Report on the
South-East Asia Regional Meeting on
Improving Quality of Care for Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH)

New Delhi, India
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Acronyms

MDG     Millennium Development Goal
NGO     nongovernmental organization
NRHM    National Rural Health Mission
QI      quality improvement
RMNCAH  Reproductive, Maternal, Newborn, Child and Adolescent Health
SARA    Service Availability and Readiness Assessment
UN      United Nations
UNFPA   United Nations Population Fund
WHO     World Health Organization
YFHS    youth-friendly health services
Executive summary

Global efforts to reach Millennium Development Goals (MDGs) 4 and 5 have focused on reaching higher coverage with key health interventions. However, the promoted interventions are often delivered with insufficient quality, particularly for hospital care. Lack of progress to achieve MDGs 4 and 5 and low utilization of health care might be partially attributed to the poor quality of services provided. Universal coverage for health will not result in improved outcomes if the quality of interventions is insufficient.

In several recent meetings held in Member States of the South-East Asia Region on child, adolescent and maternal health, the national programme managers expressed the need to develop quality improvement (QI) systems across reproductive, maternal, newborn, child and adolescent health (RMNCAH) standard guidelines and assessment tools. Additionally the World Health Organization (WHO) Regional Office for South-East Asia was requested to provide technical support and guidance on QI across the RMNCAH continuum.

The timing of this South-East Asia Regional meeting matches the advocacy for concerted efforts to accelerate progress towards achievement of MDGs 4 and 5. The meeting provided an opportunity to review the experiences in improving the quality of health care for mothers, newborns, children and adolescents in Member States, and share the available methodologies and tools for improving quality of care. Additionally, it aimed to develop a consensus on the structured framework and assessment tools to establish a QI process with which the Member States could achieve the global standards of RMNCAH care in the Region.

Deliberations and discussions over 3 days presented principles of QI and experiences from countries. Materials were shared between participants. Progress was made in the review of a draft regional framework and an assessment tool across the continuum of care. Partners from within the United Nations (UN) and outside were engaged and supportive. It was acknowledged that quality of care along the life course continuum and across various levels of the health care delivery system is crucial, in addition to scaling up the coverage of life-saving evidence-based interventions. There was a consensus that a collaborative and integrated approach of QI for RMNCAH services would be advantageous compared with a component-wise or vertical approach. Participants endorsed that the regional QI framework and the integrated assessment tool are relevant and applicable in Member States, and that they are feasible to implement following suggested revisions. Suggestions and inputs were provided to further hone and sharpen the regional framework and the assessment tool. The meeting provided participants with an opportunity to interact with each other and learn from experiences of Member States.
Background

Global efforts to reach MDGs 4 and 5, reducing under-5 mortality and maternal mortality rates by two-thirds and three-quarters respectively between 1990 and 2015 (1), have focused on reaching higher coverage with key health interventions (2, 3). Unfortunately there is evidence that the promoted interventions are often delivered with insufficient quality (4), which is particularly true for hospital care. A number of studies over the past years have documented the poor quality of hospital care provided to neonates and children, and more recently they have highlighted severe deficiencies of maternal health care for both routine and emergency services (5, 6, 7, 8). Lack of progress to achieve MDGs 4 and 5 as well as low utilization of health care can be partially attributed to the poor quality of services provided. Universal coverage for health as promoted by WHO will not result in improved outcomes if the quality of interventions is insufficient. It may not only be detrimental and harmful to the individual seeking care, but may also impact future health-seeking behaviours of the community (9). Therefore, it is mandatory to reach universal coverage with QIs that meet appropriate standards of care.

The UN Strategy – Every Woman, Every Child – provides the necessary global thrust towards improving the coverage as well as ensuring quality of maternal, newborn and child health services to accelerate progress towards MDGs 4 and 5. Additionally, the UN Commission for Information and Accountability reiterates the need to ensure quality of care as an essential parameter. Quality of care has been embedded in the recently developed global frameworks, such as Call to Action – Committing to Child Survival: A Promise Renewed; Global Action Plan for Pneumonia and Diarrhoea (GAPPD); Every Newborn: an action plan to end preventable deaths (ENAP).

