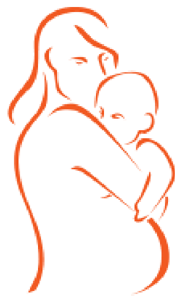
The Maternal and Child Friendly Healthcare Initiative (MCFHI)

A manual for health workers



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Advanced Life Support Group

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Preface

This is an assessment and implementation manual about 'Maternal and Child Focused Healthcare' (MCFH) written for health workers who plan, organise, provide or care for women, babies, children and their families. The manual defines MCFH by translating the articles of the United Nations Convention on the Rights of the Child (UNCRC) and a proposed new Clinical Convention on the Rights of pregnant women and girls into 'Standards' that are applicable to everyday healthcare practices. It provides a method for assessing these and a structure for making any improvements so women, babies, children and their families everywhere can receive the 'best possible' healthcare, regardless of circumstances.

The Maternal and Child Healthcare Initiative (MCFHI), a maternal and child health quality improvement programme was developed by Maternal and Childhealth Advocacy International (MCAI), Charity No: SCO 43467 and the Advanced Life Support Group (ALSG) Charity No: 4580873.

How to use this book

This book is intended to help any health planner or health worker assess the level of healthcare received by women and girls who are pregnant, babies, children and their families and make improvements working towards the 'best possible' care.

The manual can be read as a whole, but is divided into 4 sections to assist in gaining quicker understanding of specific topics.

- **Section 1** explains why a Maternal and Child Friendly Healthcare Initiative (MCFHI) is needed, discusses the principles involved and its relationship with the United Nations Convention on the Rights of the Child (UNCRC) and a proposed clinical human rights convention for pregnant women and girls and their newborn babies. **'Maternal and Child Focused Healthcare'** (MCFH) is defined.

- **Section 2** describes and discusses each of the 12 MCFH Standards and their supporting criteria.

- **Sections 3 and 4** explain how to find out if your facility provides Maternal and Child Focused Healthcare and how to use results from an assessment to 'make it better' by planning, making and acknowledging improvements. They also explain how others can help you. The concepts, ideas and processes in these chapters are not new, but condensed in this manual.

- **The Appendix on the website www.mcai.org.uk** contains **'**The MCFHI Toolkit'. The tools cover the assessment of all the aspects of healthcare for pregnant women, girls, babies, children and their families. Tool 1 is designed to help identify, prioritise and select MCFHI Standards for improvement; Tool 2 provides a more detailed assessment of the chosen aspect of care including identification of the level of care currently provided and, if not suggests the 'best possible' improvements by planning and implementation of realistic, and sustainable development.

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Acknowledgements

The original version of a parallel document on the Child Friendly Healthcare Initiative (CFHI) that led to this manual was written by Sue Nicholson and Andrew Clark and edited by Sue Burr, Oliver Ross, Alice Leahy and

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THE MATERNAL AND CHILD FRIENDLY HEALTHCARE INITIATIVE

GLOSSARY OF TERMS

ADVOCACY in this context means speaking on behalf of pregnant women and girls, their babies and children and/or their families who are either unable or unwilling to speak about their needs, situations, or people who make them feel unsafe or abuse their rights. It is acting as a 'voice' for someone who has no 'voice' or is unable to use it.

ASSESSMENT /SELF-ASSESSMENT is the process of measuring the quality of an activity, service or organisation. It is a method of:

- Identifying evidence to validate judgements
- Finding a base-line so improvement can be measured
- Arriving at an objective view of current performance
- Highlighting areas that show where performance is satisfactory or good
- Highlighting areas that require further improvements
- Identifying ways to achieve continual improvement

ATTITUDES are complex mental processes that motivate behaviour and are thought to influence the way we process information.

A CARE PATHWAY *(patient pathway)* is the exact story of a mother or child's healthcare from the time of arrival at a health facility to the time of discharge or death.

A **CARE PLAN** is a written document that is developed with the woman or girl who is pregnant, parent/carer of a child, and if old enough the child. It details the needs of the patient and roles and responsibilities of everyone involved in health care and when this requires reviewing.

A **CARER** is a person nominated by a parent/s or the state to provide care for a child or adult in place of a parent/s.

A **CHILD** is a person up to their 18th birthday/the age of 18 years (UN)
An **older child** is a child around the age of seven and older. Common sense is needed in interpreting 'an older child' as children will vary in their maturity and ability to understand and answer questions.
A **young child** is usually less than seven years of age, although sometimes a younger child will be able to answer questions designed for the parents and older children
An **adolescent** is a person in the 10 – 19 years age group *(WHO)*
A **vulnerable child** is a child whose right to survival, development, protection or participation is not being met or is compromised

COLLABORATIVE means working together.

CONSULTATION is a discussion during which the opinions of everyone involved are sought before a decision is made.

CRITERIA provide the more detailed and practical information on how to achieve each MCFH standard. They can be described as structure, process or outcome criteria. They illustrate the standard and provide a way of measuring it. (Criteria *describe activities to be performed, whereas standards state the level at which they are to be performed. An essential criterion is one that must be met*)

- **Structure criteria** are the resources required in order to carry out the process stage of a standard eg policies, procedures, documents, personnel, training, equipment
- **Process criteria** are the actions undertaken by staff in order to achieve certain results. For examples, assessment techniques and procedures or patient education
- **Outcome criteria** are the desired effect of care in terms of patient responses, behaviour, clinical condition, level of knowledge, satisfaction with care.

DISABILITY is a lack or impairment of a particular capability or skill

ETHNICITY concerns nations or races; it is about the customs, dress, language and food of a particular racial group.

EMOTIONAL MATURITY is reached when a person acts and behaves responsibly, is able to contribute to the well-being of their community, and understands and is able to meet and support their own or their child's emotional needs.

FOOD SECURITY (GLOBAL) is a state of affairs where all people at all times have access to safe and nutritious food to maintain a healthy and active life, and where there is no risk of households losing physical and economic access to adequate food (The State of Food Insecurity in the World 2003 Monitoring progress towards the World Food Summit and Millennium Development Goals. Food and Agriculture Organisation of the United Nations ISBN 92-5-104986-6).

GLOBALISATION is the process of increasing economic, political and social inter-dependence and global integration that takes place as capital, traded goods, persons, concepts, images, ideas and values diffuse across state boundaries (*WHO definition*).

A HANDICAP is any condition that prevents or hinders the pursuit or achievement of desired goals.*(Sheridan M 1969).*

HEALTH is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. *(Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.* The Definition has not been amended since 1948.

HEALTHCARE is informed advice, assessment, monitoring, assistance or treatment given for health reasons. It includes preventive, investigative, curative, palliative and supportive care.
Appropriate healthcare is the 'best possible' healthcare given without compromising the care given to other mothers or children sharing the same health worker, health facility or health service.
Effective health care is healthcare that achieves its objectives.
Evidence-based healthcare is based on a process of using contemporaneous research findings to support the healthcare given.
A healthcare related policy is a written principle that must be followed by all health workers (a must do), for example an evacuation policy, a drug safety policy, a hand washing policy and others.
A system of care is a clear detailed method for dealing with a situation, event or problem.

A **HEALTHCARE ENVIRONMENT** is any situation where a patient is given informed advice, assessment, monitoring, assistance or treatment.

A **HEALTH FACILITY (HF)** is a place designated and funded for providing health care.

An '**In-patient' HF** is a hospital or other institution where users stay overnight for health reasons (that is are resident).

A HEALTHCARE PROVIDER is any organisation or individual that is in any way responsible for planning, organising and/or providing health care.

A HEALTHCARE ORGANISATION is any authority that is responsible for providing healthcare services.
Primary or community services are usually located near the mother or child's home and give basic health care to a mother or child living at home whose health problem is not serious enough to require admission to a health facility or an opinion from another more skilled health worker.
Secondary/referral level/specialist services are those provided and given by maternal and child health workers who see a child referred from primary care for a second opinion, or a specialist opinion, about their health problem. They are usually able to admit a mother or child for overnight healthcare and include all types of hospital care.

A HEALTH WORKER is any person employed to give any form of health care, or who is working as a volunteer.
A professional health worker is any person with a health or health related qualification who is employed to give any form of health care, or who is working as a volunteer.
A skilled health worker has experience and special training to equip them for the job they are doing. They may or may not have a professional qualification relating to healthcare.
A key health worker is an identified individual with special responsibility, for example for a woman/child/family or a project/program such as infection control.

HYGIENE is principles and practices relating to cleanliness.

An INDUCTION TRAINING/PROGRAM is a program of learning activities designed to introduce new health workers to a clinical area, type of health care or employment to function effectively in their new job.

An INFECTION is the state or condition in which the body, or part of it, is invaded by a pathogen that, under favourable conditions, multiplies and causes a health problem.
Infection control is a program of activities that investigate, prevent and control the spread of infections and the micro-organisms which cause them.
A healthcare acquired/related infection is an infection acquired while receiving any type of healthcare or related to receiving healthcare. A hospital acquired/related infection is an infection acquired while attending or resident in a health facility. **A** pathogen **is a bacteria, virus, fungus or parasite that can cause disease.**

The INTEGRATED MANAGEMENT of CHILDHOOD ILLNESS (IMCI) is a World Health Organisation Program for delivering healthcare to children. It has very clear management, treatment and referral pathways and an associated training program for the health workers who implement it. *(www.who.int/child-adolescent-health/integr.htm)*

MONITORING is the process of collecting information about performance. Monitoring may be intermittent or continuous.

OUTCOME is a measure of the effects, beneficial or adverse, which a person experiences as a result of care, treatments or services they have received.

PEER REVIEW is a review of a service by those with expertise and experience in that service, either as a provider, user or carer.

A POLICY is a set of instructions about how to do something that must be followed by all health workers, for example, a hand washing policy. It is usually written.

A PROGRAMME is a planned series of events for a purpose.

A PROTOCOL is a written recommendation, rule or standard to be followed in a situation *For example, a plan of action, an antibiotic protocol for a certain condition/s, assessment and treatment of shock.*

PSYCHO-MOTOR DEVELOPMENT is a combination of motor and psychological (mental, social, behavioural and emotional) development.

RISK ASSESSMENT and MANAGEMENT is a systematic approach to assessing and managing risk. Its aim is to reduce loss of life and financial loss and maximise health worker availability, health worker, maternal and child and carer safety and maintain buildings, equipment and reputation.

A SAFE MOTHERHOOD PROGRAMME includes healthcare during pregnancy, delivery and immediately after and advice given about sexual health, breastfeeding and family spacing.

SANITATION means the infrastructures and equipment for preserving public health and protecting people from harmful contamination; for example keeping the water supply and waste disposal safe and secure.

SKILL MIX is a term given to the mix of posts, grades or occupations in an organisation or combinations of activities or skills needed for a job (WHO).

SOCIAL WORK is the provision of advice and practical help for problems resulting from social circumstances. A social worker supports vulnerable people.

A STANDARD is an agreed level of performance, appropriate to the population addressed. It is observable, achievable, measurable and desirable.

Generic **STANDARDS** are standards that apply to most, if not all clinical services.

A SYSTEM is a clear detailed way of dealing with a healthcare situation, event or problem.

A TOOL assesses performance against a standard. Tools include interviews (open, semi-structured or structured), questionnaires, structured observations, checklists and benchmarking.

Section 1

Why a 'Maternal and Child Friendly Healthcare Initiative (MCFHI)?

An ill newborn baby in a public hospital in Afghanistan

Why is Maternal and Child Focused Healthcare important?

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

Despite the huge efforts of many health workers in a large number of health improvement programmes at local, national or international level, women and children are still:

- Dying, or becoming disabled, from the complications of pregnancy, treatable diseases and accidents
- Suffering unnecessary pain
- Experiencing unnecessary fear, anxiety and suffering during and after a health care experience, because their mental and emotional health needs are being overlooked.

Such healthcare contravenes the articles of the United Nations Convention on the Rights of the Child (UNCRC) and a new proposed Convention on the Rights of pregnant women and girls and their newborn infants. These bad practices continue in every country in the world. During a pilot project for this initiative based only on child healthcare (the Child Friendly Healthcare Initiative), over six hundred health workers, parents, carers and children in hospitals in eight countries were interviewed between May 1999 and December 2002. Even in the most disadvantaged health facilities, there were many examples of excellent care, but everywhere there was care described as very 'child unfriendly'.

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

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

Care of critically ill children in Africa. More than one child sharing an oxygen cylinder

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

The quality of healthcare varies enormously between countries, different healthcare environments in the same country and within different clinical areas in the same health facility. It is usually more dependent on the health workers responsible than on the other resources available. Many improvements can be made without an increase in existing resources by changing behaviours and attitudes, creating more opportunities for sharing knowledge and skills, better leadership and team working and understanding and practicing the articles of the UNCRC and proposed CRWG.

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

Every health worker in every country, from the Government Minister to the health worker that cleans the toilets, has an essential contribution to make to the provision of healthcare. Virtually all the world’s countries have ratified the UNCRC, so health workers have a responsibility to follow its philosophies during their daily work. The CFHI has developed simple ‘Child Friendly Healthcare’ Standards that

translate its articles into every day health practices. This new initiative (the MCFHI) recommends similar practices with respect to women and girls who are or may become pregnant.

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

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

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

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

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

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

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

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

The Convention is divided into three parts.

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

The articles that relate directly to children's health care are:
Article 2: Equal rights to care with no discrimination for any reason
Article 3: Whenever an adult makes any decision about a child or takes any action that affects the child this should be what is best for the child
Article 6: The right to live
Article 7: The right to a name and nationality, and to be cared for by parents
Article 9: The right to remain with parents, or in contact with parents, unless this is contrary to the child's 'best interests'
Article 12 and 13: The right to receive information and express views and ideas freely
Article 19: The right to be protected from any form of harm including violence, neglect, and all types of abuse
Article 23: The right of those with a disability (physical or mental) to lead a full and decent life within their community
Article 24: The right to the highest standard of health and medical care attainable (the best possible healthcare). In this article 'States' are advised to place special emphasis on the provision of primary and preventive health care, public health education, and the reduction of infant mortality, to encourage international cooperation in this regard and to strive to ensure that no child is deprived of access to effective health services
Article 27: The right to a standard of living adequate for physical, mental, spiritual, moral and social development'
Article 28: The right to education (school-type learning)
Article 30: The right of a child belonging to an ethnic, religious or linguistic minority to enjoy their culture practice their religion and use their language
Article 31: The right to rest and play
Article 38: The right to be protected from and during armed conflicts, and not to be recruited to take part in hostilities, especially before 15 years of age
Article 42: Is about the duty of the state to ensure that children's rights relating to health are made known

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

A summary of the proposed draft convention on the rights of pregnant women and girls and their newborn infants (published in Archives of Disease in Childhood 2012).

Mortality and major morbidity rates for pregnant women and girls and their newborn infants in poorly resourced countries remain extremely and unacceptably high. Their rights are incompletely covered in existing UN human rights conventions and often not implemented. This proposed convention combines a new human rights convention with evidence-based guidelines to create a **right to health based convention**. The proposed convention is easier to monitor and objectively and specifically evaluate, and also encourages national ownership and accountability. It is designed to be relevant to local situations and to be incorporated into clinical governance systems. It may be of particular value to those countries not on target to meet the Millennium Development Goals (MDGs). To provide more effective support, the proposed convention suggests "twinning" of whole or regions of countries that are on track to meet

the MDGs with those countries or regions that would benefit from assistance with respect to maternal and neonatal health. Finally, the convention draws attention to how some rich and powerful countries can damage mothers and babies, for example, through exploitation of government trained health workers and arms trading.

In 2005, more than 500,000 women died due to complications of pregnancy in the pre/peri/postnatal period. This totals approximately one death per minute. Seventy four percent of these deaths were preventable and 95% occurred in Africa and Asia. A pregnant woman/girl in Sub-Saharan Africa has a risk of dying from preventable and/or treatable conditions of 1/22. In well resourced nations this risk is 1/7,300. For every woman that dies as a result of childbirth, 30 more suffer injury, infections and disabilities, often leading to discrimination.

'Hundreds of pregnant women alive at sunset last night never saw the sunrise this morning. Some of them died in labour, some died of haemorrhage in a hospital lacking blood, some died in the painful convulsions of eclampsia, and some died on the table of an unskilled abortionist, trying to terminate an unwanted pregnancy'.
"Women are not dying because of a disease we cannot treat. They are dying because societies have yet to make the decision that their lives are worth saving". – Mamoud Fathalla, President of the International Federation of Gynecology and Obstetrics (FIGO), World Congress, Copenhagen 1997.

Mother and her newborn baby in a poorly resourced hospital in a war zone

The most striking reductions in maternal mortality rates have occurred in countries that have made it a matter of policy to ensure basic and comprehensive EmOC [Emergency Obstetric Care] is universally available'.

The proposed clinical human rights convention comprises 44 articles. Here are some of those relevant to the MCFHI:

1. Registration of all maternal and neonatal deaths (Articles 4 and 32)
2. Later/delayed marriage (Article 7) and the reduction of childhood pregnancies (Article 7).
3. Healthy Timing and Spacing of Pregnancy-education and counselling to minimise and optimise management of high risk pregnancies (Article 7).
4. Freely available confidential family planning services and advice regarding antenatal, peri-partum and postnatal plan (Articles 7 and 8).

5. Education to at least secondary level for all girls (Article 9) including teaching on sexual and reproductive health and life skills relating to pregnancy and newborn care (Articles 8, 9, 31 and 34).
6. Routinely available, high quality antenatal care with attention to HIV issues, nutrition, immunisation, advice on the avoidance of activities, including work-related which can be hazardous during pregnancy and when to seek advice from health workers (Articles 10 to 14).
7. Birth preparation by community health workers, community awareness of finances, birth registration, birth plans including management of any emergency that occurs (Article 15).
8. Skilled care during pregnancy and at delivery with accountable birth attendants taking responsibility for the mother and baby's care including recognition of emergencies, how to undertake basic resuscitation, and achieve rapid transfer to higher levels of care when appropriate (Articles 16, 17 and 26).
9. Delivery in health facilities where basic emergency obstetric care is available and transfer to other facilities when more advanced care is required (Articles 18, 19 and 20).
10. Constructive male engagement in issues relating to pregnancy and delivery (Articles 18, 31, 39)
11. Protection from abuse (Articles 21, 23, 42 and 43) and exploitation (Articles 32 and 40).
12. Termination of pregnancy (Article 22), including discouraging the practice of selecting female fetuses for abortion (Article 22).
13. Recognition and treatment of perinatal mental illness (Article 25).
14. Neonatal care, including resuscitation at birth, birth registration, nutrition and recognition and management of neonatal emergencies in the community and health facility (Articles 26, 27, 28 and 29).
15. Home visits after birth by community health workers to check mothers and screen babies. Early referral system for mothers and babies with evidence of serious illness (Articles 17 and 28).
16. In cases of maternal or neonatal deaths or stillbirths, a review (clinical audit) of the circumstances leading to the death, including identification of avoidable factors (Article 30).
17. Retention of nationally trained health workers in the public health system (Article 17).
18. Article 31 examines the dangers to the mother and unborn child of smoking during pregnancy and/or the taking of illicit drugs and alcohol
19. Article 42 addresses the need for the special protection of pregnant women, girls and babies during armed conflict.

The contents of the remaining articles of the convention are reflected in some form in existing UN treaties and address the following issues:

a) In the pregnant woman and girl, the importance of health education, disability and pregnancy, social security, social care and support including adequate nutrition, clothing and housing, the care of refugees who are pregnant, support for those who are in prison and the prevention of occupational (including sexual) exploitation.

b) In the newborn infant issues concerning birth registration, social care, fostering and adoption.

What is different about the MCFHI from other programmes?

- It has a global mandate since it derives its principles from the articles of the UNCRC and proposed draft convention for pregnant women and girls and their newborn infants.
- It is not prescriptive or dictatorial (imposed by a higher authority) but belongs to all health workers
- The suggested practical approaches of the assessment and improvement programme are relevant and applicable to health workers and health planners at all levels, in any healthcare environment and in any country, as they have been developed with the help of health workers and families in many different countries and health care environments.
- It can be used for self-assessment or can be supported by invited external assessors

- Its assessment process seeks the ideas and possible solutions to problems from the health workers, women, children and their parents/carers thereby giving them a voice in helping to develop their own services and healthcare systems
- It enables and empowers local health workers to solve their own problems and find a way forward, however small, to improve the care they give to women, children and their families
- Any health care improvements made as a result of the program reflect what health workers want, what women, children and families want and what is feasible
- It raises levels of awareness by promoting what is possible and sharing good ideas
- It is a vehicle for other local, country and international programmes, especially those seeking standards. It aims to promote all other validated programmes.
- It can be adapted to suit local circumstance
- It is low-cost or cost-neutral

What is the programme's guiding principles?

1. Maternal and Child Healthcare at its best possible level of practice

2. All activities based on the rights of the pregnant woman, pregnant girl and child linked with the responsibilities and duties of health workers in partnership with parents/carers, other significant family members and friends to meet these rights within the healthcare context.

3. Planned improvements arising from the programme compatible with a country's own plans for health and acceptable to the countries' health care providers at organisational level.

4. To be a positive, encouraging and motivating experience for women, children, families and health workers.

5. To seek the views and opinions of women, children and their families in the assessment process and reflect these in the prioritising, planning, and implementing of improvements.

6. The views and opinions of all involved health care workers *(managers, health professionals, other types of health worker such as ward cleaners, porters, security staff, engineers etc)* to be sought in developing and implementing the programme and to be reflected in the prioritising, planning, and implementing of improvements.

7. Barriers preventing the best possible MCFH identified by the assessment process and recognition of changes needed to be implemented.

8. The focus for improvement on making the most appropriate use of existing resources and systems of care, facilitating changes of attitude and behaviour, and optimising the skills, approaches and knowledge of health workers.

9. Planned improvements in healthcare:
    - Facilitated by sharing of good ideas, examples of good practice, skills and knowledge within a healthcare environment and from other healthcare environments in the same country and other countries
    - Facilitated by empowering health workers to identify and prioritise their problems, find their own solutions and function better by raising their awareness to the possibilities
    - Enabled by promoting team problem solving

- Acceptable to religious, ethnic and cultural beliefs of the people involved providing these are compatible with the articles of the UNCRC and proposed CRWG.
- Appropriate, sustainable and where possible achievable within the available resources
- Implemented in prioritised stages
- Support for improvements to be provided by any existing national and international humanitarian aid and other possible in-country support.

10. Advocacy to seek more resources or additional support (new humanitarian aid projects), when without such input the healthcare available is significantly compromised.

11. Regular review and evaluation of all activities

12. Incorporation into the existing "Strengthening Emergency Healthcare" programme of MCAI including involvement of the Ministry of Health (MOH) of each country at the earliest possible stage and also including the MOH as partners as well as our existing SEC partners, the Advanced Life Support Group and WHO in the country. Ideally, local offices of UNICEF and UNFPA in each country would also be partners in the initiative. Please see: http://www.reproductive-health-journal.com/content/7/1/21

The history of the MCFHI program

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

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

In 1996 a small delegation presented a proposal for a child friendly healthcare initiative based on such 'Standards' to UNICEF New York, who supported the idea. In 1999 a grant was received from the Community Fund UK by Child Advocacy International (CAI) to undertake a pilot project for the child friendly version of the Initiative in hospitals in the UK (also funded by a small grant from UNICEF UK) and in hospitals in four poorly resourced countries. CAI, now MCAI, is a non-governmental organisation and now the lead agency for the MCFHI

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

The number of sites that contributed to the pilot project was limited by the time and resources available. Its remit was to research and develop the "child friendly" Standards and their supporting criteria, to promote and support child friendly healthcare practices, and with the help of the health workers and families in the chosen hospitals to develop processes to assess and improve 'Child Friendly Healthcare'. The Initiative was guided by an 'Advisory Committee'. The tools and methods developed have been designed to help health workers make progress with 'Child Friendly Healthcare' themselves without the need for an officially supported program.

The initiative has been developed in a number of countries since the completion of the Community Fund Grant but now has been extended to include the pregnancy related right to health by MCAI which has taken over from CAI as it has become more involved in maternal health.

Who will 'own' MCFHI?

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

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

What is 'Maternal and Child Focused Healthcare'?

The best possible' integrated health care provided by health workers who minimise suffering of women, children and their families by supporting and practising the Maternal and Child Focused Healthcare 'Standards'.

Another very special baby is born in Liberia by Caesarean section

Healthcare that:

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

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

- a child of any age and a woman or girl of reproductive age
- a woman or child of any developmental level
- any type of health care problem
- health workers in any country
- all types of health worker

Childbirth: a joyful occasion or one of grief?

'To be pregnant in Africa is to be haunted by the ghost of death - either before childbirth, during labour or soon after birth' Malawi

'My mother died at childbirth when I was 12 years old. Medicine women massaged her stomach and spat gnawed leaves over her body. After two days of suffering she died' West Africa

'To be pregnant in Africa is as dangerous as swimming in a river full of crocodiles' Tanzania

'The root cause of maternal deaths is abject poverty and the brain drain that affects most African countries' Zambia

Typical labour ward in a public sector hospital of a poorly resourced African country. The bed is basic and there is very little medical equipment or essential drugs available. There is no local blood transfusion service, no operating theatre and no oxygen.

Tell me and I forget; show me and I remember; let me do and I understand.

Who else can promote 'Maternal and Child Focused Healthcare'?

Any committed health worker who is familiar with its practices and principles can promote MCFH by sharing information about the MCFHI and the UNCRC and proposed convention on the rights of pregnant women and girls and their newborn infants with others in the same healthcare environment, in other healthcare environments in the same country and with health workers in other countries. 'Maternal and Child Focused Healthcare' belongs to every health worker that looks after women, children and families whether they are involved in planning, organising, providing or giving care.

We are not sure that words can always save lives but we know that silence can certainly kill.
MSF Nobel Peace Prize 1999

What is the 'best possible' healthcare?

Emergency obstetric care given in a rural hospital in a very poorly resourced African country

The practice of MCFHI Standards at their best possible level

- Considers the woman and child's 'best interests'
- Covers preventive, investigative, curative and palliative health care considering the most up-to-date evidence for each care given
- Is affordable and effective
- Is appropriate, allowing for resources (human and material) and technology available, to meet all women's and children's needs
- Is women and child centred (see below)

What are a woman and child's 'best interests'?

For healthcare to be in a woman or child's 'best interests', any action or decision taken on behalf of a woman or child must:
- accommodate the circumstances of the situation
- prioritise the woman or child's needs and safety
- consult the woman or child (whenever possible) and relevant others

- balance this with the wishes and needs of the parents and carers wherever possible
- incorporate “common sense”
- look at present and future needs
- be reviewed regularly and revised if circumstances change (be flexible)

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A skill station in newborn resuscitation where a Gambian midwife who has undergone both a

Section 2
The 'Standards' and their supporting criteria

'Maternal and Child Focused Healthcare' aims for the best possible healthcare provided by health workers who minimise the fear, anxiety and suffering of women, babies, children and their families. It strengthens healthcare systems by supporting and practicing the following 12 standards with the support and in partnership with the Government:

STANDARD 1: Monitors and promotes the health of women, babies and children; preventing women and children from developing serious infections and injuries, when possible, preventing the complications of pregnancy by good antenatal and postnatal care and the implementation of Healthy Timing and Spacing of Pregnancies (HTSP).

STANDARD 2: Provides the 'best possible' healthcare within the resources available within well staffed healthcare facilities in which appropriate drugs, medical suplies and equipment are always present.

STANDARD 3: Recognises the need for emergency care and gives appropriate resuscitation, emergency and continuing treatment without delay for pregnant women and girls, newborn infants and children who are severely ill.

STANDARD 4: Provides healthcare focused on the needs of each individual woman or girl, infant and child.

STANDARD 5: Provides healthcare safely in a safe, secure, clean 'woman, infant and child focused' environment.

STANDARD 6: Shares information and keeps every adult and child, and parents/carers when appropriate, fully informed and involved in all healthcare decisions, ensuring that each individual (or parent/carer) is free to give fully informed consent to healthcare procedures.

STANDARD 7: Recognises and relieves pain and discomfort and when needed provides high quality palliative care.

STANDARD 8: Provides each woman or child of reproductive age with appropriate advice on reproductive health.

STANDARD 9: Recognises, protects and supports vulnerable and/or abused women, girls, infants and children

STANDARD 10: Supports the best possible nutrition for women, infants and children

STANDARD 11: Recognises mental illnesses in women and children and provides appropriate support and treatment:

STANDARD 12: Recognises the value of adequately trained and supported health workers and acknowledges that without them maternal and child healthcare is not possible.

There are 4 'supporting criteria' common to all the MCFHI Standards, and although omitted from the beginning of each of the descriptions of the 12 standards below, in the interests of space, their importance cannot be overemphasised.

Each of these 4 topics are covered in detail in **Section 5**

- **Mission statements**.
- **Education and training**. Standards will not be met unless all healthcare workers have the motivation and the facilities to keep up to date with current practices. They must also receive training to work in line with improved standards.
- **Data collection and management**. These are key components of an effective, functioning health care system.
- **Clinical Audit.** Participation in audit is an essential process for all those involved in healthcare. It ensures that necessary changes are made to meet with accepted standards, and that all aspects of healthcare are kept under review

STANDARD 1: Monitors and promotes the health of women, babies and children; preventing women and children from developing serious infections and injuries, when possible, preventing the complications of pregnancy by good antenatal and postnatal care and the implementation of Healthy Timing and Spacing of Pregnancies (HTSP).

'Health care providers, organizations and individual health care workers, share a responsibility to promote the health of women, babies and children, protect women and children from serious illness and injury, prevent serious infections and other illnesses and reduce the complications of pregnancy and to promote HTSP"

Supporting criteria

1. **Antenatal care.** All pregnant women or girls should receive free of charge antenatal care with standards defined by the World Health Organisation (WHO). This antenatal care should include, where appropriate for that country, prenatal nutrition, immunisation against tetanus, measures to prevent and treat malaria, and regular assessments during pregnancy with respect to the health of both the pregnant woman or girl and the fetus-unborn child. In particular, all pregnant women and girls should be screened and subsequently treated for anaemia and should receive free of charge iron and folic acid supplements throughout the pregnancy.

2. **HIV prevention and treatment.**

Pregnant women face increased vulnerability to HIV infection. This is due to the physiological immunosuppressant effects of pregnancy, as well as reduced use of condoms as contraception is not required. Consequently, efforts to prevent transmission of HIV must focus on the disease in the context of pregnancy.

Every pregnant girl or woman should have access to confidential counselling and testing with regard to possible HIV infection.

If HIV infection is identified, every pregnant woman or girl must be offered free of charge appropriate anti-retroviral drug treatment and such treatment must include measures taken around the time of childbirth to avoid HIV transmission to the newborn infant.

Health workers undertake to provide up to date and appropriate advice and support to HIV positive mothers on whether, and how, in their individual situation, they should breastfeed their infant (see Standard 10)

3. **Nutrition during pregnancy.** A system for monitoring, and education about, nutrition should be available to women, including the importance of folic acid in the diet before pregnancy begins.

4. **Blood transfusion.** Community sensitisation and mobilisation concerning the importance of donating blood for transfusion should be emphasised.

5. **Medical conditions.** All pregnant women and girls should be given appropriate treatment for any medical conditions they had prior to, or developed during, pregnancy such as diabetes, epilepsy, asthma or heart conditions.

6. **Immunisation**. To prevent severe infections in women and children, immunisation should be appropriate to the country's Extended Immunisation Programme. A system for immunising women

and children, including scheduled and catch-up immunisations should be coordinated by lead health workers. Immunisation against tetanus is essential. The system must include the safe storage and transport of vaccines and standardised guidelines for the administration of vaccines and management of adverse effects. Particularly relevant for girls is immunisation against the Human Papilloma Virus (HPV) which is a cause of cervical cancer.

7. **Dangers of drugs and smoking in pregnancy**. The deleterious effects of smoking, ingesting certain drugs (pharmacological or herbal) or alcohol on the development of the unborn child should be communicated to everyone through community education, particularly to women or girls who are or may become pregnant.

8. **Monitoring during childbirth.** During labour and childbirth, each facility should ensure monitoring of the well-being of both the pregnant woman or girl and the fetus-unborn child. The sophistication of this monitoring will depend on the resources available in each particular country but, as a minimum, this monitoring should include the partograph of the World Health Organisation (WHO) and include the correct monitoring of fetal heart rate during labour.

9. **Monitoring after childbirth.** Women and girls and their newborn babies should be monitored closely during the 48 hours after the birth, when the largest proportion of maternal and neonatal mortality occurs.

