, muscle development, fine and gross motor skills, sensory skills and a child's ability to learn, interact socially and make sense of the world around them are all helped by play. Children who

are ill, injured, malnourished, developmentally delayed or who have a disability have an even greater need for play and the help to do this.

3. **Reduction of a child's anxiety and stress**

When a child is ill or in a healthcare environment, such as a hospital, many of the things that were familiar to the child disappear and are replaced with unfamiliar and often frightening situations, environments, people, smells and sounds that the child has no control over. Play helps a child to regain some familiarity and control over their surroundings and to understand some of the things that might happen to them by 'pretend' playing, drawing and talking. Bringing a familiar toy from home can also help. For children admitted for non-emergency treatment, an earlier visit to the hospital is helpful. Although play may happen spontaneously, a child who is anxious or frightened often withdraws and may need help to play.



Play materials used to help prepare children for procedures or operations

4. **Easier assessment, treatment and procedures leading to improved outcomes**

When a child is ill, distressed, anxious or frightened it can be difficult for health workers to make a good examination and assessment of the child's needs. Encouraging the child to play (within their capabilities if they are ill) often helps health workers to do this and can also help build a child's trust in them.

Many treatments and procedures are frightening, unpleasant or painful for children (for example changing a dressing and taking blood etc.). Play can be a distraction or a preparation for these.

Using play to prepare a child before a procedure by showing the child what is going to happen to them and allowing him/her to become familiar with some of the equipment used by health workers can help enormously. For example, a child can 'practice' the procedure on a doll, maybe by bandaging it or putting a tube down its nose. This allows a child to gain some control. Asking their permission before the treatment or procedure and allowing them to help also gives them more control. This usually, even in quite young children, makes it easier for the health worker. Stories that explain about health problems, treatments or procedures also help.

From the child's point of view, refusing to comply with unpleasant treatments is reasonable behaviour. By using play many potential difficulties can be overcome, thereby improving compliance and the eventual outcome for the child.

5. Better communication with the child

Health workers need to be able to communicate effectively with children to find out how they feel and to gain their views and opinions about what is happening to them or may happen in the future. This is difficult for health workers if a child is ill, frightened, anxious or distressed. Many children find it easier to express their feelings and distress through play rather than by using words. A child might also find it easier to talk about how he/she feels when they are playing. Play allows a child to express their anger or sadness, frustrations, fears and also happiness.

The aims of a health facility play service are therefore to aid normality, help children develop, communicate and contribute to and cope with their healthcare experience in the best possible way, in order to improve their health outcomes.

In a hospital some ways play can be supported are by:

- All health workers acquiring the skills to enable children to play
- Providing the best possible play opportunities in every clinical area used by or visited by children.
- Supervising play at the bedside where necessary and appropriate
- Employing skilled play specialists or nominated health workers to organise and supervise play by working together with health workers and parents/carers.
- Identifying separate and supervised play areas for child patients and for child visitors (who are not patients) where they can be left by a carer for a limited period of time.

Bare playroom before improvements



Same playroom after improvements



Best possible' or 'gold standard'(see later) play areas include:

- A separate supervised play area for all children in or near every clinical area.
- A noisy indoor play area
- A quiet indoor play area for activities such as reading and computing
- An outside play area for child patients and child visitors
- A room for watching television or videos or listening to the radio
- Appropriate and safe play materials

Health workers visiting the home or working in a community also have an important role in encouraging and supporting play to make it an enjoyable, stimulating and learning experience for the children and their families.

Supporting criteria for learning



A school room in a large children's hospital in the UK

1. Support for school type education/learning includes:

- Making possible continuing 'school type' education (learning) for each school age child who is in a hospital for more than a few days and is well enough
- Supporting and encouraging learning for children in other healthcare environments

2. Resources in a hospital or other residential health institution (such as those for children with physical and mental health and other learning disabilities found in some countries) that include:

- A lead health worker with teaching skills, or a specially supported teacher who comes into the health facility, to support learning and liaise with a child's parents/carers and local school
- A separate place to learn that is safe and clean in the clinical area where continuing school type education can be given
- Actively encouraging children and parents to bring their own education materials or providing education materials

3. Systems to provide:

- Relevant information to individual schools about every individual child with a disability or health problem that affects or may affect their education
- Advice and information to schools about general health issues.

