Policy and practice

ASSESSMENT AND IMPROVEMENT OF CHILDREN'S RIGHTS IN HEALTH CARE: PILOTING TRAINING AND TOOLS IN UZBEKISTAN

Ana Isabel Fernandes Guerreiro,[1] Aigul Kuttumuratova,[2] Mavjuda Babamuradova,[3] Zulfia Atajanova,[3] Martin W. Weber[2]

[1] Independent consultant, Albufeira, Portugal.
[2] World Health Organization Regional Office for Europe, Copenhagen, Denmark.
[3] World Health Organization Country Office,Tashkent, Uzbekistan.

Corresponding author: Ana Isabel F. Guerreiro (email: ana_isabel_guerreiro@hotmail.com)

ABSTRACT

There is growing recognition of the importance of adopting rights-based approaches to children's healthcare, as demonstrated by *Investing in children: the European child and adolescent health strategy 2015–2020* and national programmes. The World Health Organization (WHO), together with the Government of Uzbekistan, is carrying out activities to enhance reproductive, maternal, child and adolescent health services. In early 2015, the WHO Regional Office for Europe delivered training on children's rights in healthcare and conducted a field test of draft tools for the assessment and improvement of children's rights in primary healthcare. The aim of this paper is to present the two activities and make recommendations for the future. The training and field test revealed knowledge gaps among health professionals on the Convention on the Rights of the Child and its applicability to healthcare and the national regulatory framework. The results of the field test provided evidence on the utility of the tools and their use in the context of quality of care improvement for children. This work will inform both the finalization of the assessment tools and the efforts to scale up related national processes in collaboration with other sectors.

Keywords: CHILDREN'S RIGHTS, QUALITY OF CARE IMPROVEMENT, PRIMARY HEALTHCARE, UZBEKISTAN

BACKGROUND

During the past decade considerable changes have occurred in the maternal and child health protection system in Uzbekistan, notably through the government's launch of the state programme to further improve reproductive, women's, children's and adolescents' health for 2014–2018 *(1)*. In 2013, Uzbekistan was one of the countries with the highest estimated under-five mortality rate in the World Health Organization (WHO) European Region *(2)*. Quality improvements in primary and secondary health services for mothers and children are thus major priorities.

The importance of adopting a human-rights based approach to health *(3)*, is emphasized in *Investing in children: the European child and adolescent health strategy 2015–2020 (4)*. A human-rights based approach to health in the context of children's health and well-being that is compliant with the Convention on the Rights of the Child (CRC) *(5)* must encompass all of children's life settings and the relevant actors and institutions. This perspective clearly contributes to the WHO Regional Office for Europe's Health 2020 policy framework and strategy by addressing and improving health and well-being of the population through strengthened leadership and governance, enhanced participation and empowerment of people and improved quality of care for all *(6)*.

CONTEXT

In line with the adopted strategies, the WHO Regional Office for Europe provides continuous technical support to Uzbekistan in developing innovative policies and improving the quality of care by strengthening the child patient's rights in healthcare. In 2014, the WHO Regional Office for Europe supported an assessment of children's rights in the hospitals of the Namangan region. Two of the main findings were lack of knowledge (i) of the principles of the CRC and (ii) of the practical implementation of an approach to healthcare based on patients' rights. The present paper reports subsequent work done on application of the CRC in primary health care in Uzbekistan in 2015.

APPROACH

TRAINING WORKSHOP ON CRC

A two-day training workshop on children's rights in healthcare took place in February 2015. The aims of the training were: first, to introduce the principles of the CRC relevant to healthcare and second, to discuss how to use the CRC as a framework to plan, assess, monitor and improve health services for children. The 21 workshop participants were healthcare professionals working at national and regional levels who had been selected by the Ministry of Health. An international consultant led the workshop and a technical officer from the WHO Regional Office for Europe presented information on children's rights and health promotion, including an assessment of children's rights in hospitals in Tajikistan and Kyrgyzstan and improvements attained in 2013–2014. Training was delivered through presentations, discussions and group work; participants also received training handouts and a copy of the presentations in Russian in an electronic format. A post-training evaluation form was completed by all participants at the end of the workshop.