10. **Healthy Timing and Spacing of Pregnancies (HTSP).** Ensure that any woman or girl who has been pregnant or may become pregnant in the future, is provided with comprehensive education in sexual and reproductive health, including confidential family planning advice, including a range of safe, free of charge or affordable and readily available measures that can allow her, if she wishes, to control when she might become pregnant in the future.

Communities should understand the increasing complication rate and dangers to mothers and their newborn infants when pregnant as a child, the younger the child, the higher the incidence of complications Similarly, being pregnant at 35 years or more is associated with progressively more frequent complications the older the woman is.

Educate communities in understanding complications and dangers to both pregnant women or girls and their newborn infants of entering pregnancy too close to a preceding pregnancy, whether this has resulted in the birth of a child or a miscarriage or abortion. Ideally there should be a delay of at least 24 months after a live birth and 6 months after a miscarriage or abortion.

Women and girls and their families must be informed of options to help them ensure that pregnancies occur at the healthiest times of their lives.

Educate communities on fertility awareness methods, that is, methods not dependent upon supply of contraceptive commodities.

Ensure that any woman who has completed her family is provided with access to sterilisation free of charge, if that is how she wishes to prevent further pregnancies.

11. **Attention to those living in the worst poverty.** Systems/policies should be in place to identify and support women, children and their families whose health is vulnerable because of severe poverty.

12. **Injury prevention.** Systems to prevent injuries in the home and in the community, especially the prevention of road accidents and assault, should be developed.

13. **Growth and development monitoring.** There should be health monitoring (including growth and development monitoring) in the community for all children, especially those who are under 5 years of age, to detect a childhood development problem or serious childhood illness.

Monitoring a child's physical (motor and sensory) and psychomotor (mental, emotional, behavioural and social) development is ideally part of any existing country programme. It should include standard protocols for referring children with suspected problems to specialist referral services for investigation and treatment.

14. **Minimising time in hospital.** A mother or child should be admitted to hospital only when needed and remain in hospital for the shortest possible time needed to provide appropriate treatment unavailable in the community.

15. Registration of all births and deaths. This process is essential as part of the management of healthcare services

A rural office in The Gambia for registering births

Supporting information

Admitting mothers and children to hospital only when essential and for the shortest possible time period

A day care unit in Pakistan for children with respiratory illness. Children are observed through the day and sent home at night if well enough

Best practice is to recognise and treat mothers and children with illnesses, disabilities and other physical or mental health problems in the community as soon as possible to avoid a hospital visit or admission. Children should only be admitted to institutions if appropriate health care cannot be given at home. **Care at home is always preferable.** When care at home is not appropriate, fear, anxiety and suffering can be minimised by making the hospital experience as comfortable as possible, including keeping mothers with children in the hospital when possible.

Community preventive health education to help families recognise illnesses, health screening, monitoring of children's growth and development and the close monitoring of pregnant women (safe motherhood programs) can limit the number of mothers and children needing hospital care. This type of high quality health care should be provided by appropriate, effective and affordable comprehensive primary health care services that are accessible to all families, regardless of their financial status.

In advantaged countries, where accessible, integrated health services do exist, patients may be admitted to, and remain in, hospital unnecessarily. Some of these admissions can be prevented by:

- Effective triage
- Rapid same day access to a referral level (specialist) opinion if needed
- Appropriate emergency management
- Good communication between health workers to limit unnecessary delays in treatment and discharge
- Specialist care supervised by referral level/specialist health workers given at home when possible
- 'Referral/specialist level' day care facilities for assessment, investigation and treatment so children can sleep at home if they live nearby

Mothers and children with complex or chronic illnesses (for example mental health problems, asthma, diabetes, disability and others) can be successfully managed at home if there are specialist referral services with out-reach care providing the necessary support for them and their families. Care in the home is only feasible when these resources are available and home conditions are satisfactory.

Standard admission procedures, daily review and discharge policies, and verbal and written discharge plans can reduce the length of time a mother or child remains an in-patient. Best practice is to develop these in collaboration with primary care and/or other relevant community professionals. To be effective they need to include a diagnosis or reason for the patient's admission, a prognosis and clear instructions concerning any actions, treatment or follow-up necessary that will have implications for carers and health care staff in the community**.** There are advantages to writing this information into patient-held health records

Arrangements for follow-up by the hospital, if this is necessary, and/or prescribing and dispensing drugs for taking home need to be made well before the patient is due to leave so that unnecessary delays are minimised. Delay in dispensing drugs or a long wait to be discharged for any reason is unacceptable.

Best practice is for the length of stay in an in-patient health facility depends on research evidence, local knowledge and evidence based treatment regimes. Patients should not be kept in hospital for unethical treatments such as painful intra-muscular injections (when oral drugs would work equally well), treatments that can be given at home, or for convenience of health workers.

In all countries, but particularly in poorly resourced countries, babies and children are sometimes abandoned in health facilities, especially if their mother is not kept in hospital with them. These children often receive inadequate nutrition with minimal stimulation (developmental and play opportunities) and no one-to-one care. An attachment to a single carer is essential for a child's long-term mental health and development so discharge rapidly to foster families rather than institutions is best practice.

Advocacy by health workers for early fostering and/or adoption for abandoned children and/or those in need of protection and care is important.

Finally good data management, regular audit leading to evaluated change, and joint education/training opportunities for all health workers (community health services and the referral level services) will

contribute to meeting this component of Standard 1 keeping patients with their families at home as much as possible.

Tele-medicine technology that enables doctors working many miles away to see x-rays and give advice to the nurses providing the service locally

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Injury Prevention:

Unintentional injuries are among the top three causes of death in children and the leading cause in 10-19 year olds. They are responsible for many thousands of child deaths throughout the world each year, as well as serious disability. Road accidents are the commonest cause with drowning, burns and accidental poisoning also causing many fatalities. Poverty is linked to an increased incidence of accidental injury and death in all countries, but low- income countries are the worst affected, and children are most vulnerable.

There are effective measures to reduce the number of accidents and severity of injury, such as enforcing speed limits, reducing alcohol consumption, using cycling helmets, covering wells, and building safe bridges and roads.

Child injury prevention strategies, several of which are simple and low cost, have the potential to save lives. They should be the responsibility of many sectors in government and in communities, but are currently under funded and given low priority. Physical and sexual assault are common forms of childhood injury in many countries

Growth and development monitoring:

It has been estimated that many millions of children in low- income countries fail to reach their developmental potential by the age of 5. These children then go on to perform poorly in education and continue to be disadvantaged throughout their adult lives. There are many causes of this, among them poor health and nutrition, iron deficiency and under stimulation in the home – all are linked to poverty and most are remediable.

Awareness of the importance of monitoring children's growth and development has been lacking in many developing countries, but where programmes to provide stimulation and attention to the

growth of young children have been implemented, the results have shown lasting improvement in the children's cognitive skills.

There is evidence that child development programmes which are integrated with other family support, health and nutrition services are the most effective. Thus it is the responsibility of health workers to raise awareness of this, and to consider growth and development in children they see in any health facility.

References

The HTSP Toolkit, which includes a range of counseling, education and advocacy tools for policymakers, providers and program managers, as well as a DVD to support quality HTSP counseling, is available at: http://iframe.k4health.org/toolkits/HTSP Accessed 16/07/11

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Discussion of approaches to meet the family planning needs of postpartum women, a highly vulnerable group with a very high unmet need for family planning in most countries, is available at:http://pdf.usaid.gov/pdf_docs/PNADP671.pdf Accessed 16/07/11

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Antenatal care

Postnatal care

STANDARD 2: Provides the 'best possible' healthcare within the resources available within well staffed healthcare facilities in which appropriate drugs, medical supplies and equipment are always present.

'Health care providers, organisations and individual health workers, share a responsibility to advocate for the 'best possible' healthcare' to be provided for pregnant women, girls, infants and children in health facilities of all levels'.

Supporting criteria

1. **Integration of community and facility based care.** Primary (community) and secondary (hospital) health workers and health facilities for pregnant women and girls, infants and children provide services that:
    - closely integrate and share policies (such as the Integrated Management of Neonatal and Childhood Illness)
    - use jointly agreed referral pathways, including appropriately functioning ambulances and community out-reach services
    - use jointly agreed upon referral criteria and management protocols
    - include excellent telephonic communications between facilities
    - are accessible without potentially dangerous delays
    - are free or easily affordable – should not be refused if women or children cannot pay
    - include the views of women, children and families and health workers when these services are planned
    - are based on a system ensuring the most in need are targeted; for example, those living in rural deprived areas
2. **A transparent (open) management system for every health facility.**
    This system should:
    - manage all the important services which support healthcare in the facility including human resources, security, budgets, maintenance, water and sanitation, safety, catering and food supply, electricity, temperature control, laundry, pest control, and ensure the logistic control of and on-time ordering of supplies and drugs so that they are always available
    - ensure that important healthcare tasks (such as infection control, sterilisation, breast feeding, resuscitation, emergency care, child protection, audit, lifelong learning) are undertaken by lead health workers who have responsibility for the policies and supported by pathways of care and appropriate training
    - appoint and dismiss health workers, validate qualifications, assess suitability for employment, have a health worker identification system, enable safe staffing levels, identify and address intimidation (bullying) and have systems for disciplining health workers
3. **Sufficient numbers of well trained staff.** Sufficient numbers of appropriately trained health workers of all levels (ward cleaners, traditional birth attendants, nurses, midwives and doctors) in the disciplines required for a functioning health facility (see Standard 12). This requires that the country provides sufficient training and that newly trained health workers remain in the public health service for a defined period of time.
4. **An occupational health service.** This should screen health workers for health problems, provide advice about the prevention of work related medical, psychological and emotional problems and support individual health workers when these occur. Ideally the hepatitis B, HIV and rubella status of doctors, midwives and other staff performing surgery should be checked.
5. **Laboratory, X-Ray and pharmacy support services** These should be appropriate for the level of care given.

6. **Clinical structures, medical supplies and devices and essential drugs.** Essential resources relevant to the level of care needed and the type of health care environment, include:

- Health facilities suitable for the level of care needed
- Appropriate, effective, safe and sustainable medical devices (essential list of equipment compatible with WHO recommendations) **www.PET.org.za**
- A free or affordable, safe, secure supply of essential drugs and medical/surgical disposables with standardised policies for their use (essential lists compatible with WHO recommendations)
- A blood transfusion service appropriate to the needs of patients attending the facility as well as laboratory support needed to screen donors for life-threatening infections such as hepatitis B and C, HIV infection, malaria and syphilis, group and cross match blood and store it safely in every facility (see Standard 3)
- A continuous and sufficient supply of **oxygen** from a combination of cylinders and concentrators
- An operating theatre that is equipped and staffed for emergency obstetric surgery in all hospital facilities where high risk deliveries occur

Ultrasound, oxygen concentrators and pulse oximeters are three of the most important pieces of equipment in hospitals in poorly resourced countries. They all have few things that can go wrong, need minimal supplies (hard copies are unnecessary) and, apart from a constant supply of electricity, are inexpensive to run. Hopefully with current efforts to supply solar energy even this will be less of a problem**.**

7. **A logistic management service.** Maintenance of a constant supply of the essential items in **6**. above which are replaced before they run out.
8. **Evidence based care.** Evidence-based systems of care, policies, clinical guidelines and other pathways of care that are known and used by all the health workers working in the same healthcare environment.
9. **A system of continuous professional development.** Lifelong (during and after training) learning (education/training) opportunities (self, internal and external) and access to published research and other healthcare literature.
10. **Medical records system.** Management of written information (data) that includes the use and organisation of health records, coding systems for health problems and the collection and examination of reliable data for important key indicators about women and children's health.
11. **Clinical audit.** Multidisciplinary clinical audit meetings linked to evaluated change/s for all health workers to include discussions about patients who have died or could have died.
12. **Ethical advice.** Access to ethical advice on clinical care and research issues for all health workers.
13. **Facilities for effective Emergency Obstetric Care (EmOC).** Every pregnant woman or girl must be provided with a facility in which safe childbirth can occur and where any complications of birth can be managed. This includes the availability of emergency obstetric surgical treatment, including Caesarean section when appropriate
14. **Infection control.** Each health facility should observe high standards of cleanliness and safety (see Standard 5)
15. **Emergency care practised adequately by health workers of all levels.** Each facility should be staffed by trained healthcare professionals who can safely manage emergencies that might affect the pregnant woman or girl, the newborn infant or the child. (see Standard **3**)
16. **Skilled birth attendants**. Every pregnant woman or girl should be provided with a skilled birth attendant during and immediately after the birth. If this is not possible because of lack of trained staff in a country or area of a country, those attending the birth should have skills and equipment to identify emergencies or potential emergencies that demand skilled care and be able to summon emergency assistance to stabilise and transfer the woman or girl to a well equipped and safe maternity facility with minimal delay (see Standard 3).

17. **Essential drugs for pregnancy and childbirth.** During pregnancy and childbirth, essential emergency drugs (as defined within WHO publications) must be available at all times for all facilities treating women or girls who are pregnant. These include the following: additional inspired oxygen, antibiotics, anti-hypertensives, anti-convulsants, uterotonics, and opiate analgesics. These drugs must always be available when and where needed (see Standard 3 for emergency drugs) and appropriate staff trained in their use and control.

18. **Care after female genital mutilation.** In countries where female genital mutilation is carried out, health workers must understand the complications that these procedures may cause during childbirth and be trained to minimise these. Health workers should advocate for the total cessation of female genital mutilation in their country. (see Standard 9).

19. **Caesarean section.** Bearing in mind the risks to the mother and sometimes the fetus and newborn infant of a Caesarean section, such procedures should be undertaken only when medically indicated and not for the convenience or remuneration of the doctor undertaking the operation or the mother's convenience.

    Adequate information and education should be provided for women and girls (and their partners) about the risks of unnecessary Caesarean section, including an increased risk of infection, increased risk of subsequent abnormal position and attachment of the placenta leading to the risk of haemorrhage and the potential for rupture of the uterus during future pregnancies. Mothers should also be informed of the longer recovery time, postnatal restrictions in movement and increased risk of deep vein thrombosis and life-threatening pulmonary embolus.

20. **Newborn resuscitation**.

Every newborn infant should be provided immediately after birth with an attendant skilled in recognising any emergency, who can initiate immediate, appropriate care and is able to initiate transfer of the newborn, if required, to an appropriate healthcare facility. Since any newborn baby can require assistance at birth to establish breathing, a person skilled in providing assisted breathing should be available at all births, whether at home or in a health facility. Ideally this person will be a trained qualified health worker. However, volunteers in the community such as traditional birth attendants, lady health workers and village health workers should all be trained and provided with adequate basic equipment to undertake such resuscitation - a self inflating bag and mask system. (see Standard 3).

21. **Routine care of the newborn infant** This should include drying of the baby, early breast-feeding and routine vitamin K treatment.

22. **Materials and expertise for the management of neonatal illnesses**

Drugs to help mature the lungs of the fetus-unborn child are available (corticosteroids) and should be given to any pregnant woman or girl in preterm labour (after 34 weeks gestation) to help protect the newborn infant from lung disease of prematurity.

Health facilities providing care for newborn infants must ensure that these are equipped to a level appropriate to the resources available in that country. Such facilities should have the highest standards of cleanliness to reduce the risks of infection and should be staffed by well-trained health professionals, who can safely any illnesses that might affect the newborn infant.

All facilities caring for newborn infants must be able to provide effective gastric feeding of expressed breast milk, intravenous fluids/glucose, oxygen, antibiotics and, appropriate to the level of their resources, assistance in breathing.

All facilities for treating newborn infants must have essential drugs identified by the World Health Organisation available needed for their care, including oxygen

In order best to prevent and treat hypothermia, health workers caring for the newborn infant should show mothers how to prevent hypothermia using "kangaroo care", and be trained in the safe use of the health facility's incubators.

A traditional birth attendant who has been delivering babies in her village for more than 20 years. She is a volunteer and is greatly respected. However, she needed and readily accepted training in the recognition of emergencies and when to refer patients to the hospital. She was also able to practice emergency first aid measures such as resuscitation of the newborn and massage of the uterus in cases of post-partum haemorrhage after training.

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Supporting information

'To give the best possible care to mothers, babies, children and families, health workers need to integrate the highest quality scientific evidence with clinical expertise and the opinions of the family' (Moyer VA. Elliot EJ. Preface in 'Evidence Based Paediatrics and Child Health).

Millennium Development Goals (MDGs) 4 and 5
Health care in a mother, child and family's 'best interests' has to be balanced with what is possible, and with the needs of other patients sharing the same health worker, health facility or service.

Millennium Development Goals (MDGs) 4 and 5 seek to improve maternal and child health by 2015. MDG 4 aims to achieve a $^{2}/_{3}$ reduction in child mortality as shown by the under 5 year mortality rate. Other indicators relate to infant mortality and immunisation rates. MDG 5 aims for a ¾ reduction in maternal mortality from pregnancy related causes. An additional indicator is an increase in the number of births attended by skilled health personnel. The prevention of stillbirths is not mentioned in the MDGs but should not be forgotten.

However, it is now apparent that human resources were not considered when the MDGs were formulated, and that the huge worldwide shortage of healthcare staff disproportionately disadvantages the poorest families in low-income countries.

If the desired reduction in maternal mortality is to be achieved, then a huge investment needs to be made in the global healthcare workforce (see Standard 12), especially in sub-Saharan Africa, which currently has , only 10% of the doctors, nurses and midwives per capita compared with Europe . It is estimated that a tripling of staff numbers is required in these countries, adding one million whole time equivalents through improved recruitment, retention and training.

Africa has 25% of the global burden of disease, but only 1.3% of the global healthcare workforce. Moreover, the total number of healthcare professionals in Africa has decreased since 2000, and is set to continue to decrease until the MDG target year of 2015. Increases in population further decrease the number of healthcare workers per capita in poorly resourced countries.

Evidence is accumulating that the use of task shifting to 'non-physician clinicians' in low-income countries can potentially provide a solution to the lack of healthcare professionals, especially in maternal healthcare, where immediate surgery is often required if the mother is to survive a complication of pregnancy. One development is the training of midwives in surgical skills including Caesarean section, a project being set up in the Gambia by MCAI.

Maternal and child healthcare in camps for displaced persons or refugees

The provision of healthcare in these situations is particularly difficult. It is estimated that 20% of women of childbearing age are likely to be pregnant.

Conflicts and natural disasters place pregnant women and girls, their babies and children at risk because of loss of medical support, compounded by trauma, malnutrition, disease and violence.

It is the responsibility of health organisations to ensure these services, structures, resources and activities are in place. It is the responsibility of health workers who give the care in partnership with the mother, child and family to access, use and participate in these. If this is not possible because they either do not exist, or are of low quality, health workers have a responsibility to advocate for these and to continually try to 'make it better'. Advocacy is an individual and collective responsibility inspired by strong, but open and accountable leadership.

There is evidence to show that support services and generic clinical tasks (such as immunisation, breast feeding advice, infection control, acute labour ward care, child protection and others) are usually of higher quality when delegated, providing the nominated health workers are also given the authority to coordinate the task and develop, monitor and maintain its practice. When developing their services best practice for these coordinators is to:

- Follow any existing evidence-based recommendations made by WHO and other International and National Organisations
- Acquire and regularly update their skills and knowledge
- Consider the evidence-base for their actions and policies

Lifelong learning opportunities and access to the evidence that supports 'best possible' healthcare are essential for health workers if they are to maintain their skills and knowledge. Best practice is therefore for all professional health workers to have access to a library containing medical and nursing books and journals, the Internet, and also to professional continuing life-long education/training. However it is important to remember that access to evidence and other learning opportunities does not guarantee change from poor practice to good practice.

Policies, standardised systems of care, clinical guidelines and job aids all contribute to supporting the best possible healthcare. However to be used successfully they need to be 'owned' and their value recognised.

Danger signs in pregnancy from Bangladesh

Job aids in Pakistan showing pathways of care to be followed in emergencies

Reliable data management is needed to support all aspects of health care planning and provision, audit and advocacy. This starts with the clinical record, includes recording of high quality information, the effective organisation and management of records, the reliable coding of disease and retrieval of this information to produce reliable statistics for the key maternal and childhood indicators of health. All health workers have a vital part to play.

Effective manual data management in Moldova reflected by this well organised low-cost storage system

The final criterion for providing the 'best possible' health care is to have access to reliable independent advice on ethical issues associated with clinical practice and research.

However difficult, best practice is to allow time (without compromising patient care) for these important supporting activities during working hours. All these activities are described in more detail in later sections of this book, especially in Section five which explains one way to do these.

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Poorly covered examination couch

Completely unsuitable bed for immediate post-natal use by a mother

Unsuitable labour ward bed; the only one available

Training staff in the use of a pulse oximeter as part of a project to assess the need for oxygen to be available in ambulances

Empyema drained in a child with failure to thrive due to tuberculosis in a public sector hospital

What hope for this child with acute appendicitis in a country at war?

Typical ward in a state sector hospital of a country that spends less than 1% GDP on health and needs to have nuclear weapons to keep pace with an arms race promoted by rich and powerful countries.

Scenario based teaching on how to resuscitate a mother suffering massive post partum haemorrhage

Baby recovering from pneumonia

STANDARD 3: Recognise the need for emergency care and give appropriate resuscitation, emergency and continuing treatment without delay for pregnant women and girls, newborn infants and children who are severely ill.

'Healthcare providers, organisations and individual health care workers, share a responsibility to ensure appropriate resuscitation and emergency care '.

Supporting criteria

1. Training of community health workers and families to recognise emergencies

Health workers in the community, such as traditional birth attendants, lady health workers and village health workers, must be trained to recognise as early as possible emergency clinical signs in women, babies or children that require urgent treatment if they are not to progress to cardio-respiratory arrest and then almost certain death, and then to provide first aid before transfer to an appropriate health facility. Families should also be educated in the recognition and first aid treatment of emergencies

- A significant proportion of newly born infants do not breathe at birth and require skilled assistance. Any delay in resuscitation can lead to death or permanent brain damage and therefore all attendants at births must be able to resuscitate the newborn. . Such attendants must all be provided with the necessary training and basic equipment to undertake this, whether it is in the home or health facility.(see Standard 2)

- Healthcare workers in the community should be educated to recognise life-threatening emergencies occurring in pregnant women and girls especially sepsis, eclampsia and severe pre-eclampsia, massive haemorrhage and obstructed labour.

- Healthcare workers in the community should be educated in recognition of life-threatening emergencies occurring in infants in the first weeks and months of life (in particular hypothermia, breathing difficulties, infections and fits), and in children. There should be reliable emergency transport to ensure that these patients are transferred to a facility where treatment is available. The Integrated Management of Neonatal and Childhood Illnesses (IMNCI) programme of WHO and UNICEF provides a good framework for the introduction of this system of care.

Following training undertaken by African instructors who have undergone a 2 day course in medical education, this traditional birth attendant now knows how to give life-saving breaths to a newborn baby who does not breathe at birth.

Mobile telephone communication systems for training village health workers in how to refer patients without delay to the nearest appropriate health facility.

Teaching midwives the management of emergencies in labour: here shoulder dystocia

2. Emergency ambulance system There must be a suitable system for alerting an emergency ambulance service, ideally with a health worker trained in resuscitation and emergency care, to transfer the patient without delay to an appropriate hospital facility.

Systems for **transferring** very ill patients should have:

- Written policies for transfer to hospital from the community or from a less equipped health facility, internal transfer within a hospital and for transfer from one hospital to another
- 'Standardised' clinical guidelines for managing common emergencies
- Thorough handover of clinical information
- Skilled health workers to accompany the patient during transfer
- Safe, reliable ambulances or other appropriate vehicles
- Monitoring and other equipment for use during transfer. This must include oxygen, suction equipment and suitable bag/valve/masks to assist any patient with inadequate breathing
- Simple method of keeping infants warm during transport (eg Kangaroo Mother Care (KMC) or thermal blankets)

Motorcycle ambulance

System for transferring mothers suffering complications of birth to hospital. TBAs equipped with mobile telephones and emergency ambulance with skilled birth attendant available 24 hours a day.

3. Emergency care in health facilities. On arrival at the hospital there must be immediate provision of appropriate resuscitation/emergency treatment and continuing care for very ill pregnant

women and girls, infants and children, coordinated by lead health workers and given by safe numbers of skilled health workers throughout the 24 hour period. There should be regular and effective monitoring of patients at risk of deteriorating, with appropriate interventions.

In every healthcare facility and, depending on whether it is a primary clinic, a secondary or tertiary hospital, there must be:

- Essential monitoring and emergency equipment such as bag/valve/ mask ventilators and suitable manual and electric suction equipment, medical supplies and emergency drugs.
- Pathways of care for treating emergencies such as shock, severe asthma, post-partum haemorrhage and major trauma
- Staff trained in the " Structured Approach" to emergencies as contained for example within the EMNCH (Emergency Maternal and Neonatal Healthcare) programme of the Advanced Life Support Group and MCAI (see www.mcai.org.uk)
- Standardised and universal clinical guidelines for managing common emergencies
- Oxygen available at all times and in sufficient amounts with equipment to administer it safely
- **Essential*** age-appropriate resuscitation and emergency care equipment (clean, regularly checked and accessible)
- A secure supply of essential emergency drugs and guidelines for their use
- A safe, effective blood transfusion service

***Essential** means that all the equipment and drugs that are on the country's essential equipment and drug lists, if available.

The first blood transfusion given in 2008 in a hospital covering 250,000 patients

4. Triage A system for triage (seeing the sickest patients first) should be established 24 hours a day which includes:

- A policy for placing patients into categories of severity
- A system for getting appropriate assistance:

5. High dependency/intensive care. An appropriately staffed, designated area to provide appropriate emergency and continuing care to a very ill woman, infant or child should be available, ideally providing:

- Clear management protocols
- A policy of continuous monitoring of vital parameters (for example, depending on resources, heart rate, blood pressure, respiratory rate, urine output, oxygen saturation, blood glucose levels and temperature)
- Appropriate monitoring equipment
- Monitoring charts for recording vital parameters
- Oxygen available at all times and in sufficient amounts with equipment to administer it safely (oxygen concentrators very useful)
- Appropriate resuscitation and emergency treatment equipment (clean, regularly checked and accessible)
- A secure supply of essential drugs and standardised guidelines for their use
- Waiting area/s for families
- A separate culturally appropriate private area for the families of women or children who have died

6. Family support. Support for families when relatives are suffering life threatening illness or injury.

7. Critical incident monitoring and clinical audit meetings

Where adverse outcomes occur, analysis of critical incidents is important, and should be part of any maternal and child healthcare programme. The focus should be on organisational features rather than on performance of individual healthcare workers. A formal protocol facilitates a systematic, comprehensive and efficient investigation, and enables strategies for improving patient care to be devised.

Regular (perhaps monthly) clinical audit meetings on the wards involving deaths or "near misses" are an invaluable way of improving the healthcare given (see Section 5 for how to arrange these meetings).

Many critically ill children with pneumonia sharing the only available oxygen

Danger signs relating to emergencies during pregnancy

Baby in a health facility in locally made cot

Supporting information

Labour ward in a health facility. No resuscitation equipment for the newborn infant

The early onset of appropriate resuscitation and emergency healthcare in neonates, both at and after birth, and for very ill or injured children and pregnant women or girls is essential as delays not only cause harm that may result in death or handicap, but may also make early treatment less effective and more prolonged. Immediate triage to detect emergency and priority signs on arrival at a health facility (in a hospital with trained staff available for the whole twenty-four hours), is essential. Children or mothers with emergency signs need to be treated immediately and those with priority signs urgently, before registration, to minimise unnecessary deaths and disabilities.

As a patient's condition can change rapidly, close monitoring by skilled health care workers is essential to detect the early warning signs of deterioration in very ill or injured mothers and children, also those undergoing surgery and those who have been given systemic analgesia and/or sedation

Emergency Obstetric Care (EmOC)
UNFPA places emphasis on making emergency obstetric care accessible to all women.

The five main causes of maternal mortality, namely haemorrhage, sepsis, hypertensive disorders, obstructed labour and the complications of abortion/miscarriage must be able to be managed at a well-staffed, well-equipped health facility.

Where rapid access to a facility is impossible for reasons of geography and/or transport, the provision of emergency staffed ambulances (see above) or 'waiting homes', where women can spend some days or weeks before delivery close to health facility may be invaluable.

1. Basic emergency obstetric care – includes facilities able to:-

- Treat sepsis, eclampsia and administer antibiotics, utero-tonic drugs and anticonvulsants.
- Treat prolonged or obstructed labour
- Provide care following abortions
- Treat incomplete miscarriage
- Undertake manual removal of placenta
- Undertake assisted vaginal delivery (ventouse or forceps).

2. Comprehensive emergency obstetric care

- Typically available at district hospitals.
- Includes all basic functions above, plus emergency surgery including Caesarean section and blood transfusion.
- Such a facility should have at least two skilled attendants 24 hours per day, seven days per week, assisted by trained support staff.

The facility must have a functional operating theatre, and be able to administer safe blood transfusion and anaesthesia.

Guidelines issued jointly by WHO, UNICEF and UNFPA in 1997, and revised in 2007, recommended that for every 500,000 people, there should be four facilities offering basic emergency obstetric care, and one offering comprehensive obstetric care.

The 'Three Delays' model is useful in identifying when potentially fatal delays can occur in the management of obstetric complications.
1. Delay in deciding to seek care.
2. Delay in reaching appropriate care.
3. Delay in receiving care at the health facility.

For safe motherhood programmes to succeed, the three delays must all be prevented. In practice, it is crucial to address the third delay first, as it would be fruitless to facilitate access to a health facility if it were not staffed and equipped to provide a good standard of care.

Postpartum care is often underemphasised in maternal health programmes, but it is crucial to maternal and neonatal survival and wellbeing. It is estimated that 50% of all maternal deaths take place in the 48 hours following delivery. Postpartum care by a trained attendant is also an ideal opportunity to assess the wellbeing of the newborn, and to discuss breastfeeding and nutrition.

Triage in a Ugandan hospital

Monitoring in a high dependency/intensive care unit in Pakistan

The emergency care system needs to be integrated within the health service of every country and is dependent on a well-managed collaborative network of health care services, effective health education for parents and families, effective training for all health workers, efficient transport services and the necessary human and material resources.

To ensure that health workers give the best possible emergency and critical care, best practice is to develop and use guidelines and other pathways of care that act as reminders for life support and recognition and initial management of common, severe illnesses. Guidelines and pathways of care need to be accessible, evidence-based and used by everyone. Community, outpatient, and inpatient staff should all be trained together in emergency care to develop an understanding of each others' roles and to foster a team approach. Working together is vitally important to ensure the provision of the best possible care for the very sick pregnant woman, infant and child in order to reduce mortality and morbidity.

Pathways of care for providing life support: see www.mcai.org.uk for what is written on the charts

Emergency equipment laid out for immediate access in the emergency department of a hospital in a poor country

v cost but safe and easy to use ubator in a public hospital in meroon

ntegrated Management of Neonatal and Childhood Illness (IMNCI), essential antenatal, and peri-partum care, essential care of the newborn, basic life support (neonates and children), neonatal and paediatric life support and advanced paediatric life support and the new Emergency Maternal, Neonatal and Child Healthcare (EMNCH) program.

To provide the best care, good practice includes regular meetings to review the systems used to ensure they achieve their objectives. All those involved in providing triage, resuscitation, emergency and critical care need to attend these audit meetings. Specific issues for audit must include the circumstances leading to deaths and near misses.

Access to clinical ethics advice is sometimes helpful when discussing appropriate care for individuals.

Kangaroo Mother Care. This is an ideal way of nursing babies to keep them warm, especially in poorly resourced countries. This technique is particularly valuable for keeping reasonably well preterm infants warm.

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Labour ward requiring renovation and cleaning

Labour ward bed with tears in the mattress (no analgesia given during labour) creating an infection risk as well as being uncomfortable

STANDARD 4: Provides healthcare focused on the needs of each individual adult, infant and child.

'Health care providers, organisations and individual health workers, share a responsibility to ensure equity of health care, treating patients as individuals without discrimination, giving them culturally and developmentally appropriate rights to privacy, dignity, respect and confidentiality'.

Supporting criteria

1. **Equal access.** Policies and systems of care that ensure equal access to and opportunities for, preventive, investigative, curative and palliative health care that meet the needs of every adult, infant or child

2. **No discrimination.** Policies and systems of healthcare that ensure there is no discrimination in the provision of health concerning age, sex, race, ethnicity, legitimacy, disability or any other reason

3. **Individuality of care.** Policies and systems of care to ensure individuality (that include birth registration and use of the date of birth, a clinical record number, use of preferred name and language, provision of personal space, knowledge of personal preferences, use of own possessions and clothes).

