Regional Workshop to Improve Inpatient Hospital Care of Children in South-East Asia

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Regional Workshop to Improve Inpatient Hospital Care of Children in South-East Asia

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Contents

1. Background

The Integrated Management of Childhood Illness (IMCI) strategy seeks to strengthen prevention and care for children through appropriate community and household care, primary care and care at the first-level hospital. It has been estimated that about 10%-20% of sick children presenting for primary care, i.e. the most severely ill, may require referral to a first referral or district hospital. It is also well known that families often take very sick children directly to referral facilities. This leads to underutilization of infrastructure at the primary health care level, built at great cost to the national exchequer. Severely ill children brought to hospitals often die as the severity of their illness is not recognized in time or the capacity to manage these emergencies is limited.

The quality of care provided in these hospitals is likely, therefore, to have a major impact on the health and lives of millions of children each year. Unfortunately, there is good evidence that hospital care is often deficient in many countries. A study of 21 hospitals across seven countries in Asia and Africa, including Indonesia and Timor-Leste from the WHO South-East Asia Region, showed that more than half of the children were under-treated, or inappropriately treated with antibiotics, fluids, feeding or oxygen. Lack of triage and inadequate assessment; late treatment; inadequate drug supplies; inappropriate nutritional practices; and lack of community, household and round-the-clock care were identified as major deficiencies.

There is now substantial global experience of strategies and interventions that improve the quality of care for children in hospitals with limited resources. Child and Adolescent Health Department at WHO/HQ has developed a toolkit containing adaptable instruments, including a framework for quality improvement, evidence-based clinical guidelines in the form of the Pocketbook of Hospital Care for Children, teaching materials, assessment and mortality audit tools. These tools have been field-tested by doctors, nurses and other child health workers in many developing countries.

The WHO Regional Office for South-East Asia (SEA) organized the workshop to enable SEA Region Member countries to introduce a process of quality assurance to improve in-patient care for children with severe diseases. It may be pertinent to note that one of the recommendations of the SEA Region Child Health Programme Managers Meeting held in December 2007 was to build national capacity for improving hospital care of children.

2. Opening session

The meeting was opened by Dr Duangvadee Sungkhobol, WHO Representative to Bangladesh. She read out the message of Dr Samlee Plianbangchang, Regional Director, WHO SEA Region. In his message, the Regional Director mentioned that in spite of good progress made in reducing under-five mortality, the South-East Asia Region still accounts for about three million deaths annually. About 10%–15% of sick children have conditions that necessitate hospital care. Improving the quality of care for children in hospitals would not only improve hospital utilization rates but also contribute to country efforts at reducing child mortality. WHO has developed tools that can help countries set hospital standards for child care and conduct assessments of hospitals. He was confident that the workshop deliberations would assist the development of a Regional Framework for Improving Hospital Care for Children in South-East Asia.

Prof. M.A. Faiz, Director-General of Health Services, Ministry of Health, Bangladesh, and Dr S.M. Asib Nasim, Health Manager, Health and Nutrition Section, United Nations Children's Fund, Bangladesh, addressed the gathering.

The workshop was formally inaugurated by Mr A.K. Zafar Ullah Khan, Secretary for Health, Government of Bangladesh. In his inaugural address, Mr Khan highlighted the achievements made by Bangladesh in reducing infant and child mortality. He pointed out the success of programmes such as the control of diarrhoeal diseases and acute respiratory infections, Integrated Management of Childhood Illness, immunization and vitamin A prophylaxis as major factors contributing to reduce child mortality in Bangladesh. He also mentioned that improvement in social determinants such as education and empowerment of women and improvements in communication have also contributed to the success. He congratulated

WHO for organizing the workshop in Bangladesh and hoped it would assist SEA Member States to further improve child health services. He wished the workshop participants all success in their deliberations.

