

## Section 1

### Why a 'Child Friendly' Healthcare Initiative (CFHI)? An introduction



*child friendly healthcare initiative*

#### **Why is Child Friendly Healthcare important?**

The aims and objectives of the CFHI are to improve the quality of health care given to children and families across the world and to reduce unnecessary fear, anxiety and suffering during and because of a healthcare experience. It does this by promoting the CFHI standards that define 'Child Friendly Healthcare' and through an assessment and improvement programme, with designated Gold, Silver and Bronze standards support health workers in providing the best possible healthcare for children and their families.

Despite the huge efforts of many health workers, a large number of health improvement programs at local, national or international level, and the humanitarian aid provided to disadvantaged countries by the international community, children are still:

- Needlessly dying, or becoming disabled, from treatable diseases and accidents
- Suffering unnecessary pain
- Experiencing unnecessary fear, anxiety and suffering during and after a healthcare experience, because their mental and psychosocial health needs are being overlooked.

Such healthcare contravenes the articles of the United Nations Convention on the Rights of the Child (UNCRC) and continues in every country in the world, rich and poor. During the pilot project for this initiative over six hundred health workers, parents, carers and children in hospitals in eight countries were interviewed between May 1999 and December 2002. Even in the most disadvantaged health facilities, there were many examples of excellent care, but everywhere there was care that can only be described as very 'child unfriendly'.

It is not surprising if health workers do not meet a child's mental, emotional and social health needs when many children in the world do not have even their basic health needs met, but it is even more unforgivable if these needs are overlooked when resources are such that a high level of healthcare is possible.

**The first duty of a nurse is 'to the patient do no harm' Florence Nightingale 1889**

Worldwide most children's health workers work hard to provide the 'best possible' health care for each child and their family. However many feel overwhelmed, undervalued and uncared for and many do not know what the 'best possible' care could be. The result is a lack of incentive to make the efforts required for change. Allied to this is the belief that many resources are needed for change, leading to a sense of helplessness when these are absent or hard to come by.

*Care of critically ill children in Africa*



Others feel that they do not need to change, failing to recognise that good care can always be better. There is always the need to constantly review provision of care to meet changing needs as the needs of any society and its children change in response to new threats to health, such as changes in the economy or population movements.

The quality of healthcare varies enormously between countries, between different healthcare environments in the same country and within different clinical areas in the same health facility. It is usually more dependant on the health workers responsible than on the resources available. Many improvements can be made without an increase in existing resources by changing behaviours and

attitudes, creating more opportunities for sharing knowledge and skills, better leadership and team working and understanding and practicing the articles of the UNCRC.

During the pilot study, many of the health workers interpreted what ‘Child Friendly Healthcare’ means differently. There was a lack of awareness about the UNCRC and many misconceptions about the contents of its articles. Senior health workers in positions of authority, believed that children’s rights and ‘Child Friendly Healthcare’ (which they often thought was only about play and communication) were not important priorities as they were much too busy looking after ill children. These health workers when questioned more closely knew little about the articles of the UNCRC. In many of the countries visited the UNCRC was not in the nursing or medical school curricula, nor was it a topic usually covered by life-long education/training opportunities.

Every health worker in every country from the Government Minister to the health worker that cleans the toilets, often the lowest paid and least valued health worker yet amongst the most important, has an essential contribution to make to the provision of healthcare. Virtually all the world’s countries have ratified the UNCRC, so health workers have a responsibility to follow its philosophies during their daily work. The CFHI has developed simple ‘Child Friendly Healthcare’ Standards that translate its articles into every day health practices.

Promoting, assessing and supporting these ‘CFH Standards’ will contribute to sustainable improvements in the quality of healthcare received by children and families across the world, whatever the circumstances.

### **A reminder about the United Nations Convention on the Rights of the Child**

UNCRC adopted by the United Nations assembly on 22<sup>nd</sup> November 1989, is a legal International document of unprecedented scope. The convention with its 54 articles is the most widely accepted International convention in the world with all but one country ratifying it. It is about a child’s right to

- **Survival** (to life and healthcare),
- **Protection** (from all forms of abuse, exploitation or neglect),
- **Development** to their fullest potential physically, mentally and socially),
- **Participation** (to be informed, able to express their opinions freely and to have their views taken into account).

*‘In the middle of difficulty lies opportunity’ Albert Einstein)*

*A reminder about the UNCRC  
found in a ward in a hospital in  
Pakistan*



The articles of the Convention, which were developed following wide global consultation and research, apply to every child from birth to 18 years of age without discrimination. They focus on a child's best interests and, although they reinforce the role of the family as the main carers and protectors, they also re-affirm the State's responsibility to provide legal and other protection. The Convention is different from other human rights laws as it recognises that, because of the special vulnerability of children, they need special laws and care to support their nurture and protection. It respects cultural values but also highlights the importance of international cooperation.

