



**World Health
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REGIONAL OFFICE FOR **Europe**



Improving the Quality of Care for Reproductive, Maternal, Neonatal, Child and Adolescent Health in the WHO European Region

**A Regional Framework to Support
the Implementation of Health 2020**





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Abstract

This regional framework proposes a quality improvement (QI) system that extends across the Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) continuum and all levels of care and aims to achieve “effective coverage”, meaning high and equitable coverage of quality care for all in order to reduce and eliminate preventable mortality and morbidity. It delineates activities to take place at regional, country and health facility levels.

Key words

Quality of Health Care

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Infant Health

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Acronyms and definitions

BTN	Beyond The Numbers
HBSC	Health-Behaviour in School-aged Children
HIV	Human Immunodeficiency Virus
ICESCR	International Covenant on Economic, Social and Cultural Rights
IM(N)CI	Integrated Management of (Neonatal and) Childhood Illness
KMC	Kangaroo Mother Care
MDG	Millennium Development Goal
PDSA	Plan–Do–Study–Act
PHC	Primary Health Care
QI	Quality Improvement
PMTCT	Prevention of Mother-to-Child Transmission of HIV
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SES	Socioeconomic Status
STI	Sexual Transmitted Infection
SDG	Sustainable Development Goal
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
WHO	World Health Organization

For the purpose of this document health facility, hospital and outpatient health facility are defined as follows:

HEALTH FACILITY: any location where healthcare is provided, including, hospitals, clinics, outpatient care centres

HOSPITAL: Health facility with beds for inpatient treatment

OUTPATIENT HEALTH FACILITY: Health facility providing only outpatient treatment, these facilities may or may not be located on hospital grounds

Improvement is, I believe, an inborn human endeavour. My belief arises mostly from watching children. You cannot find a healthy child who does not try to jump higher or run faster. It takes no outside incentive. Children smile when they succeed; they smile to themselves. And so, it is my premise that almost all human organizations contain in their workforce an internal demand to improve their work. Improvement is not forcing something; it is releasing something.

Donald M Berwick (Institute for Healthcare)

If people are good only because they fear punishment, and hope for reward, then we are a sorry lot indeed.

Albert Einstein

Better care

Although maternal, child and adolescent health in the European Region show continuous improvement, there are important causes for concern. Despite substantial progress in recent decades, disparities in child and maternal health between and within countries persist.² The Region includes countries with the lowest infant and child mortality rates in the world, but mortality in countries with the highest rate for children under five years is 25 times higher than that in countries with the lowest rate (Figure 4) and inequities are even larger for maternal mortality (Figure 5). A child born in the countries of the Commonwealth of Independent States (CIS)¹ is three times as likely to die before the age of five years as a child born in a EU country.³ Instead of catching up with their Western neighbours, many countries in Eastern Europe and Central Asia have been falling behind. In addition, over the past decade or more, key outcomes in health financing have not converged with those of the 15 pre-2004 countries of the European Union (EU).⁴ And even among the EU-15 countries, there is considerable concern about the fact that some countries are doing severely worse than others in reducing child mortality rates, irrespectively of their Gross National Product.⁵ If all the 15 pre-2004 countries of the European Union had child mortality closely similar to that of Sweden (the country with the best rate of the EU-15), more than 6000 deaths per year could be prevented.⁵

The average maternal mortality ratio for the WHO European Region official figures decreased from an estimated 35 deaths per 100 000 live births in 1990 to 16 in 2008. Nevertheless, the highest national maternal mortality rate in the Region is now estimated to be an appalling 40 times the lowest. Several studies document that the quality of care provided to newborns and children is often poor, particularly at the hospital level⁶ and that severe deficiencies exist in the quality of interventions for maternal health, for both routine and emergency care, and disrespect of basic patients' rights is a common problem in the European Region.^{7,8} The same holds true for the quality of care provided within the private sector.

Unmet contraception needs are directly linked to the quality of health services and varies across the European Region. In some countries many women who need modern contraception do not get it. They may have to cope with poor services, difficult access, high cost, custom and other cultural factors. Unmet family planning needs differ widely across the Region from 5% to nearly 23%.

Slowing progress towards good health outcomes can be partially attributed to the poor quality of the services provided. Ten per cent of patients in the European Region experience preventable harm or adverse events in hospital, causing suffering and loss and taking a financial toll on health care systems³ and all too often systems-level improvement does not occur and the price of failing to improve health service delivery is a worsening of health disparities both local and global.⁹ Complexity makes managing modern health care one of the most difficult managerial tasks in the whole economy. Nevertheless, many countries still consider investing in management a waste of resources and effort. There is more scope for significantly improving health care delivery by applying modern methods of quality improvement and management than by any clinical innovation currently in trials. Too little effort is put into ensuring that basic systems and organization are in place and function effectively.³

¹ The CIS consisted of Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, the Republic of Moldova, the Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan when the data were collected.

There is increasing evidence of the impact of human rights in health and how to adopt a human rights-based approach to health. Human rights are shaping laws, policies and interventions, which in turn have an impact on health improvements for children, adolescents and women.¹⁰ This is of no minor importance: human rights treaties go beyond an aspiration and provide common and obligatory standards for all Member States who ratify them; at the same time, the evidence is demonstrating that these obligations may have an impact on health outcomes¹¹. Recently, strong practical knowledge and technical guidance has been made available on how to systematically integrate human rights principles and standards in all aspects of health care legislation, policies and provision of care, as a means to improve the health and well-being of women, children and adolescents.^{12,13,14,15,16,17}

The Office of the United Nations High Commissioner for Human Rights has stated that “this begins with an assessment of relevant legislative measures, governance and coordination mechanisms, planning, budgeting, implementation, monitoring and evaluation efforts, mechanisms for remedy and redress and international cooperation to determine the extent to which existing measures, mechanisms and processes are fully compliant with recognized human rights standards and principles and where gaps and barriers remain that must be addressed. This should build on existing efforts with additional attention to human rights standards and principles as required.”

The 53 Member States in the WHO European Region have agreed on a new common policy framework – Health 2020. Their shared goals are to “significantly improve the health and well-being of populations, reduce health inequalities, strengthen public health and ensure people-centred health systems that are universal, equitable, sustainable and of high quality”. They have also adopted the European Health Strategy for Children and Adolescents that demands a better focus on systematic rights-based maternal, child and adolescent law, policy and programme assessments and assessments of the quality of care based on child rights at all levels that will contribute to a stronger focus on children and their health and well-being. To support member states in the implementation of these strategies WHO/UNFPA/UNICEF established a Regional Inter-agency Reference Group on Quality of Maternal, Newborn and Child Health Care in 2015.

This regional framework proposes a quality improvement (QI) system that extends across the RMNCAH continuum and all levels of care and aims to achieve “effective coverage”, meaning high and equitable coverage of quality care for all¹⁸ in order to reduce and eliminate preventable mortality and morbidity. It delineates activities to take place at regional, country and health facility levels.

Dimensions of quality

The framework aims to achieve quality of care in six dimensions, in line with article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) on the highest attainable standard of health.^{19,20}

1. Effectiveness: health care provided adheres to an evidence base and results in improved health outcomes for individuals and communities, based on need.

- Any form of treatment or patient care provided at the health facility is based on protocols and guidelines that follow international scientific evidence.
- Health-care providers have skills and competency to provide the required health services.

- The health facility has the equipment, supplies, and basic infrastructure necessary to deliver the required health services.
- Health-care providers are able to dedicate sufficient time to work effectively with their patients.

2. Appropriateness: health care is delivered in a manner that maximizes resource use and avoids waste and provided in a setting where skills and resources are appropriate to medical need.

- The required health-care services provided fulfil the needs of all patients either at the point of health service delivery or through referral linkages.
- Services are organized to provide continuity over time (within one health facility) and between providers (referral to and from higher or lower levels of care).
- Resources are used appropriately to ensure optimum benefits for patients and the population.

3. Accessibility: health care provided is timely, geographically reasonable and affordable.

- Health facilities, goods and services must be accessible to all children and their families, in law and in fact, without discrimination on any of the prohibited grounds.
- Health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups of children and their families, including those belonging to minorities and indigenous populations, children with disabilities, children living with HIV/AIDS, children in rural areas.
- The hospitals have 24 hours of operation for emergency care and deliveries.
- Policies and procedures are in place that ensure that health services are either free or affordable (and informal payments are avoided). Payment for health care services, as well as services related to underlying determinants of health, must be based on the principles of non-discrimination and equity, ensuring that services, whether privately or publicly provided, are affordable and do not impede their accessibility. This includes issues concerning social protection, user fees, transport costs and other.
- All population groups have the right to seek, receive and impart information and ideas concerning health issues.

4. Acceptability/patient-centeredness: health care provided takes into account the preferences and aspirations of individual service users and the cultures of their communities.

- The health care provided is patient-centred, responsive to and respectful of the patient's values and choices to promote patient satisfaction and fulfilment of human rights.
- All areas of the health facility have a safe, clean and appealing environment.
- All health facilities, goods and services must be respectful of medical ethics and be culturally appropriate, sensitive to gender and life-cycle requirements, as well as designed to respect privacy and confidentiality of those seeking services.
- Health-care providers are non-judgemental, considerate, and easy to relate to.
- The facility ensures that a system for triage is in place and consultations occur in a short waiting time, with or without an appointment, and (where necessary) swift referral is organized.

- A system to collect patients' views and feedback is organized and taken into account when planning services.

5. Equity: health care provided does not vary in quality because of personal characteristics such as age, gender, race, ethnicity, geographical location or socioeconomic status.

- Policies and procedures are in place that do not restrict the provision of health services on any terms.
- Health-care providers treat all patients with equal care and respect, regardless of status.

6. Safety: health care provided minimizes risks and harm to service users and providers.

- The provided health care ensures that the patients and staff do not suffer undue harm from the treatment itself or from the manner in which it was given.
- Patients along the continuum of care participate in the design, development and assessment of services.

The situation in the European Region

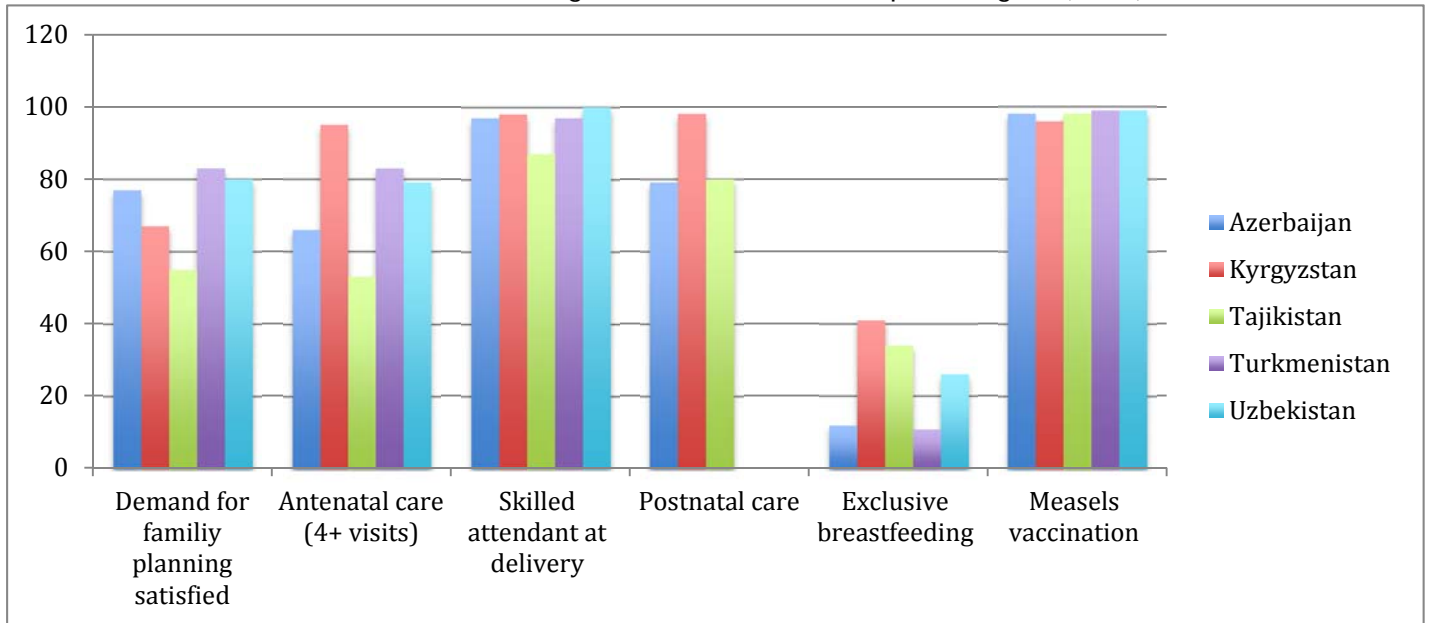
The population of Europe enjoys better survival and health than ever before. However, significant inequalities persist within and between countries.