Healthcare given by skilled, caring and named health workers in partnership with family members

The importance of treating pregnant women or girls during childbirth as individuals and with respect and dignity should be emphasised (see Standard 9).

During childbirth, pregnant women or girls should be supported in adopting whatever positions they find best to give birth and to be mobile during labour if appropriate.

Health care for children should be given in areas separate from adult patients. These areas will have facilities and resources that are suitable for children of different developmental ages, their carers, breast feeding mothers and visitors.

4. **Respect and dignity.** Policies and systems of care that ensure respect and preservation of dignity with avoidance of degrading, unnecessary procedures and treatments.

5. Policies and systems of care that ensure cultural and developmentally appropriate visual and sound privacy (especially when dressing, washing, toileting), when undergoing treatment and when dying; also provision of security for possessions.

6. **Confidentiality**. Policies and systems of care that ensure written and verbal confidentiality.

7. **Parents in children's care**. Excluding parents from health facilities can add to anxiety in both child and carer. In contrast, involving carers has been shown to reduce stress, improve compliance and reduce time spent in hospital. *A child should not be separated from their parents, unless this is in their 'best interests' Article 9 of the UNCRC.*

8. **Support**. Supportive care (general and psychosocial) for women, children and families. Fathers should be encouraged, if they wish, to be with and support their partners during childbirth.

9. **Care for patients with disabilities.** Special provisions to promote dignity, self-reliance and facilitate treatment in the mentally or physically disabled woman or girl who is pregnant, infant or child should be available.

10. **Decisions on resuscitation orders.** A system for "do not resuscitate" orders should be established. Such orders must be properly organised with full consent of the patient and/or appropriate family members.

11. **Decisions on resuscitation of the newborn infant.** Health facilities responsible for providing care for newborn infants should establish guidelines regarding how appropriate it is to institute invasive life-saving treatments where there is extreme prematurity or the presence of major congenital abnormalities, which may not be compatible with survival.

12. **Play facilities for the child who is in hospital** Ensure that for children who are undergoing healthcare, there are facilities for play that include the following:

- For all children who are well enough - encouraging and helping children to play when they are awake, 'especially at the bedside' when a child is too ill or unable to get to an area set aside for play.
- Ideally a play service with a trained play worker/s, or a lead health worker with the skills to set up and supervise play. Supervised lay play workers are very effective
- A separate**,** safe and clean place to play in each clinical area, providing there is space available, that can be used by all children who are well enough
- Providing safe and culturally appropriate play materials. Alternatively, or in addition, encouraging parents to bring and use the child's own toys
- Secure storage for play materials
- Provision of advice to all children and families about safe and appropriate play materials (including toys) for use at home
- The promotion and use of strategies involving play for**:**
  - Recreation and stimulation of development
  - Helping children to cope with their health problem (therapeutic play), for example play to distract, for procedure preparation, for stress relief, for expression
  - Helping to manage pain and other distressing symptoms.

13. Education for the child who is in hospital

- Continuing 'school type' education (learning) for each school age child who is in a hospital for more than a few days and is well enough
- Supporting and encouraging learning for children in other healthcare environments
- Establish communication between the child's school class and the child in hospital

Resources for education in a hospital or other residential health institution (such as those for children with physical and mental health and other learning disabilities) that include**:**

- A lead health worker with teaching skills, or a specially supported teacher who comes into the health facility, to support learning and liaise with a child's parents/carers and local school
- A separate place to learn that is safe and clean in the clinical area where continuing school type education can be given
- Actively encouraging children and parents to bring their own education materials or providing education materials

The provision of relevant information to schools about every individual child with a disability or health problem that may affect their education

Supporting information

Despite ratification of 6 existing UN treaties, inequity and discrimination continue to occur in most countries regardless of resources. An adult or child's right to survival should not be dependant on their sex, age, legitimacy, whether or not they have a disability, their family's wealth, race, religion, ethnic

origin or any other factor. Health workers are ideally placed to set an example to others by developing systems and policies to ensure there is no discrimination.

Equity of health care for mothers and children is dependent on many things - how far the family live from a health facility, whether there are health workers to provide care near a patient's home, whether there is transport to a health facility and/or whether there is a health facility within easy reach, all influence equity. However the two most important influencing factors in many of the world's countries are a family's wealth and their knowledge about health.

In many countries there are often good private health services but inadequately resourced public health services that are inaccessible to many families. Even if a mother or child from a poor family does access the services, inequity remains if the family does not have the money for investigations, necessary drugs and treatments or experience a lower level of nursing and medical care than others.

In well-resourced countries there can be differing qualities of care given in different geographical areas and by different services in the same health facility. Children who are admitted to separate children's hospitals or to children's wards generally get better care and opportunities than children cared for on adult wards; for example they have better access to play facilities and specialist nursing skills. Some children looked after in a children's ward are also seen in adult facilities such as accident and emergency, x-ray and some surgical outpatient departments. These departments may not always meet the needs of children who use their services.

Country and global inequity also exists for investigation and treatments, particularly the availability and affordability of appropriate essential drugs and other clinical equipment. Advocacy for drug companies to make drugs more affordable in disadvantaged countries can help and needs to continue. Drug donations need regulation to ensure they are needed, appropriate for their purpose, of good quality and in-date. Drugs should not be tested without proper informed consent in any country and continued advocacy will be needed to ensure patient safety.

Equity is not only about giving the same care to each adult or child, but is also about giving care to meet the individual patient's health needs.

A mother or child has a right to be recognised and respected as a unique person with individual physical, emotional, social and spiritual needs. Health workers can respect a patient's individuality by ensuring that they:

- Approach a patient in an age and developmentally appropriate way
- Use the patient's preferred name
- Give every baby their own health registration number at birth and a written birth certificate
- Allow personal space and possessions such as clothes and toys for children
- Seek, listen to and acknowledge the patient's opinions and ideas
- Ensure that a patient feels he or she always matters.
- Include any special needs in a patient's daily care plan and make this plan in conjunction with the family if possible

A mother or child also has the right to maintain their dignity, privacy and confidentiality (all appropriate to age and culture). Frequently, these rights are not respected for children. In addition to having policies and systems of care, constant vigil is needed by health workers to ensure that they do not contribute to any unnecessary fear, anxiety or suffering by failing to respect these rights.

Screens used to give visual privacy for a treatment area. Screens do not protect sound privacy.

The inclusion of education/training about the articles of the UNCRC and other human rights topics in the core training curriculum of students, and as part of life-long learning will help all health workers understand and meet this Standard.

The importance of having parents with children when they are in hospital

A child should not be separated from their parents, unless this is in their 'best interests'
Article 9 of the UNCRC

Excluding parents can add significantly to the worry of both child and carer. In contrast, involving them has been shown to reduce many potential stress factors, improve coping mechanisms and compliance, and reduce time spent in hospital. It also reduces the work load of the staff

In some countries children are still separated from their parents and families when admitted to a hospital and in others, although mothers are allowed to stay with their children during the daytime, they are often unable to sleep near their child at night. In most, fathers have little if any access to their hospitalised baby or child, despite a lack of evidence to support the reasons given for their exclusion. It costs very little, or nothing, to allow families to have free access to their children in hospital and the benefits are far greater than any possible disadvantages. In countries where fathers have free access, concerns have not been realised.

If a young child with limited understanding is separated from a parent they feel abandoned. This feeling can cause intense suffering, similar to the suffering and grief felt by an adult when a loved person dies, and may have an impact on future mental health. To avoid this emotional damage, care given at home and by familiar carers is best whenever possible (Standard 1). When this is not possible and 'inpatient' care is in the 'best interests' of the child, emotional suffering can be minimized if a parent (or another carer familiar to the child chosen by the parents) is encouraged to remain with the child, especially during procedures. If a child is asleep, unconscious or anaesthetised it is even more important that a parent/carer is there when they wake. An ill child needs the reassurance of their family's love and care even more than they normally do. Best practice is also to enable other family members and close friends to visit frequently and freely, with restrictions only when this is in the child's best interests.

KMC provided to infants by either parent during hospital visits may improve weight gain, reduce the risk of hospital-acquired infections and reduce hospital stay.

Health workers need to always respect the parents' role as the main carers. This means helping parents/carers to care for their child as they would at home. This includes enabling the child to follow their familiar routines wherever possible.

Mother using her own mosquito net

Mother contributing to the special care of her premature baby

Creating a partnership of trust between health workers, patients and their families

Elements of partnership include:

- Openness and honesty
- Mutual respect and trust
- Freedom to express oneself
- Sensitivity
- Commitment to sharing
- Understanding
- Mutual support
- Empowerment
- Flexibility
- Sharing, including rights and responsibilities
- Mutual accountability
- Agreeing to sometimes disagree

- Being challenging
- Accepting of each other's reality
- Sharing a vision
- Listening to each other
- Not being manipulative

A kind welcoming attitude that shows respect for the individual mother, child and family costs nothing but can minimise anxiety and fear making healthcare and treatment easier.

Best practice is to centre healthcare for each individual mother, child and family round **their** needs not the health workers. Healthcare is best planned in partnership with the patient, if old enough, and with parents/carers.

Healthcare that meets a mother or child's needs is more likely when this care is given by health workers trained to look after the specific needs of pregnant mothers or children. For example a neonate will need a very different type of care to a child or a young person, as will children who have physical or learning disabilities. Unskilled, unqualified or newly appointed health workers, benefit from initial supervision by more experienced and/or skilled staff.

The anxiety of patients can be further reduced if a mother or child becomes familiar with their main health workers. This familiarity can be achieved by allocating the same health worker whenever possible so that the number of different health workers each patient sees is reduced (a patient allocation system). The use of this system can also help with the organisation of care and improve information sharing between health workers and families.

A simple reminder given to a patient about their nurse for the day

Note: in some countries it might be more appropriate to use Nurse and surname

Research shows that a welcoming, stimulating, pleasant environment contributes to faster recovery from illness**,** and faster catch up growth and development after illness.

Ideally children should be cared for in specialist areas or wards with different specialties going to the children rather than children going to adult areas for specialist services. Many in-patient facilities have separate areas for caring for children. It is best if this age separation is flexible and more concerned with developmental age than actual (chronological) age. If it is in the child's best interests to be cared for on an adult ward, it is important to ensure that the child is cared for in a special area of the ward and that they have access to the same stimulation, environment and care provided in children's wards.

To minimise fear, anxiety and suffering during investigations and treatments, best practice is for treatment areas, X-ray departments and other areas used by children to have 'Child Friendly' environments, and be staffed by health workers with 'Child Friendly' behaviours and attitudes. Stairs, long corridors, waiting areas and treatment rooms can all be especially frightening for children. These can be made 'Child

Friendly' at little cost by using local materials and resources thus reducing a child's fear, anxiety and distress.

'Child Friendly' stairs, UK hospital

'Child friendly' play corner in a waiting area, UK

'Child Friendly' treatment room, UK

Hospitals need to have suitable facilities for resident parents/carers including somewhere to sleep, preferably near the child (particularly if the child is breast fed or very young). For young children beds that provide enough room for both child and parent to sleep together can be beneficial. Best practice is to have a chair at the bedside for the parent/carer to sit on during the day, storage space for possessions, adequate washing and toileting areas, food and drink provision and a suitably furnished area for relaxation of the same standard as found in the average family home.

Mothers able to sleep opposite or next to their child/baby

It is also important to have private, suitably furnished areas for giving explanations and other sensitive information to parents/carers and for mothers to breastfeed, with facilities for expressing breast milk The support, care and understanding needed for bereaved parents/carers and families is best provided by their familiar health workers in an environment that is as pleasant as possible. Best practice is always to advise parents/carers about all the facilities, and to provide instructions about their use

Poverty is repeatedly shown to have a direct link with a mother or child's health, educational achievement and emotional development. When a poor family is unable to provide these independently, the State has a duty to intervene by providing financial and other support. Health workers are ideally placed through their intimate knowledge of a family to identify poverty and other adverse psychosocial circumstances, and to support a response to their individual problems. Best practice is to identify any special difficulties or problems for the family by asking about these early, ideally in the initial history taking. Any family with special difficulties need to be supported as much as possible, including referral to social welfare or similar services, if these exist.

To prevent additional anxiety, fear and suffering, it is particularly important to support the emotional needs of ill patients and their families.

Finally health workers also need support if they are to cope with the considerable stresses imposed by giving healthcare. Access to support systems enables health workers to avoid the 'burn-out' that may lead to incapacity and/or deprive the health service of their skills and experience *(See also Section 5).*

Unnecessary transport of mother with eclampsia from district hospital to tertiary hospital as no surgeon available

Child recovering from pneumonia and receiving additional inspired oxygen through nasal cannula. He is tied to the bed to prevent him pulling out the cannula but is this necessary?
The way forward is surely to have a relative (ideally the mother) sitting with him. After a short while the child usually becomes used to the cannula.

Malnourished children and their mothers learning how to play in a Ugandan Hospital.

A simple way of telling mothers they are welcomed and supported to see their babies, also a hand washing reminder

Postnatal ward: no mattresses on beds

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STANDARD 5: Giving healthcare safely in a safe, secure, clean 'adult, infant and child focused' environment

'Health care providers, organisations and individual health workers, share a responsibility to ensure that healthcare is given safely in a secure and clean 'adult, infant and child focused' environment'.

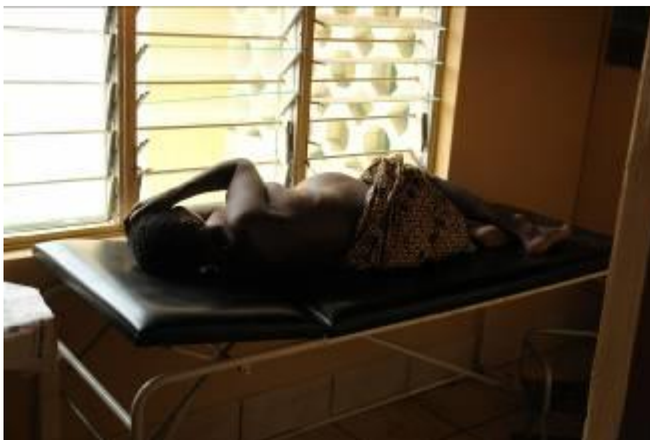
Supporting criteria

1. **Safety and security within the health facility.** Effective security and safety policies and systems to protect women, infants, children, carers, visitors and health workers from accidents or other dangers must be in place. Best practice is for all health workers to have regular training about these issues and an opportunity to audit compliance with policies to ensure these are achieved at the 'best possible' level with the resources available.

Security gate and guards at entrance to a hospital in The Gambia

Evidence-based clinical guidelines and other job aids should be followed by all health workers in the healthcare environment. These include hand hygiene, fire safety and evacuation, no smoking, the dangers of advertising, safe sharps disposal and management of needle stick injuries, lifting patients, food safety, laundry safety, safe waste disposal and radiation protection.

There should be a system that marks equipment to deter thieves or even a GPS sensor and monitoring system for particularly valuable items



A pregnant mother who has just recovered from eclampsia but who remains semi-conscious. There are no protective rails around the trolley to prevent her from falling off and damaging her and her unborn baby.

2. **Prevention of health facility acquired infection.** Policies and systems that are used by everyone to keep equipment and health care environments clean to minimize the risk of acquiring a healthcare related infection include:

- A good example set by senior health workers (studies have confirmed that they are the worst offenders) and a culture for hand washing. Easily accessible hand washing facilities must be available in all wards and nurseries
- A method for drying hands properly

- An alcohol based product to use for hand cleaning when it is not possible or practical to wash hands. Hands must always be cleaned before handling an infant
- Effective methods of handling and disposing of bodies, specimens, human waste, body fluids and other waste, including a method of separating different types of waste material.
- Clean clothes worn by health workers
- A 'no touch' policy that is followed by everyone. This means not touching anything or anyone unless essential (the hugging of children is an essential act that must be allowed but kissing other than by family members should be avoided) and only after hand washing.
- Hygienic food preparation, handling and storage (see The World Health Organisations' ten steps to hygienic food preparation) will reduce the possibility of a food-born illness. Poor and infrequent hand washing is strongly linked to food poisoning.
- Good laundry systems that ensure all bedding/curtains/towels/flannels are regularly washed with a detergent/disinfectant. Access to Industrial quality washing machines is preferable. Water temperatures of at least 60 degrees C and preferably above should be used to destroy micro-organisms on clothes and other materials. The uniforms of health workers need to be kept clean and used only in the same clinical area to prevent moving micro-organisms from one clinical area to another. If health workers visit more than one clinical area they should change uniforms or clothes between each area or wear disposable protective clothing over their own clothes when they move.
- The equipment, furniture, building and grounds of the hospital must be kept scrupulously clean.

Additional measures that can help to reduce infection include:

- Micro-organisms become more difficult to treat if they develop a resistance to antibiotics. This occurs if antibiotics are used indiscriminately. Best practice is for every health facility to develop and use an antibiotic policy to control and restrict the use of antibiotics. For this to be effective all prescribing health workers need to follow the policy.
- Limiting the number of people who look after each patient.
- Avoiding over-crowding. Adequate space between beds will also limit the risk of cross-infection

Unnecessary over-crowding of babies in a ward in Eastern Europe

- Having a system to ensure that equipment, surfaces and other objects are cleaned before use by another patient
- Having a lead health worker and, when resources permit, an infection control team to develop and supervise infection control practices following consultation.
- Having a wound management policy (including an umbilical cord management policy)
- Having healthy staff who do not have infectious diseases themselves.

3. **Effective water and sanitation systems.**

In every health care environment ensure enough safe drinking water for every adult, child, parents/carer and health worker.

Oral rehydration solutions, including ones appropriate for patients with co-existing malnutrition, should be provided free of charge.

A water supply that is:

- Secure (never runs out)
- Clean and safe to drink (and is regularly tested for dangerous micro-organisms)
- Enough for drinking and for cleaning
- Hot for washing and cleaning procedures (For safety ideally hot water should be stored at 65 degrees Centigrade distributed at 60 degrees C and then reduced to 43 degrees C to be used from the taps)
- Accessible in all areas where adults, infants and children receive healthcare

Toilets which are inspected regularly and kept clean.

Separate toilets for patients and staff.

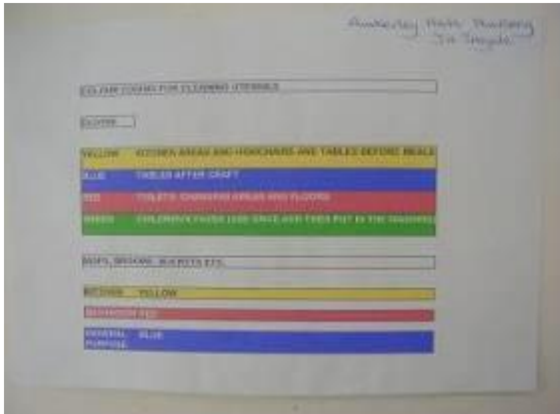
4. **Keeping the health facility clean.** Health workers who clean are best supervised by clinical health workers and given adequate status and pay that recognises the importance of the work they are doing. They need access to sufficient cleaning agents and materials, preferably colour coded, for different areas and special training about the health facility's policies and cleaning systems.

Effective, supervised cleaning policies and systems for cleaning the entrances, corridors, wards (floors, walls, window-sills, light fittings and curtains), toilets and washing facilities, kitchens and all other areas in a health facility will contribute to reducing risk of acquired infections and should cover:

- Cleaning methods used for all these different areas, also fittings, fixtures, furniture, bedding and other non-clinical equipment
- Cleaning frequency
- Cleaning materials and for what - colour coding of cleaning cloths/materials for use on different surfaces can be helpful.
- Use of cleaning agents, including disinfectants in appropriate dilutions for the task
- Effective management of spills of body fluid (blood, urine, vomit, faeces and saliva etc.)
- The cleaners or, if cleaners are not always available, others need to be trained and supervised by the senior health worker for the clinical area.
- Waste disposal systems and waste separation. Safe waste disposal systems and policies will prevent body fluids, faeces, drugs and disposables being a danger to others.

A budget for cleaning is essential.

Entrances of health facilities should have equipment for removing dirt from the visitors' shoes. Corridors need to be cleaned at least twice a day with a disinfectant and ward areas need to be kept scrupulously clean. Cleanliness of toilets and washing areas/bathrooms should be priority. Best practice is for these to be kept scrupulously clean throughout the twenty-four hours by frequent cleaning and disinfection.



A method for using different coloured cleaning cloths for different surfaces

5. **Fire prevention and fire management.** Systems in the health facility to ensure that fire risks are minimised and that fire-fighting equipment is immediately available in all areas where adults, infants or children are cared for. All fire extinguishers should be tested regularly and kept in-date.

6. **Electrical safety**. Systems to ensure that all electrical outputs are safe must be in place.

7. **Occupational health care for all staff.** Systems and policies to minimise work related physical, emotional and mental health problems in health workers.

Screening for hepatitis B and HIV infection of healthcare staff in clinical contact with patients (with appropriate counselling and support) is essential.

Immunisation for all staff against hepatitis B and special precautions for avoiding TB such as face masks when caring for patients with "open" TB infection.

8. **Protection from armed conflict.** In areas where there is armed conflict, protection for all health workers and health facilities from attack and intimidation. (http://www.ihpi.org)

Supporting information

Every health worker has a responsibility to give healthcare safely and to make sure that areas where they give care are secure, clean and concerned with providing the safest possible healthcare.

It is important to protect health workers, patients and families from dangers and to protect possessions from damage, loss or theft. Possible personal dangers for adults, children, parents/carers, visitors and/or health workers include:

- Physical harm, for example abduction or a deliberate injury
- Accidental injury from unsafe equipment, fittings, electrics, furniture, buildings
- Unwanted side-effects from any system of care or treatment programme
- A healthcare related infection
- A work related injury or illness such as HIV/AIDS, hepatitis, back injury or a stress related mental health problem.

Unsafe electrical connections on maternity unit

Unclean shower in post natal ward

Old autoclave with broken seals on a very busy labour ward: unsafe for sterilising instruments.

To prevent these dangers, best practice is for health workers and patients to identify possible problems and solutions. Health workers need to be able to report openly about any security or safety concerns, without fear of losing their job or harming their career prospects. Families need to be able to voice their concerns without fearing that an adult or child's healthcare may be adversely affected. Best practice is for all health facilities to have an effective system to assess, prioritise and investigate concerns.

To give healthcare safely, there need to be enough health workers to look after people needing healthcare throughout the twenty-four hour day All too often in many poorly resourced countries, health workers are present during "office hours" but very few during the late afternoons, evenings and nights. Patients are ill throughout the 24 hours, therefore staff need to be allocated in safe numbers for every time period. Best practice is always to have enough health workers on duty to ensure each patient's safety.

To help limit the number of clinical mistakes, best practice is for everyone to use the same policies and guidelines for giving healthcare and to use other job aids as reminders. To develop a sense of ownership

these need to be developed and introduced following wide consultation. It is also important for clinical guidelines and other job aids to be compatible with WHO and/or other evidence based international guidelines, and with any country and/or regional guidelines.

Examples include:

- Security, cleaning, waste disposal, hand washing and control of infection.
- Common investigations and clinical procedures, blood transfusion.
- lifting patients
- The use of drugs and disposables and quality control measures to minimise harm caused by inappropriate treatment.
- Safe and appropriate use of blood and blood products

A hand washing reminder, but the sink is unsafe as it has a taped crack

Responsibility for these and the management of risk can be delegated to named lead health worker/s who is/are given the authority to develop, monitor and change, as well as coordinate, related activities.

Safety and security for people and possessions will be helped by:

- The use of name badges by health workers and a method for identifying inpatients, such as wrist bands
- A security system and/or security staff at the entrances of health facilities
- Lockable storage facilities: but not for emergency equipment as this needs to be immediately available
- Having a system for patients, families and health workers to report and investigate accidents, drug administration errors and infections acquired during an in-patient stay
- Monitoring availability and condition of health facility property
- Accountability for, and secure storage of drugs and other disposables
- Giving an individual named health worker the responsibility for protecting equipment, books and other items
- Using a structured system to reduce or eliminate losses due to accident or misadventure (risk management). The aim of risk management is to improve the quality of care by identifying and

reducing risks that might result in damage to a patient, visitor or health worker, or result in a complaint and/or litigation

To minimise the dangers associated with a fire or other disaster, best practice is for all individual health workers to: know about evacuation, fire management and other emergency procedures, and to contribute to any disaster practice drills.

Other ways to reduce accidents and harm include:

- Keeping the utilities (electrical circuits and plumbing), buildings, fittings, medical and other equipment and furniture in good condition by good organisation and management, regular maintenance, risk-prioritised repairs and funding.
- Protecting patients, their carers and health workers from radiation by using safe X-ray machines, lead aprons, gonad protectors and guidelines for 'which clinical problems need an X-ray and which do not'

Gonad protectors of different sizes

- Safety gates on stairs and to help prevent children leaving a ward.

Safety gates on the third floor of a building

- Window safety catches or locks to prevent children falling from opened windows.
- Banning potentially harmful advertising from a health facility, for example of formula milks
- Not allowing smoking in areas where there are children, oxygen cylinders or flammable liquids/gases

A very dirty toilet; a common finding in public sector hospitals of poorly resourced countries

No smoking sign on a children's ward in Eastern Europe

Reducing healthcare acquired infections

Healthcare related infections cause unnecessary deaths and suffering in patients and their families and also incur large costs to a health service. They affect at least 10% of all hospitalised patients in well resourced countries and probably a higher percentage of patients in disadvantaged countries. These

infections may be acquired from patients sharing the same facilities and equipment, from the environment, especially the work surfaces or directly from health workers. Only a very small number are caused by visitors or by other patients.

The effectiveness of hand washing and the cleanliness of the washing facilities and toilets in a health care environment have been shown to reduce the healthcare acquired infection rate.

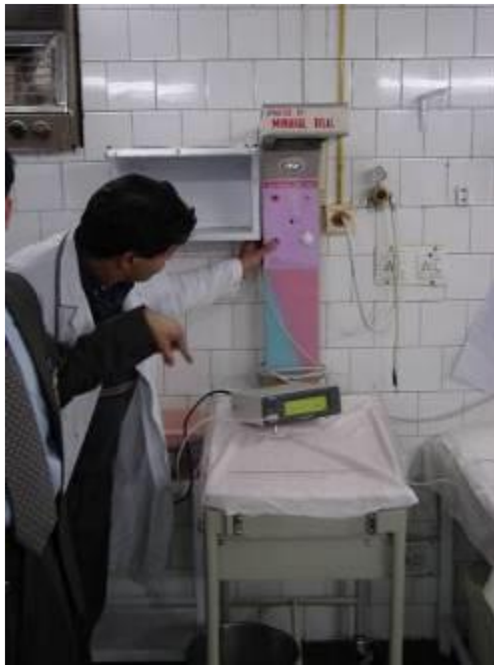
Most infections are caused by the micro-organisms that are always around in a healthcare environment. They contaminate the hands and uniforms of health workers and colonise the sinks and other equipment.

Why is cleaning so important?
At least half of healthcare related infections can be prevented if health workers keep their hands, their uniforms, the environment and the equipment scrupulously clean to reduce the number of organisms around. It is essential that each health worker examines their own practice, keeps up-to-date with infection control policies, especially hand-washing, and follows such policies themselves as well as ensuring that other health workers also comply.

Effective hand washing is the most important way a health worker can prevent a healthcare acquired infection

A bucket used to flush an adjacent nurse's toilet: there are no spare parts to repair the flush mechanism, which broke a year previously, no soap and no method of hand drying

Only forms of heating available in an public sector hospital in Afghanistan



Low cost neonatal resuscitaire Pakistan

What is needed to keep hands clean?

- Enough clean toilets with nearby sinks for hand washing and a facility for hand drying
- Enough clean sinks and showers that are easy to use
- Knowledge about the importance of hand washing
- Strict hand-washing policies.
- Hand washing reminders at all sinks (when and how)
- A secure and adequate supply of soap

Soap on a string: An effective way to prevent it from being stolen

The only facility for washing kitchen utensils and hands in a hospital kitchen in Eastern Europe.

An effective, clean, accessible resource for hand washing in a children's war. There is no excuse for not keeping your hands clean if you have this resource.

Low cost hand-washing system. The pieces of material in the larger clean bucket are taken to dry the hands. Then they are placed in the smaller blue bucket for washing. When there are no resources for buying paper towels, cut up material squares used once only, then laundered are just as effective

- A method for drying hands properly
- Effective methods for handling and disposing of bodies, specimens, human waste, body fluids and other waste, including a method for separating the different types of rubbish.
- A good example set by senior health workers (they are sometimes the worst offenders) and a culture for hand washing

A water supply that is:

1. Secure (never runs out)
2. Clean and safe to drink (and is regularly tested for dangerous micro-organisms)
3. Adequate in amount for drinking and for cleaning
4. Hot for washing and cleaning procedures (for safety and ideally hot water should be stored at 65 degrees C, distributed at 60 degrees C and then reduced to 43 degrees C to be used from the taps)
5. Accessible in all areas where patients are given healthcare

- An alcohol based product to use for hand cleaning when it is not possible or practical to wash hands with water
- Clean clothes always worn by health workers
- A 'no touch' policy that is followed by everyone. This means not touching anything or anyone unless essential (the affectionate hugging of patients is an essential act that must be allowed) and only after hand washing.

What else needs to be clean?

Food

Hygienic food preparation, handling and storage (see The World Health Organisations' ten steps to hygienic food preparation) will reduce the possibility of a food-born illness. Poor hand washing, frequency and technique, is strongly linked to food poisoning.

Unhygienic, unsafe parents/carers kitchen

Laundry

All bedding/curtains/towels/flannels must be regularly washed with a detergent/disinfectant. Access to industrial quality washing machines is preferable. Water temperatures of at least 60 degrees C and preferably above should be used to destroy the micro-organisms on clothes and other materials. The uniforms of health workers need to be kept clean and used only in the same clinical area to prevent moving micro-organisms from one clinical area to another. If health workers visit more than one clinical area they should change uniforms or clothes between each area or wear disposable protective clothing over their own clothes when they move to a different clinical area

Unhygienic personal laundry facilities at a hospital in Asia

The equipment and furniture and the whole of the hospital, including the grounds, must also be kept scrupulously clean.

A scrupulously clean environment is the responsibility of each and every person in the health care environment

Health workers who clean are best supervised by regulated health workers and given adequate status and pay that recognises the importance of the work they are doing. They need access to sufficient cleaning agents and materials, ideally colour coded for the different areas to be cleaned, and induction training about the health facility's policies and cleaning systems.

Effective and supervised cleaning policies and systems for cleaning the entrances, corridors, wards (floors, walls, window-sills, light fittings and curtains), toilets and washing facilities, kitchens and all other areas in a health facility will contribute to reducing the risk of acquired infections and should cover:

- Cleaning methods used for all these different areas, also fittings, fixtures, furniture, bedding and other non-clinical equipment
- Cleaning frequency
- Cleaning materials and for what - colour coding of cleaning cloths/materials for use on different surfaces can be helpful.
- Use of cleaning agents, including disinfectants in appropriate dilutions for the task
- Effective management of spills of body fluid (blood, urine, vomit, faeces and saliva etc.)
- The cleaners or, if cleaners are not always available, others need to be trained and supervised by the senior health worker for the clinical area.
- Waste disposal systems and waste separation. Safe waste disposal systems and policies will prevent body fluids, faeces, drugs and disposables being a danger to others.

A **budget for cleaning** is essential.

Entrances of health facilities should screen visitors' shoes for dirt. Corridors need to be cleaned at least twice a day with a disinfectant and ward areas need to be kept scrupulously clean. The priority is the adequacy and state of the toilets and washing areas/bathrooms. Best practice is for these to be kept scrupulously clean throughout the twenty-four hours by frequent cleaning and disinfection (See also Section 5 for more information about how to clean).

All these issues may be seen as costly for a health service but save costs when balanced against the increase in hospital stay due to infection, the additional medications needed, and the sometimes unnecessary deaths.

What else can be done to reduce the risk of a healthcare related infection?

Micro-organisms become more difficult to treat if they develop a resistance to antibiotics. This occurs if antibiotics are used indiscriminately. Best practice is for every health facility to develop and use an antibiotic policy to control and restrict the use of antibiotics. For this to be effective all prescribing health workers need to respect and follow the policy.