Participants of the workshop included representatives from Bangladesh, Bhutan, India, Indonesia, Maldives, Nepal, Sri Lanka, Thailand and Timor-Leste. Representatives from DPR Korea and Myanmar were not able to participate. Partner organizations, viz. UNICEF Bangladesh, International Paediatric Association and International Centre for Diarrhoeal Diseases and Research, Bangladesh (ICDDR,B) also participated. WHO staff from headquarters, Country Offices of Indonesia and Nepal and from the Regional Office attended the Workshop (see list of participants at Annex 1).

The workshop employed different methods for achieving the objectives. These included plenary presentations followed by group discussions, group work, and poster presentations followed by group discussions. A mock marketplace was held to introduce available tools and guidelines for supporting countries to implement improvements in hospital care (see workshop agenda at Annex 2).

Dr R.N. Salhan, Additional Director-General, Directorate-General of Health Services, India, and Prof. Ruhul Amin, Professor of Paediatrics, Bangladesh Institute of Child Health, Dhaka Shishu Hospital, and Secretary-General, Bangladesh Paediatrics Association, were nominated as Chairperson and Co-Chairperson respectively. Dr Yasho Vardhan Pradhan, Director, Child Health Division, Department of Health Services, Nepal, was nominated as Rapporteur.

3. Objectives

The general objective of the workshop was to assist SEA Region Member countries to improve quality of inpatient care provided to children in hospitals.

The specific objectives were to:

(1) Review experiences for quality improvement of inpatient care of children in SEA Region countries.

(2) Familiarize participants to the methodology and tools for improving quality of patient care of children.

(3) agree on a draft regional framework for improving quality of inpatient hospital care of children.

(4) Develop country-specific roadmaps for improving inpatient hospital care of children.

4. Global experience in hospital care of children in resource limited settings

The global experience from studies in seven countries on quality of hospital care in less developed countries was presented and discussed. This study revealed deficiencies in the following aspects of child care:

(1) Absence of triage and emergency treatment.

(2) Poor organization of emergency services.

(3) Initial in-patient assessment and monitoring.

(4) Adverse factors in case management including inadequate assessment, inappropriate treatment and inadequate monitoring is as high as 76% cases.

(5) Inadequate knowledge of health staff (doctors, nurses, medical assistants) in managing common childhood illnesses.

Global experiences for improving quality of care were discussed. These include improvements in patient flow, triaging, management of emergencies, standards settings, capacity building and so on.

Meeting participants appreciated the work on improving quality of hospital care and emphasized the following points:

(1) The assessment of hospital care must emphasize the need to look at the overall enabling environment for the provision of quality hospital care, which would include: policy and management issues, human resources, coordination, logistics, etc.

(2) There is need to document systematically how technical materials are distributed, whether they are reaching the intended audience and are being used by health workers. Their effectiveness and impact should also be measured.

(3) Medical councils have an important role to play in improving hospital care and should be engaged in the process early in time. They can provide a regulatory framework and also monitor malpractices.

5. Experiences in improving hospital care of children in South-East Asia

Poster presentations provided countries with opportunities for sharing experiences and initiatives taken for improving hospital care in their respective countries. Some of the experiences included the introduction of accreditation system in Indonesia, Sri Lanka and Thailand, the involvement of the paediatric societies and the community at large and the establishment of centres of excellence. Thailand has extended the quality improvement process to include home visits and home care through the "Health Promotion Hospital" (HPH) accreditation system. Another innovation is "Family Bonding Hospital" to strengthen health promotion and child development. Different entry points have been used to introduce improvements in hospital care. For example, reviewing standards for newborn care was an entry point for India; Timor-Leste plans to establish national standards using the WHO pocketbook as a reference. India has established Indian Public Health Standards that include standards for personnel, equipment and infrastructure.