By ratifying the Convention's 54 articles, 192 governments of the world's 193 countries have pledged to review their national laws and practices to comply with these. A democratically elected International Committee monitors compliance via mandatory five-year progress reports from these countries.

The Convention is divided into three parts.

- Part 1 (the main part) contains the 41 articles that relate to children's rights.
- Part 2 has four articles that are concerned with a country's implementation and monitoring of the convention; in particular a country's obligations to actively inform their citizens about the convention and to contribute to the monitoring committee.
- Part 3 contains nine articles about its administration.

**The articles that relate directly to children's health care are:**

Article 2: Equal rights to care with no discrimination for any reason

Article 3: Whenever an adult makes any decision about a child or takes any action that affects the child this should be what is best for the child

Article 6: The right to live

Article 7: The right to a name and nationality, and to be cared for by parents

Article 9: The right to remain with parents, or in contact with parents, unless this is contrary to the child's 'best interests'

Article 12 and 13: The right to receive information and express views and ideas freely

Article 19: The right to be protected from any form of harm including violence, neglect, and all types of abuse

Article 23: The right of those with a disability (physical or mental) to lead a full and decent life within their community

Article 24: The right to the highest standard of health and medical care attainable (the best possible healthcare). In this article 'States' are advised to place special emphasis on the provision of primary and preventive health care, public health education, and the reduction of infant mortality, to encourage international cooperation in this regard and to strive to ensure that no child is deprived of access to effective health services

Article 27: The right to a standard of living adequate for physical, mental, spiritual, moral and social development'

Article 28: The right to education (school-type learning)

Article 30: The right of a child belonging to an ethnic, religious or linguistic minority to enjoy their culture practice their religion and use their language

Article 31: The right to rest and play

Article 38: The right to be protected from and during armed conflicts, and not to be recruited to take part in hostilities, especially before 15 years of age

Article 42: Is about the duty of the state to ensure that children's rights relating to health are made known

In countries that have ratified the UNCRC, all health workers at all levels have a duty to ensure that its principles are followed during their day to day delivery of healthcare to children and families. The CFH 'Standards' enable them to do this by translating the articles into everyday healthcare practices

#### **What is different about the CFHI from other programs?**

- It has a global mandate since it derives its principles from the articles of the UNCRC
- It is not prescriptive or dictatorial (imposed by a higher authority) but belongs to all health workers
- The suggested practical approaches of the assessment and improvement program are relevant and applicable to health workers and health planners at all levels, in any healthcare environment and in any country, as they have been developed with the help of health workers and families in many different countries and health care environments.
- It can be used for self-assessment or can be supported by invited external assessors
- Its assessment process seeks the ideas and possible solutions to problems from the health workers, children and their parents/carers thereby giving them a voice in helping to develop their own services and healthcare systems
- It enables and empowers local health workers to solve their own problems and find a way forward, however small, to improve the care they give to children and their families
- Any health care improvements made as a result of the program reflect what health workers want, what children and families want and what is feasible
- It raises levels of awareness by promoting what is possible and sharing good ideas
- It is a vehicle for other local, country and international programs, especially those seeking standards. It aims to promote all other validated programs.
- It can easily be modified and adapted to suit local circumstance
- It is low-cost or cost-neutral

#### **What are the programs guiding principles?**

1. Child Friendly Healthcare at its best possible level of practice
2. All activities to be based on the rights of the child linked with the responsibilities and duties of health workers in partnership with parents/carers, other significant family members and friends to meet these rights within the healthcare context.
3. Planned improvements arising from the program to be compatible with a country's own plans for health and acceptable to the countries' health care providers at organisational level.
4. To be a positive, encouraging and motivating experience for children, families and health workers.
5. To seek the views and opinions of children and their families in the assessment process and reflect these in the prioritising, planning, and implementing of improvements.
6. The views and opinions of all involved health care workers (*managers, health professionals, other types of health worker such as ward cleaners, porters, security staff, engineers etc*) to be sought in developing and implementing the program and to be reflected in the prioritising, planning, and implementing of improvements.
7. Barriers to providing the best possible CFH and the forces to create changes that achieve this to be identified by the assessment process.