In recent meetings on child and adolescent health, as well as maternal health, in Member States of the South-East Asia Region, the national programme managers expressed a need to develop QI systems across the areas of RMNCAH, with an emphasis on the continuum of care component. This is because care to women, mothers, newborns, children and adolescents is delivered in the same health facilities. In these settings, elements of health systems, in terms of physical infrastructure, human resources, and essential supplies and equipment, are common. All these elements of quality of care need to be assessed and improved through integrated approaches. With this as a focus, a series of consultative meetings was convened through the Member States as well as partners to develop a framework for QI across the RMNCAH continuum of care as well as the standard guidelines and assessment tools. Additionally the Regional Office was requested to provide technical support and guidance on QI across the RMNCAH continuum.

The timing of this South-East Asia Regional meeting matches the advocacy for concerted efforts to accelerate progress towards achievement of MDGs 4 and 5. The meeting provided an opportunity to review the experiences in improving the quality of health care for mothers, newborns, children and adolescents in Member States and share the available methodologies and tools for improving quality of care. Additionally, it aimed to develop a consensus on the structured framework and assessment tools to establish a QI process with which the Member States could achieve the global standards of RMNCAH care in the Region.
Opening session

4.1 Welcome and remarks

Dr Sangay Thinley, Director, Department of Family Health and Research, welcomed the participants. He recognized the considerable efforts made at country, regional and global levels to achieve MDGs 4 and 5. He noted that countries, especially in the South-East Asia Region, are making progress, and several interventions for adolescent and child health are currently being scaled up. However, there is a need to improve quality of care while simultaneously scaling up interventions to achieve MDG 4 and 5 targets. The Regional Office convened this meeting to bring together partners from all Member States to deliberate on possible ways to improve the quality of care. Dr Thinley mentioned that the participants in the meeting came from all 11 Member States of the Region, with representation from not only country WHO offices, but also from nongovernmental organizations (NGOs), sister UN agencies, WHO Collaborating Centres and experts in the field. He hoped that at the end of the deliberations, the participants would be able to develop a good framework for the improvement of quality of care.

4.2 Message from the Regional Director

Dr Monir Islam, acting Regional Director and Director Department of Health Systems Development, WHO Regional Office for South-East Asia, read out the inaugural message from the Regional Director Dr Samlee Plianbangchang who acknowledged the progress made in the Region in reducing child and maternal mortality in the last two decades as well as significant improvements made in reproductive health outcomes. However, he noted that available evidence suggests that effective life-saving interventions are often of poor quality, particularly in the case of hospital care. He reiterated that poor quality is partially responsible for low utilization of health-care services by the population in some Member States, leading to inadequate progress towards achieving MDGs 4 and 5. Member States have identified poor quality of care as a predominant threat for RMNCAH at recent regional meetings of national programme managers of child, maternal and reproductive health. Dr Samlee Plianbangchang reiterated that the deliberations of the Regional meeting would be effective in sharing experiences, cross-learning and inspiration to achieve the set goals in improving the quality of health care for mothers, newborns, children and adolescents among the Member States through the development of a Regional framework and country-specific action plans for improving quality of care for RMNCAH.

4.3 Introduction of participants

Dr Neena Raina, Regional Advisor, Child and Adolescent Health, WHO Regional Office for South-East Asia, welcomed the participants. The meeting brought together multiple stakeholders including national programme managers from ministries of health, representatives from professional bodies, NGOs, UN and Development Partners, and staff members from WHO Headquarters, WHO South-East Asia Regional Office and Member States. Participants of the meeting included representatives from all 11 Regional Member States including Bangladesh, Bhutan, Democratic People’s Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste (the list of participants is given in Annex 2).
4.4 Goal

The goal of the meeting was to improve the quality of health care for all mothers, newborns, children and adolescents by identifying and addressing the key areas for improvement and bottlenecks that hinder provision of care with appropriate quality at various levels.

4.5 Objectives

The objectives of the meeting were:

• to review experiences with QI of health care for mothers, newborns, children and adolescents in countries of the South-East Asia Region
• to share available methodologies and tools for improving quality of health care
• to agree on a draft regional framework for improving the quality of health care
• to develop country-specific action plans for improving the quality of health care
• to embark on a collaborative QI process in the region to achieve the international standards of care in countries of the South-East Asia Region.

