

## Section 4

### 'Making it better'

#### How to improve the care you give

'Child Friendly Healthcare' belongs to every the health worker that looks after children and families whether they are involved in planning, organising, providing or giving care.



*The first photograph shows a chaotic, poorly organised, child unfriendly working environment. Mothers were not welcomed, only allowed to visit at certain times and did not share in the care of their babies. The mortality rate was high, health workers were de-moralised and both mothers and health workers unhappy.*



*The second photograph taken less than a year later shows a cleaner, well organised ward (although still overcrowded), unstressed health workers, parents free to come, go and share their babies care, a much improved environment with more information on the walls, child-friendly curtains and wall frieze. This was achieved by re-organising the way care was given, developing a team approach, sharing knowledge and skills, changing old behaviours and attitudes and making the environment friendlier and cleaner. All was achieved by the health workers themselves.*

#### Important reasons for making it better are:

- Children are still dying and suffering needlessly when receiving healthcare
- There are always problems that need solving, regardless of circumstance or resource level
- It is always possible to improve on current practice as research evidence continues to show better outcomes from new or different methods of care and treatment
- Society is continually changing, bringing with it both new benefits and new threats to the health of children and families that need to be considered

#### Making it better for children by improving the care you give means making changes

##### Barriers to change

To make changes happen the barriers against change and the forces for change need to be recognised and fully understood. Some of the barriers to change are found outside and some inside the healthcare environment and some are more outside the control of ordinary health workers than others. They are also found in individual health workers.

*'It's not the strongest of the species that survive, not the most intelligent, but the one most responsive to change' (Charles Darwin)*

**External barriers** (usually outside the control of the health workers in a healthcare environment)

- ❑ Adverse circumstances in the country (natural and man-made disasters)
- ❑ Complex healthcare bureaucracy
- ❑ Constantly changing policies at local and governmental level (instability)
- ❑ A low budget and poor planning for children's healthcare
- ❑ Poorly integrated primary and secondary healthcare services
- ❑ Many demands for change imposed by others
- ❑ Low salaries. Low pay means that supplementary income generation, such as private practice, is an important priority. This inevitably leads to inequity of care and a low commitment to provide the same standard of healthcare to all children.
- ❑ Poor job security so health workers fear voicing their opinions.
- ❑ Limited opportunity for professional advancement and little recognition of worth.
- ❑ Poor work environment (low investment in equipment and infrastructure)
- ❑ The unreasonable expectations of people who use the health services (complaints/litigation)
- ❑ A blame culture in society

**Internal barriers** (within the healthcare environment (can often be influenced by health workers)

- ❑ Little or no consultation with the children, their families and the health workers giving or supporting the care, by those planning services or systems of care. Often non-professional or junior health workers lack 'a voice'.
- ❑ Poor sharing and unequal distribution of resources
- ❑ Poor organisation of the material resources that are available
- ❑ Poor maintenance, especially cleaning, of the healthcare environment
- ❑ A vertical management structure with little delegation. This can restrict innovation and development
- ❑ No opportunities for education and for health workers to learn effective management and organisation skills
- ❑ No fair and open system for employing, dismissing or disciplining health workers
- ❑ No system for the recognising and praising the contributions of individual health workers or clinical areas
- ❑ Poor organisation and no standardisation of systems of care
- ❑ Poor organisation of human resources (frequent changes of carers, poor skill mixes)
- ❑ Poor support systems for health workers
- ❑ No, or little access to the world literature and the evidence-base for healthcare changes.
- ❑ Few standards, policies, guidelines and other job aides
- ❑ No opportunities made to review existing policies and guidelines to see if they achieve their objectives (audit)

**Barriers in individual health workers**

- ❑ A negative attitude and low morale
- ❑ Difficult personal circumstances that are taken to work and affect performance or time spent working
- ❑ Poor time management
- ❑ A lack of respect for others
- ❑ Lack of knowledge and skills or awareness of what is possible
- ❑ Reluctance to share skills, knowledge and resources