Some of the challenges mentioned for developing and maintaining standards of care mentioned included high turnover of expatriate doctors. This was mentioned particularly by Maldives and Timor-Leste. Access to referral care and the attitude of health workers were also mentioned as important challenges in the way of improving hospital care. The need for achieving synergy between the child health programmes implemented at the field level through the primary health care system and hospitals is an issue in some of the countries. This is because of the structural arrangements in some ministries of health where different units/departments are responsible for hospitals and public health, including

child health programmes. There was a view that coordination between these departments is sub-optimal in some situations.

Hospital improvement will be a complementary intervention that the MoH will be introducing in Bangladesh. To date, interventions for improving care at the first-level health facilities and improving family and community practices have been implemented under the Integrated Management of Childhood Illness Strategy.

The Bangladesh team presented plans for conducting an operations research on improving hospital care. The research will be conducted by the MoH in collaboration with ICDDR,B and WHO/SEARO. The research will be conducted in phases which will include baseline assessment of current practices, adaptation of tools and guidelines, selection of interventions, implementation, and documentation and evaluation. Results from the study will inform a national initiative for improving quality of inpatient care of children in the country in Phase II.

6. Standards for hospital care for children

Day 1 concluded with a presentation on "Standards of Hospital Care for Children and Introduction to the WHO Pocketbook". This presentation introduced the concept of standards in relation to improving hospital care for children and the link to standards in the "Pocketbook of Hospital Care for Children: Guidelines for the management of common illnesses with limited resources". A description of the Pocketbook and its features and contents followed. The section on "cough and difficult breathing" was described in more detail with examples of the illustrations, charts and tables found in the Pocketbook. Finally there was a brief description on uses of the Pocketbook. Key issues raised during the discussion include:

(1) The need to include as annex a section on handling of essential equipment – practical list of what to do in handling common equipment (e.g. what to do when the Nasogastric tube is blocked) and also practical advice on key principles and tips for disinfecting.

(2) The need to respond to the question of "does the existence of tools and guidelines such as the Pocket Book and their application have any impact on improving hospital care"? It was

pointed out that the operational research planned in Bangladesh will help address this and other similar issues.

(3) The need to adopt the Pocketbook to align with local epidemiology and policies was highlighted.

(4) It was pointed out that the Pocketbook does not replace standard paediatric text books but is a clinical aid to manage common childhood illnesses.

7. Hospital assessment

Presentations were made on the hospital improvement process; hospital assessment tool; "collaborative approach"; and "hospital self-assessment processes and tools". Issues raised during the discussions include:

- The focus should not be only on the process of hospital improvement but also on the outcome of interventions. Does the process lead to reduction in mortality? We should build in processes to document this.
- Hospitals need to have standards of care. Setting minimum standards of care as outlined in the WHO Pocketbook will be a good starting point.
- The hospital improvement process should involve stakeholders such as families, caregivers and hospital staff including available staff such as gatekeepers, cleaners, etc.
- The local government must have a role in improving hospital care, especially at the district level.
- Assessment of hospital care should not be seen as a means to "harassment" or censure but as a process for bringing a change.
- Continuous medical education should be strengthened.
- Emergency Triage and Treatment (ETAT), especially for children, needs to be well addressed as a key aspect of improving hospital care.
- Setting standards is an important but challenging step that needs to be well addressed.

- Currently most national strategies and national action plans do not include hospital improvements as component. Hospital improvements will need to be part of the national strategy for child survival.

- The experience from India in setting national standards for public health should serve as an example of what it takes to revise and set standards of care at the different levels of the health system. In India, the Citizens Charter was put in place and the process involved public-private partnership. Participants recommended that such experiences be documented so that the experience can be shared and disseminated widely. The most important aspect of the documentation should include the process used or followed to reach a consensus on setting standards.