FIELD TESTING OF NEW ASSESSMENT AND IMPROVEMENT TOOLS

During 2014, the WHO Regional Office for Europe developed the *Children's rights in primary health care series.* This six-volume series comprises a manual and tools that enable the assessment of, and improvement in, quality of care for children through a human-rights based approach to health *(7)*. The five tools allow assessment of adherence to eight standards on children's rights in primary health care and target managers, health professionals, parents/carers, children aged 6–11 and children and adolescents aged 12–18 (Table 1). The standards, each of which comprises substandards, were derived from the 2012 *Manual and tools for the assessment and improvement of children's rights in hospital (8)*. Each tool comprises a semi-structured questionnaire with a short statement on each standard and substandard, mainly closed-ended questions and the opportunity to add comments. The tools for managers and health professionals may be used for external or self-assessment, while the tools for children/adolescents and parents/carers are designed to be used in an interview setting. The tools also comprise templates for focus group discussions with parents/carers and children/adolescents.

TABLE 1. STANDARDS AND RELATED ARTICLES OF THE CRC

STANDARD	TOPIC	RELATED CRC ARTICLES
1	Quality services for children	Articles 9, 24 and 31
2	Equality and non-discrimination	Articles 2 and 16
3	Parenting	Articles 5, 18 and 24
4	Information and participation	Article 12
5	Safety and environment	Article 3
6	Protection	Articles 6, 19 and 39
7	Chronic illness and other long-term health care needs	Article 23
8	Pain management and palliative care	Article 24

Source: Manual and tools for the assessment and improvement of children's rights in primary health care. Copenhagen: WHO Regional Office for Europe *(7)*.

The field test of the tools was carried out in February 2015 in the Kashkadarya region, which had been selected by the Ministry of Health. The aims of the field test were to verify the relevance and applicability of the tools to the care provided in facilities and to identify areas of the tools that needed revision. As such, this was a first and qualitative observational study of the process of assessment itself and not a quantitative study of the performance of facilities.

A one-day capacity-building workshop was delivered to participants prior to the field test. The aim of the workshop was to introduce the tools and discuss the methodology of the field test. The participants were 21 health professionals selected by the Kashkadarya

health authority and representing the national paediatrics centre and regional and local coordinators from primary health care facilities.

In order to test the tools in different primary health care contexts, a mix of larger outpatient health facilities (polyclinics) and rural health units were selected. Local coordinators were responsible for leading the assessments and interviewing all stakeholders. Their role was to identify a focal point in each facility, undertake data collection and complete a local report. The focal points identified the stakeholders to be interviewed and allocated interviewing rooms. The tools for the assessment had been translated into Russian and then into Uzbek prior to the field test. Both interviews and focus group discussions were carried out with the stakeholders. Each evening, feedback discussions were held between the local coordinators and the international team to discuss the process, information gathered, working methods, doubts and biases encountered.

OBSERVATIONS

TRAINING WORKSHOP ON CRC

Observations during the training workshop demonstrated that participants had little previous exposure to the CRC and had difficulty in understanding the essence and applicability of rights to the healthcare setting. Additionally, the participants seemed to lack knowledge on Uzbek legislation concerning children's rights in healthcare, such as a child's right to informed consent to treatment. At the same time, the participants demonstrated a great interest from the start; they were motivated and participated actively in the discussions throughout the training. Of the 21 participants, 16 completed the post-training evaluation forms. The overall feedback from the training was positive. Only two participants reported having received prior training on children's rights and 13 reported that some of the issues covered had been addressed by their medical studies.

FIELD TESTING OF NEW ASSESSMENT AND IMPROVEMENT TOOLS

The field test of the tools was carried out in 12 polyclinics and rural health units over four days. Consent was obtained from all participants. A total of 12 managers, 18 health professionals, 36 parents, 40 children aged 6–11 and 35 children and adolescents aged 12–18 participated. The local coordinators preferred focus group discussions to individual interviews with the health professionals.

The data collected showed a tendency by the managers and health professionals to reply "yes" to all questions, particularly for standards 1–4 and 7. Specifically, 80% of managers replied "yes" to 75% of the items in standards 1–4 and 7, while 80% of health professionals replied "yes" to 80% of the items in the same standards. When follow-up questions were asked, the responses were not always consistent. For example, when asked whether adolescent-friendly services were provided, all managers and health professionals replied "yes". However, in one polyclinic, when the international team further asked whether adolescents had access to contraception, the manager, head doctor and head nurse replied "no". The health professionals were more likely to provide supporting evidence to their answers than managers. The evening sessions were useful to discuss process-related issues with the local coordinators.