**Forces that support change**

Despite facing many of these barriers, health workers are frequently able to make simple but effective improvements in the care they give. Forces for change include:

**External forces**

- ❑ Stabilities in government (including Ministers of Health), in situation and in the country's boundaries

- ❑ Political vision within a country for improving children's healthcare (for example the Kosovan Department of Health and Social Welfare's visionary health policy for Kosova, February 2001). This vision works best if it is:
  - Shared by all the main stakeholders in children's health.
  - There is a detailed plan for its implementation with funding where necessary
  - Individual health workers are encouraged and supported to achieve the vision
- ❑ The desire and the support of the wider community
- ❑ Good working relationships with other stakeholders in children's health such as WHO, UNICEF and non-governmental organisations (NGOs)

### **Internal forces**

- ❑ A collective commitment to make things better
- ❑ Sufficient skilled health workers to provide safe care. If there are too few health workers, it is difficult to introduce any changes that require extra effort or time, although 'many health workers' does not always mean the 'best possible' care or a collective commitment to change.
- ❑ Consistency of staffing in a ward or other clinical area, especially the senior staffing. However consistency of staffing can also be a barrier to change. Health workers often prefer to stay with what they know, rather than embrace new skills and change well-tried working practices
- ❑ A change of leader/s
- ❑ Fair and open management with delegation
- ❑ A culture of team working, especially team problem solving
- ❑ A system to consult service users (the children and families) and respect their views
- ❑ A collective respect for human rights and a named health worker responsible for coordinating related activities.
- ❑ Regular training/educational opportunities for all health workers and good human resources
- ❑ Good systems for sharing and disseminating information between health workers, such as in Moldova and Kosovo where all senior health workers meet to share information at the beginning of the working day. These meetings work best when they are not dictatorial or proscriptive and are attended by representatives of each type of health worker, each service and each clinical area concerned
- ❑ Established forums for discussion and case review, such as regular audit meetings. Those responsible for coordinating audit need to encourage attendance and ensure that everyone understands why audit is so useful.
- ❑ Access to the evidence base for practice.
- ❑ Clear standardised (the same and used by everyone) policies, guidelines and job aides with training (See Section 5: Information Sheet about Job Aides)
- ❑ A satisfactory, well-maintained working environment raises morale.
- ❑ Sharing resources and equipment
- ❑ An effective and efficient system for managing data (collection, circulation, collation and examination), Good data are essential for supporting plans for change, for showing that change works and for supporting advocacy for more resources.

### **In individual health workers**

- ❑ Visionary leadership able to share visions, motivate and organize others. For example, the visionary leadership of a paediatrician in Mulago Hospital Complex, Uganda that improved care for the newborn, a new ward sister in Mulago that improved the care given on her ward and of a single-handed Cuban paediatrician in The Jubilee Hospital in South Africa who improved the care of very ill children.
- ❑ Ability to participate in team problem solving. Best practice is to organise staffing to meet the needs of children and their families and not to accord with the needs or traditions of health workers. It is best to use a team approach to decide how best to use the human resources available.
- ❑ Wanting and being given the responsibility and authority to coordinate an important healthcare task in a clinical area, such as infection control.
- ❑ Working well together with respect for the different skills of others.

- ❑ An individual commitment to making improvements
- ❑ All the senior health workers in a clinical area are committed to making changes/improvements as wanted and planned changes can be sabotaged if there is a powerful senior person not fully committed.
- ❑ An individual commitment to human rights, especially to the rights of children as others can be influenced by this, and by sharing knowledge about human rights.
- ❑ Trying to keep morale high by being a positive and good employee (See Section 5: Information Sheets on Adversity and Keeping Health Workers Happy). When the collective morale is high there is a collective desire to do better, such as found in the relatively small children's departments in Barnsley and Bridgend hospitals in the UK.

During the pilot project for the CFHI when most of these forces that support change existed in a pilot hospital, improvements in healthcare were continually being made and 'change' was a process not an event. When many of these forces were absent, although there were many visions for making it better, very little actually happened.

