parents did not regret the involvement. 85% said that they had no feelings of guilt. However, 45% felt overwhelmed by the decision.

No parent regretted the decision to be present during their child's death. All parents who had physical contact with their dying baby described this as a positive experience. The majority who had no physical contact later expressed regret for this missed opportunity. Most parents believed that their relationship became stronger after the death of their infant.

Conclusions: A study of grieving is feasible and acceptable to parents. Grief reactions vary considerably and individual differences should be taken into account through the counselling process.

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TOO LITTLE, TOO LATE: POLICY BENCHMARKING REPORT ON NEONATAL HEALTH AND SOCIAL POLICIES IN 13 EUROPEAN COUNTRIES

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The risk of dying is highest in the time around birth - a time when safe childbirth and effective

neonatal care are essential to the survival of the newborn baby. Four million neonatal deaths occur every year around the world - that is 450 every hour. Preterm birth is the major cause of infant mortality and morbidity in both developed and developing countries. In Europe, the prevalence rate of premature birth ranges from 5.5 to 11.4% - an average of 7.1% of all live births. In this report we compare the current health and social policies, as well as practices in 13 EU member states. Despite the growing prevalence and increasing costs, neonatal and preterm infant health rank low on the policy agendas of EU member states. Based on our findings we propose important issues to be considered for policies at EU and national levels.

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PARENTS PERCEPTION OF GIVING ANTENATAL CONSENT TO INCLUDE THEIR PRETERM INFANT INTO A RANDOMIZED CONTROLLED TRIAL (RCT)

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Background: RCT have shown that a slight delay in clamping the cord benefits preterm infants by reducing intraventricular hemorrhages and donor blood transfusion. One ethical problem with such study is obtaining informed consent from parents at a time when they are very vulnerable and stressed by expecting a preterm baby.

Aim: To evaluate parents' perception of including their unborn infant < 33 weeks' gestation into a RCT on a slight delay in clamping the cord or four times milking the cord.

Methods: Prospective, single centre study. Parents, whose infants had participated in the RCT, were offered to take part in a structured interview either performed at the hospital or at home. Recorded interviews were transcribed. The interview analysis was performed by a researcher, who was blinded to the infant's allocation, by using NVivo software. Analysis was then summarized by using systematic thematic analysis.

Results: 37 (31.9%) of 116 eligible parents agreed to take part in the interviews (22 female, mean age

29.9 years (19-41), 15 male mean age 33.12 years (21-46)). The results identified five main themes for parents:

- (i) timing of recruitment;
- (ii) reasons for participating in the RCT;
- (iii) implications of taking part;
- (iv) professionalism of staff (including attitude, care and information giving); and
- (v) suggestions for improvement.

Conclusions: On the basis of the sample there was no difference in parents' perceptions even when related to infants' CRIB scores between milking the cord (mean 2.52; SD 3.19; n=27) and delaying clamping the cord (mean 2.75; SD 4.15; n=28).

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EUROPEAN GUIDANCE ON END-OF-LIFE DECISIONS IN PAEDIATRIC MEDICINE

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This presentation addresses the development of European guidance on end-of-life decision-making within the Ethics Working Group of the European Academy of Paediatrics (EAP). It looks at the background to this discussion, starting in 1997, as well as recent proposals for assisting paediatric care providers with approaches for decision-making. The topics addressed include consulting with parents and families, ceasing therapeutic intervention, pain management, seeking second opinions or ethical appraisals, and palliative care. The paper approaches decision-making from an ethical point of view, taking into account different cultural values as well as medical considerations surrounding European paediatric care, including an appreciation of the current discussion on euthanasia. The presentation provides a practical approach to end-of-life decision-making in paediatric medicine.

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HEALTH STATUS OF CHILDREN ADOPTED FROM ETHIOPIA IN BELGIUM

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Aim: evaluate the demographic characteristics and health status of children adopted from Ethiopia at arrival in Belgium.

Material and Methods: retrospective review of data.

Results: 99 children (58 females, 41 males) were seen in the Institute of Tropical Medicine between 01- 2008 & 12-2009. Prior to arrival, 96% resided in an orphanage; 48% were foundlings, 32 % true orphans, renunciation accounted for 18%.

Age at arrival ranged from 3 months to 8 years. However, birthdates were found to be correct in only 36%. Medical history data were available in 28%. Immunization status was unknown in 79%.

Weight z-scores and height z-scores ranged respectively from -5,60 to 1,49 (mean -1,15) and -4,72 to 1,39 (mean -1,54). 4% were wasted, 18% stunted, and 5% had severe malnutrition.

Skin problems were detected in 54% (scabies 19% and dermatophytosis 18%). Other abnormalities included respiratory tract symptoms (18%), developmental delay (12%) and dental caries (8%).

Pathogenic intestinal parasites were detected in 49%. 34% of all children had *Giardia lamblia* infection, 22% *Hymenolepis nana*, 12% *Trichuris trichiura* and 8% *Schistosoma*. 30% had multiple parasites. 15% had *Strongyloides* infection.

4% of all children had a positive tuberculin test, 3 had latent and 1 pulmonary TBC.

Conclusion: The majority of Ethiopian adoptees were foundlings or true orphans. A considerable number have health problems that were unrecognized (parasitic infections, hepatitis B, tuberculosis, or others). Therefore, careful history taking, physical examination and laboratory studies during the first medical contact after arrival should be considered as crucial.