From our observations and data, it was clear that managers, health professionals and often parents wanted to ensure that the assessment was positive and so were quick to say "yes" to all questions posed. This bias, together with the lack of supportive evidence on how care was effectively implemented, makes reliable assessment difficult. Some coordinators demonstrated a lack of assessment and facilitation skills, such as applying the tool for children aged 6–11 to parents rather than the children themselves; inability at times to manage focus group discussions effectively; and a disregard for the need to ensure privacy and confidentiality during interviews with the stakeholders.

LESSONS LEARNED

These findings show the need to expand capacity building nationally on the CRC, the national regulatory context and data gathering techniques. In contrast to the present study, the few similar studies published to date provide no evidence on process-related information *(9, 10)*.

The field test provided significant insight not only on the relevance and manageability of the tools, standards and substandards but also on the process of

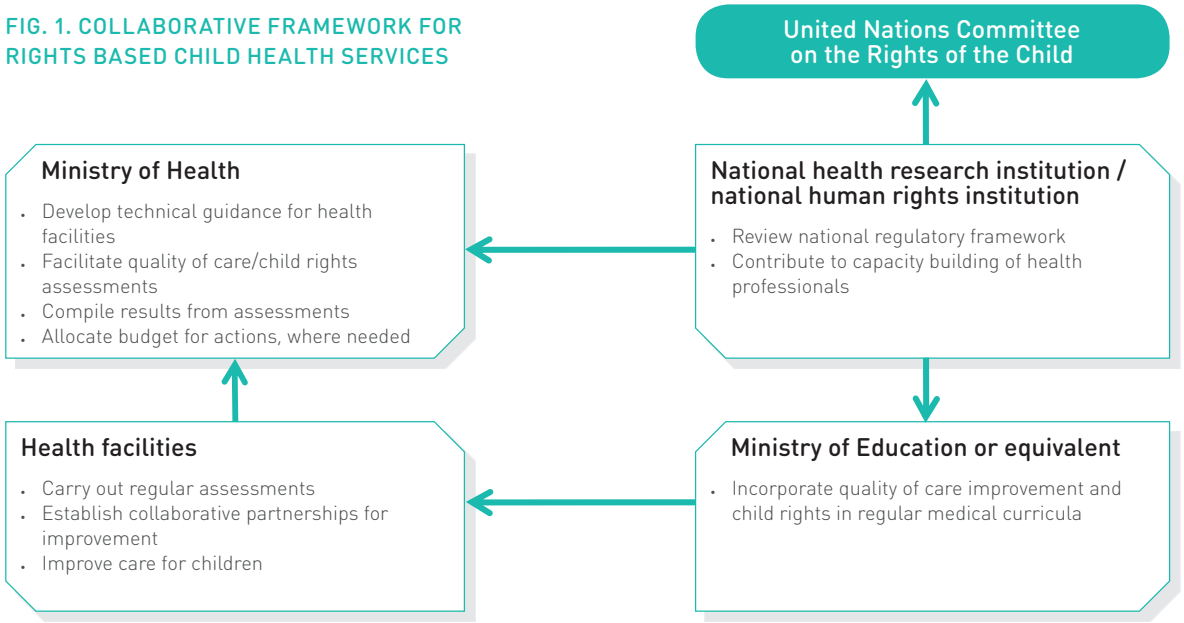
assessment itself. Overall, we conclude that the tools are useful to carry out an assessment of children's rights in primary health care and the five tools complement each other, providing information about policies and management of the facility, knowledge on health professionals and on the needs, experiences and expectations of children and parents/carers. Moreover, the information gathered via the tools provides triangular feedback, that is, all questions for the five groups of stakeholders elicit complementary evidence for the same standards and substandards. This allows collection of robust data and is a particular strength of the tools compared with other methods of quality-of-care assessment. However, the results also indicate that significant steps need to be taken in order to optimize the tools and improve the care provided.

The workshop and field test provided crucial information not only for enhancing training on the child's rights in healthcare but also on improving assessment and adopting a standardized approach in the future. Subsequent to the work reported here, the tools for the assessment and improvement of children's rights in primary health care have been revised and have now been published. Further field testing is planned for 2016.