### About improving care

To make changes that lead to improved healthcare for children and their families the barriers need to be overcome, and any forces that may help recognised and effectively used

*'Great works are performed not by strength but by perseverance' Samuel Johnson*

### What helps to start, or speed up, the change process?

- Any type of unfavourable assessment or audit
- The setting of new 'Standards' for undertaking aspects of healthcare by a country's health planners
- The influence of an important person or group of people, such as a government minister or a parents' group
- The appointment of a new health worker with vision, particularly if this new health worker is in a position of authority in the organisation
- A difficult or unpleasant experience that causes health workers to look back at what has happened
- A complaint or suggestion made by a child or parent. In many countries children and parents are still not listened to or heard
- A learning opportunity or exposure to new experiences, such as a visit by an outsider who raises awareness about some issue or opens the eyes of health workers to what is possible
- New research evidence that shows that there is a better way of giving a particular aspect of care

Large changes need to be planned and resourced by those who plan and organise healthcare, but it is important to remember that many small low, or no cost, improvements can always be made by each and every health worker and often very small changes can have a huge impact on children's well-being. It is these changes that the CFH improvement program focuses on.

*An example of a small low-cost improvement of the environment*



*‘Child friendly’ curtains, cot covers and some balloons have improved the environment and motivated health workers to do more in this excellent day care unit in Pakistan*

*‘Regarding change, remember that people can be excited about change but do not like to feel they are being changed’.*

*‘A smile costs nothing’ (The Minister of Health, Pakistan and others)*

Positive welcoming ‘child and family friendly’ behaviour in health workers can make a big difference to how well a child and family respond to their individual health problem. Changing the negative attitudes found in some health workers, however difficult; can be of huge benefit to children and families.

Attitudes and beliefs influence all aspects of healthcare. They are difficult to change but best practice for every health worker is to have child and family friendly attitudes and behaviours, and to continually try to change any negative or destructive attitudes seen in others, especially those that interfere with providing the best possible care. You can do this by sharing your knowledge about ‘Child Friendly Healthcare’ and the evidence for this. This costs nothing except commitment and time.

### **When making improvements**

- Prioritise aspects of care and start with a small but feasible project.
- Use a staged (step by step) approach. Completing a project successfully and seeing how it makes things better, gives the motivation, strength and confidence to tackle the next thing on the list.
- Use a team approach to planning and implementing your ideas and solutions with a representative from each group of health workers affected, and a representative to speak on behalf of the children and families.
- Share ideas, problems and solutions, both locally, nationally, and internationally, through publications, advertisements, the media, and at paediatric meetings
- Use human and material resources effectively (see section 5 ‘looking after health workers’). In countries that have few, or not enough, skilled health workers or cannot afford to pay them, it is best practice to train and employ less skilled people as basic health workers (not nurses or doctors). This enables the more expensive skilled doctors and nurses free to see only the very ill children and those with the most complex problems. In some countries such as Nepal, local people in isolated rural areas are trained to provide basic healthcare, helped by clear guidelines that are designed to help them recognise the patients that need to be referred to more skilled health

workers at a distant centre. It is also important to recognise that older retired very experienced and skilled health workers can still contribute, but in less onerous ways than previously.

- **Actively support and acknowledge your colleagues**

*(See also Section 5 for more information about adversity and how to look after health workers)*

Ill or unhappy health workers are not able to provide the 'best possible' care and may leave the health

service. So best practice is to support others actively and also to have formal systems for supporting

and looking after the physical, mental and emotional health needs of health workers. This is cheap compared to the cost of the loss of health workers to a health service. So support and value each of

your colleagues.