The WHO European Region includes the countries with some of the lowest child and maternal mortality rates in the world. However it also includes some wide variation between countries in the region: the rates in countries with the highest mortality among children younger than five years are 20–30 times the rates of the lowest (see Figure 4), while the highest national maternal mortality rate in the Region is now estimated to be an appalling 40 times the lowest (see Figure 5).

Azerbaijan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan have among the highest burden of maternal and child mortality in the Region and their progress towards the MDGs and expansion of coverage of essential interventions for maternal and child health have been closely monitored and reported by the Countdown 2015 initiative over the last decade. Figure 1 below depicts the coverage of selected interventions for reproductive, maternal, newborn and child health for these five countries in the Region.

Progress has been made with the expansion of coverage of essential interventions. However maternal and child mortality rates remain high in some countries (Figure 2–5); while the data show that there is still some scope for improving coverage further (particularly in relation to breast feeding), the information on the quality of health interventions delivered is very limited.

Figure 1: Coverage (%) along the continuum of care (without adolescent health) for the countries with the highest burden in the European Region (2015)

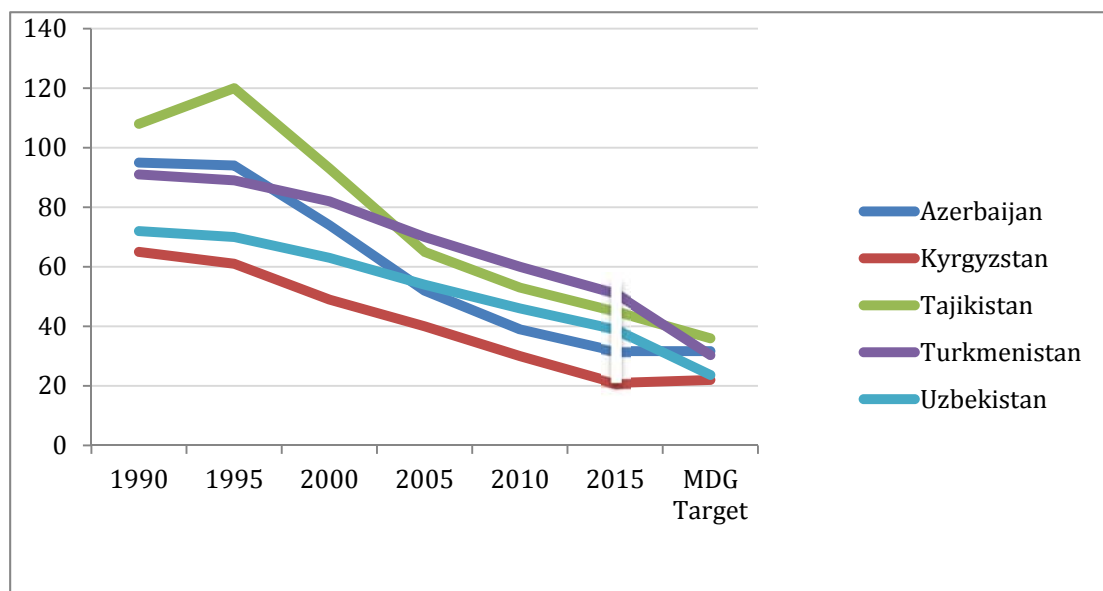


Source: Data were extracted from Countdown country profiles 2015 (primary source latest available demographic health surveys (DHS), multiple indicator cluster surveys (MICS), other national sources)

Skilled delivery at birth is virtually universal in the depicted countries, however, maternal mortality rates remain comparatively high. Suggesting a potential need for improvement if the quality of care provided.

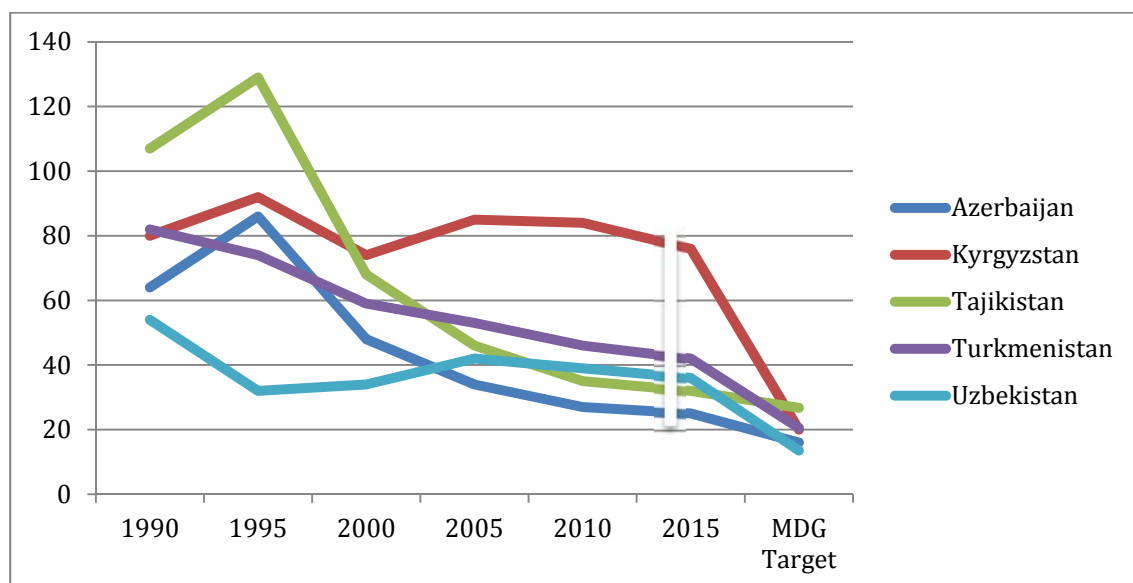
Decline in maternal and child mortality and achievement of MDGs in countries of the European Region

Figure 2: Under-five mortality rates (deaths per 1000 live births) for the countries with the highest burden in the European Region by year



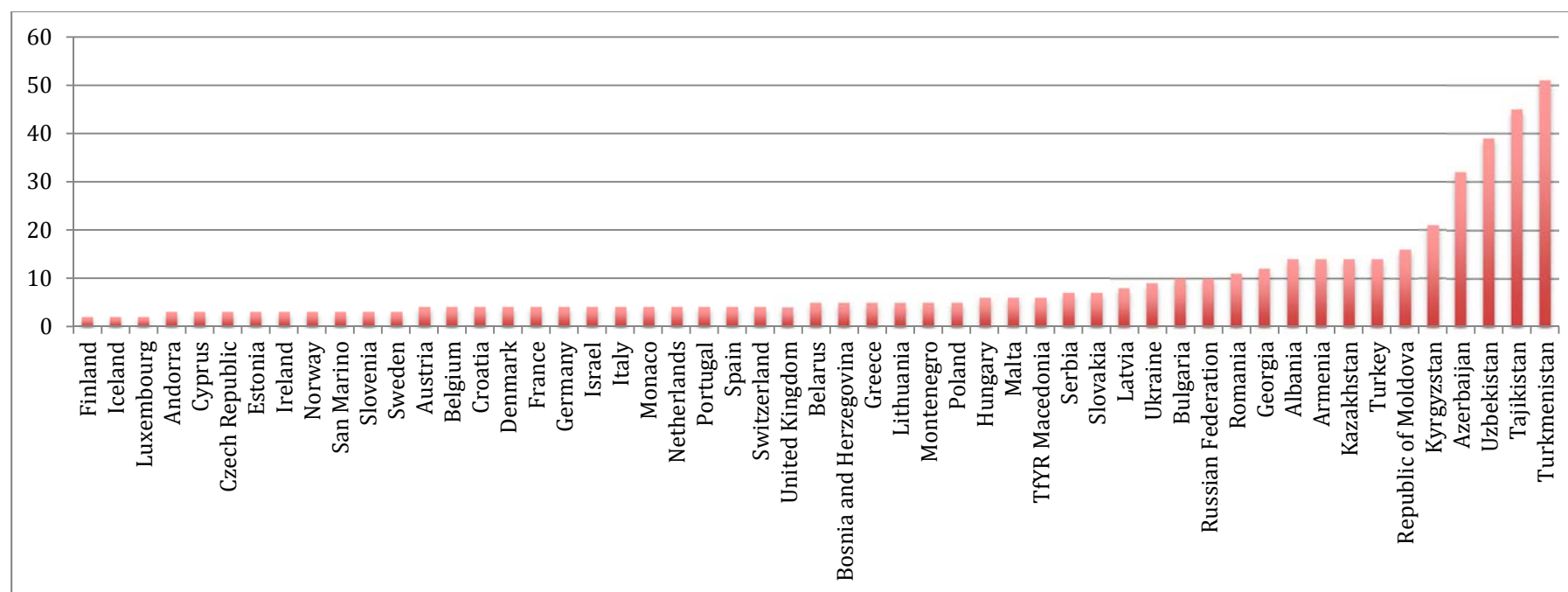
Source Child mortality estimates CME info <http://www.childmortality.org/index.php?r=site/> accessed 22.02.2016

Figure 3: Maternal mortality rates (maternal deaths/100 000 live births) for the countries with the highest burden in the European Region by year



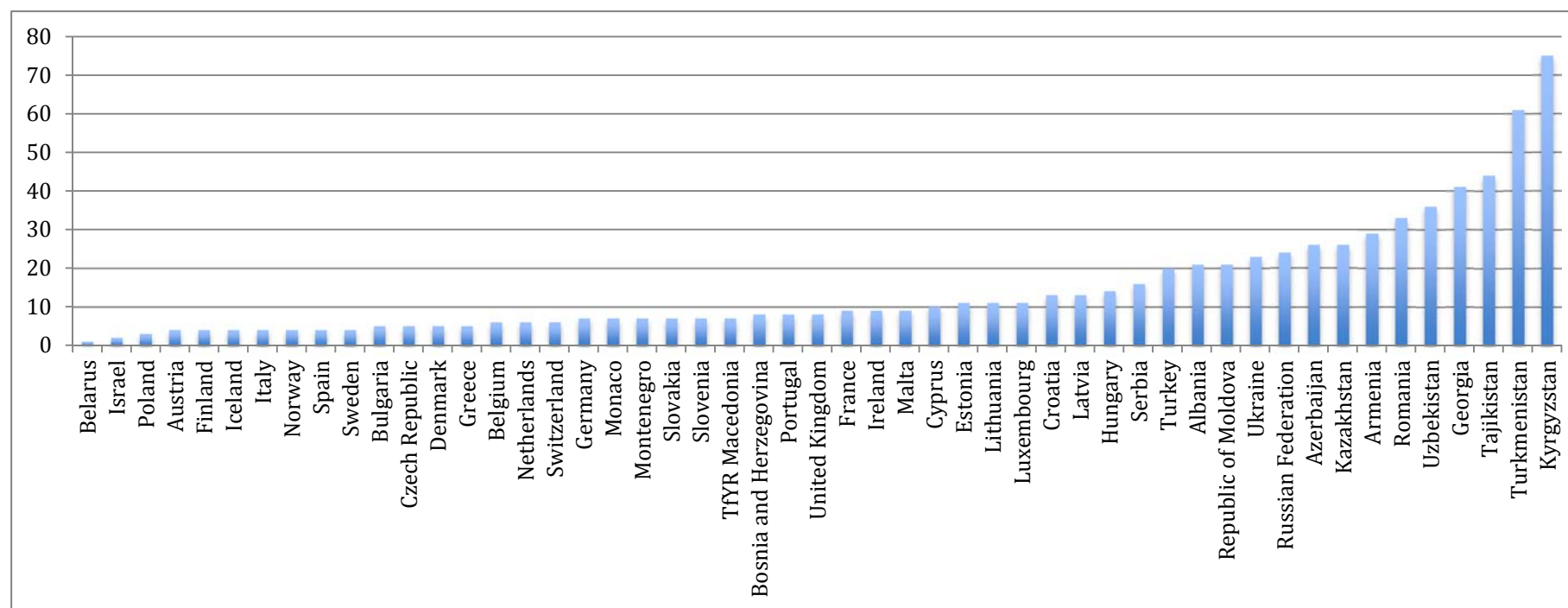
Source WHO, UNICEF, UNFPA, The World Bank, and United Nations Population Division Maternal Mortality Estimation Inter-Agency Group http://www.who.int/gho/maternal_health/countries/ accessed 22.02.16

Figure 4: Under-five mortality rates (deaths per 1000 live births) across the countries of the European region (2015)



Source: Child mortality estimates CME info <http://www.childmortality.org/index.php?r=site/> accessed 22.02.2016

Figure 5: Maternal mortality rates (death per 100 000 live births) across the countries of the European region (2015)



Source: WHO, UNICEF, UNFPA, The World Bank, and United Nations Population Division Maternal Mortality Estimation Inter-Agency Group, http://www.who.int/gho/maternal_health/countries/, accessed 22.02.2016

In addition to survival, the trends in disease and disabilities have changed over the last decades and across the whole population, non-communicable diseases or chronic/long-term diseases are increasingly dominant. This has an impact in the organisation and delivery of services, as well as, the way patients will be treated. Children, parents and pregnant women with chronic diseases now have a longer contact with health care services, which must pay attention to effective referral, patient education and transition services.

