Aim

The aim of this chapter is to consider the concept of childhood and the enhancement of the overall health and wellbeing of children and young people.

Learning outcomes

On completion of this chapter the reader will be able to:

• Define and discuss the concept of ‘childhood’.
• Consider the child’s ‘voice’ and the importance of involving children in decision-making processes.
• Explore the role of family, friends and the local community in relation to children’s overall wellbeing.
• Define and discuss the concepts of health and wellbeing within a child-focused context.
• Define child public health and consider associated key policies.
• Reflect on the potential health promoting role of the nurse.
• Consider childhood morbidity and mortality within a 21st century context.
Chapter 1

The child in society: enhancing health and wellbeing

Introduction

Health in childhood determines health throughout life and into the next generation. ... Ill health or harmful lifestyle choices in childhood can lead to ill health throughout life, which creates health, financial and social burdens for countries today and tomorrow.

(World Health Organization [WHO], 2005: ix)

This quote confirms that the promotion and maintenance of children’s health and wellbeing is of paramount importance, both now and for the future; this is something that has been widely recognized and has received considerable attention (e.g. the UK Department for Education and Skills [DfES], 2004; DfES and Department of Health [DH], 2004; Department for Children, Schools and Families [DCSF], 2007a; DCSF and DH, 2009; DH, 2010a–c; Department for Education [DfE], 2011).

Children are a fundamental and invaluable part of society. To promote their overall health, it is essential that key aspects of children’s lives are appreciated, as well as some of the factors that have the potential to impact on their overall wellbeing. This chapter provides an introduction to the concept of childhood, reflecting on the child’s ‘voice’ and the importance of involving children in any decisions that may affect them. The significance of the child’s immediate environment, in terms of their family, friends and community, is considered; this is followed by a discussion focussing on children’s health and wellbeing (including the public health agenda) and the potential health-promoting role of the nurse. The chapter concludes by briefly considering childhood morbidity and mortality, thus ‘setting the scene’ for the subsequent chapters.

The term ‘child,’ used throughout the chapter, refers to children and young people aged between 0 and 18 years.

Test your prior knowledge

- Can you name two key Acts of Parliament from the last 25 years that focus on protecting children?
- Is involving children in decision making a professional, ethical and legal obligation for healthcare professionals?
- Where is it stipulated that ‘The child shall have the right to freedom of expression’?
- Which law states ‘Everyone has the right to freedom of expression’?
- What was the name of the review that was published in 2010 to identify how health inequalities could be addressed within the UK?
- What were the five key outcomes identified within Every Child Matters (Department for Education and Skills [DfES], 2004)?
- Which Act of Parliament reflects the five key outcomes from Every Child Matters (DFES, 2004)?
- Where was the UK ranked out of 29 ‘rich countries’ by UNICEF in 2013 in relation to a child’s wellbeing?
- What are the three key areas that child public health focuses on?
- Which Nursing and Midwifery Council (NMC) standards state that children’s nurses must ‘Support and promote the health, wellbeing, rights and dignity of people, groups, communities and populations’?
The concept of childhood

This section introduces the concept of childhood with consideration being given to the meaning and evolvement of the term childhood over the years and the ‘emergence of “children’s voice”’ (Prout and Hallett, 2003: 1). In addition, the value and importance of involving children in decisions that impact on them is addressed.

A rudimentary dictionary definition of childhood is:

*The condition of being a child; the period of life before puberty.*

(*Collins Dictionary and Thesaurus, 2000: 195*)

However, it is also generally acknowledged that childhood spans four key phases – infancy and toddlerhood, early years, middle childhood and adolescence (Hutchison, 2011). Eminent psychologists, such as Erikson (1950), Piaget (1952) and Kohlberg (1984) have considered different aspects of children and young people’s cognitive development.

Prout and James (1997: 8) offer more clarification and suggest that childhood is not simply about the organic maturation of children, but is a ‘specific structural and cultural component of many societies.’ Importantly, Frønes (1993: 1) states that:

*There is not one childhood, but many, formed at the intersection of different cultural, social and economic systems, natural and man-made physical environments. Different positions in society produce different childhoods, boys and girls experience different childhoods within the same family.*

This raises an important point: if children are referred to collectively within the term ‘childhood’, there is a danger that differences (e.g. in gender, age and ethnicity) will be lost (James and Prout, 1997). Frønes (1993) acknowledges the impact of society on the evolution of childhood, but also alludes to the individual experience and this perspective must surely be recognized.

