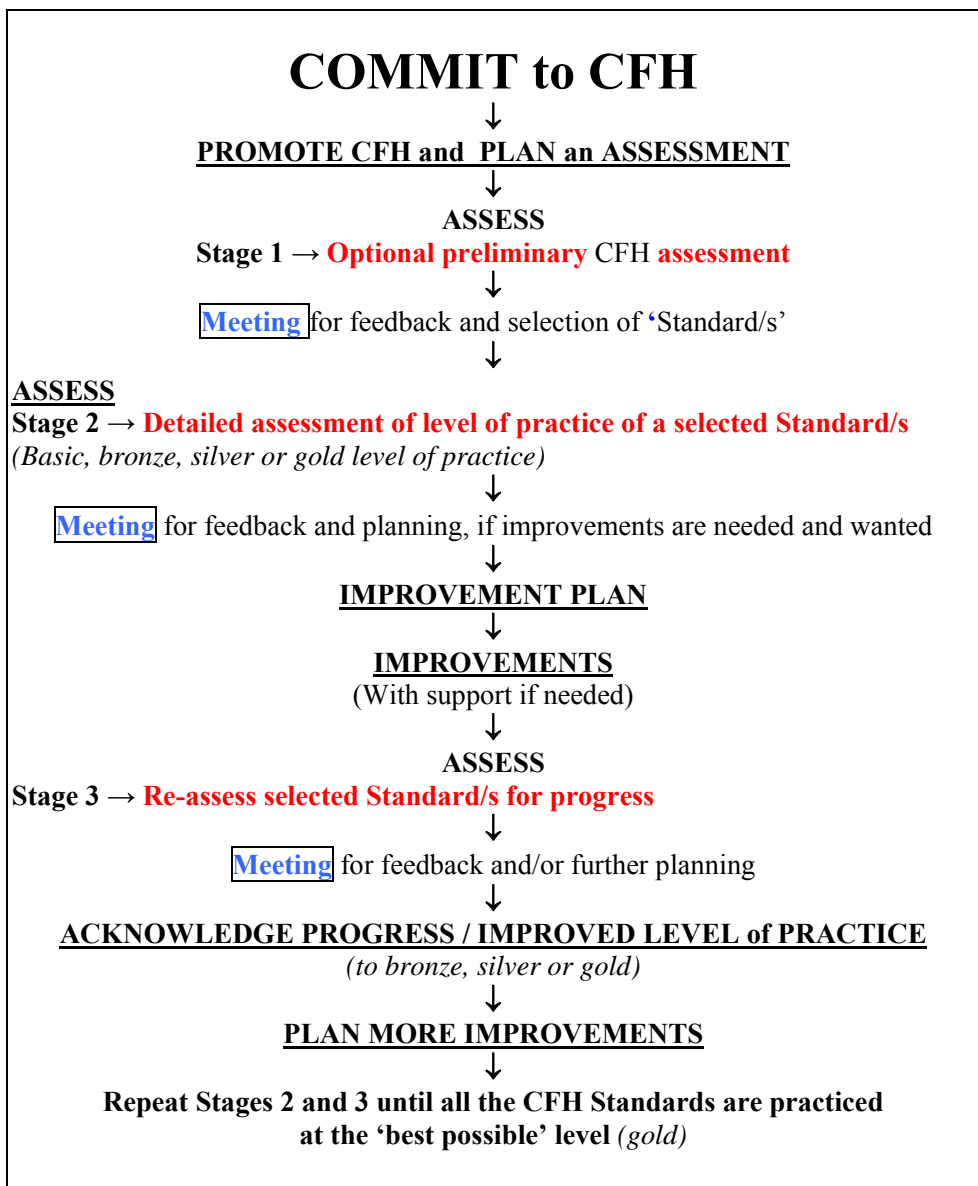


Section 3: How ‘Child Friendly’ are you? (How to assess the care you give)

This program for assessing and improving ‘Child Friendly Healthcare’ has been developed and piloted with the help of nine hospitals in seven countries. It works well in diverse countries and health services and although not dependant on health workers being familiar with the articles of the UNCRC or the concept of ‘Child Friendly Healthcare’ can be enhanced by this knowledge.