The different tools developed by WHO to support countries to introduce and implement improvements in hospital care were introduced through a "Marketplace Session". The tools are:

Marketplace materials for improving hospital care for children
Pocketbook of Hospital Care for Children
Training CD-ROM to be used in conjunction with the Pocketbook of Hospital Care for Children
www.ichrc.org: The evidence behind the Pocketbook
Generic Assessment Tool
Training courses for Emergency Triage Assessment and Treatment (ETAT)
Manual of quality improvement (QI)
Critical care pathways
Mortality audit: Child Healthcare Problem Identification Programme (Child PIP or ChIP)
Hospital Self Assessment Tool
The clinical use of oxygen: Guidelines for appropriate oxygen technology in hospitals with limited resources
Oxygen systems In children's wards: An assessment tool for evaluating systems that use oxygen concentrators and pulse oximeters in hospitals where resources are limited
Patient safety tools: Participants were introduced to the website of the WHO World Alliance for Patient Safety www.who.int/patientsafety/. A sample of resources and tools were displayed including: ➢ Hand Hygiene Implementation Pack including the WHO Guidelines for Hand Hygiene in Health Care, the Clean Care is Safer Care Information Sheets, hand-washing and hand-rub posters and the Five Moments for hand hygiene poster. ➢ 9 Patient Safety Solutions ➢ The draft Surgical Safety Checklist

8. Child mortality audit

A short presentation was given on mortality audits and the experience in countries was reviewed. It was agreed that the current experience was more on maternal mortality rather than child mortality. The need to strengthen child mortality audits was emphasized.

Some country experiences in child mortality audits

- In Bangladesh a project used computer-based neonatal death audit in 17 institutes. Paper forms were found to be a better solution than distribution of computers for mortality auditing as there were problems with the computers getting infected by virus, not being maintained adequately, and inadequate manpower trained to run the computers. Most mortality audit softwares compile data. Software that analyses data would be more useful.
- In Bhutan, one of the only countries in the Region where mortality audit is legally compulsory, village health workers are responsible for auditing community deaths using a form and reporting to the health assistant of the district.
- In Maldives for every death counted, if the death occurs at home, the doctor has to visit the home to collect information.
- According to the experiences in many countries, although deaths are reviewed no action points are made on how to improve identified deficiencies. A suggestion was made that this step should also be included in the software used for child mortality audits.
- In Indonesia, although village health workers receive information about deaths, they would not always take this information to the nurse/midwife.
- It was noted that in some countries such as Sri Lanka the maternal mortality audits are routinely done though perinatal audits are not. At the countdown meeting on tracking progress in maternal newborn and child health held in Cape Town attended by high-level participants, it was stated that we need to look "beyond the numbers" and at modifiable factors related to deaths. Another problem encountered by death reviews in the hospitals is the absence of health personnel during night-time. The reason for death is, therefore, sometimes stated as "found dead" due to lack of documentation and lack of additional information.

9. Paediatric patient safety

While it is agreed that every patient encounter with the health-care system should be free of unintended harm, an unacceptably high rate of largely preventable incidents and medical errors still occur. The potential for unintended harm in hospitalized children is especially high, particularly in the intensive care units and casualty departments. The reasons include a lack of standardized dosing, the inability of young children to provide a medical history or clearly communicate their complaints, and their unique physical and developmental characteristics.

Rates as high as 11 drug-related adverse events per 100 paediatric admissions (22% preventable) and 74 adverse events per 100 neonatal intensive care unit admissions (56% preventable) have been reported in industrialized countries based on focused chart reviews that use "triggers", i.e. occurrences that trigger further investigation to determine the presence or absence of an adverse incident, a method believed to be two to five-fold more sensitive than the traditional unfocused chart reviews.

The vast majority of incidents are attributable to systems failures rather than to negligence or poor performance of individual staff. A blame-free, learning culture is essential to encourage reporting and analysis of incidents and "near misses", as are policies and procedures to follow when things go wrong including support to patients, their families and staff in such situations.