Discussion

Health problems and disabilities often interfere with a child's learning opportunities and their ability to learn. This may compromise their chances of reaching their full developmental potential. Many children in these situations are able to carry on 'school type' learning if this is promoted, enabled and supported by health workers.

Examples of compromised education include:

- The short periods of missed education during illness at home, for healthcare attendances and when a child is in hospital
- Long periods of disrupted school attendance due to a long hospital admission because of a severe illness or trauma.

- Frequent missed school attendance because of physical illness, learning difficulties or mental health problems
- The non-attendance of children who will be living (and dying) from chronic deteriorating diseases.

Every ill and disabled child has the right to a stimulating 'school-type' education (UNCRC). It is important that they are enabled to learn when they are able to, and for as long as they are able to.

Health workers can support this by:

- Providing a place for learning in the healthcare environment
- Encouraging children and families to bring their own learning materials when they are admitted to a hospital for more than a few days.
- Supervising learning for periods of time during the day
- Liaising with a child's teacher about health problems that may interfere with a child's school attendance or make learning difficult. For example many children have a variety of temporary or permanent physical disabilities, hearing or visual difficulties, or mobility problems.

Best practice is for health workers to have education/training about learning difficulties in children and about the implications for learning of some health problems and disabilities.

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STANDARD 10: Recognising, protecting and supporting vulnerable or/and abused children

‘Health care providers, organisations and individual health workers, share a responsibility to advocate for children and to reduce the fear, anxiety and suffering of children and their families by ensuring that they recognise, protect and support vulnerable and abused children’.

Supporting criteria

1. The following important primary, secondary and tertiary activities are aimed at preventing ill treatment and abuse:

- Giving advice on parenting and other related issues to pregnant women, carers, young people, children and others.
- Systems to identify vulnerable families in which abuse might occur:
- Referrals to systems in the community (if they exist) to support vulnerable families:
- The prompt but confidential sharing of information and concern with other relevant disciplines such as other health workers, social welfare services, police, schools, playgroups etc.
- A knowledge of the country’s legal framework for child protection
- Referral to a social welfare service (or similar support service-if it exists) that provides general and emotional support to vulnerable families, and to abused children and their families

2. For suspected abuse:

- A written statement (policy) to guide health workers which includes clearly defined procedures for managing children suspected of being abused
- Lead health workers (doctor and nurse) to coordinate activities with responsibility for policies, clinical guidelines for managing the child and family, monitoring the quality of the service and training
- Clinical guidelines to help with the recognition, diagnosis and investigation of child abuse that are available to all health workers
- Systems for protecting and supporting an abused child
- Systems for protecting and supporting the families of an abused child.

3. Keeping confidential written information about vulnerable families, abandoned children and abused children. Best possible practice is to have a confidential register of all abused children which can be accessed twenty-four hours a day:

Discussion

Many health strategies and other primary, secondary and tertiary prevention activities can support vulnerable children and families and help prevent child abuse and ill treatment.

Examples of activities aimed at preventing of child abuse include (WHO):

Primary prevention	Secondary prevention	Tertiary prevention activities
<ul style="list-style-type: none"> • Pre-natal and perinatal health programs • Child health monitoring programs • Promotion of good parenting • Raising public awareness about child abuse • Raising community awareness about the UNCRC • A social welfare system • School activities re: non-violence and the prevention of bullying 	<ul style="list-style-type: none"> • A system for identifying vulnerable families • Family support systems eg home visits • Clear referral systems to support services for vulnerable families • Substance abuse treatment programs • Community based family centred support assistance and networks (social welfare system) • Accessible information about community services available for all families <ul style="list-style-type: none"> • Support services based in schools 	<ul style="list-style-type: none"> • Early diagnosis • The working together of all organisations involved with abused children to ensure: <ul style="list-style-type: none"> - medical treatment - healthcare - counselling - management and support of victims - management and support of families - re-integration into the community and schools • Adequate child protection laws • Child Friendly criminal justice systems, including facilities for the court attendance and participation of potentially abused children

Children are more likely to be vulnerable, abused and/or ill-treated when environmental factors are adverse, when parenting is not good enough or when they themselves have problems that make their families more stressed, or their care more difficult.