Does the program work in any type of healthcare environment?

The program is easy and flexible enough to be used in any type of healthcare environment – the home, a primary care surgery/clinic/health house, a refugee camp, referral out-patients or any level of hospital or other residential facility that provides healthcare. It can be adapted to suit the circumstances.

Who can use the program?

It works equally well for all types of health worker who plan, organise and deliver healthcare either in the community or secondary/specialist environment. It can be used for self-assessment or for use by an outside assessor appointed to help.

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.

How long does it take to achieve the ‘best possible’ Child Friendly Healthcare?

Healthcare is a continuum of change. Improvements will always be necessary because of new discoveries and research. The program’s simple methods and processes can be used indefinitely.

How to start the program?

The health workers responsible for managing and planning children’s healthcare:

1. Commit their health facility or health service to ‘Child Friendly Healthcare’ and the CFH quality improvement program – it works best if all the senior doctors and nurses in a participating clinical area or other healthcare environment are motivated to improve and change. During the pilot project, less motivated health workers, who initially didn’t want their clinical area to participate, saw the progress made in participating areas and then became keen for their clinical area to become involved too.
2. Appoint a CFH coordinator or coordinators
3. Decide whether to self-assess or to appoint an experienced external assessor/s to help
4. Plan an assessment

Who should coordinate the program?

A volunteer or a person selected from among the senior doctors and nurses working in the participating healthcare environment. The pilot project revealed that the program works best when coordinated and facilitated by a health worker who has the respect of their colleagues, and the authority to make decisions and initiate change. In order to engage the two largest professional groups, a nurse and doctor team works best. Good leadership, team working and problem solving skills are also of paramount importance.

The responsibilities of a CFH coordinator

The most important responsibilities of a coordinator are to:

- Promote ‘Child Friendly Healthcare’
- Be committed to the ‘best possible’ level of practice for all aspects of healthcare for children and any changes that may be needed towards achieving this
- Supervise and contribute to the program

What other responsibilities does a CFH coordinator have?

For self-assessment the responsibilities include:

1. Organising and doing the assessments, including the administration and logistics
2. Organising the planning meetings and inviting the relevant people
3. Coordinating a collaborative plan for making improvements
4. Facilitating and supervising progress work in the participating clinical area/s
5. Liaising with the health workers responsible for support services and other key jobs relevant to the 'Standard' chosen for improvement
6. Supporting colleagues in the participating clinical areas who are trying to improve the care they give
7. Co-ordinating education/learning if this is identified as needed by the assessment
8. Acting as a mentor for any health workers from another country working alongside local health workers to help with the planned improvements
9. Providing regular feedback/reports on progress and prompt sharing of any problems or concerns with relevant others, including the external assessor
10. Sharing information regularly with other important stakeholders in children's health, including the director of the health facility or service, relevant supporting organisation and other senior children's health workers.

If an external assessor helps, the coordinator contributes to the program by:

1. Acting as the link person with the external assessor/s, before, during and after an assessment
2. Providing the external assessor with any requested pre-assessment information and any relevant in country research relating to 'Child Friendly Healthcare'
3. Looking after the external assessor during their visit
4. Acting as an interpreter or appointing an interpreter if one is needed
5. Organising translation of documents or other program related materials and distributing these.

Important jobs best led and coordinated by a named lead health worker/s include:

- 'Rights' issues: *Standards 4, 6*
- Family welfare: *all Standards (1,3, 4, 5, 6)*
- Disability/rehabilitation: *all Standards*
- Hygiene Promotion/Infection Control: *Standard 3*
- Pain and symptom control (Palliative Care): *Standard 7*
- Resuscitation and emergency care: *Standard 8*
- Play: *Standard 9.*
- Education /school-type learning: *Standard 9*
- Child Protection: *Standard 10*
- Immunisation: *Standard 11*
- Health Promotion: *Standard 11*
- Breast Feeding: *Standard 12*
- Nutrition: *Standard 12*
- Clinical guidelines and job aides: *Standards 2, 7, 8, 10, 12*
- Continual Professional Development: *All Standards*
- Audit: *All Standards*
- Data management: *All Standards*
- Ethics: *All Standards*

To self-assess or use external assessor to help?

