

The Child-Friendly Healthcare Initiative (CFHI): Healthcare Provision in Accordance With the UN Convention on the Rights of the Child

Implemented by Child Advocacy International with the technical support of the Department of Child and Adolescent Health and Development of the World Health Organization (WHO), the Royal College of Nursing (UK), the Royal College of Paediatrics and Child Health (UK), and in collaboration with the United Nations Children's Fund (UNICEF).

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ABSTRACT. *Objective.* Although modern medical technology and treatment regimens in well-resourced countries have improved the survival of sick or injured children, most of the world's families do not have access to adequate health care. Many hospitals in poorly resourced countries do not have basic water and sanitation, a reliable electricity supply, or even minimal security. The staff, both clinical and nonclinical, are often underpaid and sometimes undervalued by their communities. In many countries there continues to be minimal, if any, pain control, and the indiscriminate use of powerful antibiotics leads to a proliferation of multiresistant pathogens. Even in well-resourced countries, advances in health care have not always been accompanied by commensurate attention to the child's wider well-being and sufficient concerns about their anxieties, fears, and suffering.

In accordance with the United Nations Convention on the Rights of the Child,¹ the proposals set out in this article aim to develop a system of care that will focus on the physical, psychological, and emotional well-being of children attending health care facilities, particularly as inpatients.

Design of the Program. To develop in consultation with local health care professionals and international organizations, globally applicable standards that will help to ensure that practices in hospitals and health centers everywhere respect children's rights, not only to survival and avoidance of morbidity, but also to their protection from unnecessary suffering and their informed participation in treatment.

Child Advocacy International will liaise closely with the Department of Child and Adolescent Health and Development of the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) in the

implementation of the pilot scheme in 6 countries. In hospitals providing maternity and newborn infant care, the program will be closely linked with the Baby Friendly Hospital Initiative of WHO/UNICEF that aims to strengthen support for breastfeeding. *Pediatrics* 2000; 106:1054–1064; *United Nations Children's Fund, United Nations Convention on the Rights of the Child, child protection, breastfeeding, pain control, palliative care, child abuse.*

ABBREVIATIONS. UNICEF, United Nations Children's Fund; WHO, World Health Organization; BFHI, Baby Friendly Hospital Initiative; CFHI, Child Friendly Healthcare Initiative; UNCRC, United Nations Convention on the Rights of the Child; CAI, Child Advocacy International; EACH, European Association for Children in Hospital.

In 1991 the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO) introduced the Baby Friendly Hospital Initiative (BFHI)² to improve the care given to mothers and infants and to increase the prevalence of breastfeeding. Breastfeeding, particularly in disadvantaged countries, reduces malnutrition and infection and, thereby, infant mortality and morbidity.^{3,4}

The Child Friendly Healthcare Initiative (CFHI) has broader concerns and will build on the BFHI to facilitate a process by which child health services, in both hospital and other health care institutions, will become more child-focused and subject to sustainable improvements. In many parts of the world, efforts to improve the clinical management of childhood illnesses are only just getting underway. The Integrated Management of Childhood Illness program of WHO/UNICEF is an excellent example of one approach to improving child survival, particularly applicable to programs in the community.⁵ This article focuses on the development of a pilot project that aims to establish minimum standards of health care in hospitals and other institutions, particularly those where children are inpatients.

We recognize that a health facility cannot implement these standards unless there is security in the surrounding area, clean water, a reliable power supply, adequate waste disposal systems, supportive financial strategies, and the necessary human re-

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sources. These are priorities and advocacy for their presence, before attempting an introduction of the standards of this initiative, may be mandatory. However, much can be done with the better use of existing resources. Unnecessary suffering caused by lack of respect for human rights, inadequate pain control, or hospital-acquired infection can be alleviated with additional staff training, a change in attitude, and a redistribution and/or more effective use of existing resources.

Even in well-resourced countries, advances in medical and surgical knowledge have not always been accompanied by an equivalent attention to the child's broader physical and psychosocial needs (the needs of the child as a whole).⁶⁻¹⁶ There can be a tendency to focus on systems of the body ignoring the effects of the treatment and associated experiences (for instance, separation from family in an unfamiliar environment) on the child's physical and emotional well-being.

The United Nations Convention on the Rights of the Child¹ (UNCRC) makes it clear that there is a duty on states to provide adequate health care for children as well as to ensure that in receiving this care that they are protected from harmful practices and discrimination. This pilot initiative is based on the UNCRC.

