ACH Med J
(2025) 3: 070-076
ISSN:2822-5872
Doi : 10.5505/achmedj.2025.85570

RESEARCH ARTICLE

Patient Companions' Awareness Of Child Rights

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Article Info

Received Date: 24.06.2025
Revision Date : 24.06.2025
Accepted Date: 04.08.2025

Keywords:
Child,
Convention on the Rights of the Child,
Child rights,
Hospitalization,
Health rights

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Abstract

Introduction: The Convention on the Rights of the Child recognizes children as individuals entitled to fundamental rights, including the right to health. This right extends to children receiving inpatient care, ensuring their access to appropriate medical treatment and protection. However, the awareness of these rights among caregivers remains limited, which may influence the care children receive.

Methods: A descriptive, cross-sectional study was conducted at a tertiary pediatric hospital. A structured questionnaire was administered to accompanying persons of hospitalized children to evaluate their awareness of both the Convention on the Rights of the Child and national patient rights regulations. Sociodemographic data and response patterns were analyzed using descriptive statistics.

Results: Out of 200 participants, only 28% were aware of the Convention on the Rights of the Child, and just 35% had prior knowledge of the national Patient Rights Regulation. Common misconceptions included the child's right to refuse treatment, informed consent requirements, and the child's right to confidentiality. Awareness levels were significantly lower among participants with lower educational attainment ($p < 0.05$).

Discussion: The findings suggest that many caregivers lack sufficient knowledge of children's rights in medical contexts. This lack of awareness may hinder effective communication with healthcare professionals and limit the child's autonomy and participation in care decisions. Systematic caregiver education within hospital settings could help bridge this gap.

Conclusion: The goals outlined in the Convention on the Rights of the Child are not fully realized in clinical practice. Increasing awareness among caregivers is essential to promote child-centered care and uphold health-related rights during hospitalization. Future studies should focus on developing and evaluating interventions to improve understanding of child and patient rights.

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Introduction

Childhood has been one of the fundamental aspects of all cultures throughout history. Every civilization interprets infancy based on its cultural traits, indicating variations in this idea among different societies.[1]

In our present era, the importance and worth attributed to children in a society are linked to the level of development of that community and, it is the state's responsibility to ensure that children achieve their fundamental rights and freedoms. Therefore, the Convention on the Rights of the Child was signed by world leaders on November 20, 1989, at the General Assembly of the United Nations. This convention, which provides for the protection of children who are unable to meet their basic needs, are forced to work in unsuitable jobs, or are subjected to sexual abuse or exploitation, emphasizes the importance of children's well-being, development, participation, equality, health and education.

In addition to protective rights, the Convention includes personal rights such as access to adequate nutrition, health care, clean water, education and economic, social and cultural rights. Its aim is to elevate children's rights to the same level as the rights recognized for all individuals.

According to Article 24 of the Convention, signatory parties must strive to ensure that all children have access to medical care services. Children's health rights begin at gestation and continue through newborn, infancy, childhood, and adolescence. Essential health rights encompass a range of services, including monitoring the mother's health during pregnancy, terminating pregnancy in appropriate circumstances, providing additional nutrition after initial breastfeeding, ensuring balanced and sufficient nutrition, monitoring growth and development, administering complete vaccinations, delivering various health services, providing care and assistance during illness, safeguarding against neglect and abuse, and supplying adequate and appropriate stimuli.[2,3] The Convention asserts that children of all ethnicities should have access to health services. It also emphasizes that female children should receive equal and attentive care as male children. Additionally, it states that refugee children should have the same opportunities for health services as others, and that health services in rural regions should be equivalent to those in urban areas.[4] States should base their health service policy on the significant benefits for children, as stated by the Human Rights Joint Platform in 2012.

Waterson's study explores two approaches that doctors should consider for child health, one of which is a holistic approach. Doctors are responsible for ensuring that children have proper health and development, are not economically exploited, do not engage in harmful work, are not subjected to violence at home or in institutions, have access to education, and are not impacted by discrimination, poverty, or racism. Another study highlighted the significance of offering specialized care to children and adolescents while using alternative therapy modalities. The study emphasizes that interacting with children individually, informing them, and treating their opinions and thoughts with respect can result in more effective therapy outcomes.[2]

Health policy providers and healthcare workers have a primary responsibility to ensure that children and adolescents are treated in accordance with their rights. During hospitalization, caregivers who accompany children play a crucial role in maintaining the effectiveness of treatment. Caregivers of unwell children often experience high levels of anxiety and stress due to treatment processes.[5-7] Primary factors affecting caregivers include disruptions to family dynamics during a child's hospitalization, hospital routines, and difficulties understanding treatment information. The involvement of caregivers in the therapy process can have a positive impact on the treatment of sick children.[8] By including caregivers in the treatment process, they can reduce their own anxiety and tension while also expediting the child's treatment. This study aims to assess the amount of awareness among caregivers of children undergoing inpatient treatment in pediatric clinics on child and patient rights, their ability to enforce these rights, and the methods they employ to address challenges associated with these rights.