Self-assessment works best when the healthcare environment:

- Is managed transparently
- Is good at team working
- Has transparent employment and disciplinary procedures
- Has senior health workers who understand CFH and are committed to a continuum of assessing and improving practice
- Has adequate human and material resources
- Finds that most of the systems of care, facilities, policies, guidelines, educational opportunities etc. in the initial check-list (Tool 1, Part 1) are in place
- Delegates the responsibility for the support services and most of the important clinical jobs to different health workers
- Values all its health workers
- Respects and values the views and opinions of children and their families

Although self-assessment can work well there are many advantages to using in addition external assessors (health workers who do not work in the same health facility).

External assessors are more likely to:

- Be unbiased
- Protect confidentiality, especially of the senior health workers
- Gain a more open and honest expression of views and experiences
- Provide reports that are less open to challenge or manipulation
- Share information openly
- Raise awareness levels by sharing their wider experience
- Act as a catalyst or lever for change
- Provide a role model for team working if this is a new concept for the healthcare environment
- Empower health workers and families
- Have the contacts and skills to contribute to, facilitate and support change

Who should be an external assessor?

A children's health professional or manager with assessment skills who commands professional respect and is committed to CFH. In our experience it works best if an external assessor understands the culture and languages of the Country, although it can sometimes work well using interpreters.

About the CFH assessment improvement program

The objectives of a CFH assessment are to:

- Raise awareness about CFH thereby enabling and empowering change
- Help prioritise areas of care for scrutiny
- Assess the current level of practice of these prioritised areas
- Identify local problems and their possible solutions
- Identify barriers against, and forces for change
- Facilitate 'making it better' (making healthcare improvements)
- Where relevant, identify appropriate 'aid' projects to support local health workers in 'making it better'
- Identify issues for advocacy
- Identify change and/or progress after an agreed period of time

- Acknowledge changes, however small, so that health workers are motivated to continue making it better for the children, their families and themselves

About assessment

Before an assessment it is important to:

- Obtain consent for the program from the director (or equivalent) of the Health Facility and, if relevant, also the country's Ministry of Health. In some countries it is also useful to ask for support from the WHO and UNICEF Regional and/or country offices.
- Share information about the CFHI with the Health Facility director, and if relevant with the WHO and UNICEF country representatives and the Ministry of Health
- Do an initial brief self-audit against the CFH Standards. This is useful as it sensitizes other health workers to CFH, identifies areas of health care that the health workers think they do well and areas of care that health workers want to improve

Pre-assessment information for an external assessor that is helpful includes:

- The language/s used in the health facility
- A brief report on the services provided for children
- The number of children born, seen and/or admitted during a year in the health facility
- Mortality and morbidity statistics, if collected and any other data routinely collected
- The number of doctors, nurses and others employed
- The names of relevant service and other managers and coordinators of important jobs
- The names of the senior doctors and nurses with important responsibilities
- The results of a brief self audit carried out by the CFH coordinator and others
- A prioritised problem list

After an assessment the assessor/s:

- Bring/s together the results of the assessment and present/s these at meetings
- Provide/s a written report of the assessment and circulate/s this to all involved (See appendix on website for an example of a format for writing a report)
- Contribute/s to any plan for improvements decided on by health workers in participating areas
- Facilitate/s improvements if and when possible

The assessment process achieves these objectives by using a 'toolkit' that seeks to understand by observing, listening to and questioning the people who use and deliver the health care for children and their families. The toolkit finds the problems and the possible solutions to them from the children, their families and the health workers, and identifies the quality level of practice.

The assessment process focuses not on resources, but on how health workers manage and use the resources that are available to them, and on their attitudes, skills, practices and knowledge levels.

How long does it take to do an assessment?