BACKGROUND

WHO and other international organizations are involved in activities to improve the quality of inpatient care (for instance in relation to safe motherhood) in hospitals in poorly resourced countries. In the field of child health care, appropriately, most nongovernmental organizations and UNICEF devote their attention to community programs. Child Advocacy International (CAI), the implementing agency for the piloting of this initiative, specifically aims to support local pediatricians and nurses in the provision of higher standards of hospital care for children in the state hospitals of poorly resourced countries

(see reference 17 for the report of CAI on the care available in the primary Children's Hospital in Afghanistan). The present initiative is funded by the National Lotteries Board of the United Kingdom.

Examples of Limitations in the Health Facility

Lack of security, including, for example, the presence of arms within hospital wards

Lack of water and sanitation or failure, despite these, to keep the hospital clean

Absence of safety policies, for instance, with respect to fires

Lack of basic drugs and medical supplies needed to provide a minimum standard of care

Examples of Limitations in the Performance of Staff

Inadequate basic nursing and medical training with respect to the needs of children

Lack of postgraduate medical education

Inadequate salaries for professionals

Isolation

Examples of Inappropriate Medical Practices

Failure to control pain because of misplaced fears of addiction and difficulties in the control of opiates (Fig 1)

Poor attention to effective hand-washing practices

The use of muscle paralysis without sedation/analgesia

Excessive use of intramuscular injections

Indiscriminate use of powerful antibiotics

Lack of Respect and Sensitivity for the Child

Separation of the child from parents after admission and, particularly, during invasive procedures

An environment that is frightening to the child
Failure to respect the child's need for privacy or to preserve his/her dignity¹⁸

Failure to explain the illness and its treatment to the child and/or parent¹⁸

Fig 1. This child has a neuroblastoma. Some surgery has been undertaken, but there are no chemotherapy programs available/affordable for the vast majority of children with cancer in this country (it has been estimated that 90% of children in the world do not have access to such programs). Of more importance is the lack of available pain control (paracetamol was the strongest analgesic available for children in this extremely poorly resourced state hospital). There is no palliative care available and little communication between the hospital and the poorly developed community health services. The mother gave consent for this photograph to be taken.



The use of devices such as straitjackets, straps, or ties to secure a conscious child for invasive procedures

Regularly mothers are separated from children as they are admitted to the hospital, for example, in many of the countries of Eastern Europe and Asia. A study of neonatal intensive care unit policies as recently as 1996 in Europe, showed one country where only 11% of units had unrestricted parental visiting and another where only 19% of units explicitly involved parents in decision-making.¹⁹ Conscious children in many hospitals around the world are tied to beds in order for care givers to undertake invasive procedures (albeit procedures that may be essential for treating the child). The WHO Regional Director for Europe in the Forward to the Report of the WHO commissioned study of "Care of Children in Hospital" states,²⁰ "The care of children in hospitals ranges from the very good to the horrifying. . . . There is clear lack of awareness in a surprisingly large number of hospitals of the special need, not only to cater for children's technical, medical, and nursing needs, but also to minimize the adverse effects of being separated from their families and exposed to frightening experiences that are all too often magnified by the child's lack of forewarning."

In many countries, particularly those with good resources, some of the above problems have been addressed. In the United Kingdom this has occurred primarily through the activities of Action for Sick Children,^{21,22} which since 1961 has worked to meet the psychosocial needs of children receiving health care.²³ Their actions were supported initially by individual pediatricians and pediatric nurses and later by the Royal College of Nursing,^{24,25} the Audit Commission,²⁶ the United Kingdom Departments of Health,^{27,28} and the British Paediatric Association.²⁹ Similar organizations now exist in 17 European countries and since 1993 have been strengthened by the establishment of the European Association for Children in Hospital (EACH) and the publication of its charter.³⁰ Most EACH member countries have sent the charter to hospitals admitting children in their own countries and it has now been translated into 20 languages and this year has been issued in Japanese and Chinese.

However, in many health care institutions, much remains to be done in fully implementing these recommendations. A multifaceted approach with professionals and families working together toward the same goals can be a powerful force for change. This initiative requires insight into the needs of individual children and their families and is in harmony with the essential elements of clinical and resource management.

IMPLEMENTATION

The pilot project will research existing situations in each of 6 countries and develop methods for accrediting each participating hospital, using methodology similar to that successfully developed for the WHO/UNICEF BFHI. Discussions with professionals in hospitals, with governmental and intergovernmental agencies in the 6 countries, including the United

Kingdom, are at an advanced stage, although the final decision on sites for the pilot is to be confirmed.

As the program develops, it will be tracked within an Internet web site (www.childfriendlyhealthcare.org), thus making the changes in the initiative accessible and observable to collaborating partners and other interested parties.