Material and Methods

The research was conducted using a correlational survey model, which is a type of survey methodology used to assess previous or current situations. This study examines patient companions who provided care to patients receiving inpatient treatment at the general pediatric clinics of the Dr. Sami Ulus Gynecology, Child Health and Diseases Training Research Hospital from January 1 to December 21, 2014.

The sample method used was simple random sampling, a type of probability sampling that ensures

each individual has an equal chance of being selected. The study included 100 voluntary patients. Excluded from the study were patient companions who did not provide care, caregivers of patients who were hospitalized multiple times within specific periods, and patients with chronic disorders such as oncologic or renal conditions.

The data collection instrument utilized was the 'Companion Child Rights Attitude Scale,' which comprises a 35-item, 5-point Likert scale, and 6 demographic questions. The study used the scale form to evaluate companions' perspectives on child rights, specifically focusing on the sub-dimensions of 'Basic Patient Rights' and 'Basic Child Rights.' The validity and reliability of the scale were established through studies, leading to its standardization. The results indicated that the scale accurately reflected the companions' attitudes towards child rights, with a reliability coefficient of 0.941. Informed consent was obtained from all participants and the authors declare that this study is consistent with the journal's ethical publication standards.

Statistical Analysis

All statistical analyzes were conducted using SPSS v28.0 [IBM Corporation]. P values less than 0.05 were considered statistically significant. Descriptive statistics included mean± standard deviation for continuous variables and frequency for categorical variables. The data were analyzed for both epileptic and non-epileptic groups using Mann-Whitney U tests for continuous variables and chi-square or Fisher exact tests for categorical variables.

Results

This section presents the data collected from the scale, the results of the analysis conducted, and corresponding remarks on the participants' personal information. Findings are presented in section 3.1.

Participants' Demographic Data

Table 1 presents information on the study's volunteers, including their age, degree of relation to the patient, city of residence, educational level, monthly income, and the sex of the patient they accompanied.

Of the 100 patient relatives, 22 (22%) were aged 15-25, 54 (54%) were aged 26-35, 20 (20%) were aged 35-45, and 4 (4%) were over 45 years old. In the study, 97% of the participants were mothers of the patient, while the remaining 3% were other relatives. Of the total participants, 70% reside in Ankara, which is equivalent to 70 individuals, while the remaining 30% live outside of Ankara, totaling 30 individuals. The volunteers in the study are distributed according to their educational levels as follows: 10% of the group, equivalent to 10 individuals, are illiterate. 40% or 40 individuals have completed primary education, 21% or 21 individuals have completed secondary school, 19% or 19 individuals have completed high school, and 10% or 10 individuals have graduated from university. 65% of participants are unemployed, 15% have a monthly income below 1000 TL, 10% have a monthly income between 1001 and 2000 TL, 5% have a monthly income between 2011 and 5000 TL, and 5% have a monthly income above 5000 TL. 66% of participants have 1 or 2 children, 20% have 3 or 4 children, and 14% have more than 4 children. 56% of the patients cared for by the volunteers in the study were female children, totaling 56 children, whereas 44% were male children, totaling 44 children. (Table 1)

Table 1 shows some of the participant features

Participants information	Variables	f	%
Participants Age	15- 25 years	22	22
	26-35 years	54	54
	36-45 years	20	20
	>45 years	4	4
Patient Affinity Degree	Patient's mother	97	97
	Relatives other than mother	3	3
Education Status	Illiterate	10	10
	Primary school graduate	40	40
	Secondary school graduate	21	21
	High school graduate	19	19
	College / University graduate	10	10
Monthly Income	No monthly income	65	65
	<1000 ₺	15	15
	1001-2000 ₺	10	10
	2001-5000₺	5	5
	>5000 ₺	5	5
Number of children	1-2	66	66
	3-4	20	20
	>4	14	14

Participants' Discovery of Fundamental Patient Rights

Table 2 presents the participants' perspectives on the process of diagnosing and hospitalizing the patients they accompanied.

