



child friendly healthcare initiative

How 'Child Friendly' are you?

Andrew Clarke RN(Child),
RHV, BSc, Project Officer;
and Sue Nicholson MB, FRCP,
FRCPCH, FRIPHH, DCH,
Project Director for the Child
Friendly Healthcare Initiative

The Child Friendly Healthcare Initiative is developing tools to help you answer this question, as Andrew Clarke and Sue Nicholson explain

Although progress has been made in the surgical and medical management of many childhood conditions, particularly in those countries with better resources, this has not always been accompanied by a similar consideration for the emotional and psychological wellbeing of the child and family. This lack of attention often results in unnecessary pain, anxiety and suffering. The Child Friendly Healthcare Initiative (CFHI) is a two-year pilot project with a multi-agency base which seeks to promote child and family-friendly standards, establish a straight forward and universal assessment tool to guide practice development, and improve the care received by children and their families, wherever possible within the bounds of existing resources. The International Grants Section of the National Lotteries Charities Board is funding the implementing agency, Child Advocacy International.

Background

Following the global successes of the UNICEF/WHO Baby Friendly Initiative, which was introduced in 1989, a group of interested parties from UNICEF UK, the Baby Friendly Initiative UK, the RCN, the RCPCCH and Child Advocacy International got together with the idea of seeing whether a similar type of programme could be initiated to begin to address the many outstanding needs of children and their families treated in hospitals and other healthcare settings across the world. The project is now supported by UNICEF New York and also has technical support from the World Health Organization.

Twelve Standards of care (see Box 1) have been proposed and are being promoted to act as underpinning principles for the care that children and their families everywhere should experience as a 'Right'. These are rooted in articles of the United Nations



Inexpensive but effective: At little cost, this treatment room at The Royal Hospital for Sick Children at Yorkhill in Glasgow was made far more child friendly

Box 1. Child Friendly Health Care Initiative Standards

Child = child or young person, from birth to 18th birthday (WHO and article 1 UNCRC)

1. Children will be admitted to and kept in hospital or other residential institution only when this is in their best interests (care in the community, collaborative child health care) - Articles 2, 3 & 24*
2. The hospital/healthcare facility will provide the highest attainable standard of care and treatment to new born and to children who attend or are referred (management and treatment) - Articles 2, 6 & 24
3. The environment will be secure, safe and scrupulously clean (safety) - Article 3
4. Child and family centred care will be delivered in partnership with parents, in areas dedicated to children and young people that are child and family friendly, by staff with 'children's' qualifications, or who are experienced. A parent/carer will be enabled to stay with their child and support them, especially during procedures (care delivery) - Articles 7 & 9
5. Parents and children will be kept fully informed and involved in all decisions affecting their care (communication) - Articles 12 & 17
6. Children will be approached without discrimination as individuals with their own age-appropriate and developmental needs and rights to privacy and dignity (rights/equity) - Articles 2, 16, 19, 23 & 37
7. The hospital or healthcare facility will have a multidisciplinary team to establish and maintain guidelines for the assessment and control of the physical and psychological pain and discomfort of children (pain) - Article 19
8. When children are severely ill, undergoing surgery or have been given systemic analgesia and/or sedation there will always be healthcare staff trained and experienced in the resuscitation of children immediately available, and the facilities to do this (resuscitation) - Article 6
9. Children will be able to play and learn while in a hospital or other healthcare institution (play/learning) - Articles 28, 29 & 31
10. Healthcare staff will be familiar with the signs and symptoms of child abuse and be capable of instigating appropriate and clearly defined procedures to protect the child (child protection) - Articles 19, 20, 32, 33, 34 & 39
11. Health will be promoted by example, education, immunisation, growth and developmental monitoring/assessment and multidisciplinary collaboration when a pregnant woman or child is admitted to, or attends a hospital or healthcare facility (health promotion) - Articles 17, 24 & 33
12. The hospital or healthcare facility will comply with the appropriate 'best practice' standards on the support of breastfeeding and nutrition and will ensure that the nutritional needs of each child are met (breastfeeding and nutrition) - Article 3

* refers to Articles in the UN Convention on the Rights of the Child.