To avoid a worsening of morale, particularly with respect to the impossibility in the short-term of achieving certain standards because of local or national social/economic/political issues, accreditation, if that is appropriate, will occur in stages and for each individual standard (for example, certificates of commitment, progress award, full award). Any final accreditation process will depend on the progress of the pilot project, during which no actual accreditations are anticipated.

In Hospitals With Combined Services for New Mothers, Newborn Infants, and Sick Children

The WHO/UNICEF BFHI will be promoted in the maternity unit and the CFHI in those areas concerned with providing health services for children.

It will be possible for the BFHI to be undertaken and assessed independently in such hospitals. However, for a hospital that has a maternity unit within it to be designated Child Friendly, it will first be necessary for it to have implemented the Ten Steps to Successful Breastfeeding² in full and be accredited by WHO/UNICEF as Baby Friendly.

In Hospitals Providing Facilities for Children But Without a Maternity Unit

Here the CFHI can be developed without the Baby Friendly program.

In Community Health Centers

Here the CFHI will be implemented alongside the Baby Friendly Initiative's 7 Point Plan for the Protection, Promotion, and Support of Breastfeeding in Community Health Care Settings (UNICEF UK Baby Friendly Initiative, 1998) or guidelines of an equivalent standard that may already have been produced in some countries by professional and voluntary organizations.

Other Institutions

Children may also be accommodated in institutions not designated as hospitals but that, nevertheless, have responsibility for their care and well-being. Such institutions may include residential homes for those with learning difficulties or physical disabilities. Children in such institutions may be particularly vulnerable to neglect or abuse. We argue that such institutions are rarely the most suitable places for the care and treatment of children. However, we cannot ignore their existence and should seek to ensure that they too are able and encouraged to commit themselves to the standards of the CFHI.

Details of the New Initiative

In collaboration with pediatric colleagues in the United Kingdom and a number of disadvantaged countries in which CAI has been working (Uganda,

Nicaragua, Afghanistan, and Bosnia), the working party of the CFHI has developed 12 provisional standards, although these and the means of implementing them are open to adaptation and amendment in the light of comments received, discussions with partner institutions, and the evaluation of the pilot schemes. The relevant applicable sections of the UNCRC are given in italics next to each standard.

The approach that we are developing will encourage each hospital or health center, intending to qualify for the awards, first to audit its practices in relation to each standard proposed. It could then develop a Child Friendly Policy Statement consistent with those standards identified/developed as appropriate for the cultural and other socioeconomic circumstances prevalent in each country and indicating its practical commitment to the principles of the CFHI and UNCRC. The senior children's nurse and doctor for the hospital/health center should be familiar with this policy. S/he should be able to describe how staff is made aware of it and trained in its implementation.

The policy should be available to all who have contact with children (including theater and radiograph staff, ward cleaners). It could be appropriate to exhibit the policy in all areas of the hospital/health center/institution that serve children, including departments, wards, and diagnostic and waiting areas. These will include medical, surgical, ear, nose, and throat, orthopedic, ophthalmic, and plastic surgical areas, outpatients, accident and emergency, and the radiograph department. The policy would be displayed in the language(s) most commonly understood by children, parents, and staff. It should be written in ways appropriate for children and parents of different educational attainments. Training that ensures that all staff are aware of and can practice the finally agreed standards should be in place.

PROPOSED STANDARDS AND PRELIMINARY CRITERIA FOR THEIR ADOPTION

The 12 standards need to be implemented in concordance with the UNCRC and tested as such. Policies within the standards will need to be:

1. Within existing state legislation
2. Within the resources of the country
3. Acceptable to religious and ethnic wishes of the community
4. In a language and at a level of understanding, appropriate to the recipients
5. Developed and owned jointly in each health facility by project members, health care workers, and families. In many disadvantaged countries where there is poor access to health care services there is a need to strengthen linkages with family- and community-based integrated efforts to improve the health of children (refer to a recent workshop in Durban, South Africa, 20–23 June 2000 entitled "Improving Children's Health and Nutrition in Communities").
6. Readily available to all involved
7. Linked to training of existing health care workers and those in training

8. Developed to identify minimum standards
9. Introduced by nominated key workers (coordinators) identified by the health facility within a framework of individual responsibility and accountability and with support as necessary by the project/program team
10. Sustainable
11. Coordinated with and/or harness any existing internal or external governmental or nongovernmental efforts
12. Advocating for children at all levels
13. Aiming to encourage optimal care and care delivery, good communication at all levels, and the protection of children at the same time as avoiding unnecessary fear and anxiety

STANDARD 1 (UNCRC, ARTICLES 9, 24, AND 25)

As much health care as possible should be provided in the home and community. Children should be admitted to and kept in hospital or other residential health care institution only when this is clearly in the best interests of the child.