The social determinants of health are playing an important role in the health status of the European population. In terms of child health, some of the major influential determinants are socioeconomic status, women's conditions, including literacy, migration, ethnicity, market forces and the media.²¹

Table 1: An overview of exposures and risk factors, and their impact on child health, over the first 12 years of life^{II}

Main exposure	Main health risks	Embryo and foetal stages	Birth to 2 years	Pre-school (3-6 years)	School (7-12 years)
Poor maternal health	Poor pregnancy outcomes, low birth weight	++++	+++	++	++
Inadequate nutrition during pregnancy and early years	Overweight/underweight, anaemia, infections, immune disorders	++	++++	++	++
Inadequate parenting	Psychosocial problems and behavioural disorders		+++	++	++
Discrimination and social neglect	Psychosocial problems	++	+++	++	++
Environmental toxins	Congenital anomalies, lung diseases, neurotoxicity, endocrine disorders, cancer	+++	+++	++	+
Unsafe home and outside environment	Injuries	+	++	+++	+++
Insufficient physical activity	Obesity, cardiovascular and metabolic risk in later life	+	+	++	+++
Alcohol and tobacco	Congenital anomalies (including fetal alcohol syndrome, low birth weight, respiratory disorders)	++++	++	+	+(++)

Source: Cattaneo et al., 2012

A study of socioeconomic inequalities in adolescent health between 2002 and 2010 in 34 North American and European countries showed that *higher national income inequality related to less physical activity, larger body-mass indices, and more psychological and physical symptoms. Higher national income inequality also related to larger socioeconomic status (SES) differences in psychological and physical symptoms, and life satisfaction.*²² Over the years the Health-Behaviour in School-aged Children (HBSC) study has also found that age, gender and family affluence are important predictors of young people's health in the WHO European Region. Evidence shows that *health inequalities emerge or worsen during this developmental phase and translate into continuing health problems and inequalities in the adult years.*²³

The Innocenti Report Card 12 *Children of the Recession: The impact of the economic crisis on child well-being in rich countries* shows that in 23 of 41 countries analysed, child poverty rates have risen. The largest increase was registered in Greece, Italy, Spain, Croatia, the three Baltic States, Iceland, Ireland and Luxembourg. Greece, Latvia and Spain have child poverty of above 36% and in Greece it rose from 23% to 40,5% between 2008 and 2012, the highest child poverty

^{II} Ingrid Wolfe, Martin McKee, European Child Health Services and Systems, Lessons without borders, Mc Graw Hill, Open University Press, 2013

rate in the OECD.²⁴ The recession in the EU has had a direct impact on children and youth, through material deprivation, nutrition and food security, human capital investment (health and education), mental health, protection, employment opportunities and fertility.²⁵ Finally, the report concludes that *the capacity of governments and public institutions to protect (children) has not improved accordingly in critical areas such as health and education (and in) European countries that have been moderately and severely affected by the recession, the proportion of young adults with unmet health needs has increased significantly since 2008.*

The studies reported above show that trends in mortality and survival, inequalities, child poverty, including the impact of the economic crisis and austerity measures on child health, are not inevitable. This places a strong accountability in decision and policy-makers and the health system as a whole.

Quality of care in countries of the Region

The national regulatory framework, including legislation, policies and clinical guidelines and protocols adopted by Member States, set the scene for the functioning of the health system in the country. Indeed, the way legislation is formulated may grant or deny access to health care services to all or some population groups; it may clarify or confuse health care providers about their role; and lead to better or worse health outcomes. Importantly, due to the role the determinants of health play in the health, well-being and poverty of the population, legislation and policy-making beyond the health sector, should also be considered by the health system. Taking this into account, health systems in the Member States of the WHO European Region should have a strong legal basis that affirms the human rights principles enshrined in UN Treaties and link to education, social protection, tax policies and other, as relevant. Annex 2 provides a non-exhaustive list of rights of patients enshrined in different UN Treaties and examples of violations, which may result from the lack of their respect.

Ten per cent of patients in the European Region experience preventable harm or adverse events in hospital, causing suffering and loss and taking a financial toll on health care systems. Safety is part of the quality agenda and a dimension of the quality culture, which encompasses developing networks of patients and providers; sharing experiences; learning from failure and risk assessment; facilitating effective evidence-informed care; monitoring improvements, and empowering and educating patients and the public as partners in the process of care. **Ошибка!**
Закладка не определена.

Since 2000, the WHO European Office for Europe has been assessing and improving outpatient facility and hospital services along the continuum of care. The paediatric²⁶, maternal and newborn tools^{27,28} are based on evidence-base standards for clinical care/case-management. The revised versions have been informed by the experience of implementing the tools; new recommendations and evidence-based guidelines adopted in the time that elapsed between the first and second editions; and a move towards more patient-centred care, including the respect for patient rights and equity. In parallel, the growing recognition of the importance of adopting a human rights-based approach to health, led the WHO Regional Office for Europe to invest in the assessment and improvement of human rights including children's rights in hospitals and health facilities, with the development, adaptation and use of two tools.^{29,30} The new WHO Regional Office for European Strategy for Child and Adolescent Health 2015-2020 has reinforced this commitment.³¹

Published and unpublished data from assessments of maternal and newborn, child and adolescent health in Kyrgyzstan³², Tajikistan³³ and Moldova³⁴ and other countries in the region

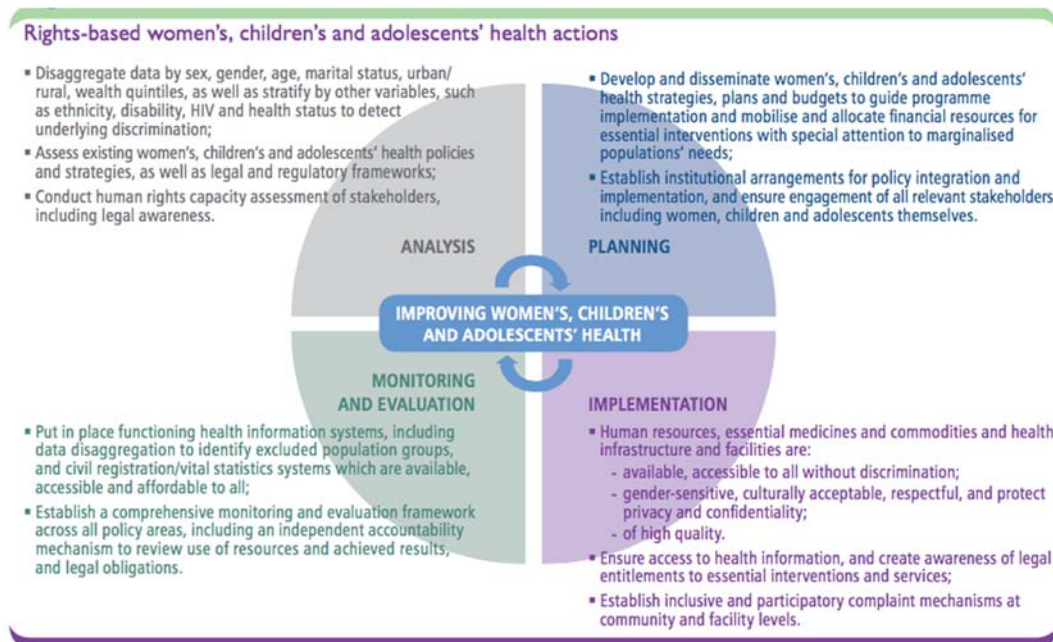
show that quality of care is often unsatisfactory in many settings. Lack of triage and inadequate assessment, late treatment, inadequate drugs supplies, poor knowledge of treatment guidelines, polypharmacy and insufficient monitoring were key adverse factors observed across study areas and countries. Practitioners were often neither aware of nor followed evidence-based guidance on best practice.

While access to skilled birth attendance is virtually universal across the region, maternal and infant mortality continue to remain high in some member states and evidence from small-scale studies indicates that quality of care continues to pose a challenge in many settings. High coverage by skilled attendants will have an impact only when these attendants follow the basic procedures and perform life-saving procedures when needed. Even in high-income countries with low maternal and child mortality rates, quality of care, patient satisfaction and adherence to evidence based standards continue to pose challenges.

Findings from the assessment of children’s rights in hospitals in Tajikistan, Kyrgyzstan and Moldova show a frequent discrepancy between what parents are entitled to and hospital practice; a difference of care provided from child to child; a lack of attention to specific rights, such as play and learning, information and participation, child protection; and a need to improve the hospitals’ infrastructures.^{35,36}

Systematic integration of human rights in actions to improve health is needed across the policy cycle and in service delivery. Figure 6 shows examples of the importance and added value of integrating human rights in various elements of the policy cycle.

Figure 6: Rights-based women’s, children’s and adolescents’ health actions



Source: PMNCH Knowledge Summary 34 - Operationalizing human rights in efforts to improve women’s, children’s and adolescents’ health

Examples for quality approaches in countries of the regions are shown in the three vignettes below.

Improving the quality of hospital care for children in Kyrgyzstan

In Kyrgyzstan, children are receiving better care and hospitals are enjoying increased capacity following a project implementing activities based on the framework for improving the quality of paediatric care in hospitals. The 3-year pilot concluded in December 2014 and was supported by WHO/Europe, with funding from and in partnership with the Russian Federation.

The project activities followed the steps outlined in this framework and reciprocally informed their adjustment.

After a national steering group was established, 10 pilot and 10 control hospitals were selected, and baseline quality of care assessments were conducted in all 20 hospitals. The WHO *Pocket book of hospital care for children* was adapted and adopted by a MoH order as the national standard clinical guideline for the management of common childhood illnesses. Training for national trainers was conducted and cascade trainings of medical staff, including mid-level staff, was carried out. Monitoring indicators and a supportive supervision tool were developed with the technical assistance of WHO experts, and six rounds of supportive supervision were carried out during 2013 and 2014. Sets of basic emergency equipment were purchased and distributed. In addition assessments of children rights in hospitals were conducted in all pilot hospitals.

Reassessment of quality of care after the intervention showed a significant reduction of unjustified hospitalizations (from 47.6% to 13.2%) and Polypragmasia (from 83.8% to 12.6%), reduction of use of unnecessary IV fluids and painful procedures, including injections.

Reception and emergency wards were reorganized and now triage of patients is taking place. Playrooms for admitted children were made available within the paediatric departments.

The hospital administrations support the provision of quality of care and facilitate quality of care improvement within their hospitals via internal audit.

Each hospital has established a quality of care improvement team and a focal person who coordinates activities.

One nurse stated, "I have been trained in this hospital for 40 years, and now we are child friendly. This project helped us a lot, we have new equipment, we have new nice interiors, and when I go to work it is like a fairy tale. Now children are not afraid of us anymore."

Assessment of the performance of youth-friendly-health-services in relation to nationally adopted quality standards in the Republic of Moldova

A core principle of quality improvement is that what is not measured cannot be improved. Therefore, evaluation has been an integral part of the longstanding agreement that a priority for each country, district and municipality should be to provide well-assessed youth-friendly services. However, assessment and evaluation by itself may have little or no effect. Only the use of the evaluation results to implement activities to improve quality of care can achieve improved outcomes and lead to the desired impact.

The Republic of Moldova has established youth friendly health services (YFHS) and used the results of an external evaluation to improve programming and ultimately the quality of services for young people.

The findings of an external assessment of the performance of youth-friendly-health-services in relation to nationally adopted quality standards in the Republic of Moldova include the following three important areas:

1. YFHCs were not fully mandated to deliver the full package of services and therefore services were often limited to the provision of information and counselling. While a specific package of services for YFHCs had been defined by the Ministry of Health, the centres were not authorized to provide the clinical services to adolescents and had to refer their clients to specialized centres for diagnostic and treatment services. This counteracted the very idea of YFHS being accessible in one place and guaranteeing confidentiality and privacy.
2. The YFHCs that were initially founded as NGOs and then subsequently designated as YFHCs by the Ministry of Health outperformed newer public sector centres in relation to the six national quality standards, particularly in relation to friendliness and acceptability. This raises questions on how to best increase motivation and improve health worker performance in the public sector and/or how to better harness existing capacities outside the Government sector.
3. While the explicitly stated objective of the project was to “improve the SRH of young men and women in Moldova particularly those vulnerable and most at risk” no specific activities were planned or carried out to reach vulnerable and most at risk adolescents. Furthermore, no data was available on how many adolescents reached by the project may belong to this group.