There can be no doubt that the perception, understanding and recognition of childhood has changed considerably over the centuries. Authors (e.g. Ariès, 1962 and Cunningham, 2006) have considered the development of the meaning of the term childhood from the Middles Ages to more recent years, recognizing that it has been influenced by a number of factors; for example, the impact of Christianity in the 18th century meant that the child was often viewed as needing spiritual salvation from evil (Hendrick, 1997); in the Victorian era, as a result of the work of a range of reformists, there was a more overt drive to protect children (Cunningham, 2006). There has been a recurrent theme over the years of viewing children in terms of purity and innocence (Cunningham, 2006), something which Holt (1975: 23) suggests is not always the case for every child – he refers to the falsehood of the assumed *‘happy, safe, protected, innocent childhood.’*

In more recent years, there has been a stronger focus on the protection of children with a variety of both legal and policy documents being published (e.g. the Children Act, 1989, 2004; DFES and DH, 2004; DfES, 2004; Royal College of Paediatrics and Child Health [RCPCH], 2010); in addition, there is now a wealth of literature that focuses on protecting children from a whole range of life events (e.g. environmental tobacco smoke [Botelho and Fiscella, 2005]; sun protection [Gritz et al., 2005]; travel risks [Mathur and Kamat, 2005]; the internet [Pogue, 2005] and divorce [Vélez et al., 2011]). It has been suggested that some aspects of protection could lead to reduced opportunities for children to socially interact, with the main conduits only existing within controlled settings such as schools and clubs (Smith, 2000). In support of this point, Palmer (2006) comments on the ‘toxic’ environment and the influence that this is having on childhood in the 21st century. Children’s lives and the nature of their childhood (at both a
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societal and individual level) is different from that of previous generations; however, it could be argued that generational differences are not new and have existed for centuries. The most important issue is that we have a clear understanding of children’s lives within the 21st century so that appropriate care can be provided by all healthcare professionals.

The child’s ‘voice’

Whilst a range of literature has for many years demonstrated a strong interest in the lives of children across the age ranges, much of this has tended to focus on the adult perspective, rather than valuing the voice and contribution of the child (Prout and James, 1997). Prout and James (1997) have offered a new paradigm for childhood that has six key features (Box 1.1).

The work of James and Prout (1997) has been invaluable in raising the profile of children as participants who are capable of being involved in decisions that may impact on their lives. The need to involve children in a range of issues has grown in acceptance (Sinclair, 2004). It is now widely established that the views and experiences of children should be taken into account wherever possible, with a range of key documents advocating their involvement (e.g. the Children Act, 1989, 2004; The United Nations Convention on the Rights of the Child [UNCRC] [1989]; DfES and DH, 2004) (Table 1.1).

Whilst Prout and James (1997) comment on the importance of involving children when decisions may impact on them, it is also important to recognize that children themselves benefit from involvement by gaining a sense of achievement, increased self-esteem (Kirby, 2004; The National Youth Agency, 2007) and enhanced communication skills (Participation Works, 2007; Carnegie UK Trust, 2008).

Fundamental aspects of children’s lives

The family

A range of prominent authors and organizations (e.g. Rutherford, 1998; United Nations, 1998; European Parliament, 2000) have acknowledged the potential impact of the family on children’s growth, nurturing and development. In addition, research into the concept of attachment has suggested that children who feel secure are more likely to adhere to rules and boundaries set by parents (Thompson, 2006) and responsive parenting fosters responsive and cooperative

Box 1.1 Key features of the paradigm of childhood (Prout and James, 1997: 8).

- Childhood is a framework for the contextualization of children’s lives.
- Childhood cannot be separated from other variables in society, for example, gender and ethnicity.
- Children’s social interactions should be studied and remain independent of the adult perspective.
- Children should be actively involved in decisions that may impact on their lives.
- Ethnography can be a valuable research approach for the study of childhood.
- A new paradigm of childhood necessitates the reconstruction of childhood.
The acknowledgement of the family’s contribution to children’s overall wellbeing has been recognized within the literature and was one of the key findings from work by Parry et al., (2010), Rees et al., (2010) and Ipsos Mori and Nairn (2011).