Implementation³¹

The following criteria are suggested to support this standard:

1. A mission statement
2. An admissions policy
3. A daily review policy
4. A discharge policy
5. A discharge plan for each individual child designed for community health professionals (when present)
6. A discharge plan for each individual child designed for the parents
7. A rapid-response outpatient service that assesses and only admits the child when absolutely essential for their well-being. There should be open access to inpatient facilities, independent of the parent's ability to pay for care
8. Day care facilities for treatment and observation with children able to go home if their condition is satisfactory
9. Community/hospital outreach care³²
10. The development of social welfare provision linked to the hospital that includes a safe fostering service for abandoned children or those in need of protection and care (if a parent or other family member cannot safely provide this)
11. Continuing advocacy by health professionals to government and other authoritative bodies to phase out institutions that provide long-term health care for children (particularly those with disabilities), moving instead to supported care within the home, extended family home, or foster home
12. Financial strategies to support these criteria, preferably within existing budgets if at all possible

The key workers include lead children's doctor, lead children's nurse, and manager (if different) of children's services.

STANDARD 2 (UNCRC, ARTICLE 3)

The environment in the health care facility should be secure, safe, scrupulously clean, and child- and family-centered avoiding the inducement of fear and anxiety in the child.

Implementation

The following criteria are suggested to support this standard:

1. A mission statement
2. A child centered/friendly environment (décor, facilities, attitudes—see also standards 3 and 8)
3. A security policy to cover:
 - Grounds
 - Hospital entrances
 - Wards
 - All other areas used by children, families, and staff
4. Safety policies to cover:
 - Fire
 - Stairs
 - Windows
 - Hazards associated with poor maintenance of buildings, internal decoration, fixtures, and fittings
 - Protection from cigarette smoke
 - Adverse effects that may be associated with the promotional activities of drug, food, and equipment manufacturers
 - Waste disposal (see hygiene/sanitation)
 - Safe disposal of needles and needle stick injuries
 - Safe storage and usage of drugs—see standard 6
 - Antimalarial measures (where appropriate)
 - Vetting of all staff suitability to work with children (see standard 10)
5. Effective cleaning policies (that include methods, frequency, materials, appropriate disinfectants and dilutions, and sterilization where necessary) to cover:
 - Rodent and pest control in all areas
 - Grounds
 - Buildings—entrances, corridors, wards, laboratories, theaters, and all other areas (floors, walls, ceilings, fittings, and fixtures)
 - Sinks, toilets, baths, showers, etc
 - Kitchens and food storage facilities
 - Equipment
 - Laundry
6. Maintenance systems to cover:
 - Buildings
 - Décor
 - Fittings and fixtures
 - Utilities
 - Equipment
7. Hygiene/sanitation/infection control policies to ensure:
 - Adequate and safe water
 - Adequate and safe sanitation
 - Adequate and safe waste disposal
 - Effective and appropriate hand-washing for all professional and nonprofessional staff, resident parents, visitors, and patients

- Hygienic food preparation
 - That appropriate clothing is worn by staff for differing venues and situations (to ensure that uniforms/other clothing/jewelry do not cause or spread infection)
 - Isolation of specific conditions
8. Specific infection control policies to protect patients and staff from:
 - Human immunodeficiency virus infection and hepatitis
 - Outbreaks of communicable infection
 - Antibiotic-resistant organisms
 9. High-quality food taking account of dietary preferences, including those linked to cultural, religious or moral commitments, and special foods for children with malnutrition or failure to thrive
 10. Policies regarding the routes of administration of medication that should be discussed with parents and the child. Intramuscular injections should only be given in emergency. When given rectally, verbal consent should be obtained from parent and child (if appropriate)

To provide the above, systems to ensure provision and maintenance of electricity (and backup) and appropriate and adequate temperature control in the facility are paramount.

The key workers include managers of utilities, facilities and hotel services, hygiene promotion coordinator, and microbiologist/infection control coordinator.

STANDARD 3 (UNCRC, ARTICLES 9 AND 31)

The health care facility will permit and encourage a parent to stay with their child and accompany and support their child during procedures. The facility will involve the parent in all aspects of the care and keep them informed about the child's illness.

