



Child-friendly
health care



Council of Europe guidelines on child-friendly health care



Guidelines on child-friendly health care

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Guidelines on child-friendly health care

*(Adopted by the Committee of Ministers on 21 September 2011
at the 1121st meeting of the Ministers' Deputies)*

Preamble

The Committee of Ministers,

Considering that the aim of the Council of Europe is to achieve greater unity between its member states, *inter alia*, by promoting the adoption of common rules and actions;

Considering the necessity of ensuring the effective implementation of existing binding universal and European standards protecting and promoting children's rights in general, as well as those covering aspects specific to health care, including:

- the United Nations Covenant on Economic, Social and Cultural Rights (1966), and in particular its Article 12 on the right to the highest attainable standard of health;
- the United Nations Convention on the Rights of the Child (1989);
- the United Nations Convention on the Rights of Persons with Disabilities (2006);
- the Convention for the Protection of Human Rights and Fundamental Freedoms (1950, ETS No. 5);
- the European Social Charter (1961, ETS No. 35) and the Revised European Social Charter (1996, ETS No. 163);
- the European Convention on the Exercise of Children's Rights (1996, ETS No. 160);
- the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (1987, ETS No. 126);
- the Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse (2007, CETS No. 201);
- the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights



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Recalling relevant texts adopted by the Committee of Ministers concerning children¹ and those concerning health care;²

Bearing in mind the Charter for Health Promotion (1986, Ottawa), and the European Charter for Children in Hospitals (1988, Leiden);

Bearing in mind that all Council of Europe member states adopted and are implementing the health for all policy framework "Health 21" for the World Health Organization (WHO) European Region in particular its target 4 – health of young people;

Taking into account the relevant recommendations of the Parliamentary Assembly of the Council of Europe and statements of the Council of Europe Commissioner for Human Rights;

Referring to the work of the Council of Europe Programme "Building a Europe for and with children", its 2009-2011 Strategy for the Rights of the Child and the future 2012-2015 Strategy for the Rights of the Child;

Recognising children as bearers of rights, including the right to the enjoyment of the highest attainable standard of health, the right to be protected, the right not to be discriminated against and the right to express their views and participate, the views of the child being given due weight in accordance with the child's age and degree of maturity;

Bearing in mind that, in all actions concerning children, the best interests of the child shall be a primary consideration;

Considering that, whenever appropriate, children's parents, other family members and carers should be closely involved in decisions relating to their health;

Considering that children, by reason of their physical and mental immaturity, need special safeguards and care, and that there are significant inequalities between and within member states of the Council of Europe in the determinants of health, access to health care and the quality of health care;

Recognising that promoting the health and well-being of children, with particular attention to the safety and quality of services, is important to society as a whole;

1. Guidelines on child-friendly justice, adopted on 17 November 2010;

Recommendation CM/Rec(2010)2 on deinstitutionalisation and community living of children with disabilities;

Recommendation CM/Rec(2009)10 on integrated national strategies for the protection of children from violence;

Recommendation Rec(98)8 on children's participation in family and social life.

2. Recommendation Rec(2006)7 on management of patient safety and prevention of adverse events in health care;

Recommendation Rec(2006)5 on the Council of Europe Action Plan to promote the rights and full participation of people with disabilities in society: improving the quality of life of people with disabilities in Europe 2006-2015;

Recommendation Rec(2000)5 on the development of structures for citizen and patient participation in the decision-making process affecting health care.



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Conscious of a substantial change in the epidemiology of morbidity and mortality in children over the last half century throughout Europe and the cost-effectiveness of new evidence-based child-friendly health care approaches, investing in integrated services for vulnerable and disadvantaged children and families, with long-term gains in health, well-being and life chances;

Emphasising the need to create coherent policies and synergies towards a co-ordinated approach for children at all levels of government and at all levels of health-service provision in particular;

Recognising the importance of ensuring participation of civil society, in particular bodies which aim to promote the rights of the child, in the elaboration and dissemination of a child-friendly health care approach,

Adopts the following guidelines on child-friendly health care to serve as a practical tool for the governments of the member states in endorsing, adopting, implementing and monitoring the child-friendly health care approach contained therein and adapting their health care systems for children and families to the specific rights, interests and needs of children;

Invites the governments of the member states to ensure that the guidelines are widely disseminated among all authorities, service providers, groups representing the interests of children and families and other stakeholders responsible for or involved with children's rights, particularly in health care.