The focus of quality improvement (QI) is "to raise the ceiling so that higher levels of care are achieved" while that of patient safety is "to raise the floor so that fewer patients experience poor levels of care or are harmed". In other words, QI and patient safety aim to do the same thing using different paradigms. As such QI and patient safety should be part of a single, integrated quality framework that uses common structures, processes and tools such as reviews, root cause analysis, mortality audits, the quality improvement cycle (Plan-Do-Check-Act) and information systems. Patient safety standards and indicators can readily be integrated into the draft QI framework for improving hospital care for children.

10. Improving hospital care for children: A framework for action in South-East Asia

The regional framework for action for improving hospital care in South-East Asia was introduced. The framework proposes a systematic health systems-based approach to improve the quality of hospital care for children. Essentially, the steps comprise making a realistic situational analysis by conducting a "hospital assessment" in a sample of hospitals; establishing realistic national standards based upon the results of the hospital assessment and comparing them with the WHO standards; defining interventions aimed towards helping hospitals achieve the national standard in a given time frame; establishing quality assurance mechanisms in hospitals; establishing a system of monitoring and evaluation of the process for hospital improvement; and developing and implementing a scale-up plan.

Countries were asked to review the draft framework in small groups. The objective of the group work was to familiarize participants with the content of the framework and solicit feedback for further refinement. The participants made the following observations:

- There was an agreement that the framework should recognize that there is a lack of systematic process in ensuring continuum of appropriate health care across the primary, secondary and tertiary levels of the health system in many countries of the South-East Asia Region.
- The framework should explicitly recommend the setting up of a national body (Steering Committee) in each Member country which should be entrusted with the specific task of improving hospital care for children. The composition of the body would vary according to the country-specific situation. However, it was recommended that the body be headed by a senior administrative authority in the ministries of health.
- The framework should emphasize that the process of improvement of care for children should go beyond the department of paediatrics as the process is dependent upon other aspects of hospital improvement which may be beyond the purview of that department.

- It would be ideal if the framework was to take a holistic view of hospital improvement for children by focusing on maternal, neonatal and child health in an integrated manner.
- The framework should recognize that many countries have their own standards. Wherever these exist, the need for establishing a system for their continuous review should be set up.
- The framework should recommend delegation of funds and administrative responsibilities to the hospital level. This would facilitate the quality improvement process.
- The framework should recommend that hospital accreditation systems, wherever they exist, should include child-care indicators for accreditation purposes. Countries that are yet to establish accreditation mechanisms should ensure that child care is included in a big way in evaluations for accreditation.
- Hospital data in many countries are not included in the child health programmes and MIS systems. Countries should be encouraged to include hospital data in the MIS.
- With a few exceptions, countries of the Region do not have a system of conducting regular mortality audits. Participants recommended that mortality audit should be a strong component of the framework.
- The group recommended that the framework should include a section on retention of staff. For this, financial and non-financial incentives for good performance should be included.
- It was felt that the framework should stress that the quality improvement process is equally applicable to public as well as private hospitals.
- The section on "scaling up" in the framework should be strengthened.
- Editorial suggestions for rewording and reorganizing some of the sections in the draft were made.

11. Monitoring and evaluation

Monitoring and evaluation of progress was identified as an important issue. Indicators for hospital care were presented and discussed.

Monitoring is important for reviewing and evaluating results of hospital improvement activities. Indicators can be selected based on nationally adopted standards of hospital care as found in the WHO Pocketbook. These may include structure, process and outcome indicators. Monitoring can include internal processes (e.g. self assessment with supportive supervision, mortality audits) and external processes (e.g. hospital re-assessment, hospital accreditation). WHO has developed indicators for all standards of hospital care for children but suggests that 14 indicators should be measured. Additionally, there is a global set of nine hospital indicators that should be compiled at the national level to assist in our global efforts for improving hospital care for children. These indicators may be collected through existing health monitoring systems and do not require additional formal surveys.

During the discussion it was mentioned that the global indicators (which are on the WHO website) are to encourage countries to collect the information for these indicators. Ideally, these should be collected from *all* hospitals and not only from those participating in the hospital improvement initiative.