The number of assessors and the time needed for an assessment is dependant on the size of the healthcare environment and the number of health workers employed. For most healthcare environments it should be possible for two assessors to carry out both a first and a second stage assessment within one week, and a third stage progress assessment in 2 – 3 days.

The views and opinions of a sufficient number of people will be needed to gain true representation. In a large healthcare environment it helps if the number of participating clinical areas is initially limited,

choosing those with the most motivated health workers. Other clinical areas can join the program at a later date.

The time needed can be minimized by:

- Meticulous pre-assessment information gathering
- Meticulous planning of an assessment, including estimating the number of questionnaires and the number of interviews with senior health workers and managers that will be needed
- Translating materials in advance if necessary
- Arranging interpreters in advance if these are needed for the interviews

Why are there three stages to the assessment process?

There are three stages because each has a different objective.

A Stage 1 assessment is optional but is particularly relevant in countries where ‘Child Friendly Healthcare’ is least developed, resources are scarce and the level of practice for many aspects of healthcare is likely to be basic. It gives preliminary information about the level of practice of all twelve CFH ‘Standards’ and complements the self-audit. It specifically:

- ❑ Finds out which Standards are practiced well and which not so well
- ❑ Identifies examples of good practice to share with others
- ❑ Identifies areas of care that could be easily improved
- ❑ Identifies the barriers to and forces for change
- ❑ Identifies issues for advocacy
- ❑ This information helps health workers choose and prioritise areas of healthcare within the CFH standards for a more detailed assessment of how well they are practiced.

In disadvantaged countries a Stage 1 assessment can be used to help plan ‘humanitarian aid’ projects. It has advantages over an unstructured assessment as:

- It is transparent and repeatable
- Systematically identifies missing or limited essential resources
- Seeks the views of all types, and levels of health worker
- Seeks the views and opinions of the families that use the service, therefore provides a balance between the needs and wishes of the families and the aspirations and wants of the health workers.

The CFH program may be the best way to identify appropriate sustainable ‘humanitarian aid’ projects

A Stage 2 assessment assesses the chosen and prioritised ‘Standard’ in detail. It will:

- ❑ Identify a quality level of practice (basic, bronze, silver or gold)
- ❑ Identify examples of good practice to share with others
- ❑ Find out the problems and their possible solutions
- ❑ Provide a framework to help health workers prioritise and plan needed, feasible and wanted improvements
- ❑ Further clarify issues for advocacy

A Stage 3 assessment is done after improvements have been made. It will:

- ❑ Find out if the planned improvements have happened or not
- ❑ Find out if the improvements made have achieved their objective: to ‘make things better’
- ❑ Find out if the quality of practice is higher (for example has changed from basic to bronze)
- ❑ Identify barriers to progress and problems encountered during improvement activities
- ❑ Identify strategies for change that worked and the reasons why so that these can be shared with others
- ❑ Further clarify issues for advocacy

Stages 2 and 3 can be repeated indefinitely until 'Child Friendly Healthcare' is practiced at the 'best possible' level (all twelve 'Standards' practiced at Gold level).