However, it is important to recognize that the ‘21st century family is not a static structure’ (Rigg and Pryor, 2007: 17). Statistics reveal that there were 117,558 divorces in England and Wales in 2011 (Office of National Statistics, 2012); although this represents a slight decrease on previous figures, it is clear that every year a great many children and young people are faced with a significant alteration in their family structure and their subsequent lifestyle, although they are the people who have been the least likely to initiate the changes (Rigg and Pryor, 2007).

It is important to understand children’s perception of a family in order to appreciate the relationships and aspects of family life that are important to them. Very few studies have been conducted to determine children and young people’s views of the family in the 21st century. However, Rigg and Pryor (2007) studied vignettes of, and interviews with, 111 New Zealand children (aged 9–13 years) from a range of family structures and backgrounds. They found that children frequently described affective factors – in other words, children perceived that family comprised of people who cared for and loved them (Rigg and Pryor, 2007); the children did not tend to make distinctions between couples being married or cohabitating.

Whilst the family has changed enormously in diversity and structure over the last century, it undoubtedly remains fundamental to children’s lives and has many positive attributes; Whiting et al., (2013) suggest that it is a complex concept that incorporates four key areas:

- **Family membership:** The family is an assumed presence that comprises of people who are always there and who are an integral part of children’s lives; this undoubtedly brings stability. It is important to note that children’s pets can also be regarded as family members.

### Table 1.1  Key documents that advocate the involvement of children.

<table>
<thead>
<tr>
<th><strong>The United Nations Convention on the Rights of the Child (UNCRC) (1989)</strong></th>
<th>Article 12: 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</th>
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<td>Article 13: The child shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds</td>
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<td>Article 42: Undertake to make the principles and provisions of the Convention widely known, by appropriate and active means, to adults and children alike</td>
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<td><strong>Children Act (1989)</strong></td>
<td>Section 22(4): Before making any decision with respect to a child whom they are looking after, or proposing to look after, a local authority shall, so far as is reasonably practicable, ascertain the wishes and feelings of the child</td>
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<tr>
<td><strong>Children Act (2004)</strong></td>
<td>Section 17: To consult children and young people on Children and Young People’s Plans</td>
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<tr>
<td><strong>National Service Framework for Children, Young People and Maternity Services: Core Standards (UK DfES and DH, 2004)</strong></td>
<td>Standard 3: Professionals communicating directly with children and young people, listening to them and attempting to see the world through their eyes</td>
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<tr>
<td><strong>Human Rights Act (1998)</strong></td>
<td>Article 10: Everyone has the right to freedom of expression</td>
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• **Togetherness:** Children and young people undertake a range of activities with family members; these include weekly family treats, holidays, special occasions and days out; these experiences provide the opportunity for the family to be both physically and emotionally close to each other, fostering and enhancing their relationships.

• **Family influence:** This plays a substantive role in the development of children’s lifestyle and interests, not just in the choice, but also in the provision of necessary resources such as food and accommodation. It is important to acknowledge that family influence can be both positive and negative.

• **Being busy:** In the 21st century, many families lead busy lives – parents frequently work and need to ‘juggle’ a home/work life balance; children and young people go to school/college and develop their own interests. Despite this, families learn to deal with their numerous commitments and frequently develop a team approach to manage the challenges associated with a busy lifestyle; this team approach can further reinforce relationships with members understanding and respecting each other’s roles.

Appreciating the crucial role of the family in a child’s life is fundamental to all child healthcare provision. Liaising and working in partnership with the people who the child perceives as their family is pivotal to the building of trusting, therapeutic, professional relationships – this in turn promotes high quality nursing care.

**Friendships**

Friendships are an integral and crucial aspect of children’s and young people’s lives, with literature suggesting that friendships can enhance a child’s overall wellbeing (Parry *et al.*, 2010; Rees *et al.*, 2010; Ipsos Mori and Nairn, 2011); friendships are also associated with other positive attributes such as enhanced social behaviour (Cillessin *et al.*, 2005).