The importance of monitoring in measuring progress and in documenting achievements as well as in helping in advocacy and resource mobilization was also brought forward. It was reiterated that external assessment offers a fresh perspective on old problems and provides new solutions. Monitoring can identify weaknesses and assist in adjusting the plans accordingly.

It was concluded that monitoring and evaluation is important in any kind of programme. When creating roadmaps for hospital care improvements it is important to include monitoring and evaluation in the plans and use indicators to measure the progress.

12. Presentations of country-specific roadmaps

Participants developed country-specific roadmaps for improving hospital care for children. These included the presenting of existing policies and strategies, plans for how to conduct hospital assessment, concrete steps for the coming six months and areas with the need for support from WHO. Highlights of country roadmaps are at Annex 3.

13. Conclusions and recommendations

Based on the discussions during the workshop, participants developed recommendations for Member countries and WHO. These were:

Recommendations for Member States

- Representatives of the Member States who participated in the Regional Hospital Improvement Workshop should disseminate the outcomes and recommendations to the concerned authorities and other stakeholders in their respective countries.
- Member States should immediately consider implementation of the improvement process, starting with the situation analysis (assessment of current quality of hospital care).
- Member States should consider including hospital improvement for children as a component of their proposals to international funding agencies through available channels like the GAVI HSS window and others.
- Where national accreditation programmes already exist, the paediatric inpatient care standards should be harmonized with those in the national hospital accreditation programme.

Recommendations for WHO

- The Draft Regional Framework for Improving Hospital Care for Children was endorsed by the participants. The WHO Regional Office for South-East Asia should finalize the regional framework incorporating the recommendations made by the participants.

- WHO should review existing mortality audit tools and develop an appropriate mortality audit tool for the context of SEA Region Member States.
- WHO to provide technical assistance to member states in improving hospital care for children, e.g. providing assistance to orientation workshops and hospital assessments.
- WHO should consider inclusion of maternal health in hospital improvement in a combined maternal, newborn, child health improvement process.
- WHO should expand the patient safety standards in the Pocketbook.

Annex 1

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Annex 2

Programme

Day/Date/Time	Topic	Responsible persons
Day 1: Saturday, 21 June 2008		
08:30 – 09:00	Registration	
09:00 – 10:30	Inaugural session	
	• Message from Regional Director, WHO/SEARO	Dr D. Sungkhobol, WR
	• Remarks by Health Manager, Health and Nutrition Section, UNICEF	Dr S.M. Asib Nasim
	• Remarks by Special Guest: DGHS, Government of Bangladesh	Prof. M.A. Faiz
	• Inaugural speech by Health Secretary, Government of Bangladesh	Mr Zafarullah Khan
	• Introduction of participants	Dr S. Malhotra
	• Objectives and expected outcomes	Dr S. Malhotra
11:00 – 11:10	Nomination of Chairperson/co-Chairperson and Rapporteur	Dr S. Malhotra
11:10 – 11:30	Quality of Hospital Care in less developed countries: Experiences from 7 countries	Dr Martin Weber
11:30 – 12:30	Experiences from SEA Region countries • Bangladesh • Bhutan • India • Indonesia	Poster session
14:00 – 15:00	Experiences from SEA Region countries (contd…) • Maldives • Nepal • Sri Lanka • Thailand • Timor-Leste	Poster session