Convention on the Rights of the Child (1989) and also share some elements with the Charters of NAWCH (1984) (now Action for Sick Children) and the European Association for Children in Hospital (1988) which many will be familiar with. Although these 'Rights' are seen as universally applicable, the specific criteria for each Standard are flexible, to take into account the vastly differing cultural and societal contexts within which care is delivered across the world.

The Standards in practice

Of course, words are easy – it is doing something constructive that is rather more difficult. To develop a consistent assessment tool and pathway that can be easily utilised and relevant when applied to such a vast range of health needs, cultures and resources in both the industrialised and developing world is certainly ambitious.

There are ten pilot sites, comprising five in the UK, and one each in Uganda, Kosova, Pakistan and two other countries that are yet to be determined (see Box 2). These pilot sites are assisting in the development of the CFHI which, with the input of parents, children, health workers and managers, is evolving flexible, transferable tools, to enable self and external assessment in relation to the Standards. Individual hospitals, departments or wards will be able to assess which Standards are already being met, which are absent and which are only partly being fulfilled.

Although guidance is offered in prioritising specific, but achievable, aspects of care for development, the decision as to which Standards (or parts of Standards) will be addressed remains with the co-ordinating team of health workers that are identified by each site. An Implementation Plan is then designed collaboratively with this co-ordinating team. The actual composition of each Implementation Plan varies to reflect the issues being addressed and also the circumstances and wishes of the site.

A plan would typically include: sharing of different approaches used by other sites facing similar difficulties, training elements, bridge-

building between the expressed priorities of children and carers and the care given, and facilitating a change in use of existing resources after a review of how these existing resources are allocated and used.

Once the specific issues to be addressed have been established, baseline data is collected to enable comparison of practice, both before and after the 'implementation period'. This will enable evaluation of whether the activities are beneficial and sustainable later on. It will also identify remaining difficulties.

A prominent feature throughout the process is the involvement of parents and children. By identifying key aspects about their experiences, both good and bad, families make a significant contribution to both the initial assessment process and, again, later, when Standards or parts of Standards have been chosen for development work, to the base line data. This is imperative as the Initiatives' focus is upon the care received, as opposed to the care that is said to be given; the difference between the two often being quite substantial.

Resource issues

In any country, there are factors that impact on care that are not within the control of local health workers. Although the CFHI encourages and supports ongoing advocacy at all levels, it is important to recognise what is, and what is not, realistically within a certain group of health workers' immediate sphere of influence. In order to facilitate empowerment and to avoid a further lowering of morale, the process tries to make a clear distinction between goals that are and feasible, and those that are not, during a given time.

At first glance it may seem overly ambitious and naive to address such a panacea of issues. However, every country, with the exception of two, has ratified the UN Convention on the Rights of the Child (1989), stating a common acceptance that minimum standards are needed and should be promoted. A start needs to be made somewhere and, as is to be expected with a 'pilot' project, the structure and tools are continually evolving to reflect progress and

Box 2. Pilot sites

- Barnsley District General Hospital NHS Trust
- Derbyshire Children's Hospital, Southern Derbyshire Acute Hospitals NHS Trust
- District hospital (as yet unspecified) Pakistan
- Gjilan Hospital, Gjilan, Kosova
- Mulago Hospital, Kampala, Uganda
- Bro Morgannwg NHS Trust, Bridgend
- The Royal hospital for Sick Children, York Hill NHS Trust, Glasgow
- Ulster Community & Hospitals Trust, Ulster

lessons learnt.

For example, originally an element of accreditation was envisaged for Standards achieved, but the complexities that such a structure would involve when applied to a global scenario have suggested the more appropriate initial format of measuring 'progress' in relation to the Standards along a continuum, using a combination of replicable indicators.

It is recognised that over recent decades substantial efforts made in some countries, including the UK, have significantly changed the experience of hospitalisation for many children and their carers for the better. However even in such countries considerable inequalities are apparent in the services available. Indeed,

'Simple solutions that work in one place can often be adapted and considered as an option elsewhere, if there is a channel to communicate the idea'

gaps often arise between the care intended to be given and that which is received.

A lack of resources is frequently cited as the excuse for not providing the standard of care we would wish to provide. But although, inevitably, this is a factor, the availability of resources alone do not automatically correlate to the practice of 'child friendly health care'.