*A paediatric surgeon in Eastern Europe who, although over 80 years old, is still employed to use her diagnostic, but not her surgical skills. She is well respected by her colleagues and prevents many children from having unnecessary surgery*



*A health worker sharing skills in Bosnia*



*Sharing knowledge in Barnsley, UK. Reading materials relating to children's healthcare found by individual health workers, and information learnt during courses and talks, were routinely put in this special area on a children's ward enabling all the other health workers on the ward to benefit.*

**Why acknowledge effort?**

Acknowledging effort is of huge importance for many reasons. For children to learn and develop to their full potential, they need approval and sometimes rewards for the things they have done well, and guidance, not criticism or blame, for the things not done well. This is also best practice for adults as in this respect we do not change. Most health workers will improve their performance and skills if they are given approval, respect and reward for who they are and what they do. If they already have this, they will try to keep it; if they do not have it or are not given this in response to their efforts, they will become de-motivated, perform poorly and have no incentive to change.



*A motivated acknowledged health worker in Uganda planning more improvements.*

Acknowledgement of health workers by both individual families and communities is also important as appreciation of their care confirms that they are doing a good job. A culture for blame has a destructive effect on all aspects of the healthcare provided. It can also cause great distress and disillusionment in the health workers concerned.

Finally, public acknowledgement of good healthcare brings it to the attention of others, and by doing so can validate a previously unrecognised or under-valued health service or activity. This acknowledgement may also attract the resources needed to make it even better and enable the good healthcare to be shared with others.

### **How others can help (including humanitarian aid)**

Others who can support improvements in healthcare include individuals, groups, organisations (governmental and non-governmental), different healthcare environments and health services. These 'others' may be from the same country, from a different country or from the international community. Advice and assistance that supports change includes:

- Agreed 'Standards' for children's healthcare (international, country, health facility and/or professional)
- Systems for monitoring, recognising and rewarding achievement of these Standards
- Health improvement programs
- Donations of money and/or material resources.
- Sharing expertise and opportunities for learning and skill-building
- Sharing good practice and solutions to problems that have been found effective in similar circumstances.
- Sponsorship
- Advocacy

There are many excellent global health improvement programs such as the Baby Friendly Initiative (BFI), the Integrated Management of Childhood Illness (IMCI), the Expanded Program for Immunisation (EPI), the Safe Motherhood Program and others. To work in the 'best possible' way these programs need to reach and support every health worker. They need to be easy for health workers to use and inexpensive, especially if new resources are not linked them. Unfortunately some are costly and need to be supervised by others making them difficult to introduce unless funding is provided by outside donors.

Very few health workers ever admit to having enough resources. Those that do are more likely to work in an advantaged country and/or in the private healthcare sector. In disadvantaged countries, even if scarce resources are managed and used in the 'best possible' way, these are still unlikely to support the sort of healthcare that health workers ideally wish to give.

Donated money and material resources can help if they are appropriate to the circumstances, are only needed for a temporary period or are sustainable after the donor leaves or discontinues their support. Donations need to be accompanied by advocacy for a higher healthcare budget for children and pregnant women. This must be part of every aid project, as in the long-term, a country cannot rely on aid, but needs to solve and resource its own problems.

The short-term unsustainable aid given in emergencies is very different to the sort of aid required to help develop children's healthcare services. It is important for donors to recognise and understand the distinction between the purpose, limits and features of 'emergency aid' and that of 'aid for development'.

Best practice for donors is always to question the appropriateness and context of their donations, to consider the possible negative impact of their actions with equal (if not greater) energy as they do the positive impact, and to ensure that those receiving aid are in a position to identify their real needs and also to recognise and say no to inappropriate donations.

### **Some of the examples of inappropriate aid seen during the pilot project:**

- Cupboards full of donated infusion pumps in one country's main neonatal unit. All said to be broken but in reality all were in working order. These were incompatible with the local electric supply, the local health workers did not know how to use them, nor were they ready to change the basic way they gave fluids. They were also unaware of the benefits such a change could bring.
- An impassioned plea from a maintenance engineer asking that donors consult him before donating equipment that he would have to maintain (no repair manuals in his language came with the equipment), and in any case he would not be able to mend it as had no budget for spare parts.
- "Out of date" drugs and disposables that were unfamiliar and not prescribed in the country. These had to be destroyed at a cost to the health facility.
- A donation of adult resuscitation and basic monitoring equipment to a children's ward. There was no training on how to use it the donation. The equipment was not passed on to the adult unit where it could have been used more appropriately,
- A donated computer system for medical records not in use for over a year as there was no funding for it to be repaired, nor was the expertise available in the country to do this.