Implementation

The following criteria are suggested to support this standard:

1. A mission statement encouraging parents to stay with and support their child
2. Written advice on the facilities available and any policies for their use (for instance in a ward book and/or leaflets)
3. Achievable minimum standard facilities for the resident parent/care taker that include:
 - A bed to lie down on at night
 - A dedicated, private area for relaxation, and/or for breaking bad news (see also standard 4)
 - A storage facility for personal possessions
 - Food and drink provision
 - Facility for safe storage of own food and drink
 - Facility to heat up own or hospital-prepared food
 - Facility to prepare hot or cold drinks
 - Financial assistance for hospital prepared food or drinks where necessary
 - A health care worker with responsibility for coordinating the needs of families

4. Verbal and written information and advice for parents explaining specific procedures and how they can help their child during these (venepuncture, insertion of venous catheters, etc)—for instance in a ward book (see also standard 4)
5. Written policies for parents to explain what will happen to their child before and after surgery and how they can help their child—for instance in a ward book (overlap standard 4)
6. Consent policies for investigations, procedures, and surgery
7. A breastfeeding policy for parents who are still breastfeeding their child or a sibling, and the facilities and human resource to support this (see also standard 12)
8. Assistance for travel where financial circumstances prevent a parent/caregiver staying with or visiting their child³³

The key workers include the coordinator of family needs, lead children's doctor and nurse, manager of children's service, and the breastfeeding coordinator.

STANDARD 4 (UNCRC, ARTICLES 6, 24, AND 31)

The health facility will provide the highest possible standard of care for the child.

Implementation

The following criteria are suggested to support this standard:

1. A mission statement
2. Use of international and evidence-based guidelines for the management and treatment of inju-

- ries and illnesses (eg, IMCI guidelines, WHO),⁵ "management of the child with a serious infection or malnutrition" (WHO),³⁴ "a manual of health care for children in hospitals; provision of minimum standards" (Child Advocacy International)³⁵
3. Regarding health care professionals, the health care facility should have systems in place to:
 - Facilitate/provide continuing professional education and development, including interactive scenario-based teaching programs (see Fig 2)
 - Identify all health care workers and their position (eg, all staff to have badges displaying name, area of work, profession, and grade if applicable)
 - Ensure validation of professional qualifications
 - Provide ongoing performance monitoring with measures in place to detect and correct any poor practice
 - Support staff and sustain their morale
 - Facilitate peer review and professional audit of medical practice
4. With regard to drugs, the health facility should have in place and available to parents (see also standard 6):
 - An essential children's drug list (for instance of WHO or CAI³⁵)
 - General guidelines for drug administration
 - Guidelines for the administration of specific drugs (eg, opiates)
5. Compliance with minimum internationally accepted standards for the provision of nutrition



Fig 2. Two midwives from the labor ward at Mulago Hospital in Kampala, Uganda undergoing training in bag and mask ventilation as part of a neonatal resuscitation course run by pediatricians from the hospital (one of whom is Dr Margaret Nakakeeto, right).

6. An ethics committee to ensure that all research and selected aspects of clinical care are subject to scientific and ethical review
7. Clinical support services, staffed and maintained to a standard recommended by WHO
8. Minimum statistical data collection as recommended by WHO
9. Information for parents/child. The health facility should keep parents and the child if appropriate informed in a language and way that they can understand by:
 - Using interpreters when necessary (avoiding the use of relatives/friends to translate where possible)
 - Having standards for communication that include written guidelines/policies on communicating with parents and ongoing staff training in communication
 - Explaining the reasons for and the results of investigations, and interpreting any results
 - Explaining the reasons for a chosen route of drug administration
 - Providing verbal and written information on different medical problems
 - Providing verbal and written advice on home management of different medical problems
 - Ensuring communication among different health professionals
 - Avoiding unnecessary delay in sharing information and any other concerns

The key workers include lead children's doctor and nurse, manager of children's service, personnel officer, senior pharmacist, and the child psychologist (if available).

STANDARD 5 (UNCRC, ARTICLES 2, 3, 7, 12, 23, AND 30)

All staff should approach children as individual people with their own needs and rights to privacy and dignity, involving them in decisions affecting their care. The standard of care and treatment provided should be in the best interest of the child, without discrimination based on gender, ethnicity, religion, or otherwise.