Most children spend the majority of their lives within a relatively small community area – as a consequence, they become familiar with their local environment and this not only gives them confidence, but also contributes to the development and maintenance of friendships. Children tend to make friends readily and via a variety of mechanisms: school, local clubs (such as swimming lessons) and in the immediate vicinity of their homes; Troutman and Fletcher (2010) found that friendships were more likely to be maintained if they crossed different contexts (e.g. school, neighbourhood and extracurricular activities) as this provides children with the opportunity to interact within a variety of different circumstances. Children’s friends are often viewed in a similar manner to a family member; it is therefore essential that professionals recognize the value placed on friendship and the potential contribution it can make to the enhancement of social and emotional wellbeing.

**The local community**

The impact that the local community can have on children and their health and wellbeing has been acknowledged (Sellstrom and Bremberg, 2006; Counterpoint Research, 2008; Fattore *et al.*, 2009; Parry *et al.*, 2010). Eriksson *et al.*, (2010) conducted a Swedish qualitative study that aimed to identify how the local neighbourhood was perceived by children (11–12 years of age) who lived in rural areas and how social capital in their immediate community impacted on their wellbeing. The seven focus groups centred around four key categories (page 5) – ‘community attachment’ (including the sense of belonging, the role of the school, community perceptions); ‘community participation’ (including local clubs and activities); ‘social networks’ (such as friends, family and neighbours). In summary, Eriksson *et al.*, (2010: 9) commented that:
The children described the familiarity of the local communities as creating a trustworthy and secure atmosphere.

Social capital is a term that has been used to describe the connections that people form in the communities in which they live; it enables people to either operate individually or together in order to enhance their situation and access resources. The familiarity that children can gain within their neighbourhood undoubtedly enables them to develop independence and responsibility within parental boundaries and reflects some of the underpinning ethos of social capital.

**Children’s health and wellbeing**

The concept of health as being more than the mere absence of disease has long been acknowledged. The focus within the 21st century has moved towards the inclusion of wellbeing and what it means to have a sense of purpose, to be able to build meaningful relationships with others and to fulfil one’s potential (Ryff and Singer, 1998). Both the UK government and the WHO would concur with this as both of their definitions clearly identify that wellbeing is an aspect of health:

*We use a broad definition of health that encompasses both physical and mental health as well as wellbeing.*

(DH, 2010b: 6)

*A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.*

(WHO, 1948: 100)

Ryff et al., (2004: 1383) suggest that:

*the core hypothesis of positive health, in fact, is that the experience of well-being contributes to the effective functioning of multiple biological systems.*

In other words, if people feel well and happy, this has the potential to positively impact on overall physical health – it is therefore crucial that healthcare professionals consider the psychological aspect of health as well as the physiological one. More recently, specific attention has been given to children’s wellbeing. The previous UK Labour government published the document, ‘Every Child Matters’ (DfES, 2004), with the fundamental aim of improving children’s wellbeing. This goal has since been reiterated:

*Enhance children and young people’s wellbeing, particularly at key transition points in their lives.*

(DCSF, 2007a: 13)

Five key outcomes were identified (being healthy; staying safe; enjoying and achieving; making a positive contribution; economic wellbeing) together with 25 aims; these outcomes were reflected in the Children Act (2004) and the English Children's Commissioner was given responsibility for ascertaining the views of children in relation to these areas (see http://childrenscommissioner.gov.uk/search?search=wellbeing for more details).

Unfortunately, despite this work, UNICEF (2007) in *An Overview of Child Well-being in Rich Countries* revealed that the UK was ranked last of the 21 countries that were included; a more recent update from UNICEF (2013) indicated that the UK was ranked 16 out of 29 counties – whilst this demonstrates an improvement, there is still a long way to go until the UK reaches the higher rankings where children’s wellbeing is concerned.
UNICEF UK commissioned Ipsos Mori and Nairn (2011) to undertake qualitative research in relation to children’s wellbeing that aimed to understand the impact of inequality and materialism on children’s lives. The research was underpinned by the work of Bronfenbrenner (1979) and compared the lives of children in the UK, Sweden and Spain; the children in all three countries highlighted the ‘the importance of family time’, ‘friendship and companionship’ and ‘being active and outdoors’ (pages 25–29); interestingly, the value of pets was also raised and the authors comment that they were frequently viewed as family members. The children perceived these three areas as being far more important than the materialistic resources that were also discussed within the study. UK parents were reported as struggling to spend as much time with children as their counterparts in Sweden and Spain (this was due to a range of reasons which included work commitments and financial resources); Ipsos Mori and Nairn (2011) comment that this has further ramifications since inequality within the UK is related to wealth, which in turn impacts on family life. In conclusion, the authors comment that:

The children in all three countries have the same needs and wants and concerns. Yet the response to these by each society is different. It seems that children are more likely to thrive where the social context makes it possible for them to have time with family and friends, to get out and about without having to spend money, to feel secure about who they are rather than what they own, and to be empowered to develop resilience to pressures to consume. (page 73)

This is an important viewpoint to consider since the ultimate aim must surely be for children to maintain their health and wellbeing into adulthood. Although there has been little consideration of the potential long-term benefits of children’s wellbeing, Richards and Huppert (2011) presented their findings from a British longitudinal study that analysed data relating to a stratified sample of 5362 people who had been born in England, Scotland and Wales within a particular week in March 1946. The aim was to ascertain whether positive wellbeing in childhood transferred into adulthood. Richards and Huppert (2011: 83) concluded that:

Children who were rated by teachers as being ‘positive’ at ages 13 or 15 years were significantly more likely than those who received no positive ratings to report satisfaction with their work in midlife, have regular contact with friends and family, and engage in regular social activities. Positive children were also much less likely to have a mental health problem throughout their lives.

The work of Richards and Huppert (2011) affirms the potential impact and importance of wellbeing in childhood and the need, therefore, for current policy to focus on it.

Child public health

Blair et al., (2010: 2) define child public health as:

The art and science of promoting and protecting health and wellbeing and preventing disease in infants, children, and young people, through the skills and organized efforts of professionals, practitioners, their teams, wider organizations, and society as a whole.

Child public health focusses on three key areas:

- **Prevention:** This includes vaccination programmes and education in relation to safe sex.
- **Promotion:** This encourages children and young people to live healthy lives by, for example, taking sufficient exercise, eating an appropriate diet and not smoking. It also promotes the child and young person’s overall wellbeing, something that has received an increased worldwide commitment in recent years.
• **Protection**: The aim of this approach is to protect the child population from harm, including from factors existing in the environment such as air pollution.

In other words, child public health involves a multifaceted approach that includes a range of healthcare professionals, as well as those from education, social care and a variety of organizations. However, the role of policy makers, both at a local and national level, is crucial in terms of the promotion and implementation of public health policy.

**Public health policy relating to children and young people**

Having clear policies relating to children’s health and wellbeing is of paramount importance since it has been suggested that good health provision in the early years of life can benefit later outcomes (Ferri *et al*., 2003; Muhajarine *et al*., 2006). Despite the fact that children are entitled to health policy that is appropriate to their needs (Muhajarine *et al*., 2006), clear child health-focused policy aims and outcomes have only relatively recently received attention (Kurtz, 2003). When ‘New Labour’ came to power in the UK in 1997, there was an increased focus on the health of children (Kurtz, 2003) with a range of key papers being produced (e.g. DfES, 2004; DCSF, 2007a,b, 2008; DCSF and DH, 2009).

To facilitate the achievement of policy, the UK government identified a wide range of public service agreements (PSAs) – Glass (2001) commented that the PSAs were incomplete as they did not encapsulate everyone and therefore, it could be argued that they did not ‘work’. Traditionally, target setting has been central to public health and goals have normally been identified in areas that can be measured. It could be argued that PSAs have underpinned and driven a deficit approach to health (in other words, waiting for a problem, such as obesity, to arise). Consideration is now being given to asset-based strategies that reflect a more positive approach to health (Whiting *et al*., 2012).

Glass (2001) commented on the fact that ‘what works’ for children may be different from what may help families or society at large – he discussed the issue of child poverty and said that the raising of household income could primarily address parental poverty (rather than child poverty). This may have implications for the achievement of the PSA that stated that there will be an end to child poverty in 2020 (HM Treasury, 2002); in fact other issues may play a more direct role than household income (e.g. housing and the environment). It is interesting to note that in the UK in January 2011, the Health in Pregnancy Grant ceased (Directgov, 2011a) and in April 2011 restrictions were placed on eligibility for the Sure Start Maternity Grant (Directgov, 2011b) – these actions could have long-term implications for the health and wellbeing of children.