I. Object and purpose

1. The guidelines on child-friendly health care propose an integrated approach to the development of the full range of child health care activities.
2. This approach places children's rights, needs and resources at the centre of health care activities, taking into account their family and social environment. It promotes policies to deliver child-oriented services based on child-specific developmental needs and evolving capacities, ensuring children's participation at every level of decision making, in accordance with their age and degree of maturity.



II. Definitions

3. For the purposes of these guidelines on child-friendly health care (hereafter “the guidelines”), “child-friendly health care” refers to health care policy and practice that are centred on children’s rights, needs, characteristics, assets and evolving capacities, taking into account their own opinion.
4. A “child” means any person under the age of 18;
5. A “parent” refers to the person(s) with parental responsibility according to national law. In case the parent(s) is/are absent or no longer holding parental responsibility, this can be a guardian or an appointed legal representative.

III. Principles of the child-friendly health care approach

6. The guidelines build on the existing principles enshrined in the instruments referred to in the preamble. They are further developed in the following sections and apply to all chapters of the guidelines.

A. Fundamental rights and children's specific rights

7. All children should be considered and treated as bearers of human rights as proclaimed in the existing international instruments.
8. It is also recognised that children are entitled to special care and assistance, and that children in difficult conditions need special consideration³.
9. The rights of children shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

3. Preamble of the United Nations Convention on the Rights of the Child.



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B. Dignity

10. All children should be treated with care, sensitivity, fairness and respect throughout any health care intervention, with special attention for their personal situation, well-being and specific needs, and with full respect for their physical and psychological integrity.

C. Participation

11. It is an established principle that a child who is capable of forming his or her own views has the right to express those views freely in all matters affecting himself or herself, the views of the child being given due weight in accordance with the child's age and maturity.⁴

12. In the health field, this principle has two dimensions:

- i. When a child, according to law, is able to consent to an intervention, the intervention may only be carried out after the child has given his or her free and informed consent. When, according to law, the child does not have the capacity to consent to an intervention, the opinion of the child shall be taken into account as an increasingly determining factor in proportion to his or her age and degree of maturity. Children should be given appropriate information beforehand.
- ii. Children should also be considered as active members of society, and not as mere passive subjects of decisions taken by adults. This implies, taking into consideration their age and degree of maturity, their being informed and consulted, and given the opportunity to take part in social decision-making processes on health care issues, including the assessment, planning and improvement of health care services.

4. Article 12 of the United Nations Convention on the Rights of the Child.



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D. Equitable access to quality health care

13. All children should have equitable access to quality health care services. This includes prevention, promotion, protection and provision of services with the active involvement of children.
14. Specific health care provision may be needed for more vulnerable children, such as children with disabilities, children in residential institutions, homeless and street children, children living in low-income families, Roma children, migrant children, refugee and asylum-seeking children, unaccompanied children and abused and neglected children.

E. Best interests of the child

15. In all actions concerning children, the best interests of the child should be a primary consideration.⁵
16. In assessing the best interests of the child, all his or her rights and interests should be taken into account. Potentially conflicting rights and interests, such as the right to protection and the right to participation, should be carefully weighed to determine the best interests of the child in the circumstances of each case.

IV. The child-friendly health care approach

A. The rights underpinning the child-friendly health care approach

17. The child-friendly health care approach constitutes an integrated conceptual and operational framework which fully respects children's rights, health needs and resources and therefore underpins all models and programmes.

⁵. Article 3 of the United Nations Convention on the Rights of the Child.