Day/Date/Time	Topic	Responsible persons
15:30 – 16:00	Quality Improvement Project – Bangladesh	Dr Shams El Arifeen
16:00 – 17:00	The concept of standards: Introduction to the Pocketbook	Dr Carolyn Maclennan
19:30	Reception	
Day 2: Sunday, 22 June 2008		
09:00 – 09:30	The Quality improvement Process	Dr S. Carai
09:30 – 10:00	Hospital assessment	Dr Carolyn Maclennan
10:00 – 10:30	The collaborative approach	Dr Martin Weber
11:00 – 12:30	Selected tools for quality improvement • Manual for quality improvement • The assessment tool • CD ROM: Training resource for management of common illnesses with limited resources • Emergency Triage Assessment and Treatment • Critical care pathways • Hand Hygiene Implementation Pack • Patient safety solutions • Surgical safety checklist	Market Place
14:00 – 15:30	Selected tools for quality improvement …. contd. • ICHRC website • Manual for the clinical use of oxygen • Oxygen systems in children's wards: An assessment tool	Marketplace
16:00 – 16:30	Mortality audit tool	Dr Martin Weber
16:30 – 17:00	Self-assessment tool	Dr S. Carai
Day 3: Monday, 23 Jun 2008		
08:30 – 09:00	Paediatric patient safety	Dr Doris Mugrditchian
09:00 – 10:00	Draft framework on improving hospital care for children in South-East Asia	Dr S. Malhotra

Day/Date/Time	Topic	Responsible persons
10:00 – 10:30	Introduction to Group Work 1: Regional framework	Dr S. Malhotra
11:00 – 12:30	Group Work 1: Regional Framework	
14:00 – 15:30	Feedback from groups	
16: 00 – 16:15	Group Work 2: Developing country roadmaps - Introduction	Dr Emdad Hoque
16:15 – 17:30	Group Work 2: Develop country roadmaps	
Day 4: Tuesday, 24 Jun 2008		
09:00 – 09:30	Monitoring and evaluation	Dr Carolyn Maclennan
09:30 – 10:30	Group Work 2: Develop country roadmaps (contd… from day 3)	
11:00 – 13:00	Feedback from countries on roadmaps	
14:00 – 15:30	The way forward: Conclusions and Recommendations	
15:30 –	Closing session	

Annex 3

Roadmaps

Bangladesh

Policy:

- Establish a National Steering Committee
- Develop a national policy and strategy for the new initiative

Hospital Assessment Exercise:

- Set standards
- Adapt them
- Field test them
- Finalize the tools
- Conduct the assessment
- Reporting and further action

Standards:

- No standards in place

Next steps 6 months:

- Conduct hospital assessment in 6 district hospital and 12 sub-district hospitals

Support:

- Technical: WHO
- Financial: WHO, UNICEF

Bhutan

Policy:

- Propose to MoH to develop policy and strategy

Hospital assessments

- Establish a multi disciplinary team: policy makers, medical director, nurse superintendent, pediatrician, neonatologists, nurses, lab and radiology, patient suggestion box
- Identify target hospitals based on a set of criteria
- Adapt WHO tools to local context

Standards:

- Paediatric standards in place (Pocketbook is used, but only two copies available)
- None for general practitioners
- Nursing standards in place and reviewed annually

Next 6 months:

- Report back to MoH on recommendations from this workshop to plan further

Request for WHO support:

- Facilitate national workshop/orientation in Bhutan
- Continued TA in development and implementation of standards

India

Policy and strategy:

- Indian public health standards
- MCH under NRHM

- National Neonatology Forum (NMF) and MoH (child health division) have already accredited 72 maternal and newborn centers

Standards:

- NAHB since Feb 2006
- Hospital Improvement Standards not included

Approval process:

- Child and Health Division within the MoH to consider proposal
- Implementation plan under Directorate HS
- Circulated to States health authorities

Adaptation – managers, physicians (paedriatricians) and nurses training

Standards:

- Yes, available up to level II - to be updated from level III

Next 6 months:

Get the ball rolling

- Prepare to a proposal to submit to Child Health Division (within 1 mo)

WHO support:

- Operational research
- TA

Indonesia

Report back to supervisors, i.e. DG Medical Care and DG Community Health

- Create a small group: DGs + KARS (accreditation body) + professional associations (paediatricians and obstetricians-gynecologists)
- Review existing policy
- Develop strategy
- Finalise the adaptation and print copies of the Pocket Book (adaptation process started in 2006)
- Disseminate Pocket Book and other tools
- Field test hospital assessment
  - Select hospitals (a suggested 50 hospitals)
  - Select and train assessors
  - Workshop to disseminate results

<u>Support from WHO</u> (and other partners, e.g. UNICEF, UNFPA): funding, TA, benchmarking

- Timetable produced

Maldives

- Hospital improvement committee already in place in Male
- Introduce accreditation process (already in national plans)

Hospital assessment:

- Form committee (MoH, PH dept, doctors and nurses, council
- Train assessors

Standards:

- Already have standards but need to be updated

Ensure sustainability considering high turnover of staff (due to many expatriate doctors)

WHO support:

- Training
- TOT

Nepal

Existing standards and guidelines need to be updated and incorporated into plans

Country orientation for policy makers and other stakeholders should be conducted

Plans for creating a national task force

Members of the task force: chief specialist, CHD, hospital directors, Medical and Nursing Councils, association of paediatricians, hospital staff and WHO

Assessment:

- Using adapted WHO tools
- Assessment teams to include: MoH and Hospital staff

Standards:

- Not for all conditions
- Essential newborn package to be implemented

Next 6 months:

- Director child health with support from Paediatric Association
- Country orientation
- Form national team
- Adapt guidelines and tools
- Select hospitals

WHO support:

- Training
- Establishing of guidelines
- Mortality audit
- Infection control – HH guidelines
- Monitoring and evaluation

Sri Lanka

National hospital assurance programme underway

Hospital assessment:

- Select hospitals – nine provinces
- Find money for baseline
- Define minimum standards
- Identify deficiencies and correct them

Standards:

- Exist for essential and emergency illnesses in children
- Exist for infrastructure

Next steps:

- Report to DGHS and College of Paediatricians
- Introduce the Pocketbook in a national workshop (WHO) and print a sufficient number (include standards in next editions of national guidelines)
- Conduct baseline survey
- Identify deficiencies
- Plan to correct deficiencies

WHO support:

- Conduct national workshop to orient
- Other

Thailand

Policy for policy improvement and accreditation – mandatory in public sector hospitals

HA responsible for accreditation

Hospital improvement team

Internal survey team

Assessment

Standards exist from Royal College of Pædiatricians which are adapted in different hospitals

Next 6 months:

- Monitor HA process
- Revisit existing tools
- New quality tools: clinical tracers, baby friendly hospital to other hospitals, trigger chart reviews etc.
- Introduce Pocketbook in Thai for pre-service training and incoming house officers

Timor Leste

Policy:

Policy to reach MDG4

Hospital assessment:

- One referral hospital and five regional hospitals
- Hospital Improvement Team should include MoH, hospital administrator, paediatricians, obstetricians, expatriate (Cuban)

doctors - to build local ownership and not to be perceived as one more WHO project

- Translate Pocket Book into Bahasa and Portuguese – will help to standardize practice
- National Case Management guidelines for all services being updated (last edition in 2004)

Next six months (start Jul/Aug):

- Workshop/orientation
- Print and disseminate Pocketbook
- Refresher training in Essential Newborn Care

WHO support:

- Advocacy MoH
- TA for workshop, assessment and training

About 10%–15% per cent of children who seek medical care at primary level facilities need referral care at higher facilities. Anecdotal evidence and experience suggests that sick children are either not taken to nearby hospitals or taken to tertiary care facilities straightaway. One of the reasons for this is the lack of or poor quality of child care in small peripheral hospitals. Participants of the Regional Workshop to Improve Inpatient Hospital Care of Children in South-East Asia, held in Dhaka, Bangladesh, from 21 to 24 June 2008, examined various aspects related to the care of children in hospitals and reached an agreement on a framework of action to improve the quality of hospital care for children.

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