Other ways of reducing infection include**:**

- Limiting the number of people who look after a patient. The risk of cross contamination is reduced if a family carer does as much of the patients' care as possible and the number of health workers who have contact with the patient is limited, particularly in high-risk areas such as intensive care
- Avoidance of overcrowding. Adequate space between beds will also limit the risk of cross-infection.
- A system to ensure that equipment, surfaces and other objects are cleaned before use for another patient
- A lead health worker and, when resources permit, an infection control team to develop and supervise all the infection control practices following wide consultation.
- A wound management policy (including an umbilical cord management policy)
- Healthy staff (see page 74)

Best practice is for all health workers to have regular training about these security and safety issues and an opportunity to audit compliance with the policies to see if these are achieved at the 'best possible' level with the resources available**.**

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STANDARD 6: Shares information and keeps every adult and child, and parents/carers when appropriate, fully informed and involved in all healthcare decisions, ensuring that each individual (or parent/carer) is free to give fully informed consent to healthcare procedures.

'Health care organizations and individual health workers share a responsibility to ensure that every adult or child old enough to understand is fully informed and involved in all decisions regarding their healthcare and in particular in giving consent for healthcare procedures'

Supporting criteria

1. **Awareness of the right to information.** Ensure there is a system for making adults, children and families aware of their right to information about their healthcare (for example a mission statement visible in all clinical areas).

Ensure adults, children and families are given information about ward facilities and routines, and about relevant general health issues.

2. **Information for decision making.** Policies, systems and/or practices should ensure that women, children and families are given sufficient understandable information about:
   - their specific health problem/s
   - any changes in their condition
   - investigations and procedures

(these make it easier for them to contribute to decision making and to give fully informed consent)

3. **Identification of health workers**

Every health worker should wear a name badge, and should introduce themselves to women, children and families (see Standard 4)

4. **Interpreters**. Skilled interpreters must be available and used when necessary. Family members and friends should not be used as interpreters.

5. **Complaints procedures.** Feedback systems should be available so that complaints and positive comments can be investigated and addressed. In addition, the opinions, views and ideas of health workers, adults, children, and their families should be sought.

6. **Consistency of information**. Healthcare workers should share healthcare information to ensure confidentiality, clinical effectiveness and consistency of information given to adults, children and families,

7. **Sharing of information and handover procedures.** Health workers should share non-clinical (general) information, for example through handover meetings on shift change.

   Communication tools appropriate for the circumstances, for example phones, pagers can aid effective, rapid communication, and be especially useful for summoning help urgently

8. **Informed consent.** Informed consent must be obtained for all invasive procedures, operations or programmes of care. In the case of operations, this consent should be in written form with adequate

information provided before signature. For those patients who are illiterate, skilled interpreters must be available 24 hours a day to ensure consent is valid. All pregnant girls and women must be able to give consent if there is an urgent need to undergo a surgical procedure to save life. There must not be a delay in order to seek the endorsement of her husband, partner or any other member of the family. Importantly, any healthcare worker who undertakes this kind of life-saving emergency surgical procedure in good faith must be protected from any subsequent claims made by any family members who would not have endorsed the woman or girl's own consent

Supporting information

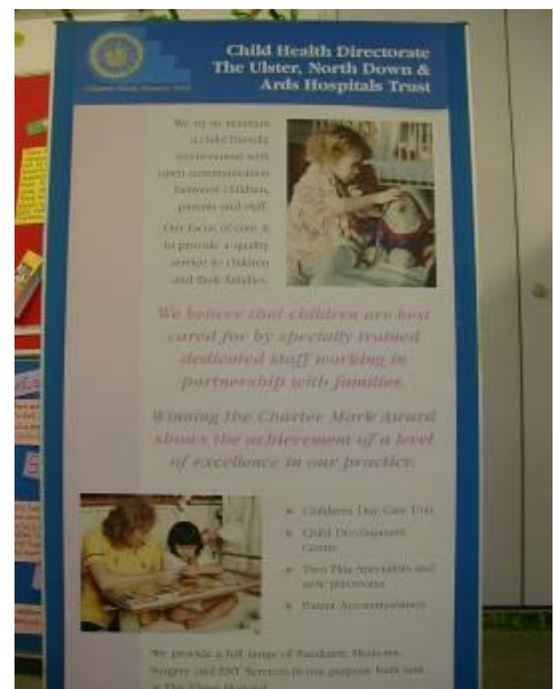
Expectations

People who use health services need to know what to expect, how to use services provided, who to complain to if something goes wrong and how to do this. They must know that they have a right to remain fully informed - in a way that they understand - about anything that might affect them. These issues are best covered in a written statement that is prominently displayed in the healthcare environment

Information sharing

Successful organizations are good at sharing information, ensuring the participation of employees and clients. This culture for information sharing minimizes misunderstandings, mistakes, disappointments and complaints. To provide the best possible healthcare, information needs to be shared effectively with mothers, parents/carers and children so that they understand what will happen to them, and are able to share in decision-making and participate in the healthcare needed.

Ward rules



An example of a mission statement

Early morning meeting in Moldova for all senior health workers to share information as the care of patients is handed over to the next shift

To share information effectively, it is necessary to have:

- A culture in the healthcare environment that encourages the sharing of information and enables participation
- A chain of responsibility and accountability that prioritises information sharing
- The desire to share and work with colleagues (team working) in partnership with mothers, children and parents
- The skills to share information effectively and consistently
- A system that keeps sensitive information confidential. Protecting confidentiality is vitally important unless this is not in the patient's 'best interests' or you have permission from a child and/or their parents to break this.
- Different methods of information sharing for different circumstances
- 'Job aids' for use as reminders, such as 'how to break bad news'
- Tools to aid information sharing, such as information boards, telephones, pager systems etc
- Privacy, mutual respect, compassion, time, and patience.

Communication tools vary depending on the technologies available and the task. Even basic low cost tools such as hand bells for summoning help and hand made hospital signing systems will achieve objectives. The priority is to identify what needs to be communicated and then to decide what method or tool to use. It is up to individuals to employ the technologies available in the most appropriate way. A well-sited communication board for sharing non-clinical information may be as effective as individual, more expensive handouts. It is important that information is put on the board, the board is easy to see, the information is understandable and in large enough print for people to read, or in pictorial form for families unable to read.

It is also important for mothers, parents/carers to be able to share information about the patient with other family members and friends. A system to enable this is of paramount importance, especially for distant family members.

Identification

Mothers, children and families have a right to know the names of the health workers looking after them. Best practice is therefore for all health workers to wear identification (such as name badges) and to introduce themselves to the patient and family.

Information for parents about their child's anaesthesia and what will happen after surgery

Appropriate information

The information health workers give to adults, parents/carers and children may not be understood for different reasons. These include:

- The language is not the first language of the adult, child or parent receiving the information
- The content is not understood as knowledge of the subject is limited
- The format and/or words used are not easily understood
- The adult, parent/carer or child does not want, or is not ready to, hear what is said
- The adult, parent/carer or child is partially deaf
- Too much information is given at once
- The recipient is distressed, anxious or upset and so is not receptive (does not 'hear')
- There is inadequate privacy

Appropriate communication

To avoid these problems, best practice is for health workers to have education/training opportunities for learning communication skills, the importance of protecting confidentiality and evidence based suggestions for giving information, particularly for transmitting bad news.
These 'rules' include:

- Privacy and no interruptions such as a telephone ringing or a knock on the door.
- Introducing yourself, say who you are and what your role is
- Making sure the adult, child or parent/carer has a close family member or friend with them if wanted
- Having a second health worker present (a doctor/nurse combination works well)
- Explaining what information you intend to share and finding out before this what the adult, child or parent/carer already knows
- Giving information honestly in the adult , child or parent/carer's first language (via an interpreter if necessary)
- When it is appropriate, trying to give any positive or reassuring information first, before giving information that adults, children and families will find difficult
- Using words the adult, child or parent/carer is likely to understand without being patronizing. Use of pictures, mime or sign language may be helpful
- Getting regular feedback by asking adult, child or parent/carer to repeat what you have said

- Giving the opportunity to ask questions
- Remembering that small amounts of information given at frequent intervals are better than too much at a time
- Reinforcing with written or pictorial information whenever possible
- Arranging a time to give more information
- Asking if there is anyone else in the family the adult, child or parent/carer would like to share the information with
- Showing compassion but remaining in control of your own emotions
- Getting permission to share with others as necessary

Mothers, children and families need to feel confident about the abilities of those who look after them. Loss of this confidence can cause much anxiety and distress.

A team approach to healthcare

Some health workers can feel protective about the families they look after. While this is usually good, it can sometimes create a dependence on an individua , and cause families to lose confidence in the care given by other health workers. This is made worse if a competitive atmosphere develops between different health workers and health care environments, especially when one undermines the care of the other. It is therefore important for health workers working in different situations to support and communicate well with each other, to share and promote consistent good practice and to be positive about all who contribute to providing healthcare for adults, children and families, even if mistakes have been made.

A simple way of telling mothers they are welcomed and supported to see their babies, also a hand washing reminder

A low-cost private 'manned' telephone in a children's hospital in Eastern Europe. This enables parents/carers to contact their friends and relatives. Until the retired health worker in the picture persuaded the authorities to allow him to install the telephone, parents/carers had no secure way of contacting their relatives.

Finally best practice is to audit compliance with the policies and systems for information sharing and to make sure they are achieving their objectives.

Consent
Consent to medical and surgical procedures is essential for safe, acceptable healthcare delivery. There is no single correct approach to discussions around healthcare, with some women and children requiring more information than others. It is important that healthcare professionals use their clinical judgment when explaining procedures and practice to women and children. They should be encouraged to request further information and be allowed time to weigh up potential risks, benefits and burdens including any personal (non-clinical) issues that may alter their perspective.

Children and young people should be involved as much as possible in any discussions about their care – even if it is considered inappropriate for them to make independent decisions regarding care.

Legal issues regarding consent will vary between countries and healthcare professionals must comply with the local laws.

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White Ribbon Alliance

STANDARD 7: Recognises and relieves pain and discomfort and, when needed, provides high quality palliative care

'Health care providers, organisations and individual health workers share a responsibility to ensure that they recognise, assess and relieve the physical and psychological pain and discomfort suffered by adults, infants and children undergoing any form of healthcare.'

Supporting criteria

1. A pain control management system. A pain and other symptom management service with lead health professionals and/or multi-disciplinary team/s. Health workers must be more aware of the suffering and discomfort that all patients may experience (especially pre-verbal children and newborn babies) due to pain and other distressing symptoms

The health worker working together with the patient can often reduce pain and other distressing symptoms by:

- Planning each adult or child's care as each person responds differently to pain and other distress.
- Anticipating pain and taking effective measures, for example giving drugs before a procedure or operation. Patients with recurrent distressing symptoms should not wait for these to re-occur before receiving relief.
- Using pain/symptom assessment tools to assess a patient's symptoms and guide the care they need.
- Giving drugs in a way that does not cause more pain and distress. Drugs are often still given in a way that is painful for the patient, for example by intra muscular injection. The same drugs are frequently available and equally effective as intravenous or oral preparations.
- Having a kind system for the restraining of children during essential procedures

Child recovering from pneumonia and receiving additional inspired oxygen through nasal cannula. He is tied to the bed to prevent him pulling out the cannula but this is unnecessary. The way forward is surely to have a relative (ideally the mother) sitting with him. After a short while the child usually becomes used to the cannula.

Tears in the mattress of a labour ward resulting from untreated pain during labour

2. The presence of an anaesthetist. In a facility treating emergencies, an anaesthetist must be available for 24 hours a day.

3. Written guidelines. Written guidelines, evidence based wherever possible, used by everyone to help with symptom relief, that include advice on the relief of different types of pain and other distressing symptoms **(both physical and psychological),** and on how to use non-pharmacological and pharmacological pain relieving strategies in different age groups.

Job aids (for example tools to assess and relieve pain) to help with symptom recognition and symptom assessment.

4. Non-pharmacological treatment. Before using drugs, or where they are unavailable, there is much that can be done to relieve suffering and make an unpleasant experience more bearable, such as:

- Being honest with the patient and preparing them for what might be a painful experience can help them to cope. Anxiety and mistrust of health workers will make the experience worse
- For children, using appropriate play, stimulation and distraction to help in the management of pain and other symptoms
- Using heat, cold, touch and other comfort measures to relieve pain and other symptoms.
- Giving psychological support, kindness and, for children, involving parents and familiar carers where possible.

5. Drugs for controlling pain. Reliable and constant supply of the following resources for effective pain control including:

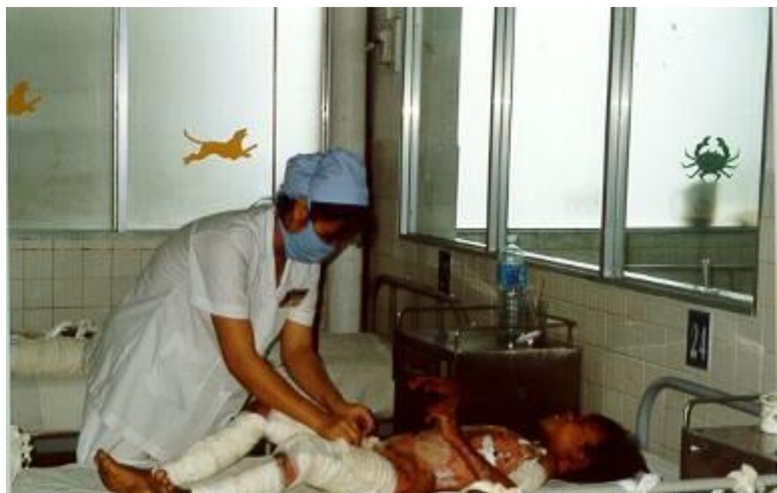
- A safe, secure supply of free or affordable essential drugs for symptom relief that includes opiates and non-opiates
- A system to manage potent analgesic drugs, including a locked safe in each ward where these are kept, and a logbook that documents the administration of these drugs to each named patient

6. Training in pain control. Training in the use of analgesic drugs for all health workers. Special training in the management and use of opiate drugs and powerful sedatives/analgesics such as ketamine for those health workers who work in areas where they are prescribed or administered.

7. Support. Support for adults, children, families and health workers who experience or witness painful and/or invasive procedures

9. **Avoidance of abuse of those suffering pain.** A system that ensures that women who display a response to pain during labour and/or child birth are not subjected to verbal or physical abuse by their healthcare workers. (See Standard 9)

Dressings of extensive burns, changed without adequate pain relief and without a parent present.



9. Palliative care. A system of palliative care for women or children with illnesses that cannot be cured and which is designed to relieve as suffering by appropriate drug regimes and support from trained professionals. Such a system should be available for implementation both in hospital and at home with close communication between health workers in each site.

1. A separate pain and other symptom management/palliative care service/s with lead health professionals and/or multi-disciplinary team/s

2. Systems of care, guidelines and job aids (for example tools to assess and relieve pain) to help with symptom assessment and restraint for procedures

3. Written guidelines, evidence based when possible, used by everyone to help with symptom relief, that include advice on relief of different types of pain and other distressing symptoms **(both physical and psychological),** and on how to use non-pharmacological and pharmacological pain relieving strategies in different age groups:

4. Material resources including:
   - A safe, secure supply of free or affordable essential drugs for symptom relief that includes opiates and non-opiates
   - Distraction toys and other resources to aid pain relief and other symptom management

5. The use of individual pain (and other symptom) plans made with the children and their parent/carer

6. Psychosocial support for children, families and health workers

Supporting information

A pilot project found large numbers of children in participating countries suffer from uncontrolled pain and other distressing symptoms, both physical and psychological.

Improved technology and potential advances in care do not always relieve symptoms and can on occasion be an additional cause. Routine procedures (without pain relief), such as dressing wounds are frequent causes of unnecessary pain and suffering for a child. In some countries it is common for a child to be paralysed by drugs or partially sedated without concurrent and appropriate pain relief.

The State has a role to play in making it better for children by not restricting or blocking the availability of pain relieving drugs (including opiates) due to security concerns or mistaken beliefs about their inappropriateness for use in children and misplaced concerns about risks of addiction.

In countries where opiates are available, there may be a reluctance to use them due to these misguided beliefs and also a lack of understanding about how to use them. Whilst it is upsetting for health workers

when they are unable to help a distressed child, the effects on the child and their family are much worse, especially if the child has chronic pain, a terminal illness or any other life-limiting condition.

It is wrong and a failure of a health professional's duty for a child to suffer from uncontrolled pain or other distressing symptoms. This is particularly the case for a child who has a permanent disability that is associated with chronic symptoms or one who cannot be cured of and may be near the end of their life. Relieving pain and distressing symptoms is not always about cure, but is about making the experience of living 'now' more bearable (that is improving the quality of remaining life).

To 'make it better' best practice is for health workers to have core (during initial training) and regular education/training opportunities about the recognition, assessment and treatment of pain and other distress. Best practice is also facilitated by having, whenever possible, separate skilled health professionals who lead and guide the treatment of pain and other symptoms. Having a multidisciplinary team dedicated to symptom relief and aspects of palliative care, and using standardised guidelines for managing pain and other distressing symptoms, are known to be effective ways of improving and sharing good practice.

Before using drugs, or where they are unavailable, there is much that can be done to relieve suffering and make an unpleasant experience more bearable, such as:

- Being honest with the patient and preparing them for what might be a painful experience can help them to cope. Anxiety and mistrust of health workers will make the experience worse
- Giving psychological support, simple kindness and involving parents and other familiar carers where possible.

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Home-made splint

STANDARD 8: Provides each woman or child of reproductive age with appropriate reproductive health advice

'Health care providers, organisations and individual health workers share a responsibility to ensure that they recognise the need for, and provide, up to date and evidence based advice on reproductive health for women and girls who could become pregnant or are already pregnant'.

Supporting criteria

1. **Education in sexual and reproductive health.** Ensure that any woman or girl who has been pregnant or may become pregnant in the future, is provided with comprehensive education in sexual and reproductive health.

2. **Family planning services.** Free confidential family planning advice should be provided by trained staff, including safe, affordable and readily available family planning measures that can allow spacing of pregnancies

3. **Healthy Timing and Spacing of Pregnancies (HTSP).** Communities should be educated about the healthy timing and spacing of pregnancy.

   Communities and individual families need to be aware of the potential dangers to health of a pregnancy occurring too soon after the ending of a previous pregnancy, whether or not this has ended in a live birth, stillbirth, miscarriage or abortion. A pregnancy occurring too soon after the ending of any pregnancy can be harmful or even very dangerous to health and life of the woman or girl.

   Communities should be informed that modern contraceptive methods can help ensure that pregnancies occur at the healthiest times of women and girls' lives and at times when their infants are more likely to be healthy.

   Communities should be informed that adverse outcomes (including maternal and newborn death, preterm birth, low birth weight, small for gestational age and induced abortion) are more likely when pregnancies occur at unhealthy times. The healthiest times to become pregnant are:
   - After the age of 18 years: aim to educate communities to understand the complications and dangers to the mother, developing fetus and newborn infant of becoming pregnant in childhood as distinct from after 18 years of age. It is particularly high risk for girls to be pregnant before 16 years of age.
   - At least 24 months after a live birth (a birth-to-birth interval of at least 33 months is associated with a healthy outcome).
   - At least 6 months after an induced abortion or miscarriage.
   - Before the age of 35 years
   - Less than 5 years apart.

     Ensure that after a pregnancy, women and girls are counselled about available contraceptives to help space or limit future pregnancies.

   Communities, and women and girls who have been pregnant, should be educated about fertility awareness methods, that is, methods not dependent upon a supply of contraception. These include the Standard Days Method and the Lactational Amenorrhoea Method.

4. **Dangers of too many pregnancies.** Communities should understand the progressively higher incidence of complications and dangers to pregnant women, girls and their newborn infants of completing more than four pregnancies.

5. **Sterilisation**. Any woman who has completed her family should be provided with access to free sterilisation, if that is how she wishes to prevent further pregnancies.
   Encourage communities to advocate for systems to enable male sterilisation.

6. **Problems following miscarriage or termination of pregnancy.**

   Ensure, through community education, that all girls and women know where they can obtain treatment for any medical or surgical complications that follow miscarriage or termination of pregnancy.

   Ensure that women and girls suffering a miscarriage or undergoing termination of pregnancy are offered post- abortion care services that include on-site provision of family planning, to help them avoid a repeat miscarriage/ abortion.

   Ensure that if termination of pregnancy is agreed to be undertaken in accordance with national laws or substantiated medical indications, it is accessible and undertaken in a well equipped facility in which termination can occur safely and where any complications can be managed appropriately by trained healthcare staff. The facility should observe high standards of cleanliness to reduce infection risk and should be staffed by well trained healthcare staff who can safely manage any emergencies that might affect the women or girl who has undergone this procedure. It is recommended that WHO guidance on the care of women or girls undergoing termination of pregnancy be followed.

   Where termination of pregnancy is undertaken against a country's laws, every effort must be made to ensure that, if there are complications, these can be treated free of charge and without legal redress for the woman or girl in a suitable health facility.

   Where a facility undertakes treatment of complications of a miscarriage or termination of pregnancy, this must be undertaken completely confidentially and in the case of illegally performed termination, the women or girl in question must never have to fear legal action against her.

   Within the laws of the country, the girl's or woman's decision for termination should be supported by appropriate medical professionals if their opinion is that the continuation of the pregnancy would adversely affect the girl's or woman's mental or physical health, and that the risk of this would be greater than if the pregnancy was terminated . .

   All possible means to discourage the practice of clandestine abortions should be pursued, as they often result in high risks to the lives or health of the women or girls who are pregnant.

   Never support a policy involving termination of pregnancy to enable gender selection of the newborn infant.

7. **HIV prevention and treatment.** Through community education, ensure that all girls and women who may become pregnant know how they can reduce the risk of acquiring infection by the Human Immunodeficiency Virus (HIV) and by sexually transmitted infections which can affect her, her fetus, or newborn infant.

8. **Access to helpful publically available information regarding pregnancy.** Ensure that the woman or girl who is pregnant has access to information and material from a national and international sources, especially those aimed at the promotion of her well-being and physical and mental health. To this end:

- Request co-operation from media and a variety of national, international and cultural sources to produce, share and disseminate information of social and cultural benefit to pregnant women and girls
- support the production and distribution of books to inform the woman or girl who is pregnant about healthy living during pregnancy and how best to care for her newborn infant or infants;
- request that the media recognise the linguistic needs of the mother or girl belonging to a minority or indigenous group;
- support guidelines for the protection of the woman or girl from information and material adversely affecting her well-being or that of her infant(s). Most important is protection from advertisements on smoking and formula feeding.

African teenagers: a beautiful carving depicting vulnerability

Supporting information

Reproductive health implies that individuals are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this last condition are the rights of men and women to be informed of, and to have access to, safe, effective, affordable and acceptable methods of family planning, of their choice, as well as other methods of their choice for regulation of fertility that are not against the law, and the right to access appropriate healthcare to enable women to be relatively safe through pregnancy and childbirth.

The provision of adequate family planning has been highlighted in Millennium Development Goal 5b as an essential part of reproductive health and reduction of maternal mortality and morbidity, as well as benefitting the wider community.

Closely spaced pregnancies have a detrimental effect on maternal health and can contribute to poor reproductive health outcomes. Women who have access to family planning are likely to take control of their lives and dedicate time to smaller family units. Smaller families are more sustainable not only the family, but for the community in which they live e.g. access to water and food. Choice is also an

important factor – many women want a small family but do not have access to contraceptives to allow them to do so.

There are currently many methods available (e.g. the oral contraceptive pill and Depoprovera injection) but the choice and access highly variable around the world. Currently, there is a large unmet need for family planning. Over 1.4 million women in Uganda would like to delay pregnancy, space children or stop childbearing but do not have access to contraception.

Although there has been a significant improvement in access to family planning and contraception since 1990, there is disparity between countries and reduction of contraceptive use in recent years as outlined in the Millennium Development Goals UN report from 2010. Low contraceptive usage is linked with poverty, rural communities, sub-Saharan Africa and a lack of education. In addition, aid for family planning as a proportion of total aid for health declined sharply between 2000 and 2008, from 8.2% to 3.2%.Recent estimates indicate that fulfilling that need could result in a 27 per cent drop in maternal deaths each year by reducing the annual number of unintended pregnancies from 75 million to 22 million. To address these issues there is urgent need to have standards of care in family planning. The provision of high quality family planning is essential and there is a need for it to be delivered by adequately trained health care staff as soon as possible.

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STANDARD 9: Recognises, protects and supports vulnerable or/and abused women, girls, infants and children

'Health care providers, organisations and individual health workers, share a responsibility to ensure that they recognise abuse and help to protect and support vulnerable and abused women and children by the development of appropriate policies and systems of multiagency care - working together'.

Supporting criteria

1. **Recognising abuse.**
   Clinical guidelines available to all health workers to help with the recognition, diagnosis and investigation of physical and sexual abuse of children and gender based violence.

   Training programmes to ensure that all health workers are able to recognise physical and sexual abuse and know how to obtain assistance in managing cases.

2. **Protecting women, girls and children who have suffered abuse.**
   - A knowledge of the country's legal framework for child protection and protection against domestic violence
   - A written statement (policy) to guide health workers which includes clearly defined procedures for managing women or children suspected of being abused
   - The prompt but confidential sharing of information and concern with other relevant disciplines such as other health workers, social welfare services (as lead agency), police, schools, playgroups etc.
   - Lead health workers (doctor and nurse) in each health facility to coordinate activities with responsibility for policies, clinical guidelines for managing the adult or child who has been abused and the family, monitoring the quality of the service and training
   - Systems for protecting and supporting an abused woman or child including the establishment of places of safety/refuge.
   - Systems for protecting and supporting the families of an abused woman or child.
   - Ensure that procedures are in place to support and treat anyone who has been raped. Provide special support if the abused person becomes pregnant as a result of sexual assault.

3. Preventing abuse. The following activities aimed at preventing ill treatment and abuse:
- Ensure through community education that men, and other influential persons/groups, understand the extremely harmful consequences of gender-based violence.
- Systems to identify vulnerable families in which abuse might occur:
- Referrals to systems in the community (if they exist: if not, they need to be developed) to support vulnerable families:
- Referral to a social welfare service (or similar support service-if it exists) that provides general and emotional support to vulnerable families, and to abused women, children and their families
- Advocate for protection of any woman or girl from all forms of sexual exploitation.

3. **Confidentiality**. Keeping confidential information about vulnerable families, abused women, abandoned children and abused children, including a confidential register of all abused women and children which can be accessed twenty-four hours a day

4. **Female genital mutilation (FGM).** In countries where there is female genital mutilation, all health workers should advocate against this practice. They should also ensure that all health facilities understand the extra medical risks that these procedures create during childbirth and have measures available which can minimise their harmful effects.

Female genital mutilation without anaesthesia

It is estimated that 100-130 million women and girls in 28 different African and Middle East countries are affected by female genital mutilation

In 1995, Amnesty International (AI) made the decision to include reference to FGM in its promotional work on human rights. The stance taken by AI marked a general change in attitude towards FGM, away from considering it a private matter or a cultural issue, towards recognising it as a form of institutionalised violence against women. The UN Universal Declaration of Human Rights of 1948 makes clear that all human beings have the right not to be subjected to cruel, inhumane or degrading treatment. This description must surely include FGM. However, while most governments worldwide embrace the concept of human rights enshrined in the Declaration, many fail to apply it to abuses within the home or community. The UN Convention on the Elimination of all forms of Discrimination against Women (CEDAW 1981) is often described as a bill of rights for women. The committee of CEDAW recommended that states must adopt appropriate effective action to prevent, punish and eradicate such practices as FGM through healthcare, advice and education.

5. Selective female abortion-pre-birth killing of unborn female babies

The quest for sons: "Having a daughter is like watering your neighbours garden" (Punjabi saying)

- 2001 Census data illustrates the terrible impact of sex selection in India over the last few decades.
- child sex ratio (0-6 years) declined from 945 to 927 girls to 1000 boys between 1991and 2001 Census

- Around 80% of the total 577 districts in the country registered a decline in the child sex ratio between 1991 and 2001

Study on Child Abuse: India 2007

Indian mothers with their male babies

6. Protecting women, babies and children from the many abuses associated with armed conflict

Multiple studies have shown that women and children are the most severely affected sections of the population when there is armed conflict. Women who are or become pregnant are particularly at risk as healthcare is often specifically targeted as a weapon of war.

In addition to losing their homes, children may become orphaned, often witnessing their parents being tortured and killed.

Rape and other sexual abuse is again often a targeted objective of warring factions, many of whom are psychopathic in their actions.

In addition to these specific concerns, there cannot be routine healthcare, including preventative healthcare, without peace and security. Indeed, most deaths of women, babies and children are not from the direct effects of weapons but are due to preventable illness, malnutrition and lack of care for the complications of pregnancy and delivery.

8. Protecting children from abuse during institutional care

http://www.mcai.org.uk/assets/content/documents/Recommendations_regarding_institutional_care_of_children.pdf

Institutional care describes *"a group living arrangement for more than ten children, without parents or surrogate parents, in which care is provided by a much smaller number of paid adult carers".* Although many of these are described as orphanages, many of their children have at least 1 parent.

Poverty is overall the main reason for these parents placing their children into institutions. Many parents - lacking other forms of support - perceive that putting their children into institutions is the best way to help them access sufficient nutrition, education and health care. Importantly, children with mental illnesses, developmental delay, physical disabilities or from ethnic minorities are over-represented in institutions. Institutions cut children off from their families and take away their critical role in promoting children's care and well-being. Indeed many problems associated with institutional care in both poor and rich countries include the increased risk of physical and sexual abuse, lack of nurturing, love and individual attention and systemic neglect.

A family based care system is the most suitable for children, and is less expensive that institution-based care. All efforts should be made to move care for children from institutions to families.

9. Protecting pregnant women and girls from abuse in the home

There is a close link between the abuse of children and the abuse of pregnant women or girls. Indeed, it has been proposed that domestic violence should be considered as a major public health problem that contributes to maternal mortality. The definition "maternal death due to domestic violence" has been suggested in order that these women can be identified and the problem tackles.

Healthcare services, including all healthcare professionals are in a unique position to identify such abuse during pregnancy. In particular midwives, obstetricians and other physicians can use pre-natal visits to make enquiries and offer solutions to vulnerable women.

Countries legal framework fro preventing and managing abuse varies widely. In India, a 2005 act aims to protect all women who have lived for a time in the same household (including single women, partners and ex-partners, sisters, mothers, widows) from men living within that household. A crucial aspect makes it difficult to evict a woman from a household.

Many countries have now passed laws making spousal rape illegal. However these laws remain poorly implemented.

10. Preventing the trafficking of women and children

Trafficking of women and children is a highly profitable business allowing individuals to exploit women and children for cheap labour or for sexual exploitation. Children and their families are often unaware of

the dangers of trafficking; believing that trafficking allows a route to a more prosperous life abroad. Trafficking always denies the right for a child to be brought up in a family environment, most often their right to attend school, to be protected from exploitation and sexual violence, and to have time to play. Trafficked children face increased risk of violence, of sexual and emotional abuse, neglect and isolation.

Often women and children are lied to in order to encourage them to move, they find themselves 'in debt' to their trafficker or 'buyer', and may be forced to work in order to repay this 'debt'. Trafficking in women and children has a profound negative impact on individuals, families and communities.

11. Marriage in childhood

Health workers should advocate to ensure that marriages of children under 18 years of age are subject to careful examination by those legally undertaking such events, ensuring that the girl involved is freely consenting to the marriage and is aware of the potential dangers to her and her unborn children of pregnancies occurring before 16 years of age.

Girl collecting items to sell from a rubbish dump in Pakistan

Casualty of armed conflict in the Palestinian Occupied Territories

Mary Ellen before and after her rescue by legal intervention by Henry Bergh President of the Society for Prevention of Cruelty to Animals New York 1874

Soldier and child in war in Sri Lanka

Camp for internally displaced during the war in Sri-Lanka

Camp for internally displaced during the war in Sri Lanka

Makeshift hospital for casualties of war in Sri Lanka

Camp for families internally displaced by war

Supporting information

Many health strategies and other primary, secondary and tertiary prevention activities can support vulnerable children and families and help prevent child abuse and ill treatment.

1. Protection of children from abuse

Examples of activities aimed at preventing of child abuse include (WHO):

Primary prevention	Secondary prevention	Tertiary prevention activities
• Pre-natal and perinatal health programs • Child health monitoring programs • Promotion of good parenting • Raising public awareness about child	• A system for identifying vulnerable families • Family support systems eg home visits • Clear referral systems to support services for vulnerable families	• Early diagnosis • The working together of all organisations involved with abused children to ensure: - medical treatment - healthcare - counselling - management and support

abuse • Raising community awareness about the UNCRC • A social welfare system • School activities re: non-violence and the prevention of bullying	• Substance abuse treatment programs • Community based family centred support assistance and networks (social welfare system) • Accessible information about community services available for all families • Support services based in schools	of victims - management and support of families - re-integration into the community and schools • Adequate child protection laws • Child Friendly criminal justice systems, including facilities for the court attendance and participation of potentially abused children

Children are more likely to be vulnerable, abused and/or ill-treated when environmental factors are adverse, when parenting is not good enough or when they themselves have problems that make their families more stressed, or their care more difficult.