Risk factors include:

Environment factors	Parent factors	Child factors
<ul style="list-style-type: none"> • Absolute or relative poverty • War or other 'natural' disasters (eg famine, earthquake, flood etc.) • Family displacement or refugee status • Confinement to a prison or other institution • Excessive family mobility 	<ul style="list-style-type: none"> • Absence of one or both birth parents • Substance (drugs, alcohol etc) abuse • Domestic violence and/or marital relationship/family problems • Poor experience of parenting by parent/s • Very young or immature parent/s • Physical or mental health problems/emotional disturbance in one or both parents • Family already known to social welfare system • Evidence of poor parenting of a sibling/s 	<ul style="list-style-type: none"> • A disability or learning difficulties • Low birth weight/premature birth • Prolonged separation from a parent (such as admission to a hospital) especially in the neonatal period • Female sex (in some cultures females are at risk of infanticide and have limited opportunities for education.) • One of a multiple birth • A 'difficult baby or child' or one who cries incessantly

WHO multilevel risk factors for child abuse

PARENT	CHILD	FAMILY	COMMUNITY/SOCIETY
<ul style="list-style-type: none"> • Young age • Single unsupported parent • Unwanted pregnancy • Poor parenting skills • Early exposure to violence or abuse themselves • Substance abuse • Inadequate pre-natal care • Physical or mental illness • Learning difficulties • Relationship problems 	<ul style="list-style-type: none"> • Female Sex • Prematurity • Separation or poor bonding in neonatal period • Unwanted • Disabled physically or mentally • Delayed development, particularly soiling and wetting past developmental age • Difficult temperament (persistent screaming, attention deficit/hyperactivity disorder etc.) 	<ul style="list-style-type: none"> • Size/density • Poor socio-economic status • Social isolation • High levels of stress • Family abuse/history of domestic violence 	<ul style="list-style-type: none"> • Non-existent, non-enforced child protection laws • Decreased value of children (minority, gender, disabled) • Social inequalities • Organised violence (wars, small arms, high crime rates) • High social acceptability of violence • Media violence • Cultural norms

The legal framework required to protect children varies in different countries. In some there may be no framework at all despite ratification of the UNCRC, and in others advanced laws especially for children, for example the 1989 ‘Children Act’ in England and Wales. Some countries that do have legislation do not have any framework for enforcing this and others have minimal legislation. Child abuse is often interpreted very differently and some countries do not have laws to protect children from enforced labour, recruitment as soldiers or to protect them if they are refugees.

Many disadvantaged countries place child protection programs low on their priority list, as they have so many other problems to solve such as border security, the provision of safe water and sanitation, affordable education and health systems, adequate employment prospects and securing their economy. However there is an obligation following ratification of the UNCRC for governments to move towards protecting children in a transparent way, whatever their problems. The International Community must continue to advocate for the global rights of children to be protected and the introduction of laws that will protect children where none exist.

Abuse, neglect or exploitation is less likely to occur if a country:

- Provides financial and other support for vulnerable children and families
- Ensures equal access to, and opportunities for, free healthcare and education for all children
- Supports educational programs that will improve parenting skills for the whole population
- Programs that identify and support vulnerable children and families (*see Standard 1*)
- Uses integrated, collaborative and standardised methods to diagnose, protect and support abused children.

Health care providers have a key role, together with other groups that work with children and families, in identifying, protecting and supporting vulnerable and abused children and their families. To do this effectively individual health workers have a responsibility to acquire the skills necessary to understand and use the preventive, diagnostic, protective and support systems that exist in their country, to advocate for these when they are absent and to collaborate with their colleagues in the other agencies and organisations that are involved with children.

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