A few months after the evaluation, a workshop with all stakeholders was held in Chisinau to review the findings and plan for the next phase. The joint review helped to identify and implement activities needed to provide adolescents with improved services.

While this experience reaffirms the important role evaluation has to play in the provision of health services for adolescents and young people, it may be important to also keep in mind that evaluations measure only what can be measured. Empathy and respect, crucial dimensions of quality of adolescent health care, remain difficult to measure and quantify.

Summary of piloting of the Reproductive, maternal, newborn and child health and human rights: A toolbox for examining laws, regulations and policies.

The WHO Department of Reproductive Health and Research, Geneva, in collaboration with the Program on International Health and Human Rights at the School of Public Health, Harvard University, Boston, USA developed the Sexual and Reproductive Health and Human Rights Module (2014) (http://www.who.int/reproductivehealth/publications/gender_rights/rmnch-human-rights/en/) that allows countries to use a human rights framework to identify those barriers and make proposals to overcome or reduce them.

Laws and policies play a key role in upholding human rights and promoting sexual and reproductive health. Yet, in many countries, laws, regulations and policies are not always consistent with human rights standards and may also represent a barrier for people achieving the highest attainable standard of sexual and reproductive health.

Two countries of the WHO European Region took part in the pilot testing of this module: the Republic of Moldova and Tajikistan. The process was led by the ministries of health with the technical assistance from WHO and active involvement of the national experts, member associations of the International Planned Parenthood Federation and other CSOs. In the Republic of Moldova the exercise was undertaken to examine, reflect on, and strengthen, the government's sexual and reproductive health program, while in Tajikistan the focus was more on human rights and adolescent sexual and reproductive health.

In Moldova the issues concerning reproductive health are regulated by the law No. 185-XV on protection of reproductive health and family planning. The law guarantees the following rights:

- the right to free decisions on reproduction (the number of children and the time for their birth inside or outside marriage),
- the right to information on reproductive health and family planning,
- the right to donate gametes,
- the right to artificial insemination and in vitro fertilization,
- the right of minors to reproductive health and sexuality education.

The Government of the Republic of Moldova has regularly presented reports within the mechanisms of various UN conventions on human rights implementation monitoring. Aspects concerning human rights and sexual and reproductive health are tackled both in the Government reports and in the conclusions and recommendations of the UN Committees. Thus, on one hand, certain progress has been achieved with respect to reproduction rights, such as the decline of maternal mortality, adoption of important national plans and programs for the promotion of women's reproductive health. On the other hand, Moldova continues to face certain problems like the use of abortion as a family planning method, low use of modern contraception methods, high number of teenage pregnancies and abortions, lack of sexual and reproductive education in the school curricula and lack of evidence based information related to sexual and reproductive health for other population groups, rising number of sexually transmitted infections, including HIV/AIDS, persisting patriarchal attitudes and deeply rooted stereotypes on the role and responsibilities of the woman and of the man in the family and society, limited access to health care services for women in rural areas and for ethnic minorities, particularly for Roma.

A report on the existing legal barriers in improving sexual and reproductive health and recommendations to overcome them was developed and presented to broad range of stakeholders. Inter-ministerial committee for monitoring sexual and reproductive health and human rights to accelerate the progress of implementation of these recommendations was developed in the Prime Minister's Office of the Republic of Moldova.

The study of existing legislation, policies, and programs of Tajikistan has addressed the issues of health protection of adolescents. Factors affecting the health of adolescents and young people have been examined. These factors are very broad and include a set of individual, medical, social, economic and environmental aspects. The Committee on the Rights of the Child, which monitors implementation progress of the Convention on the Rights of the Child, recognizes that the right to education requires the provision of necessary information for a healthy lifestyle. However, in light of Article 24 of the Convention on the Rights of the Child, the Committee recommends the Republic of Tajikistan to provide adolescents with access to education on reproductive health and access to specialized children's counseling services. In its recommendations, the UN Committee on Elimination of Discrimination against Women has recommended to promote widely education programs for family planning and reproductive health and to focus these programs both on girls, and boys with special emphasis on prevention of early pregnancies among girls in early marriages. The Committee has also expressed a concern that the official age of marriage in Tajikistan was reduced to age of 17.

The study findings helped policymakers to understand the existing problems the adolescents face and contribute to making changes in existing laws and promoting design of effective programs and projects, more specific interventions to protect adolescents in Tajikistan.

The continuum of care

The continuum of care can be defined over the dimension of time (throughout the life cycle including before and during pregnancy, childbirth, the newborn period, childhood and adolescence), and over the dimension of place or level of care (community, outpatient health facility, referral hospital).

Evidenced-based packages of interventions for family planning, safe abortion care and MNCAH have been defined and published.³⁷ These packages of services will save lives and avert the majority of preventable deaths, if they are delivered with high coverage and quality across all levels of care, with functional linkages between levels of care in the health system and between service-delivery packages.³⁸

Services to be provided throughout both dimensions of the continuum are illustrated in Figure 7.

Figure 7: Interventions and packages of services for improving maternal, newborn, child and adolescent health along the continuum of care to be delivered at all levels of care

Levels of care	Reproductive health	Maternal health	Newborn health	Child health	Adolescent health
Hospital	Emergency care Case management for STIs/HIV Elective abortion Post-abortion care Treatment of medical conditions, side effects and/or complications	Emergency obstetric care Skilled care at birth Management of complications of pregnancy, childbirth and immediate postpartum period, including caesarean section, blood transfusion, hysterectomy Induction/augmentation of labour PMTCT	Newborn resuscitation Management of a newborn with severe problems	Emergency care Case management of severe illness	Emergency care Case management for STIs/HIV Elective abortion Post-abortion care Treatment of medical conditions, side effects and/or complications
Outpatient Health Facility	Counselling and provision of the full range of family planning methods Prevention and management of STIs/HIV Elective abortion Referral	Monitoring of progress of pregnancy and assessment of maternal and fetal well-being including nutritional status (4 antenatal care visits) Detection of problems complicating pregnancy Referral	Newborn resuscitation Rooming in Exclusive breastfeeding Infection prophylaxis and treatment Immunization KMC Identification, initial management and referral of newborns with any sign of severe illness Referral	Integrated management of childhood illness Immunization Malaria insecticide-treated bed nets Nutrition, including vitamin A and zinc Care of children with HIV Referral	Youth-friendly health services providing comprehensive package of services including modern/safe contraception, prevention of HIV/AIDS, STIs, violence (and consequences), smoking, unwanted pregnancies and malnutrition Case management of common illnesses Referral
Community	Health promotion and education Adolescent and pre-pregnancy nutrition Distribution of methods of contraception, including emergency contraception Identification of signs of domestic and sexual violence and referral Prevention of STI/HIV	Information and counselling Birth planning, advice on labour, danger signs and emergency preparedness Education about clean delivery, and early care for neonates including warmth, immediate and exclusive breastfeeding	Promotion and support for: <ul style="list-style-type: none"> . exclusive breastfeeding . thermal protection . infection prevention . care of a small baby . recognition of problems, illness and timely care-seeking, routine care visits . birth registration 	Promotion and support for: <ul style="list-style-type: none"> . breastfeeding and appropriate complementary feeding . recognition of problems, illness and timely care-seeking . identification and referral of children with signs of severe illness . identification and management of diarrhoea, pneumonia and malaria 	Health promotion and education Nutrition Prevention of violence, smoking, HIV/AIDS and STIs, unwanted pregnancies, malnutrition and community support for youth-friendly health services

KMC, kangaroo mother care; PMTCT, prevention of mother-to-child transmission; STI, sexually transmitted infection.

Adapted from the Conceptual and Institutional Framework of the Partnership for Maternal, Newborn and Child Health; WHO Packages of Interventions for Family Planning, Safe Abortion Care, Maternal, Newborn and Child Health; and Kerber KJ, de Graft-Johnson JE, Bhutta ZA et al, Continuum of care for maternal, newborn, and child health: from slogan to service delivery.

The framework's vision

The vision of the framework is that all countries of the European Region provide universal access to **equitable and good quality care** for every woman, newborn, child and adolescent at all levels of care.

The framework's goal is that all countries of the Region improve the quality of reproductive, maternal, newborn, child and adolescent health services by

- Integrating human rights provision in QI processes
- Identifying key areas for improvement
- Addressing bottlenecks that hinder the provision of care
- Implementing a continuous and sustainable QI system
- Enhancing the process of implementation of human rights provisions and monitoring and reporting to UN Human Rights Treaty Bodies.

The framework aims to reach the following objectives and targets by 2020.

Action is needed to strengthen people-centred health systems to ensure universal access to high-quality maternal and child health services, particularly for vulnerable groups such as refugees and migrants.

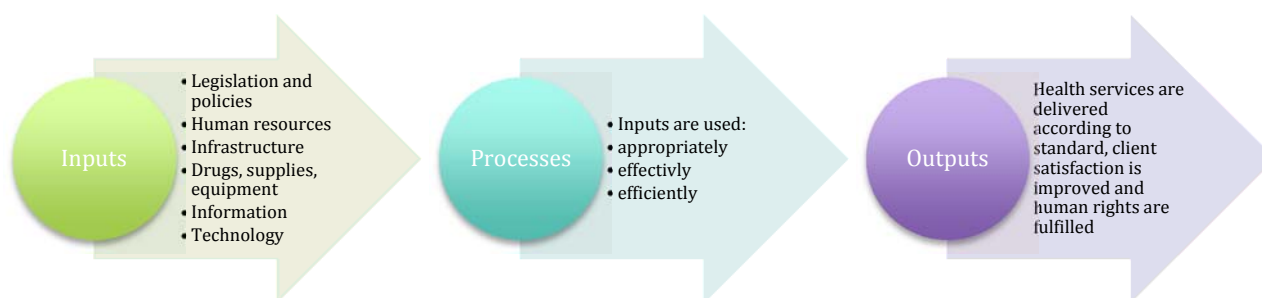
Countries will set their own objectives to meet their specific needs. The general objectives are to:

- Review the national regulatory environment is reviewed
- Develop National Quality Frameworks
- Develop missing quality standards and clinical protocols in line with international standards
- Develop or adapt tools for the assessment of quality of care and human rights against set standards and clinical protocols
- Train assessors to assess quality of care and human rights against set standards, and carry out (re-)assessments
- Establish QI mechanism is established and a collaborative improvement approach is being implemented
- Establish national or use international reporting mechanisms for quality of care, patient safety and adverse events
- Establish an accreditation/certification methodology against set standards is established
- Facilitate reporting to UN Human Rights Treaty Bodies in the context of the right to health.

Country health system targets

To be able to reach the targets listed below and to provide quality of care at all levels of the health system, several inputs have to be in place, notably human resources, infrastructure, drugs supplies and equipment. These inputs need to be used appropriately, effectively and efficiently to ensure that health services are delivered according to standards and ultimately that the targets are reached and the desired outcomes – the improved health of women, newborns, children and adolescents – are achieved (Figure 8).

Figure 8: Flow of inputs, processes and outputs to achieve standards of care



Source: Adapted from University Research Co., LLC, Quality Improvement Handbook for TB and MDR-TB Programs, 2013.

It is suggested that countries should pass regulations with targets such as:

National level

- The national regulatory environment is reviewed
- The national regulatory environment is reformed and updated
- National institutions enhance the reporting to UN Human Rights Treaty Bodies in the context of the right to health, in particular quality of care
- Protocols for implementing legislation at hospital and outpatient health facility level are developed.

Hospital level (all facilities providing inpatient care)

- All hospitals are implementing child mortality audits including adverse events audits regularly (at least every three months) which lead to relevant QI actions
- All hospitals are implementing confidential enquire into maternal death (BTN), which lead to relevant QI actions
- All hospitals are providing services for high-risk pregnancy and emergency obstetric and newborn care according to standards (international treatment guidelines)
- All hospitals are providing safe abortion services according to standards (international treatment guidelines)
- All women giving birth at the hospital receive care according to standards (international treatment guidelines)
- All newborns delivered at the hospital receive care according to essential newborn care standards (international treatment guidelines)
- All children admitted to the hospital are treated according to standards (international treatment guidelines)
- All adolescents admitted to the hospital receive care according to international treatment guidelines including a home, education/employment, eating, drugs, sexual health, suicidality (HEADSS) assessment
- All hospitals have essential drugs lists and had no stock-outs of essential drugs within the last three months

- All hospitals have a QI system, which is the result of a participatory process that included pregnant women, their husbands or companions, children, adolescents and parents
- All patients demonstrate satisfaction with the care received.