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18. All health care systems are currently facing comparable challenges. The epidemiology of childhood conditions is changing, current systems are not achieving all their expected outcomes and there are often unacceptable variations in the quality and outcomes of services for children and families. Rising costs of health care are a constant concern. Achieving improvements is often difficult without a shared approach to the planning and delivery of services, and for the achievement of better value with the combined resources available, it is essential that all services and stakeholders work together.
19. The importance of good co-ordination and continuity of care based on an integrated and multi-disciplinary approach, sometimes referred to as a “continuum of care”, should not be underestimated. This extends across the traditional boundaries of primary, secondary and tertiary health care organisations, involving health, education, social care and justice systems whether in the public, private or voluntary sectors.
20. The aim of the child-friendly health care approach is to integrate the relevant rights of children with respect to health and health care into a practical framework that drives cultural change and consequent improvement in all services which contribute to the health and well-being of children. This approach should be applicable at the level of policy/planning development, at the service-delivery level and at the level of individual children and families. The approach is universal, but one which each member state can adapt to its own situation.
21. “Child-friendly health care” includes the notion of “family-friendly”, facilitating bonding between newborn babies and their mother/parents, facilitating contacts between the child and his or her family and preventing the separation of the child from his or her family unless it is in the best interest of the child..
22. Five principles, enshrined in the conventions outlined in the preamble, are particularly relevant to the child-friendly health care approach:

Participation

23. Participation means that children have the right to be informed, consulted and heard, to give their opinions independently from their parents and to have their opinions taken into account. It implies the recognition of children as active stakeholders and describes the process by which they take part in decision making. The level of child participation depends both on his or her age, evolving capacities, maturity and on the importance of the decision to be taken.
24. Parents and families should encourage children to participate in family, community and society decision making – encouraging increasing independence and reducing their support as the child’s capacity for autonomy and independence develops.



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Promotion

25. Health promotion is “the process of enabling people to increase control over their health and its determinants and thereby improve their health”.⁶ Promotion therefore includes all actions that allow children to become more involved in their own health and increase their exposure to positive determinants of health (defined as factors which will improve health or well-being). Health promotion covers not only activities in families and communities, directed at health determinants or lifestyles, but also factors in health care services and settings which will improve outcomes.

Protection

26. Health protection includes all actions that either limit or avoid children’s exposure to any hazard which can be defined as a factor that has the potential to cause harm. Hazards can occur in families, communities and health services. Medical interventions can cause harm and patient safety perspectives highlight the fact that children are particularly vulnerable to medication errors and hospital-acquired infections.

Prevention

27. Prevention is an active process the aim of which is to avoid future health, social or emotional problems in order to enable the fullest realisation of human potential. This includes action to reduce adverse health determinants, to prevent the development of a disease or condition, to avoid complications of a disease or condition, to prevent the impact of a disease or condition on the lifestyle or aspirations of an individual and to prevent harm caused by a service or intervention. *Provision*

28. Provision refers to any service which contributes to the health and well-being of children and families, and therefore includes more than just traditional health services. “Pathway-based provision” is a concept that describes all the component parts that need to be in place and working well together to achieve an excellent patients’ experience which brings about optimal outcomes for children and families in their journey safely through services.

6. Health Promotion Glossary, WHO, 1998.



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B. A description of the child-friendly health care approach

29. The goal of the child-friendly health care approach is to ensure that the right things happen, to the right children, at the right time, in the right place and using the right staff, who are supported in the right way, to achieve the right outcomes, all at the right cost. Overall, the aim is to improve the quality of health care primarily defined by effectiveness, efficiency and equity simultaneously with attention to patient safety and satisfaction/experience. To this end, the purpose of the services should be combined with the relevant child-friendly principles in a practical approach that is applicable to individual children and families, those providing services and which informs higher levels of service planning and policy development.
30. The child-friendly health care approach assumes that at the heart of all services are the needs of children and their families. Services are then designed to enable the child and his or her family to receive a whole range of interventions, including promotion, prevention and treatment and the help and support they require, in a way that suits them and their circumstances. The individual experience of a service is called a "journey", groups of similar journeys are called a "pathway", with each individual component part being delivered by a team, with all the teams working collaboratively within a "network" that strives for continuous quality improvement.
31. For many long-term conditions, there is an initial pathway which spans the development of the condition, its identification, initial assessment and management. This is followed by a cyclical pathway where the condition is reviewed on a regular basis with a focus on the best management of the condition and prevention of complications or other morbidities. There is then a transition pathway which may represent the transition to adult services, transition back to normal if the condition has been cured, or, in the worst case, into palliative care services if there is further deterioration likely to result in death.
32. There are generally four components for each pathway: prevention, identification, assessment and interventions. Each of these components needs to be evidence-based, delivered by competent practitioners working in teams, provided in the right place and at the right time in order to ensure the right outcomes at the right price.