In the UK, the document, ‘Fair Society, Healthy Lives. The Marmot Review’ (Marmot, 2010) has the potential to have a significant impact on future UK government health policy. In November 2008, the Secretary of State for Health announced that the review was to be conducted to identify how health inequalities could be addressed and to highlight information that was fundamental to the development of future policies. The review identified six key areas for policy development – two having direct and immediate relevance to children:

- **Give every child the best start in life** (page 9): One of the objectives that this embraced was to build the resilience and well-being of young children across the social gradient (page 17).
- **Enable all children, young people and adults to maximise their capabilities and have control over their lives** (page 9).

It has clearly been identified that a high priority should be given to enhancing children’s wellbeing and ensuring that children have the best start in life – as ‘only then can the close links between early disadvantage and poor outcomes throughout life be broken’ (Marmot, 2010: 14).
The UK general election in May 2010 resulted in the establishment of a new coalition government. Since then, key documents with specific relevance to children have been published; one of the most important is ‘Achieving Equity and Excellence for Children’ (DH, 2010c). This states that:

**In order to improve services for children and young people we need a system which works to achieve the outcomes that are important for their health and wellbeing.**

It could be argued that this aim is not wholly attainable unless there is understanding of what is important to children themselves.

In the main, although not exclusively, it is the older age range of children who have been consulted in relation to policy making (Burfoot, 2003; Hill et al., 2004); it is now acknowledged that they are able to offer valuable insight into their lives. In addition, there is wider recognition of the child’s rights as a member of society (MacNaughton et al., 2007) – the United Nations Committee on the Rights of the Child, in a General Comment statement (No 7) stated that children’s views should be considered in ‘the development of policies and services, including through research and consultation’ (Office of the High Commissioner for Human Rights [OHCHR], 2005: 7).

There is some evidence that children have successfully participated in policy development; for example, the HM Treasury and DCSF (2007) established ‘Myplace’ – this was an initiative that sought to develop new facilities for young people; it stated that all funding bids must identify how children and young people would participate in the project. In another instance, young people were involved in the development of the child version of the Department of Health Drug Strategy (DH, 2003).

However, Davey (2010) in a report, jointly commissioned by The Children’s Rights Alliance for England (CRAE), The National Children’s Bureau (NCB), The National Participation Forum (NPF), The Office of the Children’s Commissioner and Participation Works, suggested that, although there has been a rise in recent years in children’s participation in decision making, there is often a failure to involve children in key areas, including health. On a positive note, a Forum, on behalf of the UK DH (2012a), sought the views of children and young people (as well as professionals, parents and carers) in relation to the health outcomes that are most important to them. The Forum asked questions about four key areas of health (acutely ill children; mental health; children with disabilities and long-term conditions; public health): the overall aim was to report the findings to the UK government so that the future Children and Young People’s Health Outcomes strategy could be appropriately informed (DH, 2013a).

In summary, there can be no doubt that health policies underpin and influence the lives that children live; therefore, the aim of policy must surely be to enable all children to optimize their potential. It is recognized that the current socioeconomic climate is challenging; therefore, it is more important than ever that the development of health policy is carefully considered to ensure that appropriate decisions are made for both the short and long term – taking children’s perspectives into account is an essential aspect of this.

**Promoting child health: the role of the children’s nurse**

One of the key responsibilities of the nurse is to promote the health and wellbeing of children and young people. This is firmly embedded in England and Wales in the NMC Standards for
Pre-registration Nursing Education (NMC, 2010) and therefore a requirement prior to registration (Box 1.2).