4.6 Expected outcomes

The expected outcomes of the meeting were:

• a summary of experiences with QI of health care in countries of the South-East Asia Region
• a summary of available methodologies and tools
• a draft regional framework for improving quality of health care
• country-specific action plans for improving quality of health care
• a common understanding of and commitment to embark on a joint collaborative process in South-East Asia.
5. Session 1: Experiences with the improvement of quality of care

5.1 Quality of care: background and rationale

Dr Wilson Were, Department of Maternal and Child Health, WHO, provided a “Global overview on improving quality of care”. Dr Were highlighted steps required to prevent newborn and child deaths at prevention levels such as skilled care at birth, postnatal care for all newborns, early initiation of breastfeeding, exclusive breastfeeding for 6 months and immunization. At treatment level neonatal resuscitation, extra care for low birth weight babies and treatment of neonatal infections are included. Family planning, safe abortion and post-abortion care, antenatal and postnatal care, and skilled care during child birth have prevented maternal deaths. While coverage of care has increased, quality of care continues to remain poor resulting in significant morbidity and mortality; in particular, care provided in referral facilities is poor.

Several WHO standard of care guidelines, protocols and tools for provision of health-care services and improving available practice of care have been adapted by Member States. Some Member States have undertaken assessments and developed QI plans. Supportive job tools have been developed, and capacity-building initiatives and mentoring and supportive supervision have been undertaken.

Dr Vineet Sharma, Regional Advisor, Reproductive Health and Reproductive Health Commodity Security, United Nations Population Fund (UNFPA) presented “Quality improvement in family planning services”. Maternal mortality could be reduced by preventing unwanted, unintended and mistimed pregnancies. Family planning can provide answers to many problems in reproductive health. Today there is an increased focus on creating an enabling environment for availability of good-quality and rights-based family planning services. Essential components for QI in provision of reproductive health services include programme efficiency, effectiveness, client satisfaction and utilization. A competent provider should have regular supplies, equipment and medication, along with informed decision through client–provider interaction and counselling for choice of methods, which are important elements of quality of care. Monitoring and supportive supervision are important as much as linkages to other reproductive health services and continuity of care and follow up.

“Quality improvement in child and adolescent health and maternal and reproductive health” was co-presented by Dr Rajesh Mehta, Medical Officer, Child and Adolescent Health, WHO Regional Office for South-East Asia, and Dr Martin Weber, Regional Advisor Maternal and Reproductive Health, WHO Regional Office for South-East Asia. The presentation highlighted the importance of formulating indicators at both impact and coverage levels to ensure provision of quality of care to the patients. To ensure provision of good quality of care, it was suggested that one needs to look at demand, service provision and availability of adequate infrastructure. There is a need to move beyond guidelines to bring about a change in practice. The need to provide adolescent-friendly health services was highlighted and the standards as developed by WHO were shared with the participants. These included awareness among adolescents about health and where to seek services when needed, community awareness about the value of providing health services to adolescents, provision of acceptable services by providers and support staff,
health facilities to provide the required package of health information, and counselling in a health facility or community, or through outreach workers. At the health facility level, there is a need to ensure availability of supplies, equipment, medicines and technology, and assess quality of service provision and use the data to improve the quality of services.

**Discussion and issues raised**

Participants highlighted the need to make actual linkages between initiatives undertaken to formulate the quality of care indicators and larger initiatives such as MDGs. A need was expressed to improve processes and integrate the quality of care improvement into the existing planning cycle, budget and actual allocation of resources required for undertaking these tasks. It was suggested that these indicators be linked with human resource management indicators since there are human beings involved in the process, including the person who is collecting the data. There is a need to increase awareness of both the people who will collect the quality of care data and those who will use the findings to improve quality of care. Acknowledging that indicators cannot be generalized within a region because of country-specific differences and in-country differences, it was proposed to nationally and regionally adapt available global indicators as per the applicability and feasibility in the particular country. It was suggested that one needs to be clear on what is one looking for: is it to improve the existing quality of care from average to good to best, or to also improve the quality at facilities that are practically non-functional or really bad and bring them up to at least average level? One needs to focus on accountability and look at who are the drivers of change as well as involve civil society organizations, community organizations and people who actually use the services. It was proposed to add global indicators for adolescent health, which are currently missing in the processes.