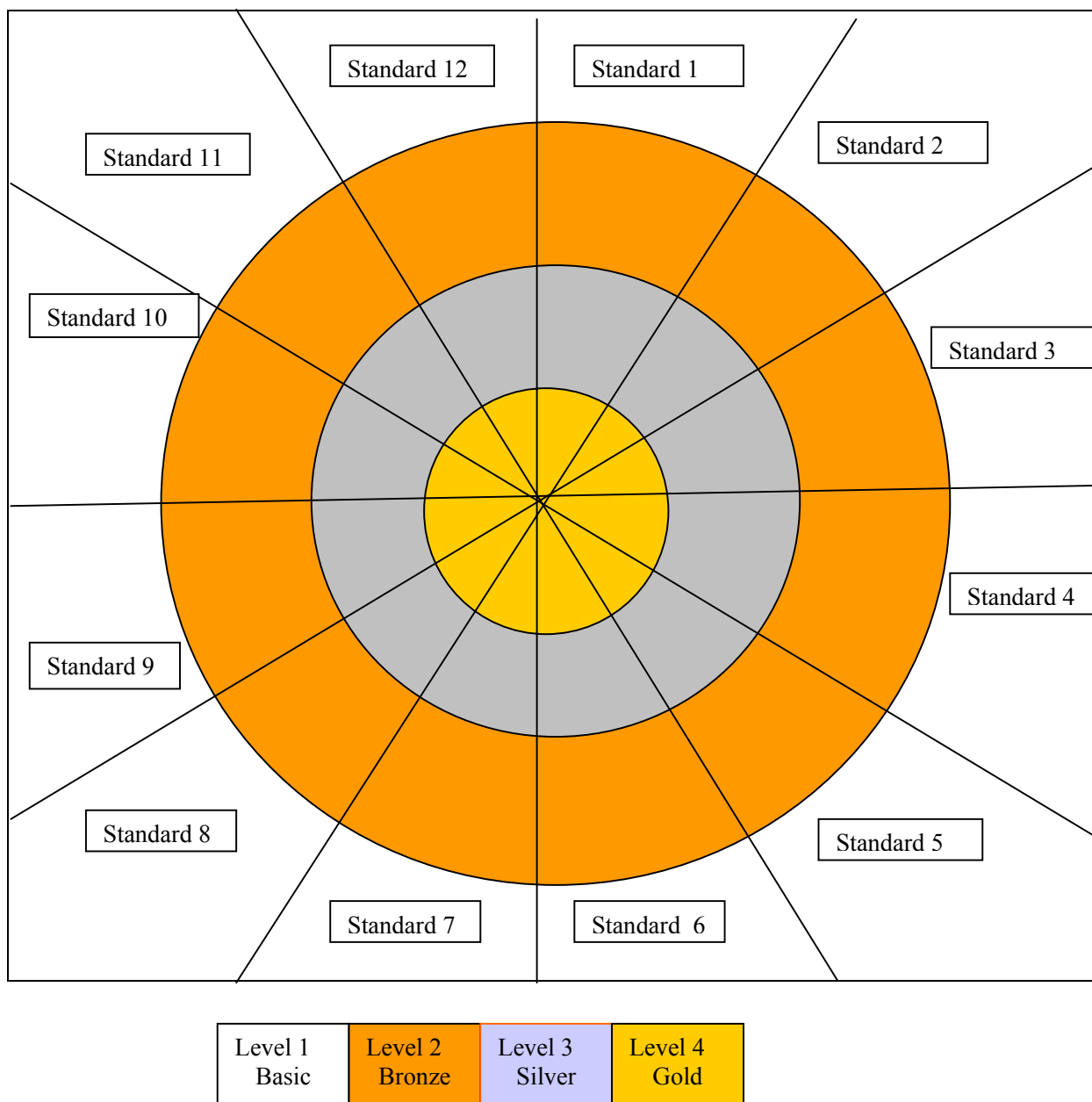
Achieving objectives and a higher level of care motivates health workers to make further staged improvements

Levels of performance

'Going for Gold' is a well-known and used concept that works especially well in encouraging athletes to strive for excellence and their 'best possible' performance at the time and in the circumstances. The concept of using a medal system to identify excellence therefore seemed appropriate and complied with our objectives.

The three qualities of performance are gold, silver and bronze, with all other levels of practice called basic practice.

Diagram illustrating four levels of quality of care for each ‘Child Friendly’ Standard.



About the CFH Toolkit

The CFH Toolkit used for the three stage assessment program contains check lists about services, facilities, resources, systems of care, written statements about care, clinical guidelines and other job aides, data management, especially the quality of medical record keeping and monitoring charts, education/training opportunities, the quality of audit, and all other activities necessary to practice the ‘Standards’. These check lists are supported by structured observations, interviews (open, semi-structured

and structured), questionnaires (including knowledge based questionnaires for some CFH Standards), and, after a stage 2 assessment, benchmarking for any planned improvements.

Child Friendly Healthcare Tool 1

For use in the Stage 1 assessment. It has three parts.