Risk factors include for abuse:

<table>
<tr><th>Parent factors</th><th>Child factors</th></tr>
<tr><td>• Absence of one or both birth parents
• Single unsupported parent
• Unwanted pregnancy
• Poor parenting skills
• Early exposure to violence or abuse themselves
• Inadequate pre-natal care
• Substance (drugs, alcohol etc) abuse
• Domestic violence and/or marital relationship/family problems
• Poor experience of parenting by own parent/s
• Very young or immature parent/s
• Physical or mental illness/emotional disturbance in one or both parents
• Family already known to social welfare system
• Evidence of poor parenting of a sibling/s
• Learning difficulties
• Relationship problems
• Confinement to a prison or other institution
• Large family size/high density living
• Poor socio-economic status
• Social isolation
• High levels of stress
• Family abuse/history of domestic violence
• Absolute or relative poverty
• Family displacement or refugee status
• Excessive family mobility</td><td>• A disability or learning difficulties
• Low birth weight/preterm birth
• Prolonged separation from a parent (such as admission to a hospital) especially in the neonatal period (impaired bonding)
• Female sex (in some cultures females are at risk of infanticide and have limited opportunities for education.)
• One of a multiple birth
• A ‘difficult baby/child’ or one who cries incessantly
• Attention deficit/hyperactivity disorder etc.
• Delayed development, particularly soiling and wetting past developmental age
• Unwanted by parent(s)</td></tr>
</table>

Community/societal risk factors for child abuse

<table>
<tr><th>COMMUNITY/SOCIETY</th></tr>
<tr><td>• Non-existent, non-enforced child protection laws
• Decreased value of children (minority, gender, disabled)
• Social inequalities
• Organised violence (gang culture, high prevalence of small arms, high crime rates)
• High social acceptability of violence
• Media violence
• Cultural norms
• War or other ‘natural’ disasters (eg famine, earthquake, flood etc.)</td></tr>
</table>

The legal framework required to protect children varies in different countries. In some there may be no, or minimal, legislation despite ratification of the UNCRC, and others have advanced laws especially for children, for example the 1989 'Children Act' in England and Wales. Some countries that do have legislation do not have any framework for enforcing this and others have minimal legislation. Child abuse is often interpreted very differently and some countries do not have laws to protect children from enforced labour, recruitment as soldiers or to protect them if they are refugees.

Many disadvantaged countries consider child protection programmes low priority, as they have so many other problems, such as border security, the provision of safe water and sanitation, affordable education and health systems, adequate employment prospects and securing their economy. However there is an obligation following ratification of the UNCRC for governments to move towards protecting children in a transparent way. The International Community must continue to advocate for the global rights of children to be protected and, where they do not exist, the introduction of laws that will protect children where none exist.

Abuse, neglect or exploitation is less likely to occur if a country:

- Provides financial and other support for vulnerable children and families
- Ensures equal access to, and opportunities for, free healthcare and education for all children
- Supports educational programs that will improve parenting skills for the whole population
- Has programmes to identify and support vulnerable children and families
- Uses integrated, collaborative and standardised methods to diagnose protect and support abused children.

Health care providers have a key role, together with other groups that work with children and families, in identifying, protecting and supporting vulnerable and abused children and their families. To do this effectively individual health workers have a responsibility to acquire the skills necessary to understand and use the preventive, diagnostic, protective and support systems that exist in their country, to advocate for these when they are absent and to collaborate with their colleagues in other agencies and organisations involved with children.

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STANDARD 10: Supports the best possible health for adults, infants and children through adequate nutrition

'Health care providers, organizations and individual health workers, share a responsibility to ensure that they support breastfeeding and the best possible nutrition for women and children.'

Nutrition can be defined as: 'who you are; what you do; what you eat'. Malnutrition before and during pregnancy and infancy kills women and children and causes lifelong illness. It is imperative that societies protect the vulnerable against this preventable disease.

Supporting criteria

The spectrum of nutritional care and intervention

1. Pre-pregnancy care: education

- Girls should NOT bear children. Until maturity/womanhood, their bodies are not equipped to nurture a fetus
- Nutrition for a child begins antenatally with attention to the mother's lifestyle and health during pregnancy and an opportunity to inform about breastfeeding and childcare. These skills are not innate and must be learned

Women should receive pre-conception adequate nutrition which should include appropriate micronutrient intake especially iodine and folic acid.

2. Nutrition during pregnancy.

- Ensure that all pregnant women or girls receive adequate nutrition to ensure their health and that of their unborn child
- Nutrition includes reducing energy expenditure through excess work (such as carrying loads), attention to personal health and **being the priority at family mealtimes**

- Supplemental foods should be provided to the poorest members of communities.

3. Breast feeding.

Protect, promote and support breastfeeding *(WHO/UNICEF Baby Friendly Ten Steps to Successful Breastfeeding).*

- Ensure the 'Ten steps to successful breastfeeding' have been implemented. Formal accreditation as a WHO/UNICEF Baby Friendly Hospital is the best possible level of practice if this is available in the country
- In a health facility providing secondary care – ensure support for breastfeeding babies attending or resident in a health facility, or their siblings, is compatible with the Ten Steps to Successful Breastfeeding'.
- Ensure evidence based advice on breast feeding for HIV positive mothers
- Breast feeding should be the exclusive means of feeding until 6 months and should continue until the age of 2

Breastfeeding is best supported if maternity units, children's wards and community children's services follow the UNICEF/WHO 10 Steps to Successful Breastfeeding which are.

1. Have a written breastfeeding policy that is routinely communicated to all healthcare staff
2. Train all healthcare staff in the skills necessary to implement the breastfeeding policy
3. Inform all pregnant women about the benefits and management of breastfeeding
4. Help mothers initiate breastfeeding soon after birth
5. Show mothers how to breastfeed and maintain lactation even if they are separated from their babies
6. Give newborn no food or drink other than breast milk, unless medically indicated
7. Practice rooming-in, allowing mothers and infants to remain together 24 hours a day
8. Encourage breastfeeding on demand
9. Give no artificial feeds or dummies to breastfeeding infants
10. Foster establishment of breastfeeding support groups and refer mothers to them when discharged from the hospital or clinic

- Breast-feeding has important health benefits both for the mother and the child.
- All mothers have the right to make a fully informed choice as to how they feed their babies and staff should not discriminate against any woman due to her chosen method of infant feeding fully supporting her once she has made her choice.
- The potential health risks from formula feeding should be discussed with all women.

- Hospitals providing maternity services should adopt a breast-feeding policy which covers all ten steps to successful breast-feeding enabling mothers to breast-feed exclusively for 4-6 months.

The Ten Steps of the BFHI

1. ✓ Have a written breastfeeding policy that is routinely communicated to all healthcare staff.

- all staff to adhere to this policy to avoid conflicting advice
- new staff to be orientated to the policy.
- the policy should be available in all areas of the maternity unit and children's wards.
- also accessible as audio or videotapes in appropriate local languages.

Comment:

- ✓Formulation and implementation of breast-feeding policy can encourage the implementation of other policies that protect children. For example the registration of the newborn is a universal human right.

2. Train all healthcare staff in the skills necessary to implement the policy.

Comments:

- although BFHI involves only health personnel in training, all administrative staff in training such as secretaries and security personnel should be included.
- This can encourage community involvement and milk bank development

3. Inform all pregnant women about the benefits and management of breast-feeding.

- every pregnant woman should have an opportunity to discuss infant feeding on a one to one basis with a midwife or health visitor.
- aim to give women confidence in their ability to breastfeed.

Comments:

- **✓To sustain a culture of breast-feeding, it is necessary to begin teaching children about breast-feeding; this may be most effective during the pregnancy or at school.**
- It is equally important to teach breast feeding techniques such as hand expressing, since 40-50% of the women have problems related to technique and lack the knowledge to overcome them.

4. Help mothers initiate breastfeeding soon after birth.

- **✓Encourage mothers to hold their babies in skin to skin contact as soon as possible after delivery in an unhurried environment, regardless of their intended feeding method (usually within 30 minutes after uncomplicated vaginal delivery and within 3-4 hours of Caesarian Section)**
- offer the first breastfeed when mother and baby are ready.
- help must be available from a midwife if needed.

5. Show mothers how to breast-feed and how to maintain lactation, even if they should be separated from their infants.

- explain positioning and attachment to the mother of the baby, who must be helped to acquire the skill for herself.
- all breastfeeding mothers should be shown how to hand express their milk.

- if the baby is separated for medical reasons it is the shared responsibility of the neonatal nurse and midwife to ensure the mother is given help to express her milk to maintain lactation at least 6-8 times in a 24 hour period.

Comment:
- although electric breast pumps are helpful, hand expression is as effective.

6. Give newborn infants no food or drinks other than breast milk unless medically indicated.
- no water or artificial feed should be given to a breastfed baby unless prescribed by a midwife or paediatrician in consultation with parents and the reason explained to them.
- parents who request supplementation should be made aware of its implications on baby's health and breast-feeding. This will allow them to make a fully informed choice.
- supplements when prescribed should be documented in the notes with the reasons.

Comments:
- UNICEF/ WHO have defined the medical reasons for prescribing supplements. These are infrequent and uncommon.

7. Practice rooming in- allows mothers and infants to remain together 24 hours a day.
- separation should only be done for medical reasons (rare).
- babies should not be routinely separated from mothers at night, including those who are formula fed.

Comments:
- to include the neonatal intensive care and newborn services.
- may result in quicker recovery of the newborn and decreased duration of stay of infants in hospital.

8. Encourage breastfeeding on demand.
- demand feeding should be encouraged.
- mothers should be informed that it is acceptable to wake their baby up if their breasts become overfull.

9. Give no artificial teats or dummies (also called soothers or pacifiers) to breast-fed infants.
- staff should not recommend these.
- parents wishing to use them should be advised of the possible detrimental effects on breastfeeding.
- cups but never bottles should be used
- any mother wishing to use a nipple shield must have the disadvantages explained and should be supervised by a skilled practitioner

10. Foster the establishment of breast-feeding groups and refer mothers to them on discharge from the hospital.
- The hospital should support co-operation between healthcare professionals and voluntary support groups.
- Contact telephone numbers and addresses of infant feeding advisors, community midwives, health visitors, and voluntary breastfeeding counselors should be issued to all mothers and be routinely displayed in all maternity areas.

Comments:

- participation of Primary Health Care professionals is essential

- the breast-feeding message to mothers should be identical irrespective of their location (Primary, Secondary or Tertiary care).
- no advertising of breast-milk substitutes, feeding bottles, teats or dummies should be permissible in any part of the hospital.
- the display of logos of manufacturers of these products on items such as calendar and stationery should be prohibited.
- No literature provided by infant formula manufacturers is permitted unless approved by a senior midwife or doctor.

Compliance with the BFHI policy should be audited on an annual basis.

HIV and breast feeding:

There are new guidelines with respect to breast feeding and HIV infection provided by WHO (see below). At present, exclusive breastfeeding is recommended for HIV-infected women for the first six months of life unless replacement feeding is acceptable, feasible, affordable, sustainable and safe for them and their infants before that time. If the criteria are met for replacement feeding, complete avoidance of breastfeeding is recommended. However, at present, advice about infant feeding practices should be provided on an individual basis, considering health status and local acceptability, to ensure the best possible long term mother and child health outcomes. Advice should also take into consideration the health services available, and the counselling and support the mother is likely to receive. WHO recommends that countries work towards providing mothers known to be HIV infected with lifelong ARV therapy, or prophylaxis interventions for breastfeeding and when appropriate, free formula feeds.

WHO recommendations 2010

Exclusive breastfeeding (not mixed feeding) for at least 6 months, and breast feeding to continue longer if circumstances are not suitable for replacement feeding. Where ARVs are available, breastfeeding should continue for one year.

If the mother is not receiving ARV therapy, the child should be given daily nevirapine until one week after breastfeeding has ended.

If the mother is receiving ARV therapy, the baby should receive daily nevirapine until 6 weeks of age.

4. Family planning/spacing

Nutrition is optimised by family spacing. Short intervals between pregnancies can kill children as the first child suffers the loss of breast feeding. The second year of life is as high risk as the first

5. Weaning

This should never begin before 6 months of age

During the initiation of complementary feeding at or after six months of age, safe water, food security, food safety and hygienic preparation of appropriate foods are paramount. Best practice is to recommend and use foods that are locally available and suitable for the age and developmental level of the individual child.

To encourage an appetite in ill children, food also needs to taste good and be well presented. Parents/carers need to be responsive to the child’s demand and pace of eating.

6. Support and screening: detection of the at risk pregnant woman, girl and child

- Should be provided within the existing health care system
- Should involve pregnant women and girls, mothers, children and families

A lead health worker/s for support and advice about breastfeeding, feeding and nutrition using locally available foods should be present in each health facility.

Each contact with the family should:

- Assess a woman or child's nutritional status to identify a malnourished person and, in childhood, poor growth. A child's weight and height should be plotted on the parent held health record growth chart AT EVERY VISIT

- If a fall off in growth is identified the child should be considered at high risk and treated as such

If the child is following an appropriate centile, each visit should review:

- The pregnant woman or girl and child's nutritional needs, including where necessary, giving micronutrients (vitamins and minerals), protein and energy supplements and advice on special feeds and diets.

- Safe food preparation and storage

7. Managing malnutrition

This is a complex situation in which mismanagement can do more harm than good. Lower risk patients can be managed outside hospital; high risk patients should be admitted as there may be concurrent pathology eg tuberculosis and HIV.

Management of severe malnutrition is as follows:

A. Emergency management

1. Feed every 2–3 hours, day and night to prevent hypoglycaemia and hypothermia
2. Keep warm
3. Rehydrate with oral low sodium fluids; monitor closely for signs of fluid overload; avoid intravenous fluids, except in shock
4. Give 100 kcal/kg body weight/day and 1 g protein/kg/day
5. Give potassium and magnesium to correct electrolyte imbalance; restrict sodium
6. Give micronutrient supplements; do not give iron until the malnutrition has been adequately treated
7. Give broad spectrum antibiotics even when clinical signs are absent as infections can be silent.

B. Rehabilitation

Rebuilding wasted tissues with high energy, high protein diets and micronutrients
Psychosocial stimulation especially in children to improve mental development
Preparations for continuing care and follow up after discharge.
Where these guidelines have been fully implemented, mortality has been reduced by at least half.

Supporting information

Difference in growth of twins: one fed by breast and the other on formula feeding

Under and over nutrition is the world's greatest epidemic. It both kills and chronically damages the physical and neuro-developmental and psycho-social health of pregnant women and girls and children. The commonest global cause of death in the under fives is malnutrition in isolation or in association with diarrhoea, respiratory infections, measles, malaria and HIV/AIDS. Children who fail to grow to their full potential in the first two years are unlikely ever to catch up (growth stunting). This stunting, which carries a later cost for adult health and quality of life, is still prevalent in many countries.

The seeds of under-nutrition often begin before conception. A chronically undernourished woman is physically maladapted to nourish a fetus and effects on her birth canal can make obstructed labour a high possibility. A suboptimal intrauterine environment leads to a lifetime of disadvantage. Growth restricted babies both have a higher infant and child mortality and, if they survive, are more susceptible to later chronic illness.

The antenatal period is a good time for health workers to give health education about breastfeeding and childcare as the quality of early nutrition is directly related to survival and later health. Following a recent review of the evidence, the recommendation of the Global Strategy on infant and young children feeding is: exclusive breastfeeding until six months of age followed by continued breastfeeding alongside complementary feeding up to two years of age.

Besides adequate and appropriate food and safe (potable) water any society has a responsibility to optimise other facets of maternal and child nutrition including: ensuring mothers' work load and energy expenditure is appropriate; to ensure that women and children are at all times treated as the highest priority; to minimise infection burden which disrupts nutritional balance

To gain the necessary skills to provide this nutritional care, all health workers need to learn about nutrition as part of their core and continuing training programs. Best practice is for this training to include learning about the management of lactation, a knowledge of what is meant by 'nutrition' and nutritional status, what is needed for children to grow and develop normally and how best to treat a child or pregnant mother with severe malnutrition. It is also important to acquire the practical skills that will enable health workers to identify and help a child with a feeding difficulty.

Malnourished children and mothers need nutritional support. The simplest and most cost-effective nutritional support is to provide enough appropriate local food for each individual. In occasional very severe cases, when appropriate, the use of enteral or parenteral nutrition needs consideration. Parenteral (IV) nutrition is only likely to be available in well-resourced health facilities and should only be used when there is gastro-intestinal failure and nutritional needs cannot be met via the gastro-intestinal tract.

To minimise the deaths of children and mothers from severe malnutrition it is essential that all health workers have received education/training in the management of severe malnutrition and follow the WHO recommended procedures. In the early stages of treatment the risk of dying is high, sometimes because the treatments and foods given are inappropriate, or associated dehydration, hypothermia, hypoglycaemia, infection and electrolyte imbalance are not correctly treated.

An ill child may not have their normal appetite, or be able to eat the foods normally accepted. Avoiding further deterioration by encouraging and helping them to eat is a simple but important part of care that is often overlooked by health workers.

Under nutrition increases the severity and length of an illness and can cause apathy, depression and deterioration of social interaction. This is of particular significance in young children who would normally be developing their physical, social and other skills at a rapid rate. There is substantial evidence to show that under nutrition in young children, particularly in association with illness, leads to the stopping or slowing of development and even a loss of skills that may never be fully regained.

At the other end of the scale, largely in the developed countries, over-nutrition and childhood obesity are causing increasing health and quality of life problems.

Mothers preparing low-cost local nutritious foods for their children in the nutrition ward in a Ugandan Hospital

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Standard 11: Recognises mental illnesses in adults and children and provides appropriate support and treatment:

'Health care providers, organizations and individual health workers, share a responsibility to ensure that they recognise mental illness and have in place systems to support and treat women and children with these conditions'.

Supporting criteria

1. **Recognition of mental illness.** Systems must be in place to recognise that mental illnesses that affect women and children are common and serious medical problems that require appropriate treatment.

   In poorly resourced countries, mental illnesses are poorly managed and often the patients suffering from these conditions are subject to abuse. Community education must be undertaken to describe the ways in which mental illness may present and ensure that the community knows that these are like any other medical problems and in most cases can be treated with good results.

2. **Treatment for mental illness.** Ensure that treatment facilities for all mental illnesses are made available in both community and hospital settings and ensure that evidence based treatments are applied.

3. **Post natal depressive illness.** Ensure through community education that it is known that every girl or woman who has recently undergone childbirth has the possibility of suffering from post-natal depressive illness or even psychosis and, when this occurs, make every effort to keep the infant with the mother throughout the treatment given, when safe for both mother and infant. .

Supporting information

Mental illness accounts for 12% of the total global burden of disease, and it is estimated that one person in four will experience a mental health problem in their lifetime.

Despite these statistics, mental health has been neglected in international development strategies, and it is only relatively recently that the United Nations and its partners have begun to include it as an integral part of their work.

In 2008, the UN Secretary-General, Ban Ki-moon, stated **'there can be no health without mental health'.**

The World Health Organisation plays a key role in setting policy standards and guidance in relation to global mental health. The WHO Director-General stated in 2008 that providing mental health care is a moral and ethical duty, it makes good economic sense and it is feasible.

The WHO list of mental health priority conditions includes depression, psychoses, and dementia, misuse of drugs and alcohol, and mental health conditions in children.

Depression is currently ranked third in the global burden of disease, and is projected to rank first by 2030. For women, however, depression is already the leading cause of disease burden in high, low and medium-income countries.

Poor mental health is both a cause and a consequence of poverty, being associated with suboptimal educational attainment, gender inequality and physical ill-health.

Most countries fail to devote sufficient resources to improving mental health, with only 2% of national health budgets globally being dedicated to it. 31% of countries have no specified mental health budget at all.

It is estimated that 80% of people with serious mental disorders in developing countries do not receive treatment.

Mental health is not referred to in the Millennium Development Goals (MDGs), but it is clear that it has an important part to play in each of them. MDGs 3, 4 and 5 specifically relate to women and children, and the role of mental health in each of these goals is as follows:

MDG 3 (Providing Gender Equality)

Women in developing countries are highly susceptible to mental health problems, at least partly due to under-valued social roles, poor socio-economic status, gender-based violence and restricted access to health services, including mental health services.

Gender-based violence is recognised to lead to depression, anxiety disorders, post-traumatic stress disorder, substance abuse and suicide (see Standard 9).

MDG 4 (Reducing Child Mortality)

Failure to thrive in childhood, and its associated high mortality, is strongly linked to maternal depression. Therefore, addressing mental health in women of childbearing age is a crucial aspect of reducing child mortality.

Poor mental health in children themselves can adversely affect their physical health and development. A report by UNICEF and WHO in 2002 stated that up to one in five of the world's children are suffering mental or behavioural problems.

Children growing up in war zones face the greatest problems, but children in more stable countries may also be vulnerable. Rates of depression and suicide in children are rising, with teenagers being of particular concern.

The UN Convention on the Rights of the Child recognises children's rights to mental health.

UNICEF is becoming increasingly active in providing psychosocial support to children during and after emergencies, as well as in integrating a psychological perspective in child protection, education and physical development.

MDG 5 (Improving Maternal Health)

Between 20 and 40% of women in developing countries experience depression during pregnancy or after childbirth; this is significantly higher than the incidence among women in more affluent countries.

Maternal mental health problems are associated with increased maternal physical morbidity, as well as with increased maternal mortality.

The risk of developing a serious mental illness (bipolar disorder, other affective psychoses and severe depressive illness), is generally reduced during pregnancy, but increased following childbirth, particularly during the first 3 postnatal months.

Women who have experienced an episode of a serious mental illness, whether pregnancy-related or not, have a 50% chance of recurrence postpartum. This confers a very significant risk of suicide, as well as of infanticide.

Postnatal depression can be looked upon as a public health issue, as its effects are recognised to extend beyond the woman herself, to include her partner, their baby and their existing children.

The UN Fund for Population Activity (UNFPA) was one of the first UN agencies to integrate mental health into its strategy. It collaborated with WHO in introducing mental health into maternal, sexual and reproductive health.

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Outside their home

Standard 12: Recognises the value of adequately trained and supported motivated health workers and acknowledges that without their valuable input maternal and child focused healthcare is not possible:

'Health care providers, organizations and individual health workers, share a responsibility to ensure that systems exist to train and support health workers working at all levels in the public health service'.

Supporting criteria

1. **Sufficient in-country training.** Sufficient resources should be in place to ensure that there are enough nurses, midwives, doctors, ancillary staff (for examples ward cleaners, porters and ambulance personnel) trained in the country to sustain the health facilities in the public sector
2. **Retention after training.** There should be a system in place to ensure that staff trained with Government resources remain working in the public health system for a defined number of years after qualifying
3. **Regulation of international organisations which employ government-trained staff.** International organisations or agencies working in countries with insufficient numbers of health workers must not be allowed to employ nationally trained staff working in the public health sector without permission from the Government.

   Lobby international organisations to ensure that when the number of health workers in the public health sector is limited these organisations should do the following:

   - replace any local public health system staff their programme or project employs, or import staff from well-resourced countries to do the project work.
   - Work in partnership with the national government to sustainably strengthen the public health system.
   - contribute to the on-going training of national staff and to work towards improving staff morale and motivation

4. **Valuing healthcare staff.** Value the contribution of health workers engaged in the public health service and ensure that they are supported by adequate salaries and decent living accommodation for the health worker and his/her family. Also give health workers the opportunity to become involved in shaping policies that ultimately influence the future development of their health facility.
5. **Counselling and support for health workers.** Provide a dedicated counselling service to support staff.
6. **Financial allowances for extra specialised work.** Provide staff who have been trained to undertake special responsibilities eg.caring for burns, looking after pregnant women and girls, caring for malnourished children with additional financial allowances
7. **Union support.** Encourage the formation of a Union or Task Force to support staff working in the hospital (work with the ILO?)
8. **Extension of skills.** Where there are limited numbers of doctors available in a country, and with the country's agreement, enable task shifting of major skills, such as training nurses to give anaesthesia and midwives to perform obstetric surgery.
9. **Encourage and support health workers to play an active role in their own continuing education. Suitable self-study material and peer group sessions with limited facilitation can**

bring ongoing learning to most health workers (Ref The Perinatal Education Programme at www.pepcourse.co.za)

Supporting information

The recruitment and retention of staff in Sub-Saharan Africa is a well known major problem. As reported by Robinson and Clark [1], **"Africa carries 25% of the world's disease burden yet has only 3% of the world's health workers and 1% of the world's economic resources to meet that challenge. Migration, together with other factors in many source countries such as insufficient health systems, low wages, and poor working conditions, are key factors determining low health-worker density in countries with the lowest health indicators."**

Shortages of health-care staff are endemic in sub-Saharan Africa. Overall, there is one physician for every 8000 people in the region and in the worst affected countries, such as Malawi, the physician-to-population ratio is just 0·02 for every 1000 (one per 50 000). (EJ Mills at al, **Should active recruitment of health workers from sub-Saharan Africa be viewed as a crime?** The Lancet, Volume 371, Issue 9613, Pages 685 - 688, 23 February 2008). There are also huge disparities between rural and urban areas: rural parts of South Africa have 14 times fewer doctors than the national average These numbers are very different to those in developed countries: the UK, for example, has over 100 times more physicians per population than Malawi. Furthermore, almost one in ten doctors working in the UK is from Africa. The insufficient number of health staff to provide basic services is one of the most pressing impediments to health-care delivery in resource-poor settings. The consequences are clearly shown by the inverse relation that exists between health-care worker density and mortality (The Lancet, Volume 371, Issue 9613, Pages 685 - 688, 23 February 2008)

The World Trade Organization's General Agreement in Trade Services http://www.wto.org/english/tratop_e/serv_e/serv_e.htm gives legitimacy to health-care being treated like any other commodity, where countries can compete to trade health services, including health professionals. But there are many other factors contributing to the haemorrhage of health professionals from sub-Saharan Africa, and the flow is not limited to crossing borders. Health workers will be attracted to the private sector, urban areas, and also to the plethora of non-governmental organisations that often pay more than the public sector. Political instability, unfavourable socioeconomic factors, and more specific issues such as poor working conditions—inadequate salaries, a lack of training, and inadequate equipment and medicines all have a contributory role. The active recruitment of health workers from resource-poor countries where, despite international ethical codes, many rich nations benefit to the detriment of poorer countries in order to ensure that there are enough health workers to prop up their own health systems occurs—a practice which Ed Mills and colleagues describes as a crime. The Lancet, Volume 371, Issue 9613, Pages 685 - 688, 23 February 2008.

For example, Ghana has lost £35 million of its training investment in health professionals to the UK, saving the UK £65 million in its own training costs between 1998 and 2002. (Finding solutions to the human resources in health. The Lancet, Volume 371, Issue 9613, Page 623, 23 February 2008).

The entrenched and complex problem of "re-distribution" of staff from the public (national) health service (NHS) to other countries, to the private sector (accessible by only a few patients), and away from remote or rural areas also involves a clash of human rights—the rights of the individual health workers to have a better life for himself/herself and his/her family, against the rights of the local population to have their health needs met. http://www.medact.org/article_ih.php?articleID=863. Unfortunately, the poorest communities are affected the most.

However, it is perversely ironic that some international organisations, research institutions, and non-governmental organisations (NGOs) aiming to promote health and relieve suffering may have the opposite effect by employing locally trained health workers (often the most able) in countries where there is a shortage of NHS staff, the only source of health provision for poor people there. (Southall D, Cham M, Sey O Health workers lost to international bodies in poor countries. The Lancet 2010, 376:498-499).

By offering better salaries and working conditions, such international organisations prevent government-trained doctors and nurses from contributing to their NHS. In an under-staffed NHS, this situation not only deprives patients but also demoralises remaining staff as they carry an increased and often dangerous workload. The problem is not limited to research organisations - NGOs, UN organisations, and faith-based hospitals are also acting in this way. Here is an example: an international organisation treats a specific health problem that is affecting patients in a poor country. It advertises and readily employs a surgeon, nurses, and midwives, all trained locally. Patients with the specific health problem are successfully treated and excellent research is published—but there is now no emergency surgery in the local NHS hospital. The labour ward and an antenatal ward containing critically ill patients with complications of pregnancy are served by only one trained midwife per shift.

Guidelines to help keep health workers in remote and rural areas, especially in poor countries, have recently been issued by WHO and the work of the Global Health Workforce Alliance http://www.who.int/workforcealliance/knowledge/en/ has helped to highlight the complex issues involved in human resources for health. The Alliance held its first Global Forum in Kampala in March 2008 http://www.who.int/workforcealliance/forum/2008/en/index.html where international participants endorsed the *Kampala Declaration and Agenda for Global Action*, http://www.who.int/workforcealliance/Kampala_declaration_final.pdf and http://www.who.int/workforcealliance/forum/1_agenda4GAction_final.pdf a historic roadmap outlining the key actions required at international, regional, national and local levels to improve human resources for health over the next ten years. The follow up Forum in Bangkok in 2011 http://www.who.int/workforcealliance/forum/2011/en/index.html reviewed progress and renewed commitments http://www.who.int/workforcealliance/forum/2011/Outcomestatement.pdf

The Alliance also has a useful resource and knowledge centre http://www.who.int/workforcealliance/knowledge/en/ in relevant topic areas such as recruitment and retention, and workforce management and performance

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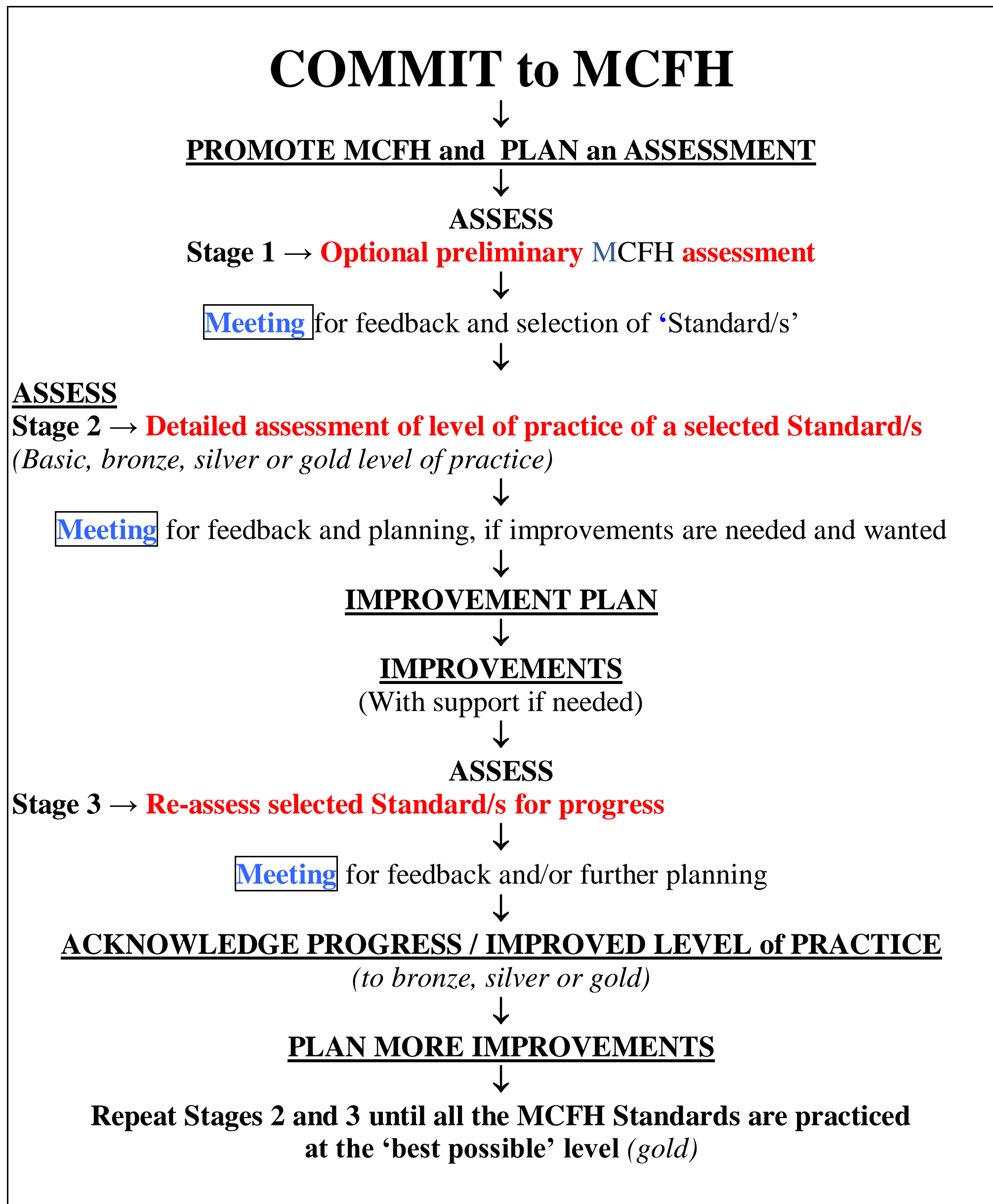
British obstetrician with Gambian midwife outside regional hospital. The obstetrician is there to train midwives in emergency surgery, including Caesarean section.