**5.2 Member State initiatives**

Bangladesh, India, Indonesia and Nepal shared their experiences with country-level initiatives on processes undertaken to improve and ensure quality of care.

**Bangladesh** summarized the results of the “Assessment of quality coverage of youth-friendly health services (YFHS) in Bangladesh”. In 2005, through a consultative process, Bangladesh established 10 national standards for YFHS to improve quality of care. The assessment aimed at understanding the quality of YFHS services in relation to the 10 standards and assessing the coverage of health services and their quality in terms of acceptability, availability and utilization. Based on a scoring system developed by WHO, data were collected from 44 intervention sites and 44 control sites for the quality assessment, and a total of 1372 male and female adolescents were interviewed for the coverage assessment. The findings showed mixed results: YFHS facilities are doing better than the comparison facilities as measured against three national standards, namely: young people are dealt with in an equitable manner irrespective of their status, privacy and confidentiality are assured, and data are collected and used to improve services. YFHS facilities perform equally as well as the comparison facilities for the remaining seven national standards, namely: involving gatekeepers to promote and support YFHS, young people's awareness of these services, young people are comfortable with the surroundings, young people are provided services respectfully, service providers are motivated, and services are provided effectively to all young people. Subsequently, implementation guidelines have been developed to operationalize the national standards more effectively so as to improve overall quality as well as the coverage of YFHS.
India presented “Accelerating progress under RMNCH + Adolescent (RMNCH + A) – generating evidence monitoring quality improving coverage”. The presentation reflected on India’s contribution to the global burden on a range of variables including total population (17.8%), childbirth (20%), newborn deaths (28%), under-5 deaths (22%), maternal deaths (19%) and extremely poor population (33%). India has made significant progress in recent years resulting from a supportive policy environment that ensures continued growth. For example, the National Rural Health Mission (NRHM) brought focus to expanding health-care provision as well as ensuring availability of appropriate resources for making it happen. Under the NRHM a series of initiatives has been undertaken including: RMNCH + A, which provides a strategic framework for Call to Action for child survival; Janani Shishu Suraksha Karyakram, which provides free care entitlement for pregnant women and infants; and Rashtriya Bal Swasthya Karyakram, which looks at steps beyond survival. However, despite this, progress in the country has not been uniform across the states. Available evidence suggests that issues around differences among states, gender inequities and rural–urban differences need to be addressed. Within the Indian context, quality of care is driven by programme guidelines and standards related to infrastructure and commodities, human resources, competencies, translation of skills into practice, and accountability and commitment. India’s 12th 5-Plan includes ensuring strong regulatory systems to monitor quality of service delivery both in the government and the private sector. There are gaps in several components of quality of care that need to be addressed for which a framework is being developed under the NRHM, and standards and protocols have been defined and put in place for different levels of facility. The way ahead includes identifying and defining key programme indicators, developing steps and standard operating procedures for each high-impact intervention in each life stage, focusing on improving effective coverage, and providing supportive supervision and onsite monitoring.

Indonesia presented the results of the “Assessment of the quality of care for mothers and newborns in health facilities in Indonesia”. Indonesia has seen an increase in skilled birth attendance from 41% in 1992 to 82% in 2010. However, maternal and infant mortality continues to remain high and evidence from small-scale studies indicates that the quality of care continues to pose a challenge. This assessment, using WHO tools adapted to Indonesian standards, was undertaken to understand the reasons for continuing high maternal mortality rates despite 90% of antenatal care being provided by health professionals and high coverage in skilled birth attendance. The tool used was problem oriented (assess all main areas), action oriented (identify areas most in need of improvement) and participatory (involving health professionals and users of services in the assessment) in nature. The aim of the tool was to gather information on quality of maternal and neonatal care provided at facility level and to identify key areas of pregnancy, childbirth and newborn care that need urgent attention for improvement. Findings give an insight into the quality of maternal and neonatal care at the national level and provide an indication about areas that need improvement. The conclusions were: in order to improve quality of care, there is a need to put in place standards and guidelines, and develop assessment tools and indicators, and have a strategy that provides motivation, professional development and incentives, and encourages different stakeholders to be part of the process, including the Ministry of Health, NGOs and international agencies. High coverage by skilled birth attendants will have an impact only when the attendants follow the basic procedures and can perform lifesaving procedures and refer when needed.