## Ten suggestions for the donation of equipment

### Only donate if this is:

1. Wanted by most, ideally all, of the health workers involved (*always consult widely with those who will be responsible for using it and maintaining it, before donating*).
2. Appropriate for the level of care that the local health workers are currently able to give (*for example if health workers currently give fluids through giving sets without chambers, it is more appropriate to give paediatric giving sets with chambers before donating syringe pumps that they may not be able to understand the need for or be able to use*)
3. Able to meet the local needs and circumstances (*for example donated anti-malaria tablets would be of no use in some countries*)
4. Compatible with the local electricity supply (*for example make sure that the donated item has the right type of plug, that there are sockets and that it will work with the local voltage*)
5. New or in a good state of repair, and preferably a make whose manufacturer has servicing and spares arrangements with the country or a nearby country
6. Accompanied by training for the health workers (*including education of a 'trainer' who can train others*).
7. Compatible with any existing similar equipment, if possible
8. Accompanied by instructions in the local language about what it is for, how to use it, how to mend it, how to clean it and where to get spare parts (*ideally spares should be affordable and available in-country wherever possible*)
9. Accompanied by funding for spares and maintenance if this cannot be provided by the recipients
10. Within its expiry date if there is one

These rules apply to donations of technology, drugs and other items

Donated learning materials need to be appropriate, wanted by and accessible to the majority of the recipients. They need to be in the language that is most easily understood, up-to-date and if they require technology, they should be usable and compatible with the local technology available.

### Some examples of systems for getting easier access to low-cost learning materials and evidence bases include:

- The WHO 'blue trunk' library system – this delivers WHO and other books to enable a health facility to set up their own basic library. It also provides training and information about how to run a lending library, but needs funding by sponsors.
- The UK BMA/BMJ information fund – this donates and sends educational materials (BMJ books, CD-ROMs and journals) to successful applicants. It accepts and funds applications from institutions not individuals. It also enables more than 100 of the world's poorest countries to have electronic access to the BMJ publishing group's 23 specialist based journals including its evidence-based compendium, 'Clinical Evidence' see [www.bmj.com](http://www.bmj.com)
- Book aid international. This is a UK non-governmental organisation that distributes the 'ABC of AIDS' and 'The International Manual of Child Health' to countries in Sub-Saharan Africa. [www.bookaid.org/resources/downloads/ar.pdf](http://www.bookaid.org/resources/downloads/ar.pdf)
- TALC (teaching aids at low cost) is a UK non-governmental organisation that provides low cost books and teaching equipment to health workers at all levels in disadvantaged countries. [www.e-talc.org](http://www.e-talc.org) or [info@e-talc.org](mailto:info@e-talc.org)
- FreeMedicalJournals.com – [www.freemedicaljournals.com](http://www.freemedicaljournals.com)
- Health Internet Access to Research Initiative. [www.healthinternetnetwork.org](http://www.healthinternetnetwork.org)

### Sharing expertise with other countries

Sharing experience, expertise and knowledge with colleagues in other countries can contribute to improving healthcare. However, it can also lead to further difficulties if certain factors are not

considered properly. It is important not to impose your own practice unless this is appropriate. It is better to first identify what is the realistic 'best possible' practice that is appropriate to the environment and local circumstances, and then to work with local health workers to achieve this by building on their existing skills.