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33. The child-friendly health care approach recognises that interventions should focus not only on managing the child's health condition, but also on their physical or social environment, thus avoiding the medicalisation of social problems. It includes addressing environmental issues (air and water quality, sanitation), socio-economic problems (poverty, social exclusion, poor housing and nutrition), access to education, or parental issues (parenting skills, parents' mental health, domestic violence or substance abuse).
34. It is important to stress the need to support children in cases where parents suffer from severe physical or psychiatric conditions, drug abuse or when parents suddenly die.
35. At each stage of the pathway, children, according to their age and maturity, and their families should be fully informed and involved. Children should be encouraged to exercise their right to participate in the decisions being made about their health or condition. Such involvement is particularly important in the cases of long-term conditions so that children are fully prepared to play an active role in managing their condition.
36. The pathway, whether initial, cyclical or transitional, should have a clear, proactive focus on prevention, either through the promotion of well-being, the protection from possible harm or early detection of potential problems.

C. Application and advantages of the child-friendly health care approach

37. The most important benefit of the adoption of the child-friendly health care approach is to bring about harmony and synergy between all the interested parties – government departments, organisations or professional groups, including children and families themselves – to create an integrated system allowing them to work together on the planning of future services for children and to consolidate and improve existing services. Three examples, corresponding to three different perspectives, will be used to demonstrate the application and advantages of the child-friendly health care approach: those of children and families, service providers and policy makers/planners.



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38. This child-friendly approach will bring the following advantages to children and families:
- a comprehensive range of services which both promote and protect their health, coupled with timely, accessible and affordable services when problems occur;
 - when using services, all component parts required to achieve a good outcome should be in place and work well together;
 - they are able to participate in decisions concerning them and are encouraged to provide feedback on their experience of services.
39. Service providers focus on ensuring that evidence-based interventions are delivered by competent practitioners, in the right place and at the right time. Good co-ordination and coherence between different interventions and institutions should be underlined as key points of a successful strategy. The advantages should be:
- improved safety, experience and outcomes;
 - a workforce committed to multidisciplinary collaboration, innovation, learning and improvement;
 - reduced costs if the potential for prevention is realised.
40. Concerning policy makers⁷/planners: the child-friendly health care approach can be used as a policy/planning tool to align objectives and values between:
- government departments, professional bodies and other agencies responsible for policy development;
 - organisations responsible for the commissioning and planning of services by different agencies;
 - by organisations and agencies responsible for the regulation and improvement of services.

V. Implementing the child-friendly health care approach

41. The priorities for implementation vary considerably between and within different member states. Three options are available, allowing for the development of an “integrated learning system”, which is the practical tool for implementation of the child-friendly health care approach, based on the five guiding principles.

⁷ The term “policy” is used in the sense of “courses of action, regulatory measures, laws, and funding priorities concerning a given topic instituted by a government, its departments or representatives”.



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Participation

42. Meaningful participation requires children and families to be fully informed about the issues they are considering in order to improve the quality of their decision making. This requires relevant information to be presented in ways appropriate to the level of development and capacity of the child. Participation should be exercised at three levels:
- i. individual decision making, whether this be lifestyle choices or involvement in medical decision making. Implementation will require accessible information, clinical staff able to communicate with children and measures for mediation when differences occur;
 - ii. children should be given the opportunity to provide feedback on their experience after they have used services. Implementation will require the development of assessment of both patient-reported outcome and patient-reported experience and different methods of involving them in the process (individually and with peers);
 - iii. with increasing maturity and capacity, children should be involved in the policy/planning process for the services they use. Implementation will require appropriate training/learning opportunities to enable them to participate in this process, for example understanding priority setting.