Outpatient health facility level

- All health facilities have essential drugs lists and had no stock-outs of essential drugs within the last three months
- All women and men receiving quality family planning services including counselling and safe abortion services according to standards (international guidelines)
- All women seeking antenatal care at the outpatient health facility receive the care according to standards (international guidelines) during at least four visits
- All women giving birth at the outpatient health facility receive care according to standards (international treatment guidelines)
- All newborns presenting for care at the outpatient health facility are treated according to IM(N)CI guidelines (or other international standards)
- All children presenting for care at the outpatient health facility are treated according to IM(N)CI guidelines (or other international standards)
- All adolescents seeking care at the outpatient health facility receive services including sexual and reproductive health services according to youth-friendly health services (YFHS) standards (or other international standards)
- All outpatient health facilities have a QI system, which is the result of a participatory process that included pregnant women, their husbands or companions, children, adolescents and parents
- All patients demonstrate satisfaction with the care received.

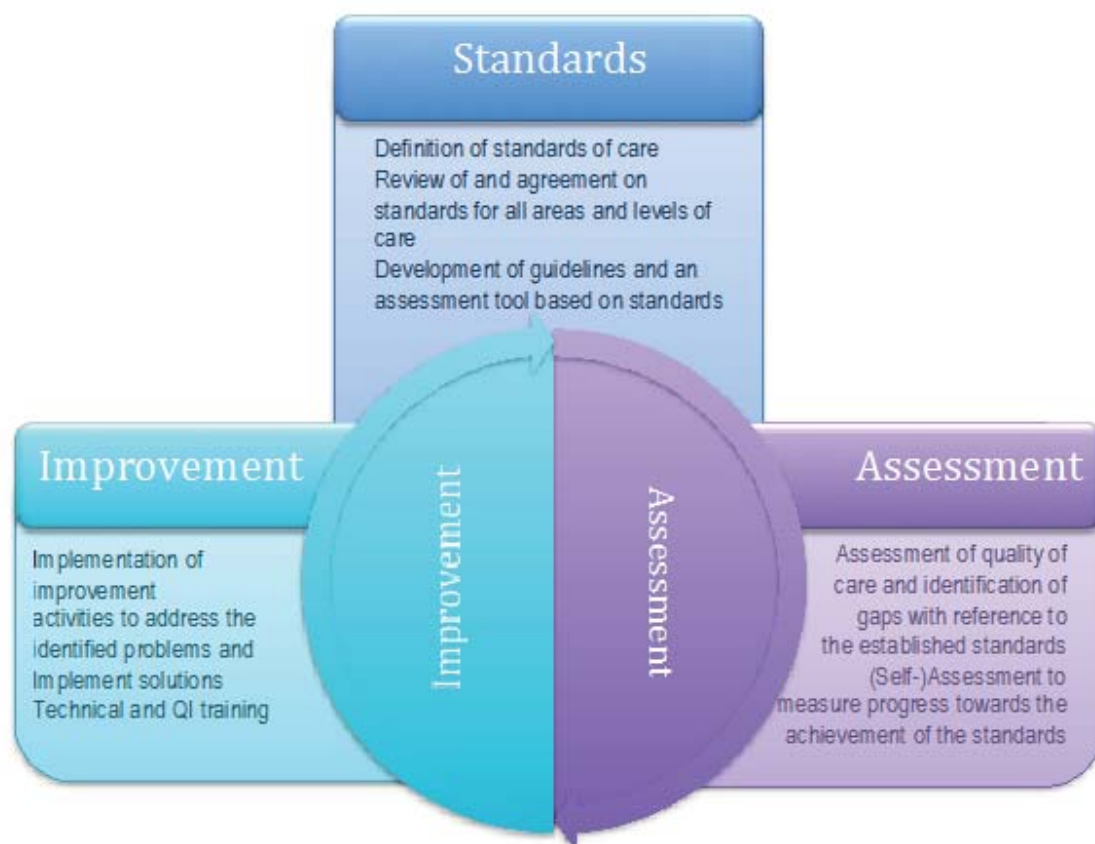
Community level

- All women and newborns receive a postnatal visit within 2 days after birth/after discharge from the hospital/outpatient health facility according to international standards
- All women and men including adolescents have access to a community health worker according to international standards
- All children have access to school health services.

Progress towards these targets will be measured using data collected through outpatient health facility and hospital assessments as well as through national health information systems and demographic and health surveys as appropriate. The mechanism for collecting quality of care indicators will be as defined and implemented at the global level.³⁹

The main areas of action to implement the process to guarantee adequate quality of care are summarized in Figure 9.

Figure 9: Core components to ensure adequate quality of health care interventions



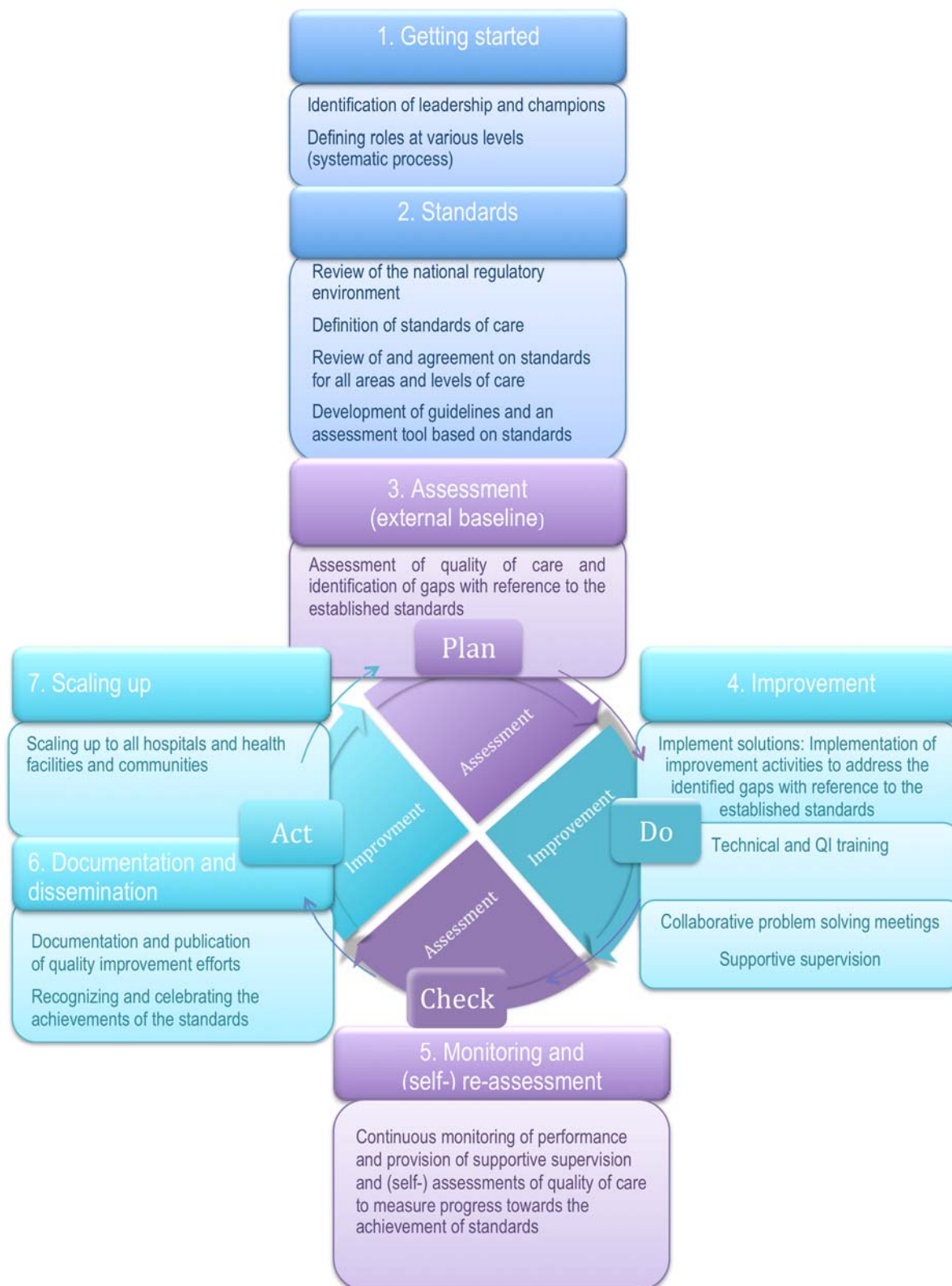
A systematic process for implementation

The implementation of a systematic process at the country level with support from the regional and global level, where and when needed, will help to ensure that health-care interventions are delivered with adequate quality, that harmful practices are avoided and that children and women rights are ensured. The proposed systematic process entails the following seven key components (Figure 10):

1. Getting started
 - Identify leadership and champions
 - Define roles at various levels
 - Review of the national regulatory environment
 - Review of available data on quality of care
2. Setting standards of care
 - Develop/adapt guidelines based on standards for quality of care and human rights
 - Develop/adapt an assessment tool based on standards and guidelines
3. Assessing current quality of care and human rights standards and identifying gaps in the provision of care with reference to the established standards
4. Improvement

- Create improvement teams to identify problems and implement the recommendations of assessments and solutions
 - Implement a collaborative approach to ensure adherence to guidelines based on standards of care
 - Train health providers to implement the quality improvement system
5. Continuous monitoring of performance and provision of supportive supervision and (self-) assessments of quality of care to measure progress towards the achievement of standards
 6. Documentation and publication of QI efforts and recognition and celebration of achievements of the standards
 7. Scaling up to all hospitals and health facilities and communities

Figure 10: Seven key components of the systematic process



1. Getting started

Identification of leadership and champions

An institutional basis and leadership at different organizational levels is essential to get started, take the improvement process forward and ensure its sustainability. The Ministry of Health will normally take the lead in countries. A national-team (steering committee) for improving quality of care should be set up, if it does not already exist.

Decision-makers may require orientation on the importance of improving quality of care. The level where these decision-makers are located will vary from country to country as many countries have undergone decentralization to varying degrees with transfer of political, fiscal and administrative powers to subnational governments.

Furthermore, it is essential to ensure leadership at the hospital and outpatient health facility levels where the improvement activities will be implemented: champions or key health-care professionals with clinical, managerial, interpersonal and motivation skills that can lead the improvement of care need to be identified.

Defining roles at various levels

The roles and responsibilities at the different levels (national, subnational, health professional bodies, etc. and the national steering committee) will vary. At the country level, governments, usually through the Ministry of Health, have a supporting, coordinating and regulatory role by committing sufficient resources, by setting standards for the different levels of care and by including the improvement process for care in national plans of action. At the local level, motivated leadership is required by senior hospital management to implement improvements in hospital care for children and facilitate collaboration with the relevant stakeholders. Health professional bodies, academic institutions or accrediting bodies will contribute to the improvement process by providing expertise at the national and local level, by including improvement processes in curricula, and by promoting hospitals and outpatient health facilities that meet the required standards of care.

National level

The Government, usually through the Ministry of Health, should ensure that improvement of quality of care is included in national policies and plans of action and other strategic directions. Improvement of care should be an integral part of the mandate of all relevant health programmes at the national level. Comprehensive plans should outline and make available the necessary human, financial and organizational resources to ensure a continuum of care, from the family-community to the health centre, to first level hospitals and thereon to tertiary facilities. Collaboration with other groups working on health-related activities should be ensured, including the national human rights institution or other body responsible for reporting to UN Human Rights Treaty Bodies.

Setting of national standards for care is a core function at the central level (refer to section: Standards).

National team (steering committee) for improving RMNCAH care

A national team (steering committee) for improving RMNCAH care may be established to assist the improvement process; it may be part of a broader health care Quality Improvement Committee. This team brings together government workers with the formal mandate and those with technical expertise to lead the improvement process. The group should have representatives from the ministry of health; national human rights institution, including the ombudsman for children, where it exists; medical doctors, nurses and midwives from main referral hospitals;

medical and nursing associations, United Nations agencies; donors; health financing; and accreditation bodies.

The role of the national team (steering committee) is to:

- Address improvement issues that require policy decisions
- Establish/revise national standards for care
- Oversee national or subnational planning and coordination of the improvement process
- Develop quality focus areas for the improvement process at national level
- Provide on-going technical expertise and support to the outpatient health facility and hospital improvement teams
- Coordinate national monitoring of the improvement process
- Plan for and implement or oversee an implementation research component of the improvement process

Health professional bodies

Health professional bodies, including medical faculties, schools of public health, public and private institutions for training health workers, and medical and nursing professional associations, will have senior clinicians and academics with technical expertise to guide the improvement process. Health professional bodies could be assigned specific roles. For example, medical and nursing associations could play an important role in setting standards and monitoring hospitals and facilities. Similarly, they could play a significant role in introducing aspects of quality care and human rights in pre-service education of doctors, nurses and midwives.