The centrality of the role of primary health care within health systems is recognized by WHO Regional Office for Europe's Health 2020 policy framework and strategy *(6)*. We believe that the tools can be used in the context of a framework to use the CRC as a means to improve quality of care for children in other countries and to scale up related initiatives. To do so effectively and with long-term impact, collaboration between sectors such as health, education and justice will be needed (Fig 1). Such collaboration involves harmonization of the national regulatory framework; undergraduate and in-service training of professionals; processes governing quality of care assessment; and national reporting to the United Nations Committee on the Rights of the Child, in the context of CRC Article 24 on "the right of the child to the enjoyment of the highest attainable standard of health".

Acknowledgements: The authors would like to thank Dr Asmus Hammerich, WHO Representative in Uzbekistan, the Ministry of Health of Uzbekistan and the regional health authorities for their support in the realization of the workshop and assessments and to all staff, children, adolescents and parents involved in the assessment in the participating facilities.
Source of funding: European Commission funded project "Improvement of Mother and Child Health Services in Uzbekistan – Phase II" EuropeAid ID US-2008-CQP-2005215056 and USAID-Grant Agreement No. 43692 through the WHO Regional Office for Europe.
Conflict of interests: None declared.
Disclaimer: The authors alone are responsible for the views expressed in this publication and they do not necessarily represent the decisions or policies of the World Health Organization.

FIG. 1. COLLABORATIVE FRAMEWORK FOR RIGHTS BASED CHILD HEALTH SERVICES



REFERENCES

1. Decree of the President of Uzbekistan on the state program to further strengthen reproductive health, maternal, child and adolescent healthcare in Uzbekistan for 2014–2018. Tashkent: Government of Uzbekistan; 2014 (in Russian) (https://www.mindbank.info/item/5298, accessed 8 October 2015).
2. World Health Statistics 2015. Geneva: World Health Organization; 2015 (http://apps.who.int/iris/bitstream/10665/170250/1/9789240694439_eng.pdf?ua=1&ua=1, accessed 18 September 2015).
3. Office of the United Nations High Commissioner for Human Rights, World Health Organization. A human rights-based approach to health. New York: Office of the United Nations High Commissioner for Human Rights, 2012 (http://www.ohchr.org/Documents/Issues/ESCR/Health/HRBA_HealthInformationSheet.pdf, accessed 17 September 2015).
4. Investing in children: the European child and adolescent health strategy 2015–2020. Copenhagen: WHO Regional Office for Europe; 2014 (http://www.euro.who.int/__data/assets/pdf_file/0010/253729/64wd12e_InvestCAHstrategy_140440.pdf?ua=1, accessed 17 September 2015).
5. Convention on the rights of the child [website]. New York: United Nations Children's Fund; 2015 (http://www.unicef.org/crc/, accessed 17 September 2015).
6. Health 2020: a European policy framework and strategy for the 21st century. Copenhagen: WHO Regional Office for Europe; 2013 (http://www.euro.who.int/en/publications/abstracts/health-2020-a-european-policy-framework-and-strategy-for-the-21st-century, accessed 17 September 2015).
7. Children's rights in primary health care series, vols. 1–6. Copenhagen: WHO Regional Office for Europe; 2015 (http://www.euro.who.int/en/health-topics/Life-stages/child-and-adolescent-health/publications/2015/childrens-rights-in-primary-health-care-series/_recache, accessed 15 November 2015).
8. Guerreiro AIF, editor. Manual and tools for the assessment and improvement of children's rights in hospitals [website]. Copenhagen: International Network of Health Promoting Hospitals and Health Services; 2012 (http://hphnet.org/index.php?option=com_content&view=article&id=1551:hp-for-children-a-adolescents-in-a-by-hospitals-&catid=20, accessed 17 September 2015).
9. Simonelli F, Guerreiro AIF, editors. The respect of children's rights in hospital: an initiative of the International Network on Health Promoting Hospitals and Health Services. Final Report on the implementation process of the Self-evaluation Model and Tool on the respect of children's rights in hospital. Copenhagen: International Network of Health Promoting Hospitals and Health Services; 2010 (http://www.hphnet.org/images/stories/Task_Force_HPH-CA.Final_Report_SEMT1.pdf, accessed 17 September 2015).
10. Mora Oviedo M, Slater Riveros C, Miranda Alarcón M, López Donoso C, Artaza Barrios O. Integrated healthcare and prevention in pediatric mental health experience: application of friendly healthcare attention model.Cuad Méd Soc (Chile). 2010;50 (3):193–201 (in Spanish).