One room home for a senior health worker in The Gambia

One room apartment for a nurse and her family. The toilets and showers are more than 100m away a major problem at night.

Section 3: How Maternal and Child Healthcare Focused are you?

(How to assess the care you give)



Does the programme work in any type of healthcare environment?

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

Who can use the programme?

It can work 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 'Maternal and Child Focused Healthcare'?

Any committed health worker who is familiar with its practices and principles can promote MCFH by sharing information about the MCHFI and the UNCRC and proposed CRWG with others in the same environment, in other healthcare environments in the same country and with health workers in other countries.

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

How long does it take to achieve the 'best possible' Maternal and Child Focused 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 programme?

The health workers responsible for managing and planning healthcare for women, infants and children:

1. Commit their health facility or health service to 'Maternal and Child Focused Healthcare' and the MCFH 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. During the pilot project for the Child Friendly version, less motivated health workers, who initially didn't want their clinical area to participate, saw the progress made and became keen for their clinical area to become involved.
2. Appoint a MCFH coordinator or coordinators
3. Decide whether to self-assess or to appoint an experienced external assessor/s
4. Plan an assessment

Who should coordinate the programme?

A volunteer or person selected from the senior doctors and nurses working in the participating healthcare environment. The pilot project for the Child Friendly Healthcare Initiative revealed that the programme works best when coordinated and facilitated by a health worker who has the respect of 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 important.

The responsibilities of a MCFH coordinator

The most important responsibilities of a coordinator are to:

- Promote 'Maternal and Child Focused Healthcare'
- Be committed to 'best possible' practice for all aspects of healthcare for women, infants and children and to instigate changes needed to achieve this
- Supervise and contribute to the programme

What other responsibilities does a MCFH coordinator have?

For self-assessment the responsibilities include:

1. Organising and assessing, including the administration and logistics
2. Organising meetings and inviting relevant people
3. Coordinating a plan for improvements
4. Facilitating and supervising progress in the participating clinical area/s

5. Liaising with the health workers responsible for support services and other jobs relevant to the 'Standard' chosen for improvement
6. Supporting colleagues in the participating clinical areas who are trying to improve care
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 achieve planned improvements
9. Regular feedback/reports on progress and sharing of any problems or concerns with others, including the external assessor
10. Sharing information regularly with others involved, including the director of the health facility or service and relevant supporting organisations and other senior maternal and child 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 'Maternal and Child Focused 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 programme related materials and distributing these.

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

- 'Rights' issues: *All Standards*
- Family welfare: *All Standards*
- Disability/rehabilitation: *All Standards*
- Hygiene Promotion/Infection Control: *Standard 5*
- Pain and symptom control (Palliative Care): *Standard 7*
- Resuscitation and emergency care: *Standard 3*
- Play: *Standard 5*
- Education /school-type learning: *Standard 5*
- Women and Child Protection: *Standard 9*
- Immunisation: *Standard 1*
- Health Promotion: *Standard 1and 8*
- Breast Feeding: *Standard 10*
- Nutrition: *Standard 10*
- Clinical guidelines and job aids: *All standards*
- 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 MCFH and are committed to a continuum of assessment and improving practice
- Has adequate human and material resources
- Has most of the systems of care, facilities, policies, guidelines, educational opportunities etc. in the initial check-list (Tool 1, Part 1) in place

- Delegates responsibility for the support services and clinical jobs to different health workers
- Values all its health workers
- Respects and values the views and opinions of women, children and their families

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

External assessors are more likely to:

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

Who should be an external assessor?

A health professional or manager with assessment skills who has professional respect and is committed to MCFH. In our experience it works best if an external assessor understands the culture and languages of the country, although it can sometimes work using interpreters.

About the MCFH assessment improvement programme

The objectives of a MCFH assessment are to:

- Raise awareness about MCFH thereby enabling and empowering change
- Help prioritise areas for scrutiny
- Assess the current level of practice of these areas
- Identify local problems and possible solutions
- Identify barriers against, and forces for, change
- Facilitate improvements
- Identify appropriate 'aid' projects, if available, to support local health workers in 'making it better'
- Identify issues for advocacy
- Assess change and/or progress after an agreed period of time
- Acknowledge improvements, however small, to motivate health workers to continue making improvements for the women, infants, children, their families and themselves

The only bag mask for resuscitating a newborn infant in this labour ward is broken

Very poorly equipped emergency room in a first referral district hospital

About assessment

Before an assessment it is important to:

- Obtain consent for the programme 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 MCHFI 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 MCFH Standards. This is useful as it sensitizes other health workers to MCFH, identifies areas of health care that the health workers do well and areas of care that health workers want to improve

Helpful pre-assessment information for an external assessor includes:

- The language/s used in the health facility
- A brief report on the services provided for women, infants and children
- The number of women, infants and children seen and/or admitted during a year in the health facility
- Mortality and morbidity statistics, if collected, and any other relevant data available

- The number of doctors, nurses and others employed
- The names of relevant 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 MCFH coordinator and others
- A prioritised problem list

After an assessment the assessor/s:
- Bring/s together and presents the results of the assessment
- Provide/s and circulate/s a written report of the assessment 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 by health workers in participating areas
- Facilitate/s improvements if and when possible

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

The assessment focuses <u>not on resources,</u> but on how health workers use the resources available to them, and on their attitudes, skills, practices and knowledge.

How long does it take to do an assessment?
The number of assessors and the time needed for an assessment depends on the size of the healthcare environment and the number of health workers employed. For most healthcare areas 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 opinions of a sufficient number of people are 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 programme 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 interviews with senior health workers and managers needed
- Translating materials in advance if necessary
- Arranging interpreters in advance if needed

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 relevant in countries where 'Maternal and Child Focused 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 MCFH 'Standards' and complements the self-audit. It specifically:
- ❑ Finds out which Standards are practised well and which need improvement
- ❑ 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 MCFH standards needing more detailed assessment

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 inadequate essential resources
- Seeks the views of all health workers
- Seeks the views and opinions of families using the service, therefore providing a balance between the needs and wishes of the families and the aspirations and wants of the health workers.

A Stage 2 assessment evaluates the prioritised 'Standard' in detail. It will:

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

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

- Find out if the planned improvements have occurred
- Find out if the improvements 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
- Identify strategies for change that worked and why so that these can be shared with others
- Clarify issues for advocacy

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

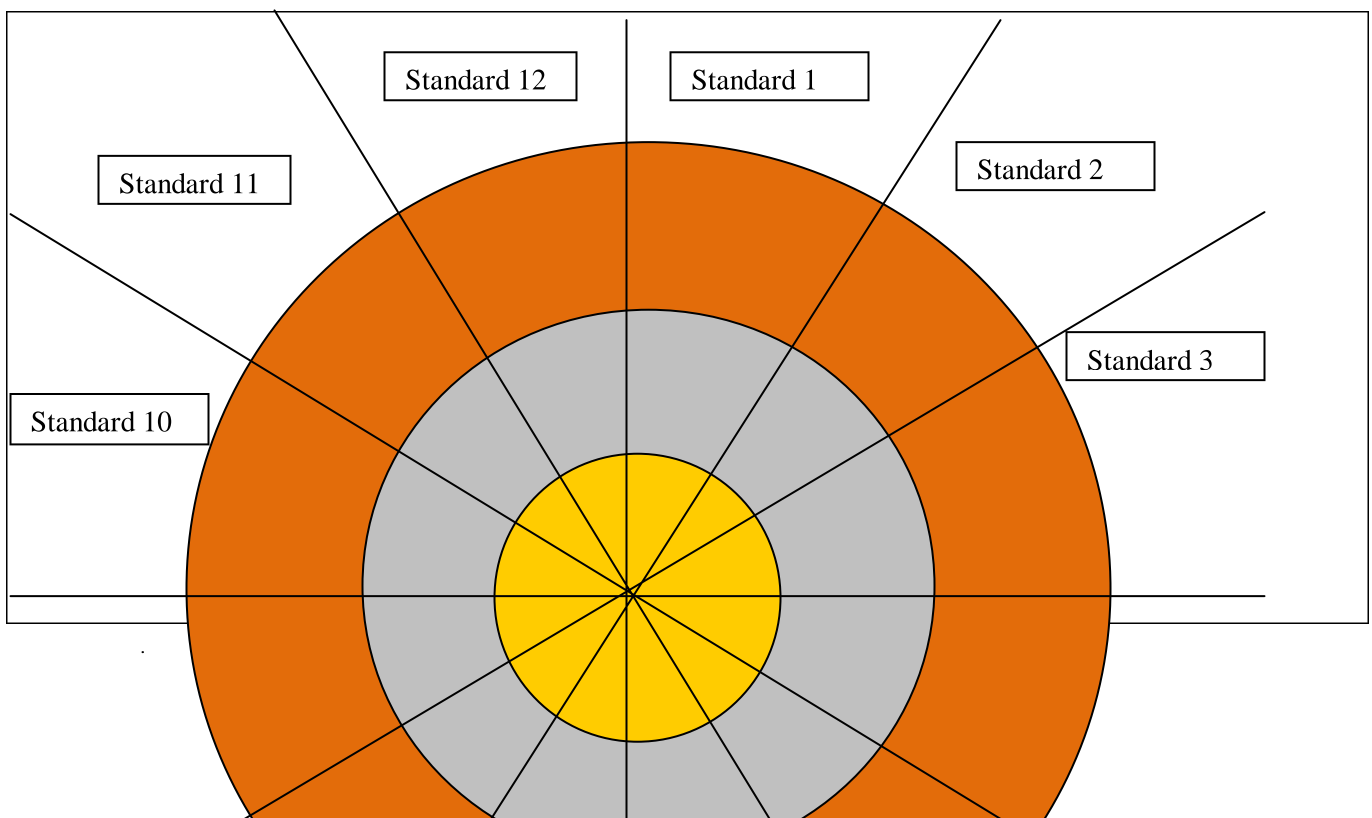
An operating theatre in rural Gambia before and after renovation

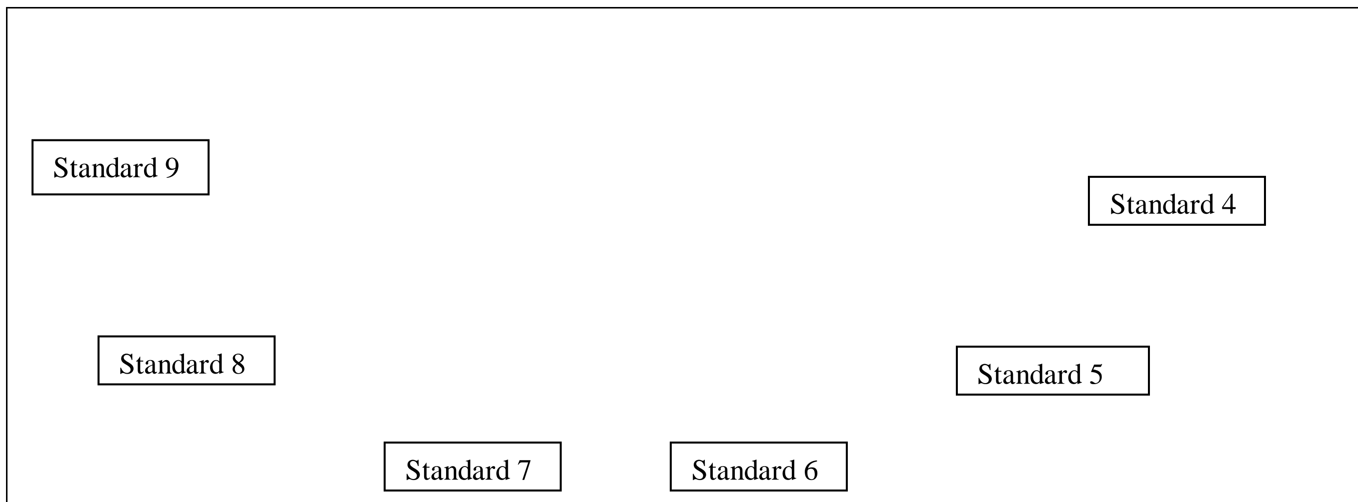
Achieving objectives and a higher level of care motivates health workers to make further improvements

Levels of performance
'Going for Gold' is a well-known concept that works well to encourage athletes to strive for excellence and their 'best possible' performance. The concept of using a medal system to identify excellence therefore seems appropriate and complies with the objectives.

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

Diagram illustrating four levels of quality of care for each 'Maternal and Child Healthcare focused Standard.





Level 1 Basic	Level 2 Bronze	Level 3 Silver	Level 4 Gold

About the MCFH Toolkit

The MCFH 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 aids, data management, especially the quality of medical record keeping and monitoring charts, education/training opportunities, the quality of audit, and other activities necessary to practise the 'Standards'. These check lists are supported by structured observations, interviews (open, semi-structured and structured), questionnaires (including knowledge based questionnaires for some MCFH Standards), and, after a stage 2 assessment, benchmarking for any planned improvements.

Maternal and Child Focused 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 MCFH coordinator with help from senior health workers, support services, *(for example palliative care, play etc),* and other relevant health workers such as doctors and nurses responsible for obstetric and paediatric healthcare or by an external assessor/s after he/she has talked to senior health workers

If an external assessor completes the list, it is advisable for him/her to confirm what has been reported by direct observation. To do this, the external assessor needs to visit all clinical areas used by women, infants and 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 and use of existing resources

Part 3

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

Maternal and Child Focused Healthcare Tool 2

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

Part 1 This is a detailed check-list that reviews the organization and management of facilities, resources and other activities relating to each MCFH Standard assessment

Part 2
This is a structured questionnaire (or interview) for each chosen standard 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 women, parents/carers and/or children concerning their experiences relating to this 'Standard'.

The **first three parts of Tool 2** have been designed to provide useful information about attitudes and experiences to help health workers prioritise and plan improvement.

Part 4 of Tool 2
This consists of a series of benchmarks for a prioritised Standard to facilitate improvements

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

Benchmarking involves assigning each planned improvement to four practice levels.
For example, assess the current situation. Is it poor practice, or in second or third categories (bronze or silver), which are steps towards the goal, or the fourth category which is the best possible quality of care (hoped for after improvements have been made) ie. gold?

Example of a benchmark

Poor/basic 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 of tool 2 provides a framework to measure improvements or deteriorations. This framework can also be used as a simple way to monitor progress. It is a rapid method for seeing which objectives have been achieved either partly or in full, and which have not.

Quantitative scoring makes it possible to identify and consistently standardise four proposed qualities of care (poor/basic, bronze, silver and gold).

The example below gives a possible scoring system for the benchmark assessment of Criteria 6e for Standard 2 on oxygen availability in the maternity unit:

Question X	**Oxygen in the maternity unit is available:** All the time Most of the time Infrequently Never	**Score =** 3 2 1 0

The score for each criteria or sub-group of a criterion measured for Standard 2 in this way can then be calculated as a percentage of the total score possible.

The percentages for each of the criteria or sub-group of criteria can be added together and averaged to give an overall percentage score that can be used to determine the level of practice (0 - 25% is poor care, 26 - 50% is bronze, 51% - 75% is silver and 76 - 100% is gold) for that particular standard at that particular time..

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

For example:

The average score after Standard 2 was assessed in maternal and child health departments of hospital X (before improvements made) was as follows:

45% = **Bronze**

6 months later after improvements were made, the averaged score for Standard 2 in this department of the hospital was:

60% = **Silver**

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 feedback, and for planning improvements. They need to be attended by key people, have an agenda and a 'chair' (leader), usually the MCFH coordinator. **The local health workers must "own" the assessment**

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 health workers in important roles may not have met others (putting names to faces).
- Share information about MCFH and the MCFH assessment process
- Answer questions
- Plan a realistic timetable and 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 improvements
- Decide a date for progress review (a MCFH Stage 3 assessment including local staff who should be encouraged to constantly assess their facility)

The people who attend MCFH meetings could include:

- WHO, UNFPA and UNICEF Country staff
- The director/chief of the healthcare environment or the deputy director
- The manager of the maternity and children's services
- The children's senior doctor and nurse
- Senior health workers who manage clinical areas
- Senior health workers who manage support services or coordinate important clinical jobs (such as immunization, infection control, pain management, breast feeding, child protection) if relevant
- The MCFH coordinator
- The external assessor/s
- Representatives from any NGO'S already working in the healthcare environment or country who might contribute

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

The input of women, children and families is essential, welcome and sought during all three stages of the assessment process - the MCHFI assessment process itself assesses communication and liaison with parents.

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

It is important to protect anonymity and confidentiality of everyone who is interviewed as this allows women, 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 before and may live in a climate of disempowerment and mistrust of officialdom. The interviewer must be impartial, trustworthy and with an independent translator if necessary (not relatives of the woman, family or healthcare staff). Any verbal or written information acquired must not be traceable to an individual woman, parent or child.

Women and 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 if they or their child needs attention.

The purposes of an interview should always be remembered ie. to gain an understanding of what is important to each individual woman, child and family, what has been particularly good or difficult, what might make their experience better and how to make things better for others in the same situation? The interviewer needs to ensure the woman, child or parent/carer understands why they are being interviewed, and what will happen to their contribution. It is important to obtain consent for the interview after this explanation.

Questions need to be easily understood and/or omitted if not relevant, appropriate or cause distress. It is important not to coerce any woman, child or family member into giving information or answering questions they feel uncomfortable with. If using an interpreter, look at and talk to the woman, child or parent, rather than the interpreter, and look at the woman, child or parent when listening to the answers given through the interpreter to see if they are correct by watching their body language. Use empathic body language yourself, as showing care and respect will encourage a woman, child or parent to say what they really think or feel

For children, it may be useful to have some form of distraction, such as a toy or a picture, to engage and amuse younger children when interviewing their parent/s.

When interviewing a young child:

- It is not appropriate to ask questions about every aspect of care
- 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 not to 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 and make sure there will be no interruptions
- Make sure the woman, child or parent is comfortable

- Tell the woman, 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 MCFH programme (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 points may be shared with others, no-one will know who said these things
- Ask the woman, 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 women, children and parents/carers should be interviewed?
As many as possible from each healthcare environment being assessed and best chosen randomly (if only volunteers are interviewed there may be some bias in the answers they give.) Ideally the same number of women, parent/carer/children as health worker interviewees provides balance.
It does not matter if different women, parents/carers and children are interviewed before and after improvements are made. This commonly occurs due to time constraints, and still allows 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 use their resources, helps understand their attitudes and assesses their skill and knowledge.

- **Senior health workers**
  Assessors need to work closely with the senior health workers in the healthcare environment, the managers of support services and any clinical coordinators 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 MCFH '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 'Standards' 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 reflect collective views if some health workers do not participate. It is therefore important to gain support from senior health workers to encourage cooperation at all levels.

Checklist for assessors
- Decide on the total number of questionnaires needed and number these
- Explain the programme to the participating health workers or design an information leaflet to hand out with each questionnaire. Distribute the numbered questionnaires
- Arrange a 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. Ensure this is done anonymously and destroy record of names before analysing questionnaires

- 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 percentage of each type and seniority of health worker selected randomly from employment or duty lists. In practice, unless careful planning is possible, selection may be dependent on availability. In larger clinical environments ten nurses and doctors is the minimum number needed.

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Section 4
'Making it better'
(How you can make improvements and how others can help)

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

The first photograph shows a chaotic, poorly organised, 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, 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 at very little cost.

Important reasons for improving healthcare

- Women and children are still dying and suffering needlessly in healthcare facilities
- 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 benefits and threats to the health of women, children and families
- Providing better care for patients is also good for the staff

Operating theatre renovated in a hospital providing health care for > 250,000 people in The Gambia. Most of the equipment is second hand from a medical auction in the UK

Barriers against change

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

Barriers to change may be external or within the healthcare environment. These barriers, and the forces for change, need to be recognised and fully understood. 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 workers in a healthcare environment)

- National circumstances in the country (natural and man-made disasters)
- Complex healthcare bureaucracy
- Lack of health workers in the public sector leading to over-work, low morale, "burn-out" and poor attendance and quality of care.

- Constantly changing policies at local and governmental level (instability)
- A low budget and poor planning for women and children's healthcare
- Poorly integrated primary and secondary healthcare services
- 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 and a low commitment to provide the same standard of healthcare to all women and children.
- Poor job security so health workers fear voicing their opinions.
- Few formal courses available for continuing education and personal growth as health workers
- Limited opportunity for professional advancement and little recognition of worth.
- Poor work environment (low investment in equipment and infrastructure; inappropriate equipment)
- 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 by those planning services or systems of care with women, children, their families and the health workers giving or supporting the care,. Often non-professional or junior health workers lack 'a voice'.
- 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
- Health workers having no opportunities to access education or to learn effective management and organisation skills (difficult to get study time)
- No fair and open system for employing, dismissing or disciplining health workers
- No system for recognising 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 literature and evidence for healthcare changes.
- Few standards, policies, guidelines and other job aids
- No opportunities to review existing policies and guidelines to ensure they achieve their objectives (audit)

Barriers in individual health workers

- Lack of health workers in the public sector leading to low morale and absence of discipline over both attendance and healthcare given.
- A negative attitude and low morale
- Difficult personal circumstances that 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
- Poor realisation that they are partially responsible for their own continuing education

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

- Stable government (including Ministers of Health), situation and country's boundaries
- Political vision for improving women and children's healthcare. This vision works best if :
  - It is shared by everyone involved in the health of pregnant women, girls, babies and children.
  - 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 others interested in women and children's health such as WHO, UNFPA, UNICEF and non-governmental organisations (NGOs)

Internal forces

- A collective commitment to make things better
- Sufficient skilled health workers to provide safe care (see Standard 12). 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 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 established working practices. **Enforced job rotation is very destructive.**
- A change of leader/s
- Fair and open management with delegation
- A culture of team working, especially team problem solving
- A system to consult health service users (the women, 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 while not compromising patient care at that time
- 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 important.
- Access to evidence based literature.
- Clear standardised (the same and used by everyone) policies, guidelines and job aids with training (See Section 5: Information Sheet about Job Aids)
- A 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, showing that change works and supporting advocacy for more resources.

In individual health workers

- Visionary leadership able to motivate and organize others. For example, the visionary leadership of a paediatrician in Mulago Hospital Complex, Uganda improved care for the newborn, a new ward sister in Mulago improved care given on her ward and of a single-handed Cuban paediatrician in The Jubilee Hospital in South Africa 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 women, children and their families and not the needs or traditions of health workers. It is best to use a team approach to decide how 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 with respect for the different skills of others.
- An individual commitment to making improvements
- All the senior health workers in a clinical area committed to making changes/improvements - planned changes can be sabotaged if a powerful senior person is not committed.
- An individual commitment to human rights, especially to the rights of women and children, 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.
- An expectation that helping others should be emotionally rewarding and enjoyable

During the pilot project when most of these forces supporting 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, little change happened.

How to make improvements?

To make changes to improve healthcare for women, children and their families, barriers need to be overcome, and any forces that help recognised and used effectively

'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' by a country's health planners
- The influence of an important person or group of people, such as a government minister or a patient 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 woman, child or parent. In many countries, women, children and parents are not listened to
- A learning opportunity or exposure to new experiences, such as a visit by an outsider who raises awareness of and/ or opens the eyes of health workers to what is possible
- New evidence showing there is a better way of giving a particular aspect of care

Large changes need to be planned and resourced by those who organise healthcare, but it is important to remember that many small low, or no cost, improvements can be made by every health worker and often

very small changes can have a huge impact on patient well-being. It is these changes that the MCFH improvement programme 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 behaviour can make a big difference to how a woman, child and family responds to their health problem and changing negative attitudes in some health workers, however difficult, can be of huge benefit.

Attitudes and beliefs influence all aspects of healthcare. They are difficult to change but best practice is for every health worker is to have a caring and sensitive attitude, and to continually try to change any negative or destructive attitude seen in others, especially those that interfere with providing the best possible care. This can be achieved by sharing knowledge and evidence about MCFH. This costs only 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 project.
- Use a team approach to plan and implement ideas and solutions with a representative from each group of health workers, and someone to represent women, children and families.
- Share ideas, problems and solutions locally, nationally, and internationally through publications, advertisements, the media, and at meetings
- Use human and material resources effectively (see section 5 'looking after health workers'). In countries that have inadequate numbers of skilled health workers, it is best practice to train and employ less skilled people as basic health workers (not nurses or doctors). This enables the more skilled doctors and nurses to see only the very ill women and 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 recognise patients that needing referral 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. Establishing peer study groups to encourage co-operative learning with self-help material has been very successful in South Africa. www.EBWhealthcare.com **and** www.pepcourse.co.za
- **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. Best practice is to have formal systems for supporting and looking after the physical, mental and emotional health needs of health workers. This is inexpensive compared with the cost of the loss of health workers to the 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

Why acknowledge effort?

Acknowledging effort is of huge importance for many reasons. For example, for children to learn and realise 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 what they do. If they have this respect, they will try to keep it; if they do not feel their efforts are acknowledged, 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 health workers are doing a good job. A culture for blame has a destructive effect on all aspects of healthcare provided. It can also cause great distress and disillusionment to 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, a different country or from the international community.
Advice and assistance that supports change includes:

- Agreed 'Standards' for women and children's healthcare (international, country, health facility and/or professional)
- Systems for monitoring, recognising and rewarding achievement of these Standards
- Health improvement programmes
- 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.
- Sponsorship
- Advocacy
- A lot of functioning equipment in good working order, which is routinely replaced in industrialised countries, could be transferred to under resourced facilities.

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

Short-term unsustainable aid given in emergencies is very different from the aid required to help develop women and children's healthcare services. It is important for donors to recognise 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 needs and also to recognise and refuse inappropriate donations.

It is vital in poorly resourced countries that international donor organisations do not further deplete existing staff to work for them rather than for the public health sector of the country who has trained them.

Some examples of inappropriate aid seen during the pilot project

- Cupboards full of donated infusion pumps in one country's neonatal unit. All said to be broken but were in working order. These were incompatible with the local electricity supply, the local health workers did not know how to use them, nor were they ready to change the way they gave fluids. They were also unaware of the benefits such a change could bring. No service contracts to maintain donated equipment. www.PET.org.za
- An impassioned plea from a maintenance engineer asking that donors consult him before donating equipment he would have to maintain (no repair manuals in his language came with the equipment), and there was no budget for spare parts.
- "Out of date" drugs and disposables that were not part of the country's drug formulary. 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 and 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 as there was no funding or expertise for it to be repaired.

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 and maintaining it, before donating).*
2. Appropriate for the level of care that the local health workers are 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 *(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.

Back-up service must be available in the recipient country.

Donated learning materials need to be appropriate, wanted 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 needed, they should be usable and compatible with the local technology available.

Donated medical and surgical supplies. No shelves to put it on and piled in a corner unopened.

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 worlds 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

- 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
- 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 or info@e-talc.org
- FreeMedicalJournals.com – www.freemedicaljournals.com
- Health Internet Access to Research Initiative. www.healthinternetwork.org
- Free website for self-directed learning courses in maternal, newborn and child care – www.EBWhealthcare.com

Sharing expertise with other countries (twinning)

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 and invited 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 women and 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 the airway and provide assisted ventilation.

- Be capable of achieving the respect of local health workers
- Be versatile in their working methods
- Consider gender as this can be a factor that may affect a visiting health worker's ability to engage local health workers
- Be able to communicate well. If the language of the local people is not spoken this can be a major handicap unless they are always accompanied by an interpreter.
- Be able to set realistic goals for themselves
- Be enthusiastic and able to motivate others and teach by example
- Support learning and skill building by providing training and educational materials, if these are not available in the country
- Be able to show the reasons why a new method 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 MCFH assessment, will provide them with information they need. It will guide and prioritise the help they can give to their disadvantaged colleagues and will help them set realistic goals 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 an unfamiliar country.
- Provide a named mentor or supporter who should contact them regularly to discuss problems, monitor their well-being and activities, and provide any support needed.
- Ensure that they are protected as much as possible from serious illness and accidents.

Shared good ideas, good practice and solutions to problems

This does not mean importing solutions that may work in different environments and circumstances. This is arrogant and may, and often does, 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 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.

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 an aspect of healthcare better, but only if the health worker returns to their own country after the learning experience to put this into practice. However, although some may initially return, they have acquired knowledge that might help them to move to a well resourced country later in their careers where they can earn more money for their families - families who have helped fund their training. 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 skills that are needed rather than those irrelevant to practice in their home country. They must either undertake education within the recipient country or ensure that health workers return to their country of origin. For these reasons, the MCFHI is very wary about supporting the training of health workers in well resourced countries. Our policy is for experts to visit poorly resourced countries and provide training.

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, women, 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)

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Section 5
Supporting materials

MCFH Information Sheets

1. Adversity and problem solving
2. Advocacy
3. Audit
4. Cleaning
5. Clinical guidelines and other job aids
6. Data Management
7. Lifelong learning and putting this into practice
8. Looking after health workers
9. Mission Statements *with examples*
10. Problem solving
11. Team working and leadership *with an example of a health facility management structure*

MCFH Information Sheet 1: Adversity and problem solving

'Life is not the way it is supposed to be. It's the way it is. The way you cope with it is what makes the difference'. Virginia Satir

'I believe that it is what you do after a disaster that can give it meaning' Christopher Reeve

Adversity can be an event or situation that compromises a woman or child's survival, development, protection and/or participation. Adversity makes a woman or child more vulnerable to actual physical, mental or emotional harm, or to abuse through exploitation or neglect.

Adverse events include natural, personal and man-made disasters. Some examples of natural disasters include earthquakes, floods, hurricanes, extreme weather conditions, drought; personal disasters may be accidental separation from a parent, accidents, illness, and disability. Examples of man-made disasters are wars, famines, poverty, separation from a parent through divorce, exploitation or neglect or poor parenting for any reason.

Children living in a war zone in Pakistan with almost no access to healthcare unless their parents can afford the private hospital services. The latter are mostly owned by USA corporations and provide as good a service as any in Western countries.

Two Afghan children orphaned by war and living in the State orphanage in Kabul

Afghan refugee family in home-made tent in New Jalozai camp Pakistan

Afghan refugees waiting for healthcare in a refugee camp in Pakistan

Child soldiers in the war in Lebanon

Children playing with a bomb in Iraq

Adverse situations are difficult circumstances, for example, poverty and other social or difficult family circumstances, including a health problem that requires hospitalisation.

An example of how an adverse situation made a child feel

'Humiliation is the worst feeling, to be excluded and ignored and to be compelled and not given the space to express our needs, our feelings, our dreams'. ***A working child in Karnataka, India.***

Some facts about adversity

- Outside intervention may be needed to stop or resolve the event or situation
- It is not the magnitude of the adversity but the effect that it has on the individual - what may seem a small, insignificant thing for many people that can be easily absorbed, for a few people may be a catastrophe with far reaching effects.
- The impact that an adverse event or situation has on a woman or child is dependent on many factors. These include the circumstances of the adversity, what else is happening in the person's life, ability to cope and emotional and psychological vulnerability.

- After the adverse event or situation is, help may be needed to recover fully, especially if 'resilience (self-healing)' is not good
- If adversity involves **any type of loss**, the grief process has to be endured and supported. Comments such as 'pull your self together' are not constructive and cause further damage to a vulnerable adult or child. Understanding is needed and listening until they are able to come to terms with their new situation.
- Only someone who has grieved themselves can appreciate that suffering is not self-inflicted and cannot be avoided. To be a victim or not, is more complex than merely being a question of individual choice. Victims need support and time to recover.
- Coming to terms with adversity and forgiving one's own possible contribution (if acknowledged), and that of others, can be a positive experience. It can lead to more tolerance and understanding, and an improved ability to help others (an example set by Nelson Mandela).
- Not all women or child victims find the forgiveness necessary to come to terms with the adversity they experienced. This failure to heal can cause long-term developmental and mental health problems. They might never develop their full potential, become emotionally mature or contribute to society.