Other parties

International organizations, donors, health-care financing and hospital accreditation bodies may support the quality improvement process in some countries by ensuring standards of care for services they are funding or supporting. Local committees for quality of public services and civil society could also contribute.

Subnational or district level

Depending on the degree of decentralization, many of the above functions will be under the mandate of the subnational or district level.

Outpatient health facility and hospital level: the improvement team

Outpatient health facilities and hospitals may receive government support and/or financial and technical support from other sources, including nongovernmental organizations according to the national regulations. As improving care primarily takes place at the facility level, motivated leadership from the health facility director, administrator and senior clinicians is essential.

The role of the improvement team at the health facility (see Annex 1) includes:

- Initiating action for improvement
- Facilitating the improvement process
- Collaborating with other improvement teams through the collaborative approach

- Coordinating with higher levels on the improvement process
- Monitoring the improvement process at regular intervals
- Communication with the community
- Carrying out implementation research on the improvement process, if desired.

Review of the national regulatory environment

The national regulatory environment includes:

- Legislation on health along the continuum of care
- Evidence-based clinical guidelines and protocols along the continuum of care
- Responsible institutions for decision-making, implementation and assessment of the provision of care.

The national regulatory environment sets out the context where health institutions operate and the population receives care. Legislation and policies should be set out in a way as to ensure the survival, development and thriving of all population groups, by guaranteeing equitable, accessible, acceptable, affordable and good quality services. It is of particular importance that the environment addresses non-discrimination, that it is in line with human rights provisions and consistent throughout.

The national regulatory environment should include guidelines and protocols, whereby legislation and policies are made operational. These should be disseminated and monitored at national and health facility-level.

A WHO tool for reviewing the national regulatory environment in relation to newborn, child and adolescent health and a tool for Using Human Rights for Sexual and Reproductive health: Improving Legal and Regulatory Frameworks are available from WHO/EURO.

2. Setting standards of care

The setting of standards of care is based on national and international evidence-based , guidelines. Standards are established in order to agree on what is expected and against which benchmark performance will be assessed. In many countries a multitude of legislation and guidelines exist that support the provision of health care; unfortunately they are often out-dated and sometimes contradictory. The initial step in the improvement process is to review and update legislation and guidelines to ensure that they are in line with human rights standards and the latest evidence-based international guidelines.

During this process, standards of care for the different levels of health care provision will need to be agreed upon, in line with current evidence and recommendations and relevant to the needs of the country, i.e. taking the preferences and expectations of the population into account.

The input of a large number of stakeholders (as described above) may be required, and political decisions may have to be taken, for example on human resource development, job descriptions and task shifting, where needed and appropriate. The outcome of this process will be established standards for RMNCAH care at all levels (hospital, health centre/midwifery clinic, as well as community-based services) and guidelines and job aids (e.g. in form of desk guides, pocket books, websites and/or smart phone applications) to communicate the defined standards of care to health-care providers.

Links to health systems approaches such as accreditation, human resource planning, drug supplies and equipment, and financing should be sought, and specific approaches in these areas need to be defined.

An assessment of the current quality of care (as described below), should be incorporated into the standards development process in order to gain a perspective on how far current practice differs from internationally accepted standards. Such an assessment might also ensure that improvement targets are realistic rather than aspirational.

Global standards for assessment and improvement of human rights including children's rights and for quality health care services for all including adolescents are available and could be used as basis for adaptation to the respective national contexts. Examples of application of the global standards for improvement of children and adolescent health based on children's rights are presented in Table 2 and 3.

Table 2: Standards for assessment and improvement of children's rights

For Hospitals	For Outpatient Health Care Facilities (PHC)
Standard 1 evaluates the best quality possible care delivered to all children	
Standard 2 equality and non-discrimination of all children	
Standard 3 play and learning	Standard 3 supporting the realization of the mother's right to health, pregnancy and the role of parents
Standard 4 right to information and participation	
Standard 5 safe, clean and appropriate environment	
Standard 6 right to protection from all forms of violence	
Standard 7 pain management and palliative care	Standard 7 right to management of chronic illness and other long-term health care needs
Standard 8 pain management and palliative care	

Table 3: Global standards for quality health care services for adolescents

Global standards for quality health care services for adolescents	
Adolescents' health literacy	Standard 1. Adolescents are knowledgeable about their own health, and know where and when to obtain health services
Community support	Standard 2. Parents, guardians and other community members and community organizations recognize the value of providing health services to adolescents. They support such provision, and utilization of services by adolescents.
The package of services	Standard 3. The outpatient health facility provides a package of information, counseling, diagnostic, treatment and care services that fulfill the needs of all adolescents. Services are provided in the facility, through referral linkages and outreach.

Global standards for quality health care services for adolescents	
Providers' competencies	Standard 4. Health care providers demonstrate technical competence required to provide effective health services to adolescents. Both health care providers and support staff respect, protect and fulfill adolescents' rights to information, privacy, confidentiality, non-discrimination, non-judgmental informed and respect.
Facility physical environment and equipment	Standard 5. The outpatient health facility has convenient operating hours, a welcoming and clean environment, and maintains privacy and confidentiality. It has the equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents.
Equity	Standard 6. The outpatient health facility provides quality services to all adolescents irrespective of their ability to pay, age, sex, marital status, education level, ethnic origin.
Data and quality improvement	Standard 7. The outpatient health facility collects, analyzes and uses data on service utilization and quality of care disaggregated by age and sex to support quality improvement. Health facility staff are supported to participate in continuous quality improvement.
Adolescents' participation	Standard 8. Adolescents are involved in the planning, monitoring and evaluation of health services, in decisions regarding their own care as well as in certain appropriate aspects of service provision.

3. Assessments

Assessing current provision of care and progress towards quality of care and human rights standards needs to be carried out to portray the current situation, identify deviations from agreed standards and, at a later stage, measure progress towards the achievement of the standards.

The assessment of the current situation of care provided might have to be interspersed into the standard development process in order to gain an understanding of the realities and to be able to develop realistic standards of quality of care and human rights. However, if there is little disagreement on the standards, the development/adaptation of the assessment tool and the baseline assessment of the current quality of care can be carried out sequentially following the definition of the standards.

A national assessment tool based on the established standards and guidelines (or adaptations of existing WHO tools, such as the Hospital care for children: quality assessment and improvement tool, WHO Regional Office for Europe 2015 second edition; the Hospital care for mothers and newborn babies: quality assessment and improvement tool, WHO Regional Office for Europe, Second edition, 2014; the Assessment Tool for the Quality of Outpatient Antepartum and Postpartum Care for Women and Newborns, WHO Regional Office for Europe 2013 based on international standards) will have to be developed. Once the assessment tool has been developed, a sample of health facilities can be assessed. The assessment process requires capacity-building of assessors including an orientation of the assessment team on the assessment tool, the process ahead of them and facilitation skills, which is essential in ensuring the effective participation of

all stakeholders, including pregnant women, partners or companions of pregnant women, children, adolescents and parents.

Findings of the sample baseline assessment are to be shared widely at the national steering committee meetings and other venues with all stakeholders and used to refine the standards, where needed, and to define the needed improvement activities through the collaborative improvement process (see below). Identified shortcomings that concern the health systems at large (supply of essential drugs, staffing, etc.) can be brought to the attention of the responsible units and plans to address these deficiencies developed in collaboration with them. Client perspectives should be an integral part of the assessment process. Client exit interviews during the assessment process, and also on a regular basis through suggestion or feedback boxes, allow learning the opinion of clients.

Selection of the assessment teams

Assessors are selected from staff from all facilities and hospitals involved in the process; external facilitators should assist each assessment team. In the initial assessment, staff members are not involved in assessing their own facilities but instead those of their peers. The team should consist of health facility representatives and Ministry of Health staff at national or subnational level. It is important that health professionals are in the team to assess case management, including nurses and midwives. External or internal experts or health care staff with knowledge on the national regulatory environment and know-how on the applicability of human rights to the healthcare setting should also be included.

As this is part of a collaborative process and intended to be a team exercise, nobody working at the outpatient facility or hospital expressing interest in participating should be excluded. The size of the teams may vary depending on the size of the facility to be assessed and on how many clinical areas are included.

An essential part of the assessment in hospitals and in outpatient health facilities is the involvement of patients and their families. These should include pregnant women, their husbands or companions, particularly at the time of childbirth; children and adolescents; and parents of hospitalised children or children attending health facilities. As aforementioned, the WHO Regional Office for Europe has used both assessment tools on the respect of children's rights in hospital and health facilities for 5 groups of stakeholders; and the revised tools for maternal and newborn and paediatric care, include interviews with pregnant women and mothers, respectively. The assessment includes both interviews and focus group discussions. Together with the data gathered by the assessment teams, the inputs provided by these stakeholders provide a triangular feedback, which enhances the reliability and validity of the data collected.

Training assessors

Assessors should be trained by somebody experienced in the assessment process. Ideally, the training team should include external national or international facilitators, who add validity to the process. The training usually takes four days.

4. Improvements

Implementing standards requires

- a collaborative approach to ensure adherence to guidelines based on standards of care
- creation of improvement teams to identify problems and implement solutions
- training of health providers to implement the quality improvement system.

Once the results of the baseline assessments are available, the scope of the collaborative improvement process can be defined in discussion with all stakeholders. The health facilities that participated in the baseline assessment are best suited to be targeted first, as areas in need of improvement have already been identified. However, since it is a cyclical process it is also possible to select a different group of health facilities for the first round of the improvement process, for example based on a specific geographical location. However, health facilities – also those that were not included in the initial assessment – will have to undergo at some stage an assessment of the quality of current care provided to identify areas of weakness, ideally by an external assessment. Capacity of assessors will already have been built during the baseline assessment described above.

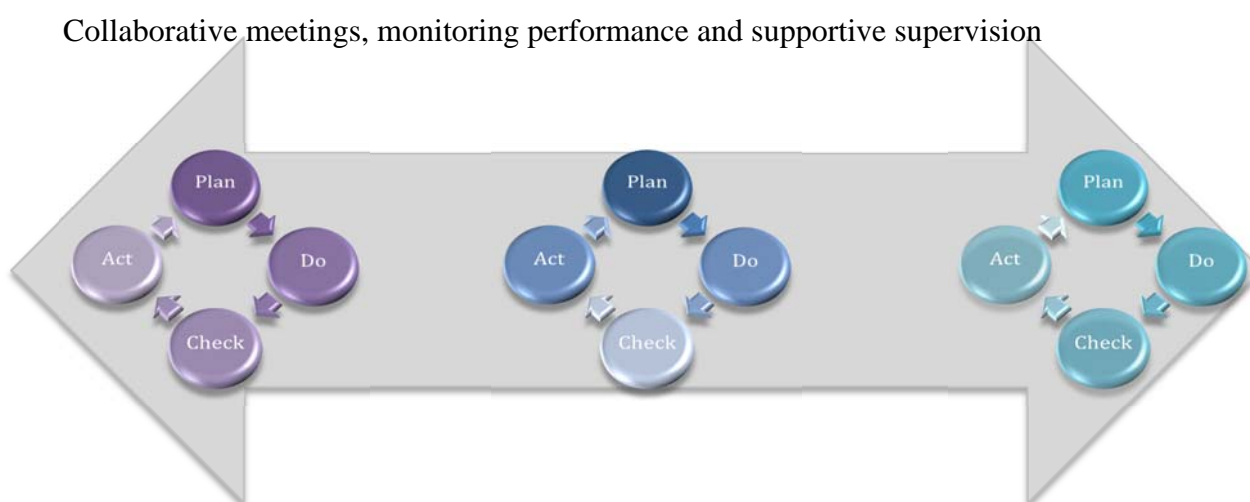
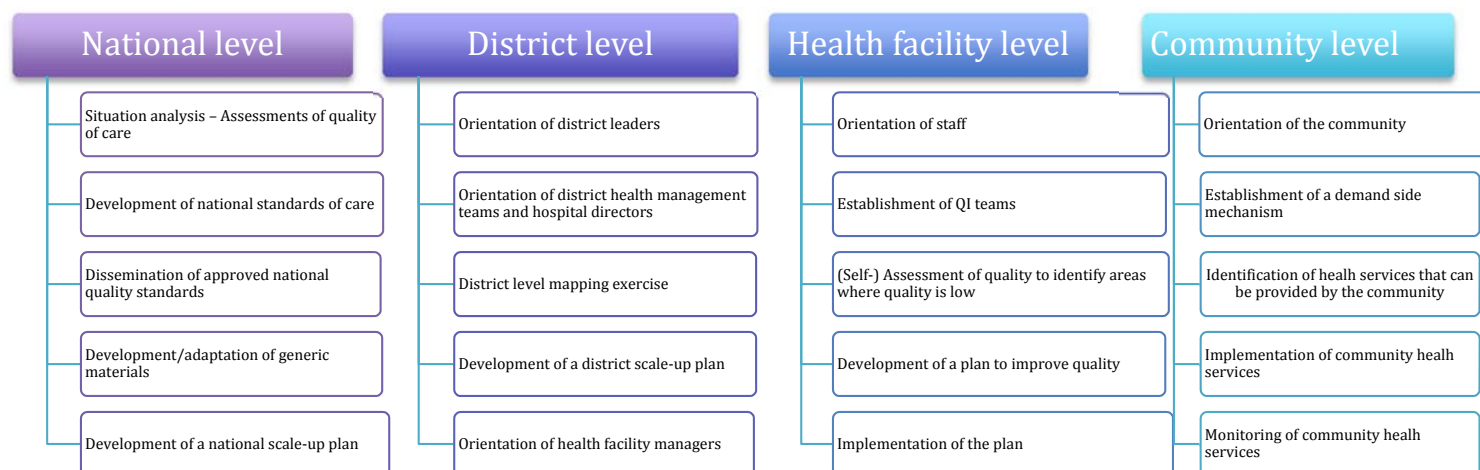
Based on the results of the assessment, a gap analysis can be carried out and improvement plans developed. The collaborative approach has been demonstrated to be a powerful tool to bring about change and achievement of standards^{40,41,42} as it not only creates capacity but also motivation, team spirit and competition. Ideally, staff from 10–20 health facilities in a geographic area will be brought together to discuss common problems and identify areas where they can learn from each other. For health centres and clinics, the process might be facilitated by their respective referral hospitals. Private health facilities should be included in the process as in many settings a large part of care is provided by the private sector.