Part 1:

This is a short yes/no check-list. It is to be completed either by the local CFH coordinator with help from senior health workers responsible for the children's services, the support services, important jobs (*for example palliative care, play etc*), and other relevant health workers such as the senior children's doctors and nurses or by an external assessor/s after he/her has talked to these senior health workers

If an external assessor completes the list, it is advisable for them to confirm what they have been told by direct observation. To do this, the external assessor needs to visit all the clinical areas in a health facility used by children and to see the facilities, systems of care, written statements about care, systems for data management, audit and educational opportunities and all the written protocols, policies and clinical guidelines. .

Part 2

This represents a semi-structured interview with health workers of all levels and types (professional and non-professional, including students). It contains questions designed to find out about their concerns, attitudes, opinions, knowledge levels and use of existing resources

Part 3

This is a semi-structured interview with parents/carers and when possible children, using short open-ended and semi-structured questions. This enables parents and children to express their views, ideas and opinions about their healthcare experiences; both good and bad.

Child Friendly Healthcare Tool 2

This is used in the CFH Stage 2 and 3 assessments. It has four parts.

Part 1

This is a detailed check-list that systematically reviews the organization and management of facilities, resources and other activities relating to each CFH Standard chosen for assessment

Part 2

This is a structured questionnaire (or interview) for each chosen standard . This is given to a random selection of professional health workers to complete. It helps assess the skill levels, attitudes, practices and education/training needs of health workers. For some of the 'Standards' it includes knowledge related questions.

Part 3

This is a semi-structured interview for each chosen standard with a random selection of parents/carers and/or children concerning their experiences relating to this 'Standard'.

How to identify the quality/level of practice of a CFH Standard?

The first three parts of the Tool 2 have been designed so that in addition to providing useful qualitative information about attitudes and experiences to help health workers prioritise and plan improvements, they can also be scored/quantitatively. Quantitative scoring makes it possible to identify and consistently standardise four proposed qualities of care (basic, bronze, silver and gold).

A scoring system that excludes questions seeking only ideas and possible solutions to problems needs to be developed and agreed by health workers in the participating country or individual health facility before they apply the program

This also makes monitoring changes easier and more accurate, and allows for comparisons to be made with other similar health facilities.

An example of a possible scoring system for a question from Tool 2: Part A for Standard 8

Question 8	Data management Health workers:		Score =
	<ul style="list-style-type: none"> • Make timely and detailed records about every resuscitation • Collect and examine the outcomes of every resuscitation • Collect and examine the outcomes for children who are very ill • Collect and examine information about the probable cause of the death 	Yes	1
		Yes	1
		Yes	1
		Yes	1

Total score = 4 Total possible score = 4 **Percentage score is 100%**

The total possible score for each part of the 3 of Tool 2 (A, B and C) is best calculated as a percentage of the total score possible. The percentages for each of the three parts can be added and divided by 3 to identify an overall percentage score that can be used to determine the level of practice (0 - 25% is basic care, 26 - 50% is bronze, 51% - 75% is silver and 76 - 100% is gold).

Score as a percentage	0 – 25%	26 – 50%	51 – 75%	76 – 100%
Quality level of care for a 'Standard'	Basic care	Bronze	Silver	Gold

For example:

The scores after Standard 3 was assessed in the Children's Ward of hospital X (before improvements made) were as follows:

Part A: Score = 45% = **Bronze**

Part B: Score = 75% = **Silver**

Part C: Score = 15% = **Basic**

Therefore average score = 45% = **Bronze**

After improvements were made, the scores for Standard 3 in this ward were:

Part A: Score = 55% = **Silver**

Part B: Score = 85% = **Gold**

Part C: Score = 40% = **Bronze**

∴ average score = 60% = **Silver**

Part 4

This is a series of benchmarks made for a Standard that is prioritised for making improvements

Benchmarking is the process of measuring the current status of an organisation or an individual's performance and comparing it with either past performance or to the accomplishment of others.

Benchmarking works best if each planned improvement is given four benchmarks.