Intervention to help a woman or child cope with adversity needs to:

- Be appropriate to the event or situation
- Be by people who have appropriate resources, skills and attitudes
- Build on and promote a woman or child's own coping strategies
- Avoid the term "victim" as this suggests helplessness, passivity and defencelessness in the face of adversity
- Include listening, but avoid further exposure to harm by insensitive questioning of women or children after an adverse event
- Combine cultural sensitivity and an understanding of developmental pathways
- Be evaluated

The adverse event or situation usually causes many problems for the woman, child and their family. These will need solving either by themselves or with the help of their community and others (a team approach).

Some simple rules for helping to solve problems

1. Define the problem/s after listening to everyone affected *(do not make assumptions about the cause of a problem. If you do, it is likely that your solution will not work. Talking to everyone makes finding the true cause/s of the problem and a workable solution more likely.)*
2. If there is more than one problem, prioritise these *(remember that the main problem may be due to several different problems each with different causes, so break a problem down into all its different parts and decide which are the most important to solve first)*
3. Look for barriers to solving the problem/s and the ways of breaking these down.
4. Decide on some possible solutions/courses of action *(after talking to those affected and if possible also to others who have faced similar problems. The more complex the problem, the more consultation necessary)*
5. Consider/evaluate the possible solutions and select the best possible with everyone's cooperation *(the problem that is easiest to solve may be best tackled first as success encourages and motivates)*
6. Try this out/implement/put into action (if there are lots of problems it is better to select only a few to act on first. Trying to solve too many at the same time may lead to failure).
7. Evaluate the results to see if the problem has been solved *(identify the lessons learned/the things that went well and the things that could be done differently or better next time)*
8. If not, try out other possible solutions

9. Review other problems from the list and repeat the process
10. Always acknowledge everyone's efforts and share the solutions that worked

MCFH Information Sheet 2: Advocacy

Advocacy in the context of MCFH means speaking on behalf of women, children and/or their families who are either unable, or unwilling, to talk about their needs, safety, or abuse of their rights. It is acting as a 'voice' for someone who has no 'voice' or is unable to use it.

Some facts about advocacy

- Its aim is to make things better for the woman, child and/or their family
- It is usually targeted at people who are able to make decisions and have influence
- Anyone can advocate and most of us do so in our daily lives, in many different situations without being aware of doing so
- Advocacy is for someone or for some people.
- It is usually done on behalf of someone, or with those affected
- It can also be done through systems such as law, healthcare 'standards' or health improvement programmes *(the UNCRC is the most important organisation that advocates for children)*.
- It can be about anything causing a difficulty or a problem for a woman or child
- Advocacy can be at many different levels. It can be communicated to other health workers in your daily work, the family, the community, the local or national government, international organisations or religious organisations.
- Health workers are ideally placed because of their knowledge of a woman or child's needs and best interests. They have a responsibility to act as advocates for them.
- It is important to have as many facts as possible concerning the problem –consult widely beforehand if possible and if circumstances allow
- Advocacy must always consider a woman or child's 'best interests'
- Best practice, if possible, is to use advocacy with the woman or child's and/or their families' consent
- If involving the woman, child or their family it can empower them, however care must be taken to avoid making their situation worse.

Some simple examples where advocacy can be helpful:

- Advocating to the ministry of health about the absence or shortage of an essential drug such as morphine or oxygen
- Advocating to a social services support system (if it exists) about a family 'in need'
- Using publications or other communication methods to highlight a problem in a health facility
- Advocating to government about the need for a health service which is equally available to all families regardless of their ability to pay
- Complaining to a manager about inadequate facilities for women or children, for example toilets which are unclean.

Some global issues for advocacy

Health workers also have a responsibility to speak out about some of the important global issues that affect women, children and families. These include:

- *Antiretroviral drugs*: Advocacy for the availability of these for the millions of HIV positive women and children has led to decisions that will improve this situation. It is widely believed that poor countries do not buy generic drugs because they are threatened by penalties in the form of reduced trade or reduced aid. This should be investigated and reported.
- *Specially prepared formulations of drugs for children:* health workers need to advocate to pharmaceutical companies (trade and generic) to produce drugs in doses and forms that can be prescribed for children to take once or twice daily.

- *Reduction of mother to child transmission of HIV*: Advocate for the availability of anti-retroviral drugs at an affordable cost or free of charge to all pregnant women and girls and children
- *The orphan issue***:** The high maternal mortality rates, HIV prevalence, droughts/famine and armed conflict mean that orphan rates in Africa and South Asia continue to rise. Family systems are already becoming saturated as grandmothers (who often become the main carers) die. **We should advocate at a national level that all children, including orphans should receive free education, free essential healthcare and be fed at school and that this should be supported by large bilateral and multinational donors.** The alternative will be more unsupported and unsupervised poor children, with poor health and vulnerable to abuse. Long term, this could result in threats to social stability and security.
- *The Arms trade***:** The arms trade is a disaster for poor people and civilians, especially children. Many campaigners have publicised that several rich countries promote (and gain huge financial benefits from) this trade by selling a large percentage of their products to poorly resourced nations, often on both sides of a conflict.
- *Debt:* The effect that debt has on healthcare and education for women and children has been widely reported and should continue to be a focus for advocacy.
- *Trade:* The tariff barriers to trade and subsidies have a huge impact on poverty and maternal and child health. There is a continuing need to raise people's awareness about ethical shopping and the impact this has on a country's ability to provide healthcare and education. (See paper on Africa's children by MCAI B O'Hare, J Venables, and D Southall Child health in Africa: 2005 a year of hope? **Arch**. Dis. Child., Aug 2005; 90: 776 - 781.).
- *IMF and the World Bank:* The introduction of user fees and other structural adjustments made by the International Monetary Fund (IMF) and the World Bank are widely believed to have had a deleterious effect on healthcare. An independent tool is needed to assess and report the impact of many of these initiatives.
- *Trans-nationals:* Their power, and the influence they have, are highlighted by lobbying the World Trade Organisation (WTO). There is a need for advocacy to ensure that the needs and interests of the less powerful (usually the poor) are represented.
- *Foreign Aid:* Some foreign aid does not result in sustainable development.

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MCFH Information Sheet 3: clinical audit – what is it and how to do it?

Clinical audit is one of the important supporting criteria for the MCFH Standards, as it improves the care given to women, children and their families. This means that it deserves a major commitment from all health workers

It is the systematic critical regular review of the way a specific aspect of healthcare is provided, managed or given, to ensure:

- This is the 'best possible'
- The outcome for an individual woman, child and their family is/was the 'best possible'
- Any improvements can be made.

Any healthcare activity can be audited in varying ways by a group of health workers meeting to share information gained from personal experience and/or medical records

Structured audit involves looking at the use and management of resources.
Process audit involves looking at the policies, protocols, procedures, clinical guidelines and other job aides to see if these are being followed and/or achieving their objectives
Outcome audit involves looking at the way health care is given, its outcome and how the woman, child and families' quality of life is affected

Audit meetings provide opportunities for:

- Identifying problems
- Multidisciplinary learning
- Group problem solving
- Teaching and learning
- Contributing to medical knowledge
- Planning changes that might improve the healthcare given
- Updating clinical guidelines and other standards
- Advising managers
- Identifying advocacy issues
- Identifying examples of good practice to share with others

It is important that audit is not used to attach blame, but to identify errors, mistakes and problems, to learn from these and plan changes to prevent the same things happening in the future.

It is also important to protect the confidentiality of individuals, both patients and health workers.

The audit cycle has four parts:

1. Setting 'standards' for the quality of care provided
2. Assessing practice, quality and outcomes against these
3. Making improvements and changing practice where appropriate
4. Looking at what happens after change (evaluating the effects of change to see if they have achieved their objectives)

Audit is best planned, organised and supervised by a **named health worker with this responsibility** (coordinator).

This important coordinator for audit needs to:

- Arrange Dates for audit meetings

- Decide on the aspect of healthcare for audit (best agreed jointly in advance)
- Delegate data collection to a named health worker/s for each audit in advance of the audit date. It is important for this health worker not to forget to ask the parents for their views and opinions about their child's illness and the impact this has had on their family when this is appropriate to the audit.
- Keep a record of meeting dates, aspects of care audited, those present, the findings, how any changes needed will be implemented, date for effect of changes to be re-audited
- Ensure that audit recommendations are reviewed and that recommended changes have been carried out and have achieved their objectives
- Tell all health workers in a health facility or organisation and encourage them to attend
- The results of audit and any changes of practice that are recommended and agreed should be shared with all relevant health workers
- Audit details should be regarded as confidential
- If appropriate share audit findings with patients/parents/carers.

It works best if the audit coordinator is skilled at:

- Problem solving
- Facilitating
- Dealing with conflict
- Managing poorly performing health workers sensitively and constructively
- Basic data analysis
- Communicating (adequate and appropriate communication is important part of the audit cycle).

Good **data organisation and management** are needed for successful audit. Data may be needed about populations, about service specific issues or about outcomes. Routine data collection is easier if healthcare records and other forms designed especially for audit meetings are standardised. **Any staff disciplining required must be managed privately and never at an audit meeting.**

Maternity clinical audit

Regular maternity case review meetings have been started at 3 of the Major Health Centres in the Gambia by the Director of Health Services,. These are qualitative, in-depth investigations of the causes of and circumstances surrounding maternal deaths/near-deaths. Benefits of these meetings include:

- ***Contribute to reduced mortality /morbidity levels***
- ***Identify where improvements needed***
- ***Provide a teaching opportunity for staff***
- ***Help improve staff performance & morale***

How to collect information for a mortality audit

Before an audit meeting, review the relevant clinical records and if possible talk to the families of each woman/child before the audit to gain their views and opinions about what happened (this needs to be done sensitively, preferably by a health worker who the family know well). They need to be seen again after

the audit to be told the outcome. In our experience, families welcome this opportunity to express their views, providing it is not too soon after the death. They also welcome improvements in care that arise because of the death of a woman or child).
The following data are useful:

- Details of symptoms prior to presenting to health worker
- Date and time of first presentation to a health worker
- Date and time of first treatment given
- Signs woman or child presented with (were these emergency or priority signs?) (*See Standard 3*)
- Triage category given to the patient
- Possible diagnosis made when first assessed
- Treatment given
- Supportive care given
- Monitoring (frequency, what was recorded, how was it acted upon)
- Level of care within the health facility (high-dependency, general ward, outpatients)
- Number of skilled health workers on duty at the time (was this 'safe?')
- Whether or not complications occurred
- Date and time of death and who was present
- Details of any resuscitation attempt
- Any relevant history about the woman, child and family
- How the family were supported after death

It is helpful to provide a summary of the clinical findings as a paper handout or data projection.
Discussion of "near misses" can also be very instructive.

Some of the aspects of women and children's healthcare that can benefit from audit include:

1. Deaths
2. How health problems have been managed, including how each woman or child with this problem has been cared for
3. Patient/carer and child (user) satisfaction (of service standards and other quality issues)
4. Adverse or critical events, for example a serious infection acquired in the health facility, an unexpected death, a prescribing mistake, something that has affected health workers and others
5. How women and children are referred to the specialty service/healthcare environment. and/or what happens when they have been referred
6. Other agreed systems of care, policies, procedures, standards, job aides etc.

How to audit deaths

- Agree on how often to do this
- Collect the total number of deaths and causes since the last audit
- If there are more than a few deaths, select a sample of cases for discussion rather then attempting to cover all cases so that maximum attention can be given to the lessons that can be learned from each case.

Selection criteria can be based on:

- Diagnoses - focus on one or two diagnostic problems at each meeting but covering the main causes of death over the calendar year
- Indicators - focus on areas where indicators show possible deficiencies in care (for example if there are more deaths in one clinical area, or for one clinical firm compared with another that is looking after similar problems, focus on the area/team with the most deaths)
- Priorities - focus on problems that should be overcome with existing resources
- Avoidable factors related to deaths

Best practice is for everyone who was involved in the care of the woman/child to attend. Each death needs to be discussed and decisions made about:

- The probable main cause of death
- Other possible causes
- Contributing conditions (other health related problems identified by health workers or caregivers)
- Modifiable/avoidable factors are then identified and classified as:
  - Carer or family or society related
  - Administrative
  - Related to substandard care given by health workers in primary care
  - Related to substandard care given by health workers at referral centre - (triage, emergency care, diagnosis etc)
  - Missed opportunities for good care

When the main causes of any problems have been identified, best practice is team problem solving. Decide what steps can be taken to avoid similar deaths in future, agree on any feasible changes for improvement, who will be responsible for coordinating these within an assigned time, the date they will be reviewed and how to share the findings and plans with other health workers.

How to audit specific health problems in an individual woman or child or group of patients with the same problem

This means looking at detailed course of illness, management and outcome for the woman or child up to the time of the audit (integrated care pathway audit*)*.

The audit topic is best decided at an earlier meeting and the relevant information collected in advance. The purpose is to review each case to see if there were any errors or problems that can be rectified so that they are less likely to happen in the future and to identify and share what did go well.

Women, child and family satisfaction audit

Ideally each healthcare environment and service will have a mission statement displayed in clinical areas to inform healthcare users, and remind providers. This statement may include such things as the intent to:

- Limit patient waiting time in outpatients
- Have a caring attitude
- Explain about health problems and their treatment
- Provide maternal and child focused facilities - toilets, cooking, washing, play facilities

Any of these intents can be the subject for an audit. To find out whether patients/parents are satisfied with the service provided, their views and opinions need to be collected before the audit meeting. This can be achieved in a number of ways, including using a questionnaire or individual interview with a random selection of parents/carers. Data is best collected by an independent person.

Examples of possible questions include:

- Were health worker attitudes caring/friendly?
- Were there any unnecessary delays?
- Was everything about the illness explained to you?
- Were facilities adequate? (for example were the wards and toilets clean; was there always soap; was there enough privacy; did you feel safe; were the facilities for cooking, washing and toilet facilities satisfactory)
- Were you always given enough information before a procedure?
- Would you be happy to use the facility in future?

The findings from questionnaires/interviews can be discussed at the audit meeting and changes made if problems are identified.

Adverse or critical event audit

Examples of events that can benefit from this type of audit include:

- Re-admissions within 48 hours of going home
- Night deaths
- Near misses where a woman or child could have died unnecessarily
- Acquired infections
- Incorrect drug treatment - the wrong drug or the wrong dose, or given by the wrong route.
- Intra-partum fetal deaths
- Newborn infants with severe birth asphyxia
- Serious accidents to patients or health workers
- Children running away from hospital
- Self-discharges (children discharged by their family against the advice of health workers)
- Other events considered important or distressing by health workers

Referral process audit

Such as audit of IMCI – don't understand this bit?? referrals or of other integrated referral systems. such an audit should be attended by health workers making the referrals as well as those receiving and managing them for maximal future benefit . Very useful to have a standardised reply form assessing and informing:

- Was the diagnosis and reason for referral correct
- Was the patient given the correct emergency management before and during referral
- The patient's condition, diagnosis, treatment and outcome at the referral facility
- Plan for possible back referral
- Possible areas where care and transfer could have been improved

Other service standards (including the MCFH practices, policies and guidelines)

This type of audit could be about topics such as:

- Immunisation coverage
- Breast feeding rates at discharge from maternity unit and at other set times following discharge
- Malnutrition rates
- Obesity rates
- Parent smoking rates
- Access to relevant health information
- Young persons' sexual health
- Teenage pregnancy rates
- Accident rates
- Age at diagnosis of disability
- Women and child protection policies and guidelines compliance
- Quality of health information provided to schools about individual children
- Other national, country, district or local guidelines

Within wards and clinical departments, many infection control activities can easily be audited. These include:

- Compliance with sharps policy

- Reporting and management of sharps injuries
- Isolation practices
- Decontamination of equipment
- Waste management
- Hand washing
- Cleaning
- Food handling and kitchen hygiene
- Compliance with antibiotic policy
- Practice can also be effectively audited against written, evidence-based procedures e.g. surgical scrub procedure.

Audit can contribute to improving women and children's care in many different ways and is a vital support activity for ensuring women, children and their families receive the 'best possible' healthcare.

MCFH Information Sheet 4: Cleaning

Keeping **yourself** (personal hygiene), **the environment** (surroundings) and **the equipment** in a health facility clean is a very important way of helping to reduce the number of healthcare related infections that happen in at least ten percent of people admitted to a hospital. It will also reduce the chances of you becoming infected.

Methods of cleaning

1. Normal cleaning - Decontamination
This is the commonest form of cleaning and the one used for most items. Normal cleaning is done using water and soap or detergent after removal of dust and dirt using a brush or vacuum cleaner. It is the most important, but often the most neglected, of the three processes. Equipment and materials that need to be sterilised or disinfected must be first cleaned using this method. Simple hand washing is a very effective method of preventing the spread of infection in health facilities.

2. Disinfection.
This gets rid of many micro-organisms but not the most resistant spores. Liquid chemicals (disinfectants) are used as cleaning agents**.** There are many different disinfectants. One of the cheapest and most effective is sodium hypochlorite (bleach). Disinfectants are active against most micro-organisms including HIV and hepatitis B, however, they do have a corrosive effect on metals and if used on fabric or carpet can bleach. Hypochlorites in dilution (usually 0.1% solution) are contained in household cleaners available in markets throughout the world for domestic use. These household cleaners can be used in the hospital environment for general cleaning of all surfaces, but stronger solutions are needed for cleaning anything that has been in contact with body fluid such as blood, urine, faeces, and others, and for cleaning following outbreaks of dangerous infections. Hypochlorites are also available as tablets that make dilution easier. Chlorine solution should be used in tepid water, not hot, as hot water increases the release of harmful chlorine vapours.

3. Sterilization.
This gets rid of all forms of micro-organisms. The cleaning agents are steam under pressure, boiling water, dry heat and certain gases or strong liquid chemicals. This method of cleaning is used for items that need to be sterile. Ideally a single separately organised and staffed system for sterilising should be present in every healthcare facility that looks after ill children, especially if there is an operating theatre.

The cleaning depends on manufacturers' instructions, common sense and local policies. Anything that has been in contact with an infected patient, a patient with a wound, or anything likely to be contaminated by body fluids, should be disinfected and if possible sterilised.

Cleaning materials (cloths, mops, sponges and other materials)
Ideally these should be used once then discarded, but this is not practical in many countries. Where this is not possible, best practice is to disinfect cleaning materials such as cloths and mops after each use. Different materials should be used for different areas and surfaces to avoid spreading micro-organisms from one area or surface to another. A colour coding system for cleaning materials helps remind health workers what they should be used for or where they should be used. An example of colour coding is red for toilets, green for isolation rooms, blue for general ward areas and yellow for kitchens. The same principle can be applied to materials used for different surfaces.

How often should things be cleaned?

When buying new items for a health facility it is important to use the recommended best practice cleaning instructions that accompanies them. If it is not possible to follow these or use an alternative cleaning

method that is safe, the item should not be purchased or used. Cleaning should be done as often as is needed to keep everyone and everything in a health facility as clean as possible.

Who should clean?

Every health worker has a responsibility for making sure that their healthcare environment and all the equipment they use is clean. If a woman or child is an in-patient, health workers should also ensure that they, their resident family carer and their visitors have the resources to keep clean (*In many countries the toileting and washing facilities provided in health facilities for families are minimal, and often dirty and inadequate for the numbers of people using them compared with those allocated to health workers*)).

Special health workers need to be employed to keep a health facility clean. These health workers (the cleaners) should:

- Be supervised by those responsible for each different area
- Feel valued by having their efforts acknowledged
- Receive training about hygiene, infection control and the cleaning practices of the health facility
- Have enough cleaning agents (cleaning solutions such as water, soap, detergents and disinfectants) and equipment
- Be part of the healthcare team

Information about providing water that is safe to drink

If water is not safe to drink, the micro-organisms that make it unsafe can be destroyed by:

- Boiling it for 1 – 5 minutes (a minimum of one minute is needed)
- Disinfecting with:
  Iodine 3 – 4 drops for each litre of clear water – mix well and wait 30 minutes before using)
  Chlorine.

The most familiar chlorine preparations are: sodium hypochlorite (bleach), a liquid compound that comes in packets, bottles or powder containing chloride mixed with lime The amount of chlorine to add to water to disinfect it depends on the strength of the chlorine preparation used. Any instructions on the packet or bottle need to be followed.

Frequent and appropriate hand washing, safe food handling and preparation, and safe waste disposal will help prevent water being contaminated with micro-organisms

Best practice is to have enough clean, safe drinking water available in every health facility for women, children, their families and health workers at all times.

Information about cleaning hands/hand hygiene

To keep hands as clean as possible 'best practice' is:

- To have clean, empty sinks, easy to get to and use in each area in a health facility
- Soap at each sink
- Avoid standing water
- A method for drying hands at each sink; disposable paper towels are best
- Sink taps that can be turned on and off without using hands (elbows)
- Everyone knows the best way to wash their hands and does this
- Everyone knows when to wash their hands and does this routinely
- No rings (except wedding rings), nail varnish or watches are worn and sleeves are short or rolled up during patient contact
- Hand washing reminders at all sinks
- An alcohol hand preparation available to use between patients, especially if hand washing is not possible and hand cleaning is needed frequently
- To have a system to remind everyone to wash their hands (wall charts etc.) -

- To regularly audit hand washing to see if this ‘best practice’ is achieved

Information about cleaning spills of blood and other body fluids

These should be cleaned up immediately to reduce the risk of a healthcare related infection

For spills on hard surfaces best practice is:

1. For each area to have ‘spillage kits’ immediately available containing all the items needed.
2. Immediately cordon off area where spillage is, to stop anyone getting contaminated.
3. Ask a colleague to bring the spillage kit.
4. Wearing gloves, place cloth/paper towel from spillage kit on to the spill.
5. Wipe up blood from outer edge to inside to avoid excessive spread.
6. Put sodium hypochlorite (bleach) solution, 5.25% 1:10 ratio (1 part sodium hypochlorite to 9 parts water which gives the high level disinfection of 5000ppm that is needed) on the area affected.
7. Leave solution on the spillage for 30 minutes to disinfect both HIV, which only actually takes 10 minutes, and possible hepatitis which takes 30 minutes
8. Wipe spillage area more thoroughly and mop area with the same strength disinfectant solution.
9. Soak the cleaning material for 30 minutes before sending it to the laundry for washing.
10. Finally wash the bucket used with the same disinfectant solution.

If the spillage involves glass first use a dust pan and brush to clear up the glass, then carry on as above. The dust pan and brush should then be soaked in the same bleach solution before it is used again.

How is it possible to keep this mattress clean when there is an incomplete cover and exposed foam?

Information about cleaning laundry (laundry means any materials used when giving health care such as bed linen, towels, flannels, clothing, cleaning materials and others).

If laundry is dirty or soiled it needs washing. Best practice in a health facility is to:

- Separate dirty laundry that is likely to be contaminated by body fluids from ordinary dirty laundry and store these different types of dirty laundry in separate bags
- If possible wear gloves when handling dirty laundry and always wash hands afterwards.
- Make sure there are no sharps or other solid items in the dirty laundry
- Wash all laundry at temperatures above 60 degrees C (to kill micro-organisms laundry should be washed at temperatures of not less than 65 degrees C for ten minutes, or not less than 71 degrees C for 3 minutes) – other methods of disinfection before washing are best used for materials contaminated by body fluids that will be damaged at these temperatures.

Information about cleaning equipment

Best practice is to read and follow the manufacturer's recommendations. If these are not available, contact the manufacturer and find out how best to clean the item, or if this is not possible, clean as for a similar item.

In well-resourced countries single use equipment for many things is best practice but when this is not possible, **all** healthcare equipment should be thoroughly cleaned by the most appropriate method before being used by another child. If equipment of any sort is shared, there is a high risk of cross-infection.

Best practice is that a bed and mattress is cleaned with disinfectant after each use.

Information about cleaning the environment, fixtures, fittings and furniture

Water, soap and detergents or disinfectants can be used as cleaning agents according to local availability and policy. Frequency of cleaning for different areas will depend on the type of soiling and local circumstances. Toilets and wash areas need special attention; best practice is that they are always clean.

Information about cleaning toys

To reduce the risk of cross-infection, toys need to be kept clean and dry, especially if they are likely to be used by more than one child. Toys that cannot be cleaned, except those not designed to be touched or handled by children (for example those used for distraction), should not be used. Best practice is that the play worker, or a named health worker, cleans communal toys after their use.

Example of a policy for cleaning and maintaining toys

1. Regularly check and clean all toys, at least once a week.
2. Pay particular attention to toys for babies and children who are at high risk from infection.
3. Take extra care with toys used by children who are known to be infectious. Their toys need to be easy to clean, or thrown away after use.
4. Always sterilise toys that babies put in their mouths, such as rattles and dummies/pacifiers, between patients. These must not be shared.
5. Throw away toys that are broken or dangerous.
6. Always follow your infection control guidelines/policies
7. Encourage parents to alert staff to dirty or broken toys

Hard toys: Clean all surfaces thoroughly with detergent and hot water rinse and where possible dry to prevent water retention.
Electrical (battery operated) toys: Wipe all surfaces with either water and detergent or alcohol wipes and dry thoroughly.
Soft Toys: Wash after being used. These toys must not be shared. Best practice is to machine wash at a high temperature and dry quickly.
Paper, books, posters, etc: Wipe the surface of books and posters regularly with a damp cloth. Throw away soiled paper. Check stored books regularly for wear and tear, signs of mildew and any insect infestation and discard.

The control of infection

This is so important that allocating sufficient resources for effective cleaning is important. Best practice is to delegate the coordination and supervision of cleaning and other aspects of infection control to a named health worker for each clinical area. The senior health workers need to support the appointed person and ensure that they have the authority and time to do this important job, and receive the respect of others. As health workers change there is a need to train new health workers, and remind others about best practice. Audit of both practice and policies will help ensure that cleaning is effective.

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MCFH Information Sheet 5: Clinical guidelines, pathways of care and other aids - what are they, how to develop them and how to make sure they are used?

'In order to give the best possible care to children and families, paediatricians need to integrate the highest quality scientific evidence with clinical expertise and the opinions of the family'. Moyer VA. Elliot EJ. Preface to 'Evidence Based Paediatrics and Child Health

Pathways of care are written or pictorial reminders about specific aspects of care. (see website **www.mcai.org.uk** for examples and details) They help remind health workers how to give the 'best possible' health care for a specific problem or issue. They include:

- Guidelines for treating a specific health problem
- Algorithms such as those for basic life support (BLS) and the Integrated Management of Childhood Illnesses (IMCI)
- Treatment pathways, drug doses.
- Lists of signs and symptoms for triage categories.
- Growth charts, developmental milestones.
- Hand washing guidelines placed near all sinks

Guidelines and pathways of care:

- Aim to improve healthcare outcomes
- Help clinical judgement
- Make the treatment of a specific health problem the same (when the same care for a health problem is given by every health worker, evaluation and comparison of care is possible)
- Need to be supported by up-to-date evidence.
- Need to be linked to audit
- Need to be reviewed regularly
- Need to be adaptable to the circumstances
- Need to be compatible with existing country and International guidelines
- May help to reduce, or enable comparison of, costs
- May protect health workers from complaints and litigation

How to develop, introduce and update a clinical guideline or other job aid

1. Create a small multidisciplinary team *(see information sheet 11 for information on team working)* of either interested volunteers or elected representatives from all groups likely to be affected by them, including a parent and child representative

2. Consult all health workers likely to be affected by the introduction, or up-dating, of a guideline or other job aid, and representatives of women, parents and children too, if appropriate, so that:

- Any barriers to their introduction and use can be identified
- Attempts to overcome these barriers can be made before their introduction
- Ownership is shared (individuals are more likely to use the guideline if they feel they have contributed to them)
- The opinions and views of those on receiving care can be considered

3**.** Find and review all existing guidelines used by the clinical area, healthcare environment, country or international community as:

- It saves time to use or adapt an existing guideline

- It is sensible to comply with existing national guidelines, if they are evidence based and up to date.

4. Find and use the evidence to support the proposed guideline/job aid:
   - For an existing guideline, review the evidence to make sure it is up-to-date and correct
   - Search the literature for quality evidence using the internet (if available) and reputable sources of information
   - Remember to record how this search was made and the information source/s
   - Interpret the evidence and match it to the resources available
   - Translate the evidence into medical and nursing care for the health workers in the healthcare environment
   - Use the written evidence to provide references for the guideline

5. Before introducing the guideline/standard:
   - Get agreement from the director/chief of the healthcare environment, the heads of departments and key clinical task coordinators for its use
   - Get agreement for a start date
   - Finalise and agree the content of the guideline and its references
   - Date the guideline
   - Arrange education for all health workers likely to be involved or affected
   - Arrange a date for its review or audit

6. Arrange an early review by the core working party to amend the guideline if necessary as:
   - The evidence for medical and nursing care can change as new research is published
   - Local difficulties with following the guideline may occur and these will need identifying quickly, to find solutions
   - Regular audit of compliance with the guideline is needed to find reasons for non-compliance and solutions

7. Arrange regular core working party meetings to;
   1. Review existing pathways of care
   2. Create and introduce more care pathways

8. Avoid failure:

Most failures to standardise care are because:
- ❑ Those affected by their introduction are not involved in their development. As they do not feel they ‘own’ them, they do not use them
- ❑ A collective culture to provide the ‘best possible’ care does not exist in the healthcare environment

Using guidelines to standardise healthcare makes sense and contributes to giving the ‘best possible’ care.

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MCFH Information Sheet 6: Data Management

Meticulous data collection is an essential requirement of each of the MCHFI standards

A Health Record is written information about the physical and/or mental health of a patient. Keeping a written record of the healthcare given, and collecting other important health related information is an essential part of a professional health worker's job.

Reasons for keeping records

1. **To inform others** (women, children, parents/carers and health workers) about a woman or child's health history and/or what healthcare is planned. This contributes to consistent healthcare and avoids time wasting duplication if all health workers use the health record.

Women, parents and children often feel frustrated when asked the same questions by a succession of different health workers.

2. **To obtain information about a population of women or children, for example** children with disabilities, so that their health needs can be assessed and appropriate intervention can be planned and resourced

3. **To obtain information about other indicators for women or children's health,** such as breastfeeding and immunisation rates, that can be used to:
   - Support advocacy for increased resources
   - Monitor performance of programmes, services and individuals e.g. effectiveness of road traffic accident prevention measures
   - Monitor effectiveness of healthcare interventions
   - Confirm that 'standards' of healthcare have been achieved
   - Plan or change policies and systems of care

4. To **facilitate research**

When deciding what information to collect it is important to:
- ❑ Consider why it is wanted/needed and what questions it hopes to answerOnly collect what is possible and practical to and no more than is necessary . . A major mistake in most data collections sytems is that too much, unnecessary information is collected
- ❑ Imagine how it will be used before designing the method and format for collecting it. Make this as **simple** as possible
- ❑ Consider confidentiality issues

Best practice is that any data collected is:
1. As **accurate** as possible and of **adequate quality**
2. **Standardised** throughout the healthcare environment, health service and/or country
3. **Anonymised** (sensitive personal data kept confidential)
4. Appropriate to provide international organisations and others with the information they request and/or need.

1. Accuracy and quality of information recording is dependent on:
- Understanding the value of recorded information (what it can be used for)
- A commitment to recording information, including the completion of forms

- The skills to:
  - Listen
  - Ask the right questions
  - Interpret the answers
  - Interpret the situation
  - Record this accurately
- Having enough time to do this. Best practice is to have sufficient time to record information during working hours without compromising patient care.
- How easy it is to use the data collection systems.
- Writing in health records legibly, promptly, accurately, and always signing and dating each entry.

Best practice for a health record or any other information recording system is for it to be:

- As simple as possible
- Easy to identify so that it can be found quickly when stored (for example each child from birth can be given a health number that is used for all their health records. This individual identity number also avoids duplication)
- Used by all health professionals involved to avoid duplication and to inform all those involved in the individual's care
- Easily accessible to all health workers (and to the woman, child and their parents/carers) but secure to maintain confidentiality
- Available when needed.

2. Standardised data collection and examination means that:

- The same information is collected by everyone but data collection is not duplicated
- The same way of recording the information is used *(the same format is used for collecting information throughout a health service)*
- The same information recording systems *(health record, investigation request and other forms or computer program)* are used throughout the health facility/organisation
- The data are analysed using the same methods *(for example if a coding system is used for coding health problems, it is best to use the same one throughout a country)*
- A good example of standardised data collection is for a country to also use parent held child health records. This requires a policy to use these country-wide and a commitment from all health professionals to make an entry each time the child has a significant health problem or health intervention, for example an immunisation or an admission to hospital. Such records are especially useful when a child sees many different health professionals in a variety of different healthcare settings as it ensures there is a complete record of the child's healthcare with the parents/carers.