Promotion

43. Effective health promotion requires synergy between evidence-based interventions at a number of levels simultaneously. It is relevant to all children, particularly the most vulnerable, and those using health services:
- i. **All children.** All children should participate in health-promotion programmes and policies, such as child-friendly cities, child-friendly schools, and child-friendly child care;
 - ii. **Vulnerable children.** The determinants of health are not equally distributed among children in society, whether they be social, emotional or financial. Where there is poor parental health, especially mental health, learning difficulties or substance abuse, children will require additional targeted support to enable them to reach their maximum potential. Implementation will require a variety of evidence-based interventions being accessible;
 - iii. **Children using health services.** Where children have repeated or long-term contact with health services, for example with complex illness, head injury rehabilitation or severe mental health problems, it is imperative that they maintain contact with their families and their friends and that their education or future health is not impaired through a prolonged stay in hospital.



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44. In order to implement the approach it may be necessary to consider the financial impact for parents whose children have long-term conditions, to offer children the possibility to have schooling in hospital and to encourage systems for maintaining contact with friends and family.

Protection

45. All children require protection from potential health hazards, but some children are more vulnerable than others either because they have a long-term condition that impairs their abilities, or because they live in sub-optimal circumstances. Children who use health services should be protected from either deliberate or unintended harm while using services:

- i. **All children.** All children require protection from physical, social, emotional or financial harm. Implementation will require interventions to improve the physical environment (for example, the quality of housing, air quality, reducing the risk of injuries and preventing violence), to improve the social environment by improving parents' parenting capacity, to prevent bullying or racism and to support families on low incomes;
- ii. **Vulnerable children.** Children with long-term conditions, whether illness or disability, require special protection from the recognised hazards that might affect them;
- iii. **Children using health services.** All interventions and systems have the potential to cause harm and/or adverse effects. Children are often at greater risk than adults due to their immaturity and less developed language and communication skills. Implementation will require the development of a coherent and comprehensive patient-safety policy framework, including a child-friendly reporting system for adverse events in order to learn from such incidents. Professionals working with and for children should, where necessary, be subject to regular vetting, according to national law, to ensure their suitability to work with children.



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Prevention

46. Proactive planning is central to preventing future problems. Unlike promotion or protection, prevention is targeted towards problems which could arise for which there are effective interventions:
- i. primary prevention includes mainly population-based interventions such as vaccination programmes, the prevention of dental caries through fluoridation of water supplies, or the prevention of neural tube defects through folate supplementation in cereals;
 - ii. secondary prevention may be population-based, such as the early detection of deafness through neonatal hearing screening programmes, or targeted towards specific groups of children to prevent, for example, the secondary complications of diabetes, or hip dislocation in children with cerebral palsy;
 - iii. tertiary prevention requires interventions to prevent secondary disabilities or deficiencies arising from established medical conditions.
47. Implementation of the approach is on two levels. Member states should decide which promotion and prevention programmes should be implemented on the basis of the entire population and which should be targeted at a selected population of children. At an individual level, health professionals, children and their families should proactively plan the management of a child's condition, recognising the likely complications or associated disabilities and thereby reduce their impact on the child's quality of life and everyday living.

Provision

48. Provision is based on pathways: there are four components common to the three stages (initial, cyclical and transitional) of a pathway for a long-term condition, the component parts of each being prevention, identification, assessment and interventions. Each component part should be:
- i. evidence-based;
 - ii. delivered by competent practitioners;
 - iii. delivered in the right way, in the right place, at the right time.
49. Implementation of the approach will require applying evidence-based and user-friendly guidelines for health professionals and families and make this evidence easily available to create an alignment of clinical expectations between patients and carers. Maintaining the competence of individuals working with children and families requires initial "child-friendly health care" training, support for staff implementing innovative measures in order to create child-friendly health care, and rewards for doing so. Likewise, assisting children to become "knowledgeable patients" is essential to achieve good outcomes