The collaborative process will also lead to the identification of necessary actions that are beyond the authority and responsibility of the individual health facility/hospital and need to be communicated to higher levels through the steering committee (especially concerning the health systems issues mentioned above). Quality improvement and technical capacity will be developed through this process.

As a next step, the developed improvement plans will be implemented at the participating health facilities and agreed upon indicators collected to measure progress. Health facility staff from the participating facilities are brought together every 4–6 months to share their experiences, and discuss achievements made and challenges encountered. In addition, they can learn from each other's experiences, embark on joint problem-solving activities, as well as receive specific training on legal health provisions, clinical guidelines and practice and QI methods as required. Going through the improvement cycle – planning (plan), implementing (do), monitoring (check), acting (act) – several times over a period of 2–3 years, defined standards should be achieved. When reaching this stage, the collaborative process could be linked up with external accreditation or certification. Similar to the assessment process, the established accreditation mechanism should be informed by experience of care and patient satisfaction surveys.

After the identification of areas that need improvement in order to meet the standards, improvement actions will have to be implemented. Staff at all levels needs to be motivated and empowered to take actions to improve performance and quality of care. Motivation has been described to depend largely on sense of purpose, mastery and autonomy. By empowering staff to set up improvement teams, set priorities for improved work and to share their experiences in the context of a collaborative approach and/or at (inter)national conferences, staff motivation may be increased. Annex 1 contains proposed steps for *implementing quality improvement activities at the health facility (outpatient health facility and/or hospital level)*.

Figure 11: Implementing a systematic approach



5. Monitoring and reassessment

Continuous monitoring of performance, and provision of supportive supervision and (self-) assessments of quality of care to measure progress towards the achievement of standards are key for the functioning of the improvement process. Unfortunately, evidence suggests that monitoring and supervision, while almost always acknowledged as being crucially important, are virtually never backed with the resources – financial or human – required to be effective. The implementation of this framework would empower staff at all levels to use standards, guidelines and tools to self-assess their adherence to internationally accepted standards. If standards are spelled out explicitly and health workers know what is required of them,⁴³ they can use the tools to assess the adherence to standards for self-assessment and to guide their work and improve performance. Ideally self-assessment should happen on a continuous basis by every health worker, and on an institutional basis at the hospital and outpatient health facility at least six monthly for selected areas. External assessment carried out by a team of assessors not working at the facility to be assessed, who may or may not include international assessors, should be carried out at least every 1–2 years to validate findings of self-assessment. Monitoring is only

meaningful if it leads to concrete improvement actions. Therefore, findings should always feed back immediately to the people who are powered to bring about change.

The involvement of other stakeholders, such as clients along the continuum of care, as described before, should be included in the regular monitoring and evaluation activities. Patient surveys^{III} and patient complaints should be integrated in this process. Findings should be fed back regularly to the national steering committee meetings and through other channels.

6. Documentation and dissemination

Implementation of changes in care and results of improvement processes should be documented, published and disseminated and the achievements of the standards celebrated, for example in meetings with relevant staff, first level health facilities or hospitals and the wider public and scientific community, if relevant. Collaborative meetings are an ideal opportunity for implementers to present experiences with the improvement process. Results can be presented verbally or in pictorial form, e.g. posters, graphs, newsletters and stories. The information could be published in national medical journals, printed in local or national newspapers or presented on the radio or other forms of media in the country. Country experiences could be submitted to peer-reviewed journals. Collaborative meetings are also a good opportunity to celebrate success and connect to the wider health community.

If a formal accreditation or certification process is put in place, health facilities and hospitals adhering to standards and therefore providing quality of care should be made publicly recognizable, for example through certificates, logos or other recognition processes – hospital of the year.

7. Scaling up

Quality improvement is a dynamic process that can start at many different places at the same or different times. It does not have to be a strictly coordinated top-down venture but can grow from both bottom and top. The main coordination required is the establishment of standards and accompanying guidelines that may need updating as new evidence becomes available. The improvement process has the potential to be responsive to changing epidemiology, demography as well as legal and social factors.

If the country embarks on a national process, assessments, planning and improvement processes may initially be conducted in defined geographical areas. Lessons learnt from the first cycle of improvements can then be reviewed to evaluate overall progress. If progress is perceived to be satisfactory, the process can be scaled up to ensure universal quality care. If progress is perceived to be patchy, a detailed assessment of the poor improvement areas will give insight into obstacles that can be directly addressed and efforts can be redirected towards overcoming these obstacles.

During the scaling-up process links should be established to existing professional regulation, accreditation and prequalification mechanisms, or if these do not yet exist the process can be used to institute them.

^{III} Patient surveys can be shorter and simpler questions (in comparison to the ‘full’ assessment), which are asked of every patient at the end of their hospital stay or appointment at the health facility, or after they have returned home. Example of questions are: were you satisfied with the care received; what do you value most when you visit a doctor or specialist; would you recommend this hospital or outpatient health facility to your family and friends?

Integration into pre-service training

Quality improvement, including the national regulatory framework, should be part of pre-service training to ensure that all health workers have the knowledge and necessary skills to provide quality RMNCAH care. The concept of quality, standards of care, and evidence-based medicine should be integrated into the pre-service training of future generations of health care providers, in order to allow for sustainability of quality improvement efforts. This requires the incorporation into the curricula of universities, medical schools, nursing and midwifery training schools.

The proposed systematic approach (see Implementation) is based on attributes of scaled up public health programmes identified by the Centre for Global Development⁴⁴ and by WHO⁴⁵ and on the nine-step scaling up approach recommended by WHO⁴⁶.

Roles at the regional level

At the start of the process

International agencies working at the regional or global level may have role to support the process and to provide technical assistance for country activities. These activities include the development of regional tools and guidelines and support to countries throughout the above-described process. Assistance should be provided to review and update existing legislation and guidelines to be in line with the human rights obligations and the latest available evidence and international guidelines and to agree upon minimum standards of care that guarantee appropriate quality of care and avoid harmful practice.

The development of job aids summarizing the updated guidance and standards concisely is essential: protocols, desk guides, pocket books, websites and/or smart phone applications based on international standards can serve as reference tools with the possibility to be incorporated in training tools.

Available WHO assessment tools can be used by countries as a template for adaptation, both for external assessments by experts as well as for self-assessment within health facilities in the context of the quality improvement approaches. A toolbox to support the implementation of the framework is available; in the text box below a list of available tools can be found.

Toolbox supporting the implementation of the framework

1. Tool for reviewing the national regulatory environment in relation to newborn, child and adolescent health, WHO 2015, Draft;
2. Reproductive, maternal, newborn and child health and human rights: A tool for examining laws, regulations and policies, ISBN 978 92 4 150742 4, WHO, 2014;
http://apps.who.int/iris/bitstream/10665/126383/1/9789241507424_eng.pdf
3. Hospital care for children: quality assessment and improvement tool, WHO Regional Office for Europe, Second edition, 2015
http://www.euro.who.int/_data/assets/pdf_file/0003/286185/Hospital-care-for-children-quality-assessment-and-improvement-tool.pdf
4. Manual and Tools for the Assessment and Improvement of children's rights in primary health care, International Network of Health Promoting Hospitals and Health Services 2012, adopted and used by 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>
5. Global standards to improve quality of health care for adolescents and related assessment tools, WHO 2015;
http://www.who.int/maternal_child_adolescent/documents/global-standards-adolescent-care/en/
6. Hospital care for mothers and newborn babies: quality assessment and improvement tool, WHO Regional Office for Europe, Second edition, 2014;
http://www.euro.who.int/_data/assets/pdf_file/0004/244831/Hospital-care-for-mothers-and-newborn-babies-quality-assessment-and-improvement-tool.pdf
7. Assessment Tool for the Quality of Outpatient Antepartum and Postpartum Care for Women and Newborns, WHO Regional Office for Europe 2013;
<http://www.euro.who.int/en/health-topics/Life-stages/maternal-and-newborn-health/publications/2013/assessment-tool-for-the-quality-of-outpatient-antepartum-and-postpartum-care-for-women-and-newborns>
8. Implementing health promotion in hospitals: Manual and self-assessment forms, Division of Country Health Systems Country Policies, Systems and Services Unit Barcelona Office, WHO, 2006;
http://www.euro.who.int/_data/assets/pdf_file/0009/99819/E88584.pdf
9. Tool for reporting to the Committee on the Rights of the Child in the context of Article 24 of the Convention on the Rights of the Child, WHO, 2015, Draft

After the process has started

Collaborative review mechanism at the Regional level

Similar to the platform to share experiences that will be created through this process within countries, regional collaborative review meetings among countries of the WHO European Region will be organized on a regular basis. This will bring together implementers to share experiences, discuss and learn from each other.

Monitoring progress

Proposed regional process indicators to track progress in Member States of the European Region are:

- The number who have reviewed their national regulatory RMNCAH environment
- The number who have developed a National Quality Framework for RMNCAH
- The number who have developed RMNCAH standards and protocols for clinical care and human rights in line with international standards
- The number who have developed RMNCAH tools to assess the quality of care against set standards and clinical protocols
- The number who have trained assessors to assess RMNCAH quality of care against set standards
- The number who have established a reporting mechanism for RMNCAH quality of care
- The number who have established an accreditation/certification methodology against set standards
- The number who have integrated components of the national regulatory environment and QI in undergraduate and in-service training
- The number who have incorporated the results of the QI efforts in the periodic reporting to the UN Treaty Bodies.

A Regional Report on Quality of Care

The implementation of the framework in the European region should lead to the preparation of a report on quality of RMNCAH health care in the WHO European Region raising the visibility to policy-makers, decision-makers, health professionals, patients and carers.

Sharing of experiences and best practices

The experience gained at the regional level is expected to feed into the global review mechanism. This will enable information flow to other regions and for countries of the European Region to learn from their experiences with similar processes. The WHO Regional Office meeting aims at facilitating a meeting within 2–3 years to share experiences and lessons learnt as well as to review progress.

Conclusion

H2020 objective in decreasing health inequalities and the SDG targets for improving RMNCAH will remain aspirational if quality of care is not put at the centre of debates on universal health coverage and receives the attention it deserves.

The Regional Framework for Improving the Quality of Care proposes a quality improvement system that extends across the RMNCAH continuum and all levels of care. It aims to achieve

“effective coverage”, defined as high and equitable coverage of quality care.⁴⁷ Its implementation stands for a fundamental shift in policy to accept quality of care as essential and to empower health providers to take responsibility for the improvement of their work of saving lives and averting preventable death and morbidity.