Nepal presented results from an “Assessment of quality of paediatric care in referral hospitals in Nepal”. Nepal has in place the Integrated Management of Childhood Illness strategy and
the Community Based Newborn Care Programme that aim to reduce neonatal and childhood morbidity and mortality. While different levels of care have been developed and a referral system approach has been adapted, with regional, subregional and central hospitals designated as referral centres, the capacity of these hospitals to provide quality paediatric care was not known. The study assessed the quality of paediatric services at referral hospitals and specifically the consistency of diagnosis and treatment of common paediatric conditions. It assessed the availability of human resources and their skills in paediatric care, and assessed the capacity of the hospital to support systems such as laboratory, statistics and pharmacy. The tool was adapted from the WHO generic tool for the assessment of the quality of care for children. Findings highlighted challenges faced in service delivery due to the lack of an adequate and well-maintained infrastructure, and inadequate manpower, equipment and supplies. Record keeping was found to be poor, hand hygiene was often not practised and treatment protocols were often nonexistent. Key recommendations included: regular supervision, provision and maintenance of equipment and supplies; provision of standard treatment protocols and job aids; and regular training of hospital staff at all levels. It was also proposed that this process should be taken to the lower levels and the so-called generic tool should be used for self-assessment in paediatric facilities.

**Discussion and issues raised**

The participants reiterated the need to identify steps needed to make YFHS interventions better. A major challenge identified was the absence of indicators for adolescents within global indicators. Fortunately, countries in the Region have adopted a standards-based approach for adolescent/youth friendly health services that makes it easily amenable to measurement of quality. It was pointed out that abortion significantly contributes to maternal morbidity and mortality, and that the QI process should also include abortion services. There was a consensus that the QI process should include all components of health care including infrastructure, manpower, equipment and supplies, and practise of standard treatment protocols as well as client satisfaction. Recognizing the important role played by private facilities in health-care provision, the participants felt that these should be included in framework and tools for assessment. Participants also expressed a need to ensure training as well as refresher training for midwifery services, including use of partographs to prevent morbidity and mortality.

5.3 **Situation in and experiences from Member States: poster session**

The sharing of experiences in promoting the improvement of quality of care was one of the most important objectives of the meeting. During a poster session, participants were invited to present posters summarizing experiences of the improvement of care for newborns, children, adolescents and mothers. There were 16 poster presentations; for more details, see the abstracts of the posters in Annex 3.

**Messages from the posters**

Posters presented a wide range of experiences around maternal, newborn and child health care. Maternal and newborn care experiences were assessed and shared by Bangladesh, India, Indonesia and Myanmar, and experiences around neonatal training to reduce infant mortality came from India and Thailand. Posters highlighted interventions that included strengthening
existing facilities and capacity development in service delivery and QI, including interventions for neonatal care and undertaking assessment of the quality of services provided. Lessons learnt included the need to develop national-level strategies, frameworks and comprehensive action plans, and a core set of indicators. Indonesia and Nepal shared their experiences in providing hospital care for children, highlighting the need for regular supervision, the need to ensure adequate supply of drugs and equipment, and availability of standards and protocols, including job aids. Focus on adolescent-friendly services came from Maldives, Sri Lanka and Thailand and they talked about the need to provide adolescent-friendly counselling and clinical services, including family planning services. A capacity-building approach focused on life skills education, peer education and mentoring programmes. Lessons learnt included the need to integrate youth-friendly services within the existing health system, to ensure that it is a permanent service delivery point and to adapt existing checklists to the country-specific context.

Overall, there were a number of experiences in all areas presented, and these can be drawn upon when implementing a more comprehensive framework and from which Member States can learn. Abstracts of the posters showing experiences of Member States are given in Annex 3.
6. Session 2: The Regional framework for improving quality of health care

6.1 Draft framework for improving quality of care for RMNCAH in South-East Asia

A draft regional framework was presented by Dr Susanne Carai. The Regional framework proposes a QI system that extends across the maternal, neonatal, child and adolescent health continuum and all levels of care, and aims at achieving so-called effective coverage, defined as high and equitable coverage with quality care. Continuum of care includes the dimension of time in the life course (before pregnancy, during pregnancy, birth, newborn, childhood and adolescence), and the dimension of level in the health system (community, first-level health facility and hospital).