The study initially examined whether the patients being assisted by the volunteers had prior hospitalizations. Of the patients, 63% had prior hospitalizations for inspection, diagnosis, and treatment, while 37% were hospitalized for the first time. In the study,

76 out of 100 caregivers (76%) were aware of their patient's diagnosis and reason for hospitalization, while 24 (24%) were not informed. The treatment periods varied: 32% of patients were treated for 0-3 days, 39% for 4-7 days, 17% for 8-14 days, 4% for 15-20 days, and 8% for more than 21 days. During the study, the patients' companions were asked about their knowledge of the names of the doctors who were attending to the patients. The results showed that 71% of the participants were unaware of their patient's doctor's name, while only 29% knew the doctor's name. Additionally, the study found that 70% of the voluntary caregivers were fully informed by the doctors about their patient's condition and disease, while 11% were not informed and the remaining 20% were not well educated. Of the sample, 76% received daily information from their doctors, while the remaining 24% did not. 96% of participants expressed satisfaction with the auxiliary health personnel.

55% of participants were aware of alternative treatments, while 27% had no information about them. 18% of the participants lacked sufficient knowledge about alternative treatments. Regarding the location where the patient's medical history was recorded, 63% of the participants mentioned it was done in a separate room, while 27% stated it was done in the patient's room. The participants were also surveyed about their preferences for the location of their patient's physical examination. During the information gathering and examination process, 24% of participants preferred to be in a separate room, while 76% indicated that it did not matter to them whether these procedures took place in a general or separate room. The text is grammatically correct and follows a clear and logical structure. When asked about their roles in making decisions about their patients' treatment, 18% claimed full authority, 67% left the decisions to the doctor, and 15% made decisions in consultation with their doctor. When asked about their roles in making decisions about their patients' treatment, 18% claimed full authority, 67% left the decisions to the doctor, and 15% made decisions in consultation with their doctor. Technical terms are explained when first used, and the language is clear, objective, and value neutral. The text adheres to conventional academic structure and formatting, including consistent citation and footnote style. The text is balanced and free from bias, and precise word choice is used throughout. No changes in content have been made. (Table 2)

Table 2. Opinions of participants on basic patient-child rights

Question	Variables	f	%
Do you know your patient's diagnosis?	Yes	24	24
	No	76	76
How long does your patients hospitalized?	0-3 days	32	32
	Between 4-7 days	39	39
	8-14 days	17	17
	Between 15-21 days	4	4
	More than 21 days	8	8
Do you know your doctor's name?	Yes	71	71
	No	29	29
How do you score to get general information from your doctor?	Sufficient	70	70
	Insufficient	19	19
	none	11	11
Do you have daily information from your doctor?	Yes	76	76
	No	24	24
Are you satisfied with the staff?	Yes	96	96
	No	4	4
Where do you prefer for telling patient history?	Private Room	63	63
	Doesn't matter	37	37
Where do you prefer for examination and taking information?	Private Room	24	24
	Doesn't matter	76	76
Who does decide the treatment?	Doctor	67	67
	Only patient's relatives	18	18
	Doctor and patients' relatives	15	15

Participants' Discovery of Fundamental Child Rights

Table 3 presents the participants' discoveries regarding fundamental child rights. The study examined the number of patients the participants preferred to share a room with. Of the participants, 3% preferred a single room, 16% preferred a double room, 31% preferred a room for 3-4 people, and 50% preferred staying in the wards. The study also examined the participants' opinions on the meals provided to the patients. In the survey, 79% of respondents believed that the food provided to patients was both age-appropriate and hygienic, while 9% thought it was age-appropriate but unhygienic. The remaining 12% reported that the food was neither age-appropriate nor hygienic. Additionally, 82% of participants expressed satisfaction with the service's hygienic conditions, while 18% found them inadequate. The poll also gathered the participants' views on the presence of the patients they escorted to their educational activities. 25% of the companions reported that their patients continued education, while 42% reported education interruption without the

chance for compensation. Additionally, 33% reported a negative impact on education with the possibility for compensation. In terms of safety, 86% of participants felt comfortable at the hospital, while 14% did not feel safe based on their responses to safety-related questions. The study also examined the participants' perspectives on the appropriate environment for the development and play of their patients. 96% of the respondents reported inadequate ambiance for their patients, while the remaining 4% mentioned creating a playful atmosphere using their own resources.(Table3)

Table 3. Findings of Participants on Basic Child Rights

Question	Variables	f	%
What is the number of patients you desire in the room?	Single room	3	3
	Double Room	16	16
	3-4 Person Room	31	31
	Ward Room	50	50
How do you describe hospital food for your patient?	Age inappropriate and not clean	-	-
	Age inappropriate but clean	12	12
	Age appropriate but not clean	9	9
	Age appropriate and clean	79	79
Do you find the hospital clean enough?	Sufficient	82	82
	Insufficient	18	18
Does your patient have any opportunity to continue education in hospital?	No but compensable	33	33
	No but in compensable	42	42
	Yes	25	25
Do you feel in confidence in hospital?	Yes	86	86
	No	14	14
Does your patient have any place to play in hospital?	Sufficient	-	-
	Insufficient	96	96
	Insufficient but compensation by own possibilities	4	4