Implementation

The following criteria are suggested to support this standard:

1. A mission statement
2. A policy to ensure that the name the child is known by is always used in any contact with or reference to the child. Reliable systems for labeling each child, especially infants and pre-verbal children and for registering all births should exist.
3. Systems to ensure that dignity and privacy is protected whenever possible
4. Systems for the prevention, detection, and correction of discrimination against patients or the employment of staff
5. Systems and facilities to provide care for children with disabilities, including the ready provision

of access into and out of hospital buildings/ departments and appropriate aids

6. Systems to explain to children the care being given in an appropriate way for age, understanding, and language
7. Policies to seek the child's views on, and to confirm their understanding of, the care given in a language and manner that they can understand
8. Specific policies for adolescents that recognize their different needs
9. Identified named health professional staff responsible for each individual child's care at all times
10. Systems to ensure that staff are aware of, and provide support for, if appropriate, any specific personal tragedies or life events affecting a child
11. A process that ensures confidentiality of medical records as well as spoken information disclosed by the parent or child
12. A process that ensures that any child admitted because of illness or injury from a place of custody is treated in accordance with the UNCRC

The key workers include lead senior children's doctor and nurse, manager of children's service, adolescent coordinator, and the psychologist if available.

STANDARD 6 (UNCRC, ARTICLE 19)

A multidisciplinary team should establish and maintain standards and guidelines for the assessment and control of pain and discomfort (psychological as well as physical) in children.

Implementation

The following criteria are suggested to support this standard:

1. A mission statement
2. A multidisciplinary pain control team with coordinator to develop, supervise, and monitor guidelines (using internationally accepted, evidence-based material) for:
 - Assessment of pain
 - Control of pain—pharmacological and non-pharmacological
 - Safe storage and use of opiates (see also standards 2 and 7)
 - Palliative care, including the continuation of such care in the home
 - Individual pain control plans developed with the child and parent
 - Policies on cultural issues that should be respected providing the child's best interests remain paramount (see also standard 7)

The key workers include lead senior children's doctor and nurse, manager of children's service, pain coordinator, and the senior pharmacist.

STANDARD 7 (UNCRC, ARTICLE 19)

All invasive procedures must be accompanied by adequate analgesia and, when systemic analgesia/sedation is used, personnel experienced in the resuscitation of children should be immediately available.

Implementation

The following criteria are suggested to support this standard:

For Analgesia for Procedures

1. A mission statement
2. The use of internationally accepted, evidence-based pain control measures (see standard 6) that are regularly monitored and reviewed by the pain team
3. Written guidelines for pain relief and/or sedation for specific procedures
4. Written guidelines for the use and practice of invasive procedures
5. Written guidelines for use of restraint
6. Consent procedures for invasive procedures (see standard 3)

For Resuscitation

1. A mission statement
2. A named resuscitation coordinator/officer who has overall responsibility for the training of staff, the resuscitation equipment, the standard of the service provided, and the policies used. These should conform with internationally accepted, evidence-based existing policies (for example, neonatal resuscitation and pediatric life support courses; see Fig 2)
3. Resuscitation equipment that is adequate, suitable for all ages, and regularly checked in close proximity to wherever resuscitation may be needed
4. Appropriate in-date resuscitation drugs kept with resuscitation equipment
5. Regular updating of all health care professionals in basic life support
6. Regular updating of doctors and some nurses (for instance, those working in intensive care or theater) in advanced life support

The key workers include pain control coordinator, resuscitation coordinator, lead senior children's doctor and nurse, and the manager of children's service.

STANDARD 8 (UNCRC, ARTICLES 28 AND 31)

Children should be able to play and learn while in hospital or other health care institutions.

Implementation³⁶

When a child is resident in a health facility or institution for more than a few days and is well enough to be able to play and/or learn, the following criteria are suggested:

For Play

1. A mission statement to support this standard
2. A separate safe, clean play area available for children well enough to play away from their bed
3. Provision of basic, clean, culturally acceptable play materials for children of all developmental levels, including play materials to mimic hospital activities
4. A trained play leader attached to the health facility who has responsibility for:
 - Supervision of play in the play area

- Supervision of play at the bedside where a child is well enough to play or learn but unable to leave their bed
- Introducing specific play activities to prepare individual children for procedures, including surgery, to aid their understanding about what is going to happen to them and, thereby, to help reduce possible fear and anxiety
- Formulation of individual plans for play jointly with parents, health professional staff-written play preparation ideas for parents to introduce at home before a planned stay

For Education

1. A separate, safe, clean area for education for children well enough to learn away from their bed
2. Provision of basic, culturally acceptable, and appropriate educational materials
3. A trained teacher who has responsibility for:
 - The selection of basic, culturally acceptable, and appropriate educational materials available for all ages and levels of understanding
 - Supervision of education in the designated area
 - Supervision of learning at the bedside where a child is well enough to play or learn but unable to leave their bed
 - Individual plans for the child's education after consultation with the child's parents and community teacher (if a child is likely to remain in the health facility for more than a few days)
 - A record of school work undertaken during the child's stay that could be shared with the child's parents and community teacher after discharge

The key workers include play leader, teacher, lead senior children's doctor and nurse, and the manager of children's service.