3. Data protection means:

- Ensuring that sensitive personal health information is kept confidential (cannot be read or seen by others, or discussed with people who do not need to know).
- Having a policy about this that is followed by all health workers.
- Regular discussion and audit of this policy to enable health workers to ensure it is working effectively.
- Including in the policy, standards about the storage of records, who is authorised to write in them, who should have access to them, what information can be shared and with whom.
- Having secure storage for records and monitoring those who access and borrow records. Health workers from a different clinical area or service should get permission from a named person before accessing a record.

- Never leaving records in an unsupervised area where they can be accessed by unauthorised individuals .
- Not allowing sensitive information to be seen by other patients/parents/carers or children.
- Understanding and following any data protection legislation.

The Management of data

To ensure data accuracy, standardisation and protection, input needs to be **managed and organised effectively.** Best practice is for all healthcare organisations to have a **data management team** with a lead health worker to coordinate data related activity.
The team needs to:

- Develop, review and update (audit) policies and systems for collecting, examining, protecting (data protection policy), storing and retrieving data (data management policy).
- Develop, review and update (audit) guidelines for taking health histories and for making entries
- Have the authority to enforce these policies and guidelines.
- Be able to contribute to decisions on data collecting systems with their Ministries of Health (If health workers are expected to complete forms, enter data and value their importance, they need to be consulted about their design).
- Train all health workers about data management. Accuracy and quality is more likely if health workers receive appropriate and regular training. This is especially important when new health workers start working in a new healthcare environment, and before new forms are introduced or new data collected
- Be responsible for the **record cycle** and any **computer systems** for data recording and/or analysis
- Be responsible for the quality of data management
- Have the necessary resources

The **record cycle** starts when a woman or child attends. It includes:

- Rapid finding of records from previous attendances
- Recording the new attendance to avoid duplicating any previous records
- Circulating records
- Ensuring that a summary is made of the attendance, and if possible a diagnosis at or before discharge
- Classifying the summary or diagnosis (using a disease coding system such as the ICD)?? What does this mean
- Examining (analysing) and collating these codes regularly in the format required by the health organisation, international organisations and government
- Sharing this collated information with relevant professional health workers
- Indexing and storing/filing the record
- Having a policy for who can borrow health records and a filing system that enables them to be easily found when needed
- Protecting data
- A commitment from all health workers is needed for the record cycle to be efficient and effective.
- Apart from hospital records (which are frequently lost), cards kept by parents such as the “Road to Health Cards” are invaluable.

Inefficient record storage!

Computer systems

Using computers to record, store and collate information can improve patient care as information can be retrieved quickly thus minimising potentially harmful delays. However it is costly, needs a back-up system and cannot be used without extra training for all health workers. To use computerised systems effectively, the following are necessary:

- A reliable electricity supply
- A budget for capital costs
- A budget for maintenance
- A budget for printers and ink
- A budget for telephone and Internet subscriptions
- Standardisation of computer programmes
- Computer programmes that are linked and provide what is needed
- The expertise to maintain
- The expertise to use
- Training programs
- A commitment from health workers

Without these, computerisation will cause additional problems for health workers and fail to meet its objectives.

Data management activities contribute to, and support the best possible health care when performed well. Therefore they need to be adequately resourced.

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MCFH Information sheet 7: Lifelong learning and how to put this into practice.

‘Wisdom, knowledge and skills are for sharing not owning’

How can you continue learning?

Two terms that are often used to describe lifelong learning are:

Continuing Professional Development (CPD)

- This means improving and acquiring knowledge and skills through a continuum of experience and learning
- It is life-long
- It needs planning, commitment and access to learning opportunities.

Continuing Medical Education (CME):

- This is a systematic process of life long learning and professional development
- Its aim is to enable health workers to maintain and enhance their knowledge, skills, attitudes and competence for effective clinical practice to meet the needs of women and children

Essentially these two systems are the same. Lifelong learning applies to everyone and not just to professional health workers. Everyone has a responsibility to continue learning and improving their practical and other skills, and also to share their knowledge and skills with others, so that women, children and families will benefit.

Health workers need to look for the evidence for what they do from published literature. In many countries this is impossible or difficult for a variety of reasons.

Healthworkers, who manage, organise or plan care need to help others to access learning opportunities and health literature. Most countries have large organisations such as WHO, UNFPA and UNICEF as part of their international community. These organisations and non-governmental organisations working in the country do have access to healthcare literature, and can help.

Some principles of lifelong learning

- Thinking about what you want and need
- It is far better to learn than to be taught
- If you are responsible for others, thinking about what their needs
- Making a plan for your learning/the learning of others (personal development plan/s) then implementing /helping others implement their plans
- Recording your learning activities, for example keeping a personal diary or portfolio of learning
- If you are responsible for others keeping a record of their learning

“Most of what I learn I remember while much of what I was taught I have forgotten”

The many different ways of learning

- Formal learning such as attending training courses, lectures, conferences, courses, journal clubs, critical reading groups, workshops and seminars and small group interactive learning.
- Informal learning with others such as using distance learning programmes, participating in audit, presenting research, watching others (such as ‘sitting-in’ with or being closely supervised by

someone with more experience and/or more skills), contributing to confidential enquiry panels, post-graduate examining, writing books and articles and doing research
- Self-learning such as reading books and journals, using the internet, making reflective notes

Best practice is to regularly experience a combination of different types of learning, although it will depend on the resources and opportunities available to you. A common mistake is to wait for someone else to come and teach you rather than be inquisitive and find out for yourself.

Before starting to work in a new healthcare environment, it is especially important for a health worker to be sure they have, or acquire quickly, the skills and knowledge to give the type of healthcare needed. The provision of induction training about policies, guidelines and systems of care used in the new environment helps to ensure this. Close supervision until the new health worker is sufficiently experienced and knowledgeable is also important.

How can you put learning or new skills into practice?

Changes of practice and attitude do not always follow learning as:
- ❑ Doing something differently never feels as comfortable
- ❑ It is not appropriate
- ❑ It turns out to be harder than you expect as:
    - You are unable to persuade others to change
    - You have forgotten some of the details
    - You come up against an unexpected problem
    - Others criticise your efforts
    - You feel you are the only one making an effort
    - Others don't see the need for change
    - 'The system' or 'hierarchy' are obstructive

If you are a junior health worker it is easier to do this if you are helped, guided and supported by a senior colleague (a mentor) who is committed to the changes in practice and attitude needed. Your mentor might be your manager or a more senior health worker. Their role is to empower, enable and help your efforts by:
- o Support and encouragement
- o Making sure you have everything you need
- o Helping you anticipate barriers and develop ways of dealing with them
- o Publicising your successes

Things you can do to help your mentor:
- Point out the benefits the women, children and families will get from the change (for example 'I know you are concerned about ….., when we make these changes they will do…………').
- Mentors need to know what the mentee and others can expect to see happening differently.
- Ask the mentor how much and how often they want to hear about your progress. The mentor may need a lot of detail in order to deal with colleagues, or may be happy to leave it to you. The mentor may have reporting targets and deadlines that you don't know about. Once you know, make sure you cooperate.
- Ask if there is any other way you can help
- The primary role of a mentor is to facilitate and support rather than teach and instruct

It usually takes longer than you expect to make any significant changes in your own or others' practice. You can maximise your chances of getting a real and lasting improvement by first planning to USE what you learn by sharing this with others.

Sharing learning

Start by deciding what you need to share, why you need to share this, who to share it with and how you can do this. It helps if learning aids are available (such as writing boards, flip-charts, overhead projectors or power point technology); but these are not essential. A learning group introduces the benefits of peer tuition and cooperative learning. You both learn from your colleagues and teach each other without needing a formal trainer.

The most important reason for sharing learning is to influence changes in the way care is given to make this better for women, children and families.

People you may need to share with include:

- Professional colleagues at all levels
- Other health workers – cleaners, security guards, maintenance, drivers etc
- Women, children and their carers
- Other people who can help you – teachers, people of standing in the community
- People who may disagree with you and may be obstructive
- Other people who have had the same learning experience

Ways you can share your learning include:

- Informally discussing what you have learned
- Organising a meeting about it or presenting at a departmental meeting
- Putting information on a bulletin board (paper or electronic), or circulating leaflets
- Writing a newsletter about it (send to others on paper or by electronic mail), or writing an article to go in an existing newsletter
- Devising a story or a song about it, or getting the patients and their families to make one up
- With illustrated posters and using them to decorate the ward
- Giving a formal presentation or organising a training course about it

MCFH Information Sheet 8: Looking after health workers

To perform well, health workers need to have the best possible physical and mental health. Best practice to ensure this includes access to:

- Adequate food and clean drinking water while working
- Preventive health measures such as immunisations, needle-stick injury management and lifting advice
- Care of physical and mental health problems.

The physical health problems of health workers are often well managed, but in many countries, mental health problems are neglected, especially the stress related problems caused by work.

Health workers only feel happy in their work and free from stress if their job is secure, their working conditions satisfactory, they feel they are doing 'a good job' and this is acknowledged both on a personal level by management, and by an adequate salary.

Being unhappy leads to discontent and demoralisation. Unhappy demoralised health workers are unlikely to:

- Be motivated to change
- Question the standard of care they provide
- Be able to express their views and opinions freely, especially if they have no job security
- Improve the care they give to women, children and their families
- Be able to give the 'best possible' care

As it takes considerable effort, time and money for a health worker to become sufficiently skilled to provide effective healthcare, health workers are a valuable resource for a country. Unhappy de-motivated or mentally ill health workers not only provide poor can but may leave the health service or emigrate.

To keep health workers happy and well it is important to protect them from acquiring mental health problems due to their work, and to look after them when they do have these. It is also important to have transparent employment procedures (including job security) and adequate income. These issues are a priority for those who plan and organise healthcare.

Other factors that contribute to a contented and motivated health worker

- Job satisfaction and sense of achievement
- Recognition and praise, when deserved
- Good leadership with consistency and fairness
- Clarity of goals, the purpose of the job and expectations of performance
- A culture that encourages flexibility and innovation
- Being consulted/having a voice
- A sense of belonging and worth
- Being part of a successful team (team working) and knowing what constitutes success
- Working with people who are loyal and supportive
- Varied and challenging work
- Having the authority, skills and respect to do the job well
- Learning new skills and having the opportunity to use these
- Opportunities for advancement
- Having a sense of morality, ethics, values and beliefs shared with colleagues

- Prevention of work related health problems (for example advice about safe lifting, and the prevention and management of needle-stick injuries)
- Management of physical health problems, especially if work-related

Good terms of employment include:

- Clearly stated goals and objectives for the job
- Reasonable pay
- Job security and transparent, fair and supportive disciplinary and dismissal procedures
- Interesting and stimulating work and the opportunity to make use of your talents and skills
- A reasonable workload (that enables a good life-work balance)
- Opportunities for advancement/promotion
- A supportive culture and colleagues
- Learning and skill opportunities
- Security and safety in the healthcare environment
- Healthcare for employees
- Adequate resources to do the job

These all depend on the culture in the healthcare environment, the skill of the leaders/managers and the allocated resources for the job.

More about stress

One of the commonest mental health problems in health workers is stress. Poor terms of employment make stress more likely. However there are many additional causes of stress associated with being a health worker. Stress and anxiety are greater in clinical jobs than non-clinical, and in some specialities than in others. Caring for women, children and families is especially stressful and requires attributes that include:

- Interest and empathy with children and their families
- A friendly "down to earth" personality
- Common sense
- A lack of interest in private income, providing the remuneration is sufficient to live as well as the average family. This is not the case in many countries where health workers have to depend on additional income. In these countries, inequity of healthcare is inevitable.
- A broad knowledge of women and children's healthcare
- The ability to communicate with people across professional, cultural and ethnic boundaries and age groups

Stressful events for health workers include:

- Carrying out an invasive procedure, such as a blood test
- Carrying out an invasive procedure in an upset child
- Not being able to do the procedure (in the case of venous access, it is a good idea to stop after a maximum of three attempts and let someone else try)
- Giving parents and family 'bad news'
- Being in charge without a senior health worker to provide support
- Having to take responsibility before you are confident or to deal with a situation for the first time (some doubt creates a thorough health worker, excess an ill and inefficient one).
- When you do not have the equipment or treatment the woman or child needs
- When a woman or child is very ill
- When a woman or child dies
- Comforting distressed parents and families

- Making a mistake
- Having a complaint made against you
- When there is too much to do and as a consequence you know that your care is suboptimal

Facts about the mental health of health workers worldwide

- Deaths from suicide, cirrhosis and road traffic accidents are higher in health workers than in the general population
- Women doctors are more likely to commit suicide than men, possibly as they are more empathetic and patients increasingly demand empathy
- Drug addiction and alcoholism are more common
- There are higher divorce rates and marriages are more 'at risk' as health workers are often torn between meeting patients' and family needs (doctors are often described by their partners as 'controlling perfectionists')
- Mental illness may be present in greater than 30% of men and up to 46% of women

Health workers, especially doctors, often feel that sharing their feelings with others is a sign of weakness and try to cope alone when distressed. However, if their emotions and feelings become overwhelming they are unable to function properly due to detachment (leading to cynicism and carelessness), a loss of short-term memory, sleep disturbance and difficulty with decision-making. Carelessness leads to mistakes, complaints and litigation. These make the situation worse and may lead to a persecutory anxiety. Another reaction to emotional stress can be to work even harder and to take on more commitments leading to 'burn-out'.

'Burn-out' is the end point of stress. This is a complex of psychological responses to the emotional stress of constant interaction with people in need. It especially affects health workers and others with similar work.

Summary of factors that can lead to discontent, stress and burn-out include:

- Major changes in workplace
- Little say about how to do the job
- Poor communication with colleagues
- Poor recognition of individual worth
- Inability to work flexible hours
- Excessive working hours
- Competing demands on time
- Inadequate resources
- Lack of support programmes

How to protect yourself against mental health problems

You can lessen the effects of stress and emotional distress and reduce the risk of burn-out and other mental health problems by:

1. Structuring and prioritising your time
2. Sharing your responsibilities and commitments (delegating tasks)
3. Recognising stress and emotional distress and taking avoiding actions (developing stress coping strategies)
4. Learning to say no
5. Asking for help
6. Protecting your marriage, family and friendships, and by getting support from those close to you (secure family relationships and the support of close friends helps protect against stress).
7. Creating a forum for a group of colleagues to support each other (peer group support)

8. Using the local support/counselling services that are available, and advocating for these if lacking
9. Being in the right job
10. Being happy with your job and terms of employment

Activities that can reduce and/or prevent unhappiness, stress and burn-out include:

1. Regular small group meetings to discuss current issues
2. Meeting after an upsetting or stressful event (such as a mistake, an accident in the health facility or an unexpected death) to discuss this with those involved and provide support for those affected.
3. Increased control of one's job/s and autonomy in daily activities
4. Redesign of job to decrease or increase responsibilities
5. Introduction of flexible working hours
6. Formal orientation and induction training for new health workers
7. Employee support programs that include skilled counselling services
8. Multidisciplinary rehabilitation for those with 'burnout'
9. Early vocational counselling so that a health worker is doing the job appropriate to their skills, talents and level of knowledge

Health workers are valuable; they have a greater risk of health problems and need looking after.

Although health workers need to be looked after properly by their employers they also have a responsibility to be good employees.

How to be a good employee!

'Take care of your work and your work takes care of you' ***(Brigitte, South Africa)***

Bad employees:

1. Complain and waste time
2. Are complacent: so be professional and sharpen your skills and add new ones.
3. Are invisible. Make an impression and be visible, volunteer for projects and help when others are overworked
4. Are negative. So don't say bad things about colleagues or seniors/managers. This backfires when your unkind words finally reach their ears. If you have a grievance, control your emotions, calmly work out what you want to say, then tell your manager or the person concerned.
5. Are unreliable. Managers value employees who are trustworthy and conscientious. Delivering on every commitment you make is a key indicator of a reliable, responsible employee..
6. Have a poor relationship with their manager. Your relationship with your manager/senior/leader is critical for promotion. Do you make your manager's life easier or harder? Do you take up concerns directly with him or her, or do you discuss it with others who cannot do anything about it?
7. Blame others. If you make a mistake, take responsibility. Accepting responsibility for your actions demonstrates your professional maturity.
8. Make the wrong friends. If you are in with the wrong crowd (the whiners, the laziest), break away. Associate with successful people.
9. Mix personal problems with the job. Marital problems, financial difficulties or other personal problems should be left at home and not allowed to interfere with your work. However, do tell your manager if you have got personal problems. They may and should be able to help.
10. Are disloyal. You don't have to agree with every decision, but managers and your seniors appreciate loyal employees who understand the objectives, and who contribute actively to meeting these and solving problems.

11. Are not conscientious or don't do their work properly. For example they do not always know about or follow policies and guidelines. They spend too much work time socialising with their colleagues or they do not reflect on what they do to make sure it is the best way.
12. Are dishonest, for example use work materials for personal use, make personal telephone calls without paying or are not honest about their behaviour.

So make yourself visible, **honest**, **learn to welcome change, develop new skills, be flexible, review what you do, respect others property and remember the power of good communication**.

Finally a senior health worker or manager can abuse others by:

- Arriving late, leaving early or frequently being absent, especially during busy periods
- Being constantly away from their desk/office
- Using stationery and equipment for personal use and/or making unauthorised private phone calls, faxes, e-mails, photocopies etc
- Making unauthorised trips or detours with company vehicles
- Abusing colleagues by constantly borrowing money or using their books, equipment and other possessions without permission.
- Leaving mistakes or unfinished work for others to sort out.

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MCFH Information Sheet 9: Mission statements

What is a mission statement?

A mission statement is a written statement or charter about the health services provided. It includes the type and quality of care that women, children and their families can expect to receive and the arrangements for seeking a solution if this fails.

Best practice is for all healthcare environments and services to have a mission statement about the healthcare they aim to give. These statements can express the intent of a hospital ward, a clinic, a specific service such as palliative care, or woman or child protection service, a professional group, or of an individual health worker.

Why are mission statements important?

Women, children and their families are often less anxious and frightened about receiving healthcare if they know what to expect. Health workers also need to know what they should be providing

Where should they be?

Best practice is to put the statement where everyone can see it such as the entrance to the health facility, department or clinical area.

Who owns a mission statement?

It is 'owned' by the health workers who work in the healthcare environment.

Who decides what a statement will say?

They work best if developed and approved by a team representing the different health workers involved, parents and older children *(See information sheet 11 for more information about team working)*. The leader of the service or healthcare environment is responsible for it.

What does it need to say?

It needs to be short and say exactly what services, or care, are provided as simply as possible. It is easier to understand if it is written in local languages and uses simple words and/or pictures. Ideally it should include the name of the health worker responsible for the service or healthcare environment and how to contact them if things go wrong. It needs to include the date it was written and a date for its review.

Example of a mission statements

Neonatal Intensive Care Unit, Mulago Hospital, Kampala, Uganda The Ten Commandments of the Newborn

The ten commandments of the newborn (written by health workers on behalf of the newborn)

1. My name is ………………………. please use this when talking to or about me.
2. Wash your hands before examining me; I do not want to get infected
3. Do not lift the lid off, or open, my incubator unless essential as I will get cold and the oxygen and humidity levels that I need will be lost.
4. If I am born early, do not examine me on your daily round unless strictly necessary in order to change my treatment, or to confirm or change my diagnosis, as you are exposing me to infection every time you touch me.
5. Try if at all possible to let me breast feed as then my infections, especially bowel infections, will be fewer, my weight gain will be better and my hospital stay shorter.
6. Before prescribing medicine think hard about the undesirable side-effects these drugs can cause, and always make sure you give me the correct dose for my age, weight and level of maturity.
7. Treat me as an individual, and remember that my problem/s may not be straight-forward. Rare conditions do sometimes occur so watch me carefully.
8. Discuss my care with your colleagues whenever you think this is necessary, sharing knowledge may provide answers.
9. Talk to my mother and teach her the rules of baby care. Tell her how to look after my special needs. Tell her how important it is for me to be breastfed, kept clean, immunized at the right times and how to help me grow and develop.
10. Treat me as if I was a member of your family. Do not discriminate against me because of my parents' financial or social position. Remember that I am the most important baby in the world to my parents, just as your baby is the most important baby in the world to you.

MCFH Information Sheet 10 How to solve problems

'If at first you don't succeed, try, try, try, again. Then quit. There's no use being a damn fool about it': W C Fields

There is nothing new about solving problems - we do this every day. Some problems are more easily solved than others. In a healthcare environment problems are often complex and affect many different people. It is better to solve them using the advice and guidance of others (a team approach).

The principles of problem solving include:

1. Defining the problem/s after listening to everyone affected
2. Prioritising these, if there is more than one problem
3. Selecting/choosing a problem to act on
4. Recognising barriers to solving the problem/s and forces that may help to solve it/them, such as people or other resources
5. Seeking some possible solutions/courses of action from those affected and if possible also from others who have faced similar problems
6. Considering (evaluating) these and selecting the best solution/s
7. Trying (implementing) possible solution/s
8. Evaluating the results (audit) to see if the problem has been solved and acknowledging everyone's efforts
9. Trying other possible solutions if problem not solved
10. Reviewing other problems and repeating the process

1. Defining the problem

- Some problems and their solutions are obvious, but some are difficult to understand and solve. Some of the causes of problems may be overlooked, or not fully understood, unless you talk to everyone affected.
- The main problem may be due to several problems each with a different cause, so break a problem down into its parts and decide which are the most important and need solving first. Unless you find the true problems you are unlikely to improve the situation.
- Do not make assumptions about the cause of a problem. If you do, it is likely that your solution will not work. Talking to everyone makes finding an effective solution more likely, especially if those you consult know more about the details of the problems.
- Remember one person's problem list may be different from that of another!

2. Prioritising problems

- Generally the discussions you have when defining the problems will help with prioritise them.
- Agreement of all involved for the final order of priorities is the best approach.
- If agreement is not possible an independent view may aid consensus.

3. Selecting a problem/s for action

- This is usually the one top of the priority list, but not if this seems too difficult
- Involve those that may have to implement the solutions in the selection of which to tackle first
- The easier to solve problem may be best tackled first as success encourages and motivates
- If there are lots of problems it is better to select only a few to resolve first. If you try to solve too many at the same time you may fail to solve any of the problems.

4. Recognising barriers to solving problems and aids to implementing possible solutions

- Look at these before you start. It is better to find a barrier earlier than later

- Use any forces that may make successful problem solving more likely

5. Seeking solutions

- The more complex the problem, the more consultation necessary
- Listen and respect the views of those closest to the problem as their ideas about possible solutions usually work best.
- Consider a wide variety of possible solutions
- Some people are more able to identify possible solutions than others.
- The solutions most likely to succeed are those that are 'owned' by those involved
- Ask how health workers in different healthcare environments have solved similar problems
- There always are solutions, identifying them is the challenge!

6. Selecting the 'best possible' solution (the project)

When deciding which is the 'best possible' it is usually the:

- Easiest, effective solution
- Most feasible with the resources available
- Solution favoured by most of the team

7. Implementing (trying out) the solution/s selected – taking action

Before making changes it is a good idea to make a detailed plan that states:

- What the goal is (usually this will be to solve the problem)
- How it is going to be achieved (the details of the plan/plan the project)
- Who is going to do it (delegation)
- How you are going to ask or persuade others that it is a good idea (motivate them)
- How you are going to show you have solved the problem
- When you are going to do the evaluation (usually after completion of the project)
- How you are going to acknowledge the team effort. You should not need money or materials for this. Public recognition and praise is very effective

8. Evaluating the results

Look at what has happened to see if you have solved the problem in the best possible way. To do this you can look at the:

- Intended and unintended impact/s of the solution you have tried and the evidence to support these.
- Effectiveness of the planned solution (project)
    - How did it work, were others able to do what was planned, was it difficult, did the goals need to be clearer?
    - Were there enough resources (human and material) to make the plan work?
    - Did unexpected change occur?
- Lessons learned - think about and identify the lessons learned (the things that went well and the things that could be done differently or better next time) by the team, organisation and by the children and families affected

Each of these three ways of looking at outcome impacts on the other two. Compare your results against the goals you set - sometimes unexpected findings are important. Make recommendations for next time and share the results/findings with everyone involved.

9. Trying other possible solutions.

This needs to be done if the problem is not solved. If you think it is not possible to solve the problem with existing resources construct a **project proposal** to take to others outside your organisation.

10. Reviewing other problems from the list and **repeating the process.** You need to keep doing this as there are always new problems to solve.

Finally remember to acknowledge and reward everyone's efforts and share the solutions with others. Having undertaken a local project, for example implementation of correct hand washing in your unit/health facility, this might help persuade sponsors that you have skills and experience to warrant their funding/support.

MCFH information Sheet 11: Team Working and leadership

When there are a large number of health workers in the organisation, health facility or healthcare environment, a team approach to problem solving and to planning, organising and delivering healthcare is best.

A multi-disciplinary team is a team of health workers including doctors, nurses, staff from professions allied to medicine, and others who have contact or involvement with the patient. For example a team may include a microbiologist, an infection control nurse, a ward clerk, a cleaner, a teacher, a play worker and others.

The team approach can be used in many different situations and levels in a healthcare environment or organisation. If there are many different teams with varying responsibilities and purposes in the same health facility, their team leaders need to communicate with each other. Wherever possible they need to avoid duplication of activities.

Most teams work better when:

- There is a leader to manage and coordinate the team's activities.
- This leader is approved of by all members of the team, or in a large team by a clear majority
- The team is as small as possible
- Members represent those most affected by its activities (it has a representative from each group of health workers, or from each area affected, and includes a parent or older child patient representative, if appropriate)
- Members share a clear vision (such as improving healthcare), or purpose (such as planning healthcare, organising a department's activities, solving problems etc.). There are agreed, clearly defined goals or aims for achieving the vision or purpose. The groups represented by team members are consulted whenever possible before any decisions are taken
- A member representing a group of health workers reports back to their own leader or manager about the team's activities. *For example a nurse reports to her senior/head nurse.*

An example of a team approach to a single problem, but who is the leader?

A team approach may solve a single problem quickly (See information sheet 10 for more information about problem solving). However most teams have long-term visions and purposes and need to meet regularly to discuss goals, aims and plan further activities.

'Great leaders are almost always great simplifiers, who can cut through argument, debate and doubt to offer a solution everybody can understand': Michael Korda

'With the best leaders when the work is done the task is accomplished'. The people say "we have done it ourselves": Loa Tsu, Chinese philosopher 700BC

A team leader's role is to:

- Identify members' skills early
- Never underestimate the skills of team members
- Create a defined role for each member that uses their individual skills effectively
- Respect and support team members
- Ensure good working relationships between team members and with others
- Communicate effectively within the team and with those represented

To ensure a cohesive approach to delivering healthcare a **team member** who represents a group of health workers also needs to report to/communicate with their own leader/manager. For example nurse members of any team in any health environment need to report back to the head nurse of the organisation or health facility. This applies to all groups of health workers.

Being a leader means:

- Recognising that change is needed
- Knowing what you want to achieve (the vision)
- Enthusing others who may help, or benefit from it, to share the vision
- Motivating, empowering and developing others to help you put the vision into practice
- Making something complex appear simple and easy to understand
- Managing conflict
- Dedication and hard work
- Celebrating success

The skills needed to be a good leader include:

- Vision
- Courage, a conviction that you are right but the willingness to also accept and admit that sometimes you will be wrong
- Motivation
- Passion and enthusiasm
- Energy
- Integrity
- Consistency
- Communication skills
- Interpersonal skills (empathy and social skills), understanding people and how to support them and get the best out of them
- Good judgement
- Knowing when to concentrate on the vision, when to be flexible and when to focus energies on the details of the tasks (planning and implementing). Generally the details are best delegated to others.
- The ability to delegate. If you try to do everything yourself, it is likely that nothing will be done as well as it could be. You will not be as effective if you are trying to do too much!
- Self-awareness (a knowledge of your own strengths and weaknesses)
- Diversity and expertise, although others can provide the latter

- Ability to finish the tasks required to achieve the vision

There are many different styles of leadership.
These include:

1. **Collaborative/democratic** – the leader shapes, develops and guides a team by consensus
2. **Autocratic/dictatorial/coercive** – everyone does what the leader says without question
3. **Laissez-faire** – the leader delegates to a team allowing the team members to do whatever they want

Each of these three types of leadership work well for specific situations

Collaborative leadership:

Works well when:	Does not work well when:
There are different issues involved and the problems are complex	The issues and problems are simple
The problems have many possible solutions	There is a single solution to problems
The leader does not have the skills and knowledge to deal with all the issues	The leader is autocratic and think they know best
There are team members with the skills to deal with each of the important separate issues	Team membership does not reflect the skills needed
The team member for an issue is skilled and respected and acts as a representative for those involved	The team member for an issue is not skilled, or not respected or does not represent the views and opinions of others involved
Authority for the different issues is delegated with boundaries clearly set and known by all	Authority is not delegated to team members or the boundaries of the authority are not clearly defined or followed
Team members respect each others roles and skills	There is little respect for each others roles and skills
The team is able to work well together	The team are unable to work together well
The team is able to meet frequently	The team are unable to meet regularly
Team members communicate well with those they represent	There is poor communication with those that a team member represents

Autocratic leadership:

Works well when:	Does not work well when:
The situation is simple with a limited number of problems	The situation is complex with many differing problems
There is a single best solution to most problems	There are many possible solutions to the problems
There are a limited number of different issues involved	There are many different issues involved
The situation is replicated in the same way frequently	The situation is variable
Followers or team members all agree that the leader has unique skills, talents, knowledge that is superior to their own	Followers or team members have opinions of their own on the issues involved and believe they know as much as the leader about them
The leader is willing to get involved in all the details	The leader is not willing to get involved in details
The leader has the capacity to be involved in the details	The leader does not have the capacity to be involved in all the details
The followers change frequently	The leader is unwilling or unable to be always available to the team
The team, if there is one, is remote	There is a pro-active team

An example of when autocratic leadership works well is a ward staffed with temporarily employed nurses when it is best if there is tight control and rules about how things are done.

Laissez-faire leadership:

Works well when:	Does not work well when:
The team is composed of a small number of similar individuals who share the same goals	The team is large or diverse
One solution to a problem is as good as any other	The situation and problems are complex
The team members know each other very well and are in frequent contact with each other	The team is remote

Although there is a place for all these types of leadership, a healthcare environment is usually complex. It encompasses many diverse issues and activities and is staffed by many skilled health workers; collaborative **leadership is likely to work best.**
If this collaborative leadership model is adopted it will result in more ideas, better insight and cooperation, more manageable demands on the leader and the proposed solutions are more likely to work and be sustainable. It is less likely to waste time and energy.

When using this model of leadership, best practice for the leader is to:

- Choose team members to represent each of the important functions and activities
- Balance the team
- Find out the individual strengths and skills of each team member
- Use these strengths and skills effectively
- Communicate effectively upwards and downwards to other health workers
- Delegate authority but make it very clear what and how much is delegated - set the boundaries clearly
- Arrange procedures for communicating

Other thoughts on leadership

1. A leadership based on facts is better than leadership based on emotions.
2. Leadership is the shift from developing yourself to developing others. Use your skills and strengths to gather your team then lead, involve, delegate, manage and enable so that the visions are implemented.
3. Leadership based on accepted beliefs and moral values works best as it treats people equally, respects everyone in the team and welcomes new ideas, initiatives and innovations. It is open, humble and has integrity.
4. Leaders need to be in training every day. They have to adapt to the crises and problems that arise around them, but they also need to train for a purpose.
5. Full engagement in leadership requires coping strategies that draw on physical, emotional, mental and spiritual (this means being in touch with your values) energy. Each of these sources of energy needs training and rituals. Like physical training, all of these sources require recovery time before you can draw on them again, for example
    - Physical recovery time - rest
    - Emotional recovery time - can be focussing on a happy thought/experience from outside
    - Mental recovery time - can be sleep or meditation
    - Spiritual recovery time - can be time alone to reflect on your values and beliefs

    All great leaders and sportsmen have recovery rituals for these energies. We are creatures of habit, so build rituals to sustain your sources of energy and avoid compromising recovery.
6. If you wake in the middle of the night, never look at the clock but use the strategies that work for you to shut out any fear, anxiety and stress.

References

David Mencheon and Yi Mien Koh. Leadership and motivation. BMJ 2000 29 July Pages 2-3