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50. Health care should be readily accessible to the population. Where possible, care should be delivered close to the child's home or in a familiar environment, for example in pre-school or school, where the child feels comfortable and where care can be delivered in partnership with his or her parents or carers. Where care needs to be delivered in hospital, the environment should be adapted to meet the needs of the child.
51. Child-friendly health care as an "integrated learning system": the child-friendly health care approach integrates the purpose and principles of the system into a practical approach based on pathways, which continually drives quality and improvement of services. Three component parts are essential in creating this virtuous cycle of continuous quality improvement and learning:
- i. clarity of purpose and principles;
 - ii. a pathway-based framework for delivery;
 - iii. a system which encourages innovation, learning and improvement.
52. Implementation requires the adoption, and where necessary adaptation, of this approach by all the agencies, organisations and professional groups contributing to services for children and families. It is particularly important to achieve alignment and synergy between:
- i. policy makers from different sectors;
 - ii. commissioners, providers and regulators of services;
 - iii. health, education and social-care organisations.
53. It is essential to integrate a culture of learning and improvement into service delivery. Each agency should have a similar approach to the choice of evidence-based interventions, priority setting, maintaining staff competence, working in teams and continuous quality improvement.
54. Feeling safe, secure and comfortable should be part of the child's therapeutic process. This requires staff to be "child-friendly" and both culturally and clinically competent. Health care should be provided in a "child-friendly" environment, and separately from adults where appropriate. Fear, discomfort and pain should be recognised, assessed and managed using age-appropriate interventions.



VI. Promoting the child-friendly health care approach

55. The promotion of a child-friendly health care approach would require all member states to recognise the importance of children's rights at all times, in all settings. Three levels of promotion would be required:
- promotion of children's rights;
 - promotion of the principles, applicable to children's health services;
 - promotion of the child-friendly health care approach, which integrates the principles into a practical model for service planning, delivery and improvement.
56. Success will depend on an alignment of motivation, thinking and action at three different levels: policy making, service planning and individual care.
57. Member states should endorse the child-friendly health care approach at an appropriate level and facilitate the incorporation and, where appropriate, the adaptation of the child-friendly health care approach into policies, service planning and practice, coupled with the development of relevant measures to monitor implementation.
58. Member states should include the principles proclaimed by the United Nations Convention on the Rights of the Child, the European Social Charter and the Revised European Social Charter, the European Convention on the Exercise of Children's Rights and the European Charter for Children in Hospitals, in all their policies, plans, and programmes.
59. Member states should organise activities or educational initiatives to promote children's rights. Human and children's rights should be integrated into the school curriculum, including links with health and emphasising the needs of vulnerable children, such as children without parental protection, those with long-term conditions and poor or marginalised groups of people in society.
60. Member states should endorse, disseminate and adapt the child-friendly health care approach to the planning and delivery of services, in order to drive improved effectiveness, efficiency, safety and equity within health care services.
61. Member states should promote the effective participation of children in improving their health, in taking part in decision making related to their care, in planning health care activities and evaluating the results, according to their age and maturity.



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62. Member states should support programmes and policies aimed at raising the awareness of children and their parents of their rights to active participation in decision making and the promotion and protection of their health, by creating legal structures and policies that support the promotion of children's rights in health care, if these do not already exist.
63. In line with the "Health in All Policies" approach, governmental organisations and other relevant stakeholders contributing to the health and well-being of children should work together and strive to continually improve the quality of their services, especially safety, outcomes and experience/satisfaction of the users.
64. Member states should pay particular attention to the investment in services for children and families in order to secure sufficient resources to create a healthy future generation.
65. Member states should involve relevant institutions and stakeholders to measure and monitor the implementation of the child-friendly health care approach in their health care policies and practice.
66. Member states should exchange practice and promote international co-operation in the field of child-friendly health care.



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The Council of Europe

The Council of Europe is an international organisation founded in 1949 which now has 47 member states. Its role is to promote human rights, democracy and the rule of law. It establishes common democratic principles based on the European Convention on Human Rights and other conventions and recommendations on the protection of persons, which of course includes Europe's 150 million children.



"Building a Europe for and with Children"

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