The first is a statement about the current situation (basic care), the second and third stages are steps towards the goal (bronze and silver), and the fourth is the best possible quality of care hoped for after improvements have been made (gold)

Example of a benchmark

Basic practice Current practice	Bronze A first step towards best practice	Silver A second step towards best practice	Gold Best possible practice (The improvement planned)
Toilet for health workers never clean	Toilet clean some of the time	Toilet clean most of the time	Toilet scrupulously clean throughout the 24 hours

Part 4 provides the framework for improvements. This framework can also be used as a simple way to regularly monitor progress. It is a rapid method for seeing which objectives have been achieved either partly or in full, and which have not.

An example of an improvement

Sink in neonatal ward before (basic quality)

Same sink after improvement (now bronze)



Assessment meetings

Multidisciplinary meetings are essential before an assessment, for assessment feedback, and for planning improvements. They need to be attended by the key people, have an agenda and a 'chair' (leader), usually the CFH coordinator.

Information about the meeting, and any decisions made during the meeting, need to be shared with the health workers they affect.

A meeting is useful before an assessment to:

- Introduce an external assessor to key people, and sometimes the key people to each other as in our experience health workers in important roles have not always met all the people they relate to (putting names to faces).
- Share information about CFH and the CFH assessment process
- Answer questions
- Plan a realistic timetable and the logistics for the assessment processes

The main objectives of a meeting after an assessment are to:

- Provide feedback
- Answer questions
- Discuss issues and problems
- Share ideas
- Collaboratively plan prioritized, **feasible and staged** improvements
- Plan a realistic timetable for these planned improvements
- Decide a date for review of progress (a CFH Stage 3 assessment)



A CFH meeting in Uganda to plan healthcare improvements

The people who attend CFH meetings could include:

- WHO and UNICEF Country staff (if relevant and perhaps only to the first meeting)
- The director/chief of the healthcare environment or the deputy director
- The manager of children's services if there is one
- The senior children's doctor and nurse
- Senior health workers who manage clinical areas
- The senior health workers who manage support services or coordinate important clinical jobs (such as the coordinators for immunization, infection control, the management of pain, breast feeding, child protection and others) if relevant
- The CFH coordinator
- The external assessor/s
- Representatives from any NGO'S already working in the healthcare environment or country who might provide help and support

How do children and their parents/carers contribute to the assessment process?

The input of children and families is essential, welcome and sought during all three stages of the assessment process. It is a key aim of the CFHI assessment process and itself assesses communication and liaison with parents.



A mother asking to talk to the CFH coordinator in Pakistan

To a certain extent, the issues raised by children and their families will always be influenced by expectations and awareness of possible alternatives. However basic issues fundamental to either easing or increasing fear, unhappiness and distress can usually be identified.

It is vitally important to protect the anonymity and confidentiality of everyone who is interviewed as this allows children and families to express their views and opinions more freely. There are inherent problems with seeking information wherever there is a likely 'imbalance of power' between assessor and participant. This is a particular problem within a health care setting, where participants may feel their answers are not confidential or that care could be adversely affected. Families in many countries may have never been asked for their opinion in such a way before and may live in a climate of disempowerment and justified mistrust of officialdom. The interviewer must be impartial and trustworthy, with an independent translator if necessary (not relatives of the family or healthcare staff). Any verbal or written information acquired must not be traceable to an individual parent or child.

Families will respond best if they feel at ease, have privacy during an interview, are shown respect, understand the purpose of the interview and feel able to interrupt or stop it if they or their child needs attention.

The purposes of an interview should always be remembered. It is to gain an understanding of what is important to each individual child and family, what has been particularly good or difficult, what might make their experience better and what their ideas are about how to make things better for others with the same problems, if they think this necessary. It is best to explain the program in a way that is understandable. The interviewer needs to check that the child or parent/carer understands why they are being interviewed, and what will happen to their contribution, by getting feedback and welcoming questions. It is important to obtain consent for the interview after this explanation.