*Locally made low cost drugs trolley from Pakistan*

**A visiting health worker also needs to:**

- Be wanted by local health workers
- Know what local health workers want and expect (best understood and agreed in advance by both parties who must share a purpose if the visit is to be successful).
- Be appropriately experienced and skilled. Seniority in one country is no guarantee that a health worker will be able to work appropriately, effectively and understand the constraints of the different environment. A relatively junior health worker is more likely to teach others about things that they are already familiar with, or be bullied in to teaching inappropriate skills and not the appropriate, but perhaps more basic skills that will benefit the majority of children. For example, in a health facility that provides basic monitoring and care for very ill children, it is more appropriate to focus on improving this before teaching how to intubate and provide assisted ventilation.
- Be capable of achieving the respect of local health workers
- Be versatile in their approaches and working methods
- Consider gender as this can be a factor that may affect a visiting health worker's ability to engage the local health workers
- Be able to communicate well at all levels. If the language of the local people is not spoken this can be a major handicap unless they are always accompanied by a very good interpreter.
- Be able to set realistic goals for themselves
- Be able to motivate others and teach by example
- Support learning and skill building by providing training and educational materials, especially if these are not or cannot be provided by the country
- Be able to show the reasons why what they do might be better than the existing local practice
- To act responsibly by ensuring that any teaching they do, or change they advocate, is appropriate to the environment and resources and can be sustained after they leave
- Be prepared to learn from the health workers they are visiting.

**Those responsible for their placement in the country need to:**

- Facilitate their visit by providing them with as much information as possible about the health facility and health workers they are visiting and the problems they face. An assessment prior to their visit, such as the CFH assessment, will provide them with all the information they need. It

will guide and prioritise the help they can give to their disadvantaged colleagues and will help them set realistic goals to achieve during their visit

- Support them and facilitate support from their family and friends. It is important that they are provided with the resources to keep in regular contact with their family and friends via telephone or electronic mail where possible, especially if they are on their own in a country that is unfamiliar.
- Provide a named mentor or supporter who should contact them regularly to discuss problems, monitor their well-being and their activities, and provide any support needed.
- Ensure that they are protected as much as possible from local serious illnesses

### **Shared good ideas, good practice and solutions to problems**

This does not mean importing inappropriate solutions that may work in completely different environments and circumstances. These may, and often do, make the situation worse.

Experience reveals that showing photographs and telling stories are useful and popular tools for sharing ideas and practices from other countries with paediatric health workers. For example after seeing the wall paintings in children's wards in other countries, health workers in one hospital arranged for a local artist to do the same in their wards.



*A CFHI coordinator and interpreter in a ward play area. The same children's area one year later*

### **Sponsorship**

Sponsoring or finding a sponsor for an individual health worker to improve their knowledge and skills in a more advantaged country is another way of helping to make it better, but only if the health worker returns to their own country after the learning experience to put this into practice. Often after a period of sponsorship, a health worker fails to return, or is unable to use their new knowledge and skills as these are not useful in their own country. Countries that host and train health workers from other countries have a duty to teach the skills that are needed rather than those only relevant to their own health service. They must encourage health workers to return to their country of origin.



*A diabetic centre in Moldova funded and maintained by a sponsor from another country. The centre sees all children with diabetes, providing them with advice, counselling and free supplies of insulin, needles, syringes and blood glucose monitoring stick.*



*Play in a children's ward in Uganda sponsored by a hospital play department and a private children's nursery from another country.*

Expertise, resources, advocacy and shared learning opportunities can all be provided within a 'twinning' arrangement with a similar health facility, department, clinical area, service or individual in another country. In both advantaged and disadvantaged countries, the sharing of experiences with colleagues can be both supportive and effective in improving practice.

### **Advocacy**

An important way for others to help is to advocate for health workers, children and families living in disadvantaged countries. Advocacy by a visiting health worker may be successful, especially if this health worker is respected. (See Section 5 for more information on issues for global advocacy)

### **References**

Feeney P. *Accountable Aid, Local Participation in Major Projects*. Oxford: Oxfam; 1998.

Rifkin S, Pridmore P. *Partners in Planning - Information, Participation and Empowerment*. Oxford: MacMillan Education Ltd; 2001

Fuerstein M. *Partners in Evaluation - Evaluating development and community programmes with participants*. Oxford: MacMillan Education Ltd; 1986

Vas Dias S The complexity of Change: Developing Child and Family Centred Care in a Russian Children's Hospital. *Clinical Child Psychology and Psychiatry*. 1997. London: SAGE; 2 (3):343-352