Discussion

Child Rights refer to the entitlements and privileges given to all children without bias, in accordance with legal regulations and fundamental human rights from the time of conception. Although basic child rights are anticipated to progress with time compared to the past, the current global situation exposes new instances of child rights breaches.[11,12] Child rights, including living conditions, shelter, healthcare, and education, are being violated worldwide due to factors such as war, migration, poverty, and child labor. It is necessary to identify, raise awareness of, and address these shortcomings in order to preserve these rights.[13,14] The topic of health in child rights is underexplored. This study aims to determine the rights of children who are ill and the level of awareness their companions have regarding these rights. The study concluded that the volunteers accompanying the patients lack sufficient understanding of the patients' rights. The ages of the individuals attending to the patients were found to be rather young. At times, underage caregivers were seen accompanying the patients. The lack of knowledge among caregivers regarding patient rights is attributed to their similarity in age to the sick children.[15] When questioned about patient rights, participants indicated that they believed they were being treated favorably. This finding is similar to the research conducted by Eksen and Karadağ[11] which concluded that adult patients have the right to receive considerate, friendly, and compassionate health services. The majority of participants in the study were mothers of ill children. Mothers of unwell children have lower educational attainment. Participants' lack of knowledge about patient rights for unwell children is due to their poor education.

Conducting a thorough anamnesis is the crucial first step in patient assessment and plays a fundamental role in diagnosis and treatment.[16] The anamnesis process begins with the doctor introducing themselves in a way that ensures patient confidentiality. The process begins with open-ended inquiries within a framework of mutual trust. According to our survey, most participants are unaware of the name of the doctor in charge of their care. The survey also revealed that participants receive daily information from their doctor.[16] The majority of those who receive daily information from their doctor are either illiterate or have only completed primary school. Most patient companions are knowledgeable about alternative treatments for managing their patients. This case supports the idea that the most important aspect of patient rights is the provision of information.[16] The participants in the study reported that they received an adequate amount of information from their patients' doctors. During the decision-making process regarding treatments and alternative therapies, it was observed that 67% of participants entrusted the responsibility entirely to their attending doctor and did not exercise their right to participate in the treatment process. The participants stated that a separate room for conducting patient interviews and examinations is unnecessary while still considering patient privacy. This instance illustrates the lack of information among participants regarding patient privacy.

The perspectives of participants on essential children's rights revealed that patient companions prefer to stay in wards with six individuals.[16,17] Patients' partners with a high school education or lower

were noted to prefer wards more frequently. Additionally, patient companions living in households with five or more individuals show a greater preference for wards. When asked, they clarified that they do not feel bored in crowded spaces. Instead, they enjoy meeting new people, forming lasting connections, and providing mutual support in various situations. The situation was attributed to the sick companions' limited social circle, distance from relatives, and experience of loneliness.[18-20]

One of the participants' findings is that patients have limited access to education while in the hospital. In our study, 71% of participants have an educational level at or below secondary school. Of the patients accompanied by them, 25 individuals (25%) are able to continue their education, while 42 individuals (42%) have no opportunity to make up for interrupted education due to hospitalization. Additionally, 33 individuals (33%) believe that their patient's education has been negatively impacted but can still be recovered. It is important to increase the rate at which patients can continue their education and to improve the educational level of caregivers.[21]

Currently, there are no play areas for children in hospitals and inpatient facilities in our country. The existing playfields were developed through collaborative efforts between individuals and the hospital. Playing is a fundamental right for children, and play therapy is crucial in treating some illnesses. Most participants reported that the hospital does not provide play areas equipped with age-appropriate toys for children's growth and meeting hygienic standards. Most participants reported that the hospital does not provide play areas equipped with age-appropriate toys for children's growth and meeting hygienic standards. Most participants reported that the hospital does not provide play areas equipped with age-appropriate toys for children's growth and meeting hygienic standards. It is recommended that hospitals offer such facilities to promote children's well-being.

Conclusion

The study recommends that hospitals implement short-term, middle-term, and long-term strategies and techniques in their patient companion activities. Further investigations are necessary to support this premise. Ambiguity about treatments provided to unwell children in hospital inpatient services may cause caregivers to develop prejudices, which could adversely impact the medical care of the ill youngster. When parents accompany their sick children to hospitals, it is recommended to provide them with comprehensive information about the medical procedures that will be performed by healthcare professionals. Additionally, involving parents more extensively in the process can be beneficial.

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