8. The focus for improvement to be on making the best and most appropriate use of existing resources and systems of care, facilitating changes of attitude and behaviour, and optimising the skills, approaches and knowledge of health workers.
9. Planned improvements in healthcare to be:
  - Facilitated by encouraging the sharing of good ideas, examples of good practice, skills and knowledge within a healthcare environment and from other healthcare environments in the same country and other countries
  - Facilitated by empowering health workers to identify and prioritise their problems, find their own solutions to these and to function better by raising their awareness to the possibilities
  - Enabled by promoting team problem solving approaches
  - Acceptable to the religious, ethnic and cultural beliefs of the people involved providing these are compatible with the articles of the UNCRC
  - Appropriate, sustainable and where possible achievable within the available resources
  - Implemented in a prioritised staged way
  - Any support for improvements from outside the healthcare environment to be provided first by harnessing and coordinating any existing international humanitarian aid and other possible in-country support.
10. Advocacy to be encouraged and used at an appropriate level to seek more resources or additional support (new humanitarian aid projects), when without such input the healthcare available is significantly compromised.
11. Regular review and evaluation of all activities

### **The history of the CFHI program**

The idea for a global initiative dedicated to improving the healthcare experiences of children and their families originated within the medical and nursing professions in the UK in the early 90's following the adoption by the United Nations General Assembly of the Convention on the Rights of The Child (UNCRC) on 22<sup>nd</sup> November 1989.

The concept of developing 'Standards' of care based on the articles of the UNCRC was influenced by the work of a number of other non-medical organisations dedicated to the well being of children.

In 1996 a small delegation presented a proposal for a CFHI based on such 'Standards' to UNICEF New York, who supported the idea. In 1999 a grant was received from the Community Fund UK by Child Advocacy International (CAI), a non-governmental organisation and now the lead agency for the CFHI, to undertake a pilot project for the Initiative in hospitals in the UK (also funded by a small grant from UNICEF UK) and in hospitals in five other countries.

In November 2000, a first draft of these 'Standards' was published in *Pediatrics*<sup>1</sup> and later the same year the Child and Adolescent Department of Health and Development of the World Health Organisation offered technical support to the project followed by help with identifying hospitals in four countries, in addition to those in the UK, where the pilot project was acceptable to the regional and country UNICEF and WHO representatives.

The remit of the pilot project was to research and consult widely to develop the CFH Standards and their supporting criteria, to promote and support child friendly healthcare practices, and with the help of the health workers and families in the chosen hospitals to develop the methodology and processes to assess

and improve 'Child Friendly Healthcare'. These are described in this book. The CFHI is guided by an 'Advisory Committee'.

The number of sites that contributed to the pilot project was limited by the time and resources available. More countries and health facilities have requested inclusion in any 'second phase' pilot. However the tools and methods developed have been designed to help health workers make progress with 'Child Friendly Healthcare' themselves without the need for an officially supported program.

### **Who 'owns' CFH?**

#### **'Wisdom, like knowledge and skills, is for sharing not owning'**

Child Friendly Healthcare does not belong to any organisation or individual, it belongs to every health worker who practices it. The initiative to promote CFH and the program to assess and improve care has no formal accrediting body and is therefore currently owned by the health workers who use it.

### **What is 'Child Friendly Healthcare'?**

The best possible' integrated health care provided by health workers who minimise the fear, anxiety and suffering of children and their families by supporting and practicing the 12 Child Friendly Healthcare 'Standards'.

### **Who else can promote 'Child Friendly Healthcare'?**

Any committed health worker who is familiar with its practices and principles can promote CFH by sharing information about the CFHI and the UNCRC with others in the same healthcare environment, in other healthcare environments in the same country and with health workers in other countries. 'Child Friendly Healthcare' belongs to every health worker that looks after children and families whether they are involved in planning, organising, providing or giving care.

### **What is the 'best possible' healthcare?**

The practice of CFH Standards at their best possible level of practice.

The **best possible**:

- Considers the child's 'best interests'
- Covers the preventive, investigative, curative and palliative aspects of health care taking into account the most up-to-date evidence-base for each care given
- Is affordable and effective
- Is appropriate, taking into account the resources (human and material) and technology available and the needs of other children sharing these
- Is child centred\* (see below)

### **What are a child's 'best interests'**

For healthcare to be in a child's 'best interests', any action or decision taken on behalf of a child must:

- Accommodate the circumstances of the situation
- Consider the child's needs and safety to be paramount
- Consult the child (whenever possible) and relevant others
- Balance this with the wishes and needs of the parents and other carers wherever possible
- Incorporate common sense
- Look at both present and future needs
- Be reviewed regularly and revised if circumstances change (be flexible)

### **\*What is 'child centred' health care?**

#### **Health care that:**

- Meets the needs of the individual child and their family
- Is given by skilled health workers in partnership with parents/carers and children
- Is given in areas that are suited to the needs of the individual child and family
- Takes account of a child and family's normal daily routines and experiences and attempts to ensure that these are disrupted minimally only in the 'best interests' of the child
- Supports a child and family's response to their individual problems

The CFH Standards cover all aspects of children's healthcare so inevitably overlap. Although numbered they are of equal importance. They apply to:

- A child of any age
- A child of any developmental level, including whether or not the child has a disability
- Any type of health care problem
- Health workers in any country
- All types of health worker

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