STANDARD 9 (UNCRC, ARTICLES 17, 23, AND 24)

Admission to/attendance at the health facility will be regarded as an opportunity to promote health through example, education, immunization, and growth monitoring.

Implementation

All health care staff have a responsibility to promote health. Particular attention should be paid to good personal hygiene and hygiene promotion, especially adherence to hand-washing and no touching policies (see standard 2). To promote children's health the following criteria are suggested:

1. A mission statement to support this standard
2. A personal, parent-held child health record containing health promotion advice
3. Easily and always available health promotion advice and literature. This could be adapted as necessary from international existing material to suit the local culture and religious beliefs. It should be in a language that children and parents can understand and ideally should be available for parents and for children of differing ages and levels of understanding

It should include advice on:

- Breastfeeding
 - Home management of diarrhea and the use of oral rehydration solutions
 - Immunization
 - Nutrition
 - Child development
 - Management of common behavioral problems and mental health
 - Accident prevention
 - Child protection
4. Health promotion advice and literature specifically for adolescents covering, where appropriate:
- Immunization
 - Sexual health
 - Sexually transmitted diseases, including human immunodeficiency virus and acquired immunodeficiency syndrome
 - Reproductive health
 - Smoking
 - Alcohol and other substance abuse
 - Eating disorders
 - Mental health
 - Disability
5. An immunization coordinator responsible for all aspects of immunization including the overseeing of policy implementation and staff training
6. A written immunization policy and, if possible, facilities to procure, store, and administer immunizations as necessary according to internationally accepted standards and protocols

The policy should include:

- Recommended immunizations and age at which they are best given
 - Taking an immunization history from every child who is seen
 - Immunizing every child who is not immunized or not up-to-date with the immunizations recommended by the country, before leaving the health facility if their health permits
 - A management/resuscitation policy for reactions (see standard 7)
 - Giving a written record of any immunizations to the child's parents (preferably immunizations should be recorded in the child's personal health record)
7. The measurement, recording, and plotting on an appropriate percentile chart of the height and weight of each child, every time he/she attends. The parent should be informed of these measurements and of any concern (preferably measurements should be recorded in the child's personal health record)
8. Systems in place to identify children with poor growth and to investigate, treat if necessary, and/or provide intervention (nutritional and psychosocial) when malnutrition is the likely cause

The key workers include immunization coordinator, adolescent coordinator, lead senior children's doctor and nurse, and the manager of children's service.

STANDARD 10 (UNCRC, ARTICLES 3, 19, 34, AND 39)

Staff should be familiar with the signs and symptoms of child abuse and be capable of instigating appropriate and clearly defined procedures to protect the child.

Implementation

It is recognized that the legal framework required to institute child protection is likely to vary within different countries. In some there may be no framework despite ratification of the UNCRC.

It should be acknowledged by states that a child protection program must be in place, even if, for example, there is armed conflict or inadequate water and sanitation.

Child abuse or maltreatment constitutes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment, or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development, or dignity in the context of a relationship of responsibility, trust, or power (WHO definition of child abuse, 1999).

The following criteria are suggested:

1. A mission statement to support this standard
2. A designated child protection coordinator
3. Tertiary and some secondary prevention activities (report of the Consultation on Child Abuse Prevention WHO; March 29–31, 1999; Geneva, Switzerland) that include:
 - Health promotion advice (see standard 9)
 - Systems to identify at-risk families
 - Clearly defined procedures to diagnose child abuse
 - Guidelines for the recording of suspected abuse
 - Guidelines for the management of suspected abuse
 - Medical treatment and support for victims
4. A social worker or other similar health professional to support families when abuse is suspected, has occurred, or there are multiple risk factors
5. Systems to ensure that staff having access to children are screened for a previous history of abuse or violent crime

The key workers include the child protection coordinator, senior children's doctor and nurse, and the manager of children's service.

STANDARD 11 (UNCRC, ARTICLES 3 AND 24)

When possible, children should be treated in areas dedicated to children and should be cared for by professionals with training in their particular health and development needs. Care for adolescent girls should be particularly sensitive to their vulnerabilities and needs.