Annex 1. Implementing quality improvement activities at the outpatient health facility and/or hospital level

In a quality improvement organization, each health-care provider and staff member believes that change and improvement are an intrinsic part of everyone's work every day, in all parts of the system. Shifting to this new focus involves substantial reframing of the idea of the work of health care, as well as the use of a wide variety of tools and methods.⁴⁸

Implementing quality improvement activities at your health facility/hospital*

Step 1: Setting up a quality improvement (QI) team

Step 2: Defining the problem

Step 3: Implementing change

Step 4: Measuring results

Step 5: Sharing results and spreading change

* Adapted from Health Quality Ontario, Quality Improvement Guide,⁴⁹ and University Research Co., LLC, Quality Improvement Handbook for TB and MDR-TB Programs.⁵⁰

Step 1: Setting up a QI team

To improve care effectively, all staff must accept quality improvement as their responsibility and feel they are empowered to actually make a difference. As QI is most effective when internally driven, responsibility for its implementation should be taken on by a group of staff members who will ideally form a QI team (Box 1).

Two or more people from the health facility/hospital where health services need to be improved can create a QI team. The team members should either share similar tasks or be responsible for complementary tasks that affect the quality of services. These teams could also include counterparts (e.g. supervisors) from the district or be constituted as a combined team from the hospital and outpatient health facility in the catchment area. Middle and/or top management will be ideally, but not mandatorily involved in a QI team. The QI team may decide to have a rotational membership system, giving other staff members the opportunity to participate as team members.

Non-QI team staff members can participate in monitoring and analysing results, and promoting change. Once the QI team is assembled, it begins the journey to understand what improvements should be made and how to know that its efforts have created a positive change.

Vignette A1.1: QI team composition

A team is generally composed of two or more staff members representing different functions. Selected members should:

- have interest in improving quality
- have good communication skills, ability to work with and listen to others
- represent different services, such as case management, nursing, pharmacy, outreach.

QI team role

- Initiate action for quality improvement using the (self-) assessment tool and other data sources to identify problems continually and develop corrective action plans
- Facilitate the improvement process: hold and document meetings to review progress and discuss quality issues, and inform, train and involve other staff in the quality improvement process
- Collaborate with other improvement teams through the collaborative approach
- Coordinate with higher levels on the improvement process
- Periodically evaluate progress: monitor and document corrective actions to assess whether they meet expectations
- Communicate with the community
- Publicize quality changes for staff and patients
- Collect and record information on key indicators.

Source: Adapted from University Research CO., LLC, Quality Improvement Handbook for TB and MDR-TB Programs.

How to do it?

- Assemble a team.
- It's important to make sustainability and expansion a focus and priority from the beginning of any initiative – this is not something that can be successfully addressed after a project is complete.

Step 2: Defining the problem – assessing quality of care

Standards and guidelines form an extremely important part of quality improvement. They define the required quality of care and serve as a basis to identify the inputs and processes needed to ensure quality of care in order to improve health outcomes. These standards can be translated into guidelines and assessment tools.

During this phase, improvement teams will explore the systems and processes in place and determine the underlying problems that contribute to less desirable results.

How to do it?

- Carry out a (self-) assessment to identify the current quality of care provided using an assessment tool based on standards
 - QI tools such as a fishbone analysis and the ‘5 whys’ can be used to explore identified problems further
- The team should review the (self-) assessment results, identify gaps in quality and set overall goals that they would like to achieve within specific timeframes
- Essential to understanding the current situation is learning what patients/clients actually experience during the health delivery process and what they would want or need if care processes were changed.
- Start to create a list of improvement opportunities that address the problems identified.

Step 3: Implementing change

Once there is a clear understanding of the opportunities for improvement, teams can begin brainstorming and testing ideas through Plan-Do-Study-Act (PDSA) cycles. This is an exciting phase that provides teams the opportunity to exercise creativity and challenge the status quo by trying different improvement ideas. The PDSA approach allows teams to try ideas on a small scale, which can smooth out any concerns in the process before sharing the success or failure of the tried change more widely. It builds confidence in the change process and creates buy-in by involving individuals that are truly affected by the proposed changes.

Once teams have trialled their improvement ideas through small tests of change and have demonstrated improvement in different scenarios – therefore have a high degree of confidence that the changes are indeed an improvement – they are ready to progress to implement changes formally into everyday practice in the unit or department where the work is done.

How to do it?

- Begin testing. Document the testing so that the team can test multiple ideas simultaneously and clearly see what tests work well and what processes require some tweaking.
- Formalize and standardize the changes and document the new process. Include information about the required steps in many places, such as: new staff orientation, training sessions for current staff, job descriptions, and policies and procedures.
- Create an on-going measurement plan. Ensuring that staff members adopt the changes requires a measurement plan to monitor adoption and continual improvement. QI teams need to identify a few key measures that will assist in determining whether new processes are being followed; detect problems; and alert staff if processes are not functioning as intended.

Vignette A1.2: Common problems encountered when implementing a quality improvement approach at the district and facility level

- Quality improvement (QI) vision and goals not closely aligned with national/district priorities
- Failure to bring in a broad coalition of stakeholders, including local private sector, local academic institutions
- Weak commitment from facility leadership
- Opposition from power-holders who feel threatened by QI process
- QI disconnected or working against facility's financial logic
- No mechanism for accountability for Quality of Care
- Not enough attention to clinical knowledge and skills
- Budget, human resources and materials for QI too weak or absent
- Lack of coaching for QI teams
- Poor participation of facility staff in identification of standards, indicators and baseline assessment results in disengagement and rejection of results
- Performance measurements done and reported but not analyzed or discussed
- Measurements not shared with community
- Difficulties inserting QI in traditional District meetings focused on coverage
- Performance not linked to incentives
- Weak or absent computer-based technology needed to manage data
- Active or passive resistance from professionals who fear losing autonomy
- Process needs time to set in and is abandoned before results can show
- Process is dependent on external support or incentives
- Too complex QI process takes too long
- QI teams weak at documenting testing of changes and lessons learned
- Poor demand for improvement knowledge
- Poor or absent mechanisms for sharing new improvement knowledge
- Scale up not planned from start
- Weak strategies to "sell" scale up to stakeholders

Courtesy Jorge Hermida MD, The USAID ASSIST Project, University Research Co., LLC

Step 4: Measuring results

Indicators are necessary to monitor progress. Indicators can be selected based on nationally adopted standards. Indicators can be of several types including input, process and output indicators. Improvement teams are encouraged to choose their own performance indicators to

measure progress towards the standard they chose to achieve at each point in time. At the beginning these may be largely input indicators – for example if commodities such as antibiotics, blood products, oxygen need to be put in place to enable the delivery of standards. Once these inputs are made available the teams may choose to focus on process indicators – percentage of children with cough and difficult breathing treated correctly (or at the hospital level, 90% of children admitted with pneumonia are treated according to standards (international treatment guidelines)).

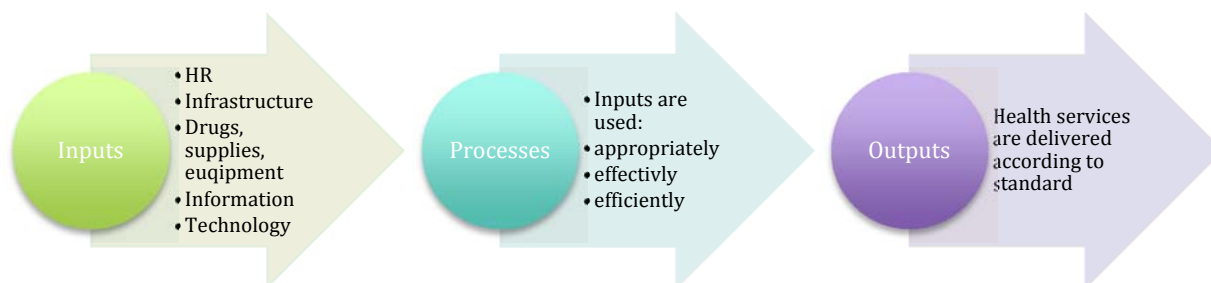
Progress towards the achievement of standards will lead to better quality of care and ultimately contribute to improved outcome indicators, e.g. decline in mortality or teenage pregnancies.

It is important to know that outcome indicators often first deteriorate with improving quality as the caseload may increase and more serious cases are taken on. It is therefore essential to collect data to be able to show that the denominator has changed and the situation is improving overall even if indicators suggest otherwise if they are not put in the correct context.

How to do it?

- Create a measurement plan.
- Measure whether a change has the desired impact and outcome.

Figure A1.1/Figure 8: Inputs, processes and outputs needed to be in place to achieve the standard



Source: Adapted from Quality Improvement Handbook for TB and MDR-TB Programs, University Research Co., LLC, 2013.

Step 5: Sharing results and spreading change

For sustainable change the QI team needs to continue sharing the improvement story and how changes have had a positive impact on the patient/client experience and outcomes. It is important to clarify the “what’s in it for me” in order to help staff understand how they benefit from on-going improvement.

As appropriate, begin to think about how to spread the change beyond the current unit or department to the entire organization. Create a team of people to help with this next step of planning.

How to do it?

- Share the stories of failure, improvement and success from the PDSA cycles. Document the exciting impact that the changes have on all the individuals involved in the process.
- Create and implement a spread plan. To determine where best to begin to spread improvement, the QI team should turn to those enthusiastic and accepting of change for improvement's sake. In other words, take the path of least resistance. By concentrating first on units or departments eager for the change, teams can build the momentum necessary to ultimately engage individuals or departments raising the most barriers to change.
- Communicate changes. Include items like the reason for changes and why all –patients and staff – will be positively affected by the changes. Appeal to the emotional as well as the logical side of the individuals with whom you are communicating.
- Create a measurement plan for spread. The measurement plan should contain key measures for continually assessing the performance and reliability of the improved processes. The measures will allow QI teams to quickly assess whether processes have begun to break down and enable immediate action.
- Remember that quality improvement is a process that requires going through the improvement cycle over and over again, demanding stamina and determination. But it is worth it!

Annex 2. Human rights of patients

Right	Treaty provisions	Examples of violations
Right to privacy and confidentiality	ICCPR 17(1), CRC 16(1), ECHR 8(1)	<ul style="list-style-type: none"> • Patient medical information is open to all staff. • Patients are forced to disclose their medical diagnosis to their employer in order to obtain leave from work. • Medical examinations take place in public conditions.
Right to information	ICCPR 19(2), ACHPR 9(1), Council of Europe Framework Convention for the Protection of National Minorities (FCNM) 9(1), European Convention on Human Rights and Biomedicine (ECHR) 10(2)	<ul style="list-style-type: none"> • A state fails to provide information on health care services. • Physicians fail to provide patients with information about treatment options and the potential risks and benefits of each procedure. • Patients are denied access to their medical files. • Information services are unavailable for people who speak certain languages.
Right to bodily integrity	ICERD 5(b), ACHPR 4, FCNM 6(1), CRC 19(1), ECHR 5 (The right to bodily integrity is not specifically recognized under the ICCPR, ICESCR, ECHR, or ESC, but has been interpreted to be part of the right to security of the person, the right to freedom from torture and cruel, inhuman, and degrading treatment, and the right to the highest attainable standard of health.) ¹³	<ul style="list-style-type: none"> • Physicians fail to obtain “free and informed” consent from patients before performing medical procedures. • Patients are not allowed to switch physicians or health care providers.
Right to life	ICCPR 6(1), ACHPR 4, ECHR 2(1)	<ul style="list-style-type: none"> • Due to inadequate reproductive health and prenatal care, complications from pregnancy are a leading cause of death for young women globally. • Ambulances fail to arrive at certain communities or for certain individuals in a timely manner, leading to patient deaths.

<p>Right to the highest attainable standard of health</p>	<p>ICESCR 12, ICERD 5, CRC 24, CEDAW 12(1), ACHPR 16, ESC 11, ESC 13</p>	<ul style="list-style-type: none"> • Maternal and reproductive health services are lacking. • Doctors and health facilities are not located near neighbourhoods of certain communities. • Social policies disproportionately exclude patients from certain communities from access to health insurance. • Patients are given inferior care.
<p>Right to non-discrimination and equality</p>	<p>ICCPR 21(1), ICCPR 26, ICESCR 2(2), ICERD, ACHPR 2–3, ACHPR 19, FCNM 4(1), ECHR 14, ECHR 3</p>	<ul style="list-style-type: none"> • Mothers belonging to certain ethnic groups are forced to stay in separate wards when delivering a baby. • Doctors refuse to provide care to people living with HIV, sex workers, or people who use drugs. • Reproductive health services for women are not addressed in national policy.
<p>Right to a remedy</p>	<p>ICCPR 2(3), ICERD 6, CEDAW 2, ACHPR 26, ECHR 13</p>	<ul style="list-style-type: none"> • The state takes no action to address any of the violations described above.

Adapted from Cohen J and Ezer T Human rights in patient care: a theoretical and practical framework. Health and human rights, volume 15, no. 2, December 2013

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**The WHO Regional
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The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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