Questions need to be easily understood and may need to be omitted if they are not relevant, appropriate, cause distress or the parent/carer or child does not wish to answer. It is important not to coerce any child or family member into giving information or answering questions they feel uncomfortable about. If using an interpreter, look at and talk to the child or parent, rather than to the interpreter, and look at the child or parent when listening to the answers given through the interpreter to see if they are correct by watching

their body language. Use empathetic body language yourself, as showing care and respect will encourage a child or parent to say what they really think or feel

It is useful to have some form of distraction, such as a toy or a picture, to engage and amuse younger children when interviewing their parent.

Points of note concerning an interview with a young child

- It is not appropriate to ask young children questions about every aspect of care (questions developed during the pilot project were about Standards 4, 5, 6, 7 and 9).
- It is always best to interview young children when they are with their parents or other familiar carers.
- The person asking the questions needs to be skilled at interacting with children
- If a child appears upset or develops any distressing symptoms, it is best to thank them for their help and withdraw rather than persist with the interview
- Interviews need to be short.
- The words used need to be simple and easily understood by the child

Interviewer's checklist:

- Find a private place to conduct the interview
- Make sure the child or parent is sitting comfortably
- Tell the child or parents/carers your name,
- Explain who you represent and what work you normally do
- Explain the reason for the interview giving a brief explanation of the CFH program (better healthcare)
- If you are an external assessor explain that you do not work in this healthcare environment and do not personally know any of the health workers
- Explain that anything they say will be confidential, and that although important things they say may be shared with others, no-one will know who said these things
- Ask the parent/s or carer if they still agree to talk, or will allow their child to talk to you-(if they say no, respect this decision)
- Get signed consent for the interview or a thumb print (this still represents an individual, and may be more acceptable) - in some countries verbal consent is sufficient (*See section 5 for an example of a consent form*).

How many children and parents/carers should be interviewed?

As many as possible from each healthcare environment that is being assessed and best chosen randomly from those available (if only volunteers are interviewed there may be some bias in the answers they give.) Ideally the same number of parent/carer/children as health worker interviewers provides balance. It does not matter if different parents/carers and children are interviewed before and after improvements are made. This commonly occurs due to time constraints, and will still allow comparative data to be gained

How do health workers contribute to the assessment process?

Involving as many health workers as possible in an assessment reveals how they manage and use their resources, helps understand their attitudes and assesses their skill and knowledge levels.

- **Senior health workers**

Assessors need to work closely with the senior health workers in the healthcare environment responsible for children's services, the managers of support services and any coordinators for the important clinical jobs to complete the Part 1 check lists. Relevant senior health workers are also

asked to contribute in the same way as others by completing questionnaires for chosen CFH 'Standards'.

- **All other Health Workers**

All types and seniority of health worker both professional and non-professional, including those in training, are either interviewed or asked to complete questionnaires. The detailed questionnaires for some parts of some 'Standard's will be most relevant for doctors and nurses; the views and opinions of other health workers will be needed for other parts.

Results may not genuinely reflect collective views if some health workers do not wish to participate or are unable to. It is therefore important to gain prior authority from senior health workers to ensure that full cooperation at all levels is possible.

Checklist for assessors:

- Decide on the total number of questionnaires needed and then number these
- Distribute and collect the numbered questionnaires
- Explain the program to the participating health workers or design an information leaflet to be handed out with each questionnaire
- Arrange a collection time or deadline for completing the questionnaires
- Agree on a method of collection
- Keep a record of the name of each health worker who has been asked to complete a questionnaire to check whether or not they have returned it
- Make sure the questionnaires are confidential and an individual cannot be linked to a specific questionnaire (no names or other identifiers on questionnaires)
- Follow up any questionnaires not returned

How many completed questionnaires are needed?

In a small health facility or clinical area all nurses and doctors should complete the Stage 2 questionnaires.

In larger health care environments or clinical areas a representative sample is sought. Ideally this sample is a manageable percentage of each type and seniority of health worker selected systematically and randomly from employment or duty lists. In practice unless careful planning is possible, selection may be more dependent on availability. In larger clinical environments ten nurses and doctors is the absolute minimum number needed.

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