In the UK, the DH (2012b) launched an initiative, entitled Make Every Contact Count [MECC]. One of the aims of MECC is to encourage nurses to think about how they can improve public health. The DH (2012b) suggests that:

*This is a programme with the potential to make a real difference. It’s about giving every NHS employee the knowledge, skills and confidence they need to support patients in making healthier life choices. It’s an approach that maximises every contact nurses make with the population and any nurse in any setting can apply it.*

(http://cno.dh.gov.uk/2012/04/20/stepping-up-to-the-challenge-how-nurses-can-improve-public-health/)

The MECC approach has been embraced by a number of NHS Trusts across the UK with organizations such a Birmingham Children’s Hospital suggesting that their aim will be to embed health promotion into routine practice, ensuring staff are competent and confident in delivering brief advice (National Health Service [NHS], 2012). It could be argued that MECC will be associated with a number of challenges, such as the time required to implement it; the impact that it could have on other roles and responsibilities; the confidence, sensitivity and knowledge required by health professionals. Despite these, it clearly identifies the expectations of nurses in terms of the promotion of the public’s health – children’s nurses are no exception to this and should therefore consider how this role can be integrated into their everyday work.

### Morbidity and mortality

Mortality refers to the number of deaths within a given population and geographical area, whereas morbidity measures the prevalence of disease or illness for a particular population within a certain area. The causes of childhood mortality and morbidity have changed considerably over the last century, with infectious diseases, for example, now causing fewer childhood
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Deaths in the UK; in fact ‘More children with serious illnesses and disabilities are surviving into adulthood and the infant mortality rate has fallen to less than a quarter of what it was at the beginning of the 1960s.’ (DH, 2013b: 2). Despite this, the government recognizes that:

It is a shocking fact that child mortality in Britain is the worst when compared to other similar European countries. There is unacceptable variation across the country in the quality of care for children – for example in the treatment of long-term conditions such as asthma and diabetes.


There is evidence that both pregnancy and the early childhood years are fundamental to the future health and wellbeing of children, with early interventions leading to a further reduction in childhood morbidity and mortality (DH, 2013a). The current UK government acknowledges that reducing childhood mortality is complex and needs a range of public health interventions (DH, 2013a). Valuable information, particularly in relation to childhood mortality is kept by the Office for National Statistics (ONS). However, this data is limited and provides little detail about the types of illnesses that children in the 21st century could die from; as a result, in 2011, the RCPCH was funded by the National Patient Safety Agency (NPSA) to conduct a review of mortality and morbidity in children and young people between the ages of 1 and 18 years. In addition, the UK government has invited a range of key organizations, such as the Royal College of Nursing, Public Health England and the RCPCH to sign a pledge to demonstrate their commitment to the improvement of health outcomes for children and young people so that they become amongst the best worldwide (DH, 2013b). The following chapters will provide information that will help you to achieve this goal.

Conclusion

Children are key members of our society and are the future of our nation; it is therefore imperative that they are consulted about decisions that may impact on both themselves and their wider community. Recognizing and valuing the contribution that children and young people can make will serve to enrich the society in which we all live; however, at the same, children and young people remain a vulnerable group and it is imperative that healthcare professionals continue to strive to enhance children’s health and wellbeing – both through care provision and the development of child health policy that is not only evidence based, but also informed, wherever possible, by children themselves. This approach is undoubtedly challenging and arguably time consuming, but it is not something that should be shied away from as it has the potential to facilitate the health of not just of our children and young people, but also the future adult population.

Glossary

Child: Anyone below the age of 18 years.

Family: A group of people who may be (but not necessarily) affiliated by consanguinity and/or co-residence.

Health: An abstract concept that incorporates physical, emotional and social wellbeing. The concept means different things to different people.
**Health promotion:** The term used to embrace the extensive range of approaches used to enhance the health of people, communities and populations.

**Morbidity:** Refers to the incidence of ill health caused by disease in a particular population.

**Mortality:** Refers to the number of deaths during a particular timeframe and/or geographical area from a specific cause – can be referred to as *mortality rate*.

**Public health:** The promotion of health and wellbeing, and the prevention of disease, through the work of professionals, organisations and society as a whole.

**Wellbeing:** A subjective concept that describes a state of feeling good, doing well, being happy and being able to carry out meaningful and engaging activities. A person’s feeling of wellbeing may vary across their lifespan as well as on a daily basis.

Don’t forget to visit the companion website for this book ([www.wileyfundamentalsseries.com/childrenA&P](http://www.wileyfundamentalsseries.com/childrenA&P)) where you can find self-assessment tests to check your progress, as well as lots of activities to practise your learning.

**References**