To suggest that a lack of resources is the sole reason for poor care undervalues the practices and skills displayed by so many health workers in areas such as information and control giving,

comfort, listening and preparation. These activities cost nothing but are valued very highly by the recipients and often enable them to cope with their circumstances far more effectively. It also negates many of the innovative and effective practices evolved by health professionals working with substantial success in circumstances where funding is minimal.

Healthcare workers across the world generally share the same aspiration to provide the best care possible for the children and families they work with. A child in pain has many similar needs, be they in Kampala, Uganda or Barnsley, and the need for relevant, understandable information is the same in Gjilan, Kosova as it is in Glasgow. In trying to provide this care, common barriers such as poor communication, ineffective systems, bureaucracy and institutionalised practices are also shared and frequently need to be overcome.

There are many examples of good practice to be found in all hospitals and healthcare facilities, and health workers everywhere can gain much from exchanging their ideas and experiences. Simple solutions that work in one place can often be adapted and considered as an option elsewhere, if there is a channel to communicate the idea. Similarly, sharing ideas that have not appeared to help can also be valuable in providing an opportunity to better

understand why that was, allowing suggestions to be made, or simply preventing the same mistake being repeated elsewhere.

A further objective of the CFHI is therefore to facilitate the exchange of good ideas between health workers in different settings, either through the web site or by making direct links. To this end, a 'bank' of good ideas is being compiled and contributions are encouraged. A register of people with specific knowledge and skills who would be prepared to provide advice or share thoughts with a



A nurse gives breastfeeding advice to a mother in Uganda. This is vital in protecting her infant from many preventable threats to health. On the walls behind are relevant health promotion posters using different languages and pictures.

counterpart elsewhere on an occasional basis (either by email or other methods) is also being developed.

Conclusions

Many healthcare professionals in both rich and poor countries often work in very difficult conditions. When faced with such circumstances and with so many simultaneous problems, it is often difficult to see a way forward and the question, 'where should I begin?' seems impossible to answer. Unfortunately, although not surprisingly, the perception of powerlessness sometimes leads to a feeling of an inability to effect any change, so consequently nothing does.

Another potential consequence that can happen (one that some aid/development

organisations have also been accused of), is that, in an effort to do 'something', actions are taken or resources put in that are completely inappropriate and can ultimately exacerbate a situation. Although there is increasing recognition of this, and 'sustainability' is the repeated mantra often heard, inappropriate aid activities and donations remain a frequent problem and need to be avoided when planning long-term approaches to developing services for children and families.

The nature of facilitating change in such a broad arena is complex, however the assessment process currently being developed is one strategy that will hopefully go some way towards answering the 'where do we start?' question and guide a chain of development

within in a realistic and achievable structure. It is also hoped that one of the indirect benefits of the CFHI will be to encourage a more objective, realistic and consultative approach from some donor organisations towards the projects they become involved in.

There is a distinction between 'child friendly health care' and the Child Friendly Healthcare Initiative. The former relates to a set of guiding principles to care that can be, and often are, practised and promoted by anyone in any healthcare contact, whereas the latter is the specific pilot programme seeking to develop assessment tools and development pathways in relation to the Standards. Although we do not expect the trials of assessment tools to be completed until the end of the pilot period, we would encourage all healthcare professionals involved in caring for children and their carers to audit their own practice against the Standards **PN**

Acknowledgements

The authors thank the members of their Steering Committee and also the National Lotteries Charities Board for their support. They also thank Clare McNamara for her valuable help during the early stages of the project, the numerous individuals who have given and continue to give their time and advice, and the staff at the pilot sites for their patience and assistance.

Further reading

Southall D *et al* (2000) The Child Friendly Initiative (CFHI): Healthcare Provision in Accordance With the UN Convention on the Rights of the Child. *Pediatrics*. 106, 5, 1054-1064.

United Nations General Assembly (1989) *Convention on the Rights of the Child*. United Nations, New York.

Further information

You can follow the progress of the CFHI and obtain more information about the project by visiting the web site, currently under construction, at:

www.childfriendlyhealthcare.org

Or contact them at:

Carol@cfhi.madasafish.com

Alternatively, call 01782 857549.