Implementation

The following criteria are suggested:

1. A mission statement that supports this standard
2. A formal review of:

- Where children are looked after within the health facility
- The qualifications, training, experience, and suitability of the health professional staff it employs to look after children in all areas of the health facility (see standard 4)
- The staffing levels it aims to achieve

Followed by recommendations for changes, where necessary, to comply, if possible, with internationally accepted standards that include ensuring that:

- Children's trained health professional staff are involved in the care of all children, including those looked after on adult wards when there is no reasonable alternative placement
 - Children looked after on adult wards are in a separate area from adults
 - Children on adult wards have access to all the same facilities and standards of care, particularly play and educational opportunity, as children on a dedicated children's ward (see all standards)
3. Dedicated and child-centered emergency services (have or be in the process of developing these)
 4. Adolescent facilities and resources (have or be in the process of developing these)
 5. Facilitation of the ongoing professional training and development of staff caring for children (see standard 4)

The key workers include senior children's doctor and nurse, manager of children's service, adolescent coordinator, and those responsible for nursing training.

STANDARD 12 (UNCRC, ARTICLES 17 AND 24)

The health care facility should comply with the appropriate best practice standards on the support of breastfeeding:

Implementation

1. A mission statement to support this standard
2. Breastfeeding should be permitted, encouraged, and fully supported in all public and private areas of the hospital. Private areas should be available for those mothers who require them. The toilet is not acceptable for this. Signs indicating infant care facilities should not feature a feeding bottle
3. If the child's mother is breastfeeding another child, provision must be made for this latter child to remain with the mother or to be brought to the mother for feeding
4. Hospitals should implement the Breastfeeding Guidance for Pediatric Units of the United Kingdom Royal College of Nursing or guidelines of an equivalent standard that may already have been produced in some countries by professional and voluntary organizations
5. Hospitals providing maternity services should implement the "Ten Steps to Successful Breastfeeding"² and hold UNICEF Baby Friendly accreditation
6. Facilities providing community services should comply with the "7 Point Plan for the Protection, Promotion, and Support of Breastfeeding in Com-

munity Health Care Settings" (UNICEF UK BFI, 1998)

DISCUSSION

Inevitably, there will be difficulties in attaining some of the standards that comprise this initiative, particularly in countries where there are very limited resources and low morale in staff. One of the most difficult will be standard 10. Most countries in the world lack the resources or social services structure necessary to protect children from abuse within the family, even if the legal frameworks exist. Pediatricians and children's nurses based in hospitals and health centers are natural advocates for the needs and protection of children. This initiative aims to encourage governments to develop systems and laws to protect children from abuse and exploitation.

In some countries, particularly those in Eastern Europe, there are problems with respect to the involvement of parents in child health care. However, at least one such country (the Czech Republic) has made considerable advances in this area (O. Stark, P. Belson, personal communication, 1999).³⁷

The specific recommendations made within the 12 standards will need to take into account local cultural norms,³⁸ concepts about illness and death, and educational practices. The Convention on the Rights of the Child enshrines the principle that decisions affecting children should be made in the best interests of the child. ("In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities, or legislative bodies, the best interests of the child shall be a primary consideration"). The principle of non-discrimination is included in all the basic human rights instruments and has been carefully defined by the bodies responsible for monitoring their implementation. The Convention on the Rights of the Child states frequently that States need to identify the most vulnerable and disadvantaged children within their borders and take affirmative action to ensure that the rights of these children are realized and protected. ("States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, color, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.") These principles are fundamental and should be applied by health care institutions and their staff in all of their interactions with children. They should be stated in the policy of the institution and mechanisms and procedures should exist to safeguard the rights of children to be free from discrimination.

The cost implications engendered by this initiative will be complicated but are unlikely to be excessive. Implementation of standard 1 should reduce hospital costs but will require strengthening/establishment of community health care systems with close integration of hospital and community health care. The cost of the others should be small and improvements in

care of children, by reducing stress, may increase the speed of recovery from illness or injury.

The pivotal importance of pain control in the management of sick and injured children has at last been recognized in many countries,³⁹ where teams responsible for addressing this issue are being established within hospitals. However, elsewhere, there are restrictions over the use of powerful analgesic drugs such as morphine. Because of fears about addiction, together with concerns about potentially life-threatening side effects, such as respiratory depression, and difficulties in organizing and controlling the distribution of opiate drugs, many children undergoing major surgery may be given paracetamol as their only postoperative analgesia. Powerful analgesic drugs are not expensive but addiction and abuse of them by staff is a reality in some countries. Implementation of standard 6 should support the efforts of governments and their Ministries of Health in their objective of providing adequate pain control for children and yet avoiding dangerous side effects or abuse by staff.

Probably the best long-term generic approach to changing the way children are treated in health care institutions will occur as a result of education for physicians, nurses, and health care technicians given before and after qualification. There should be an international curriculum encompassing the 12 standards made available to all health care training institutions.

Finally, the implementation of this initiative should provide a major boost to the promotion of breastfeeding.

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