The framework’s vision is to ensure universal access to quality care for every mother, newborn, child and adolescent at all levels of care. Its overarching goal is to improve the quality of health care for every mother, newborn, child and adolescent by identifying and addressing key areas for improvement and bottlenecks that hinder provision of quality services.

It envisages six steps for health care, including standards of care, assessment, improvement, continuous monitoring, documentation and celebrating achievements, and finally scaling up and integration into preservice training. Support provided by WHO at the Regional level includes assistance in developing Regional tools and guidelines, assistance in reviewing and updating existing guidelines, and help in agreeing to arrive at a minimum standard of care. Convening collaborative meetings at country level to share experiences and learning from each other will go a long way in ensuring the provision of quality health care services. Similar collaborative meetings at intercountry level will move the process in the Region.

6.2 Group Work 1: The Regional framework and collaborative quality improvement process

Participants reviewed and revised the draft Regional framework during group work. One group looked at “Targets and indicators” and another looked at “Systematic process for implementation”, and one at the Annexes of the document. Outcomes of the group discussions in relation to consistency and relevance of the document, as well as requirement to reach the targets and necessary changes of the framework, were presented.

As a general comment, recognizing that all women’s reproductive health, irrespective of motherhood status, needs attention, participants suggested that the vision of the framework be revised to read as “The vision of the Regional framework is universal access to quality care for every woman, newborn, child and adolescent at all levels of care”. Revision was also proposed in the overarching goal to replace the word mother with the word woman. Other general comments included the need to recognize that health infrastructure is in place, and that trained human resources and required logistics to provide quality care are available. There is a need to ensure that there is an institutional structure of governance in place and a nodal person at
national level and subnational level should be identified. This group should be an autonomous entity, be empowered to undertake the work, and have well-defined terms of reference with responsibilities and accountability. Regional indicators for the framework need to be developed.

**Targets and indicators**

It was suggested that indicators related to reproductive health services, including family planning, sexually transmitted infection, infertility and abortion care, should be included for all three levels of the health system, with a special emphasis on access for adolescents. It was proposed that all indicators mentioned in the health facility level should be included under hospital level, and that a set of indicators be developed to measure service quality and client satisfaction.

**Systematic process for implementation**

The framework should be seen as a companion document to existing QI documents, standards and targets that describe the QI process in detail. It was suggested that self-assessment be given more importance and it should be undertaken regularly and reported. QI teams should be at all levels, such as unit-facility-district-state/subnational-national level, and should also provide technical support for implementation and action. Independent assessors as well as linkages between assessors and the health facility should be clearly defined. The assessment could be started off by a small sample that would include all levels of health facility in the public sector, private sector, teaching institution, corporate sector etc. It was suggested that guidelines need to be developed, revised and updated by the national-level bodies, including guidelines on monitoring: who will monitor, how frequently, how will the finding be shared and implemented in action. Preservice training should include QI components in the curriculum of all relevant health-care providers. In addition an in-service skill and knowledge enhancement programme should be an integral part of the QI programme.

**Annex**

It was noted that the concept of QI needs planning and each step mentioned in the framework needs to be described in detail. Five steps have been proposed, including: setting up a QI team, defining the problem, implementing change, measuring results, and sharing results and spreading change. The frontline workers should not be overburdened with too many targets for improvement. The assessment can be undertaken after assessing the current situation and defining the problem(s), and then identifying the indicator(s) that require(s) improvement. In order to implement this, commitment from the management as well as local staff is essential. Once the problems have been identified and prioritized, a coordinating team needs to be set up and the personnel who are implementing change need to be trained and equipped with necessary tools and provide ongoing mentoring and coaching support. It is essential to connect processes with expected outcomes and if an expected outcome is not achieved then this provides an opportunity to check the reason and assess what the problem is.
6.3 Conclusion

The participants agreed on the importance on moving on the QI agenda at the global level and particularly at the Regional level, they and endorsed the draft framework pending the requested changes. Several concerns were raised and changes to the draft framework were proposed that need to be addressed. Participants were ready for a consultative process and the Regional Office was requested to take this process forward and finalize the framework, and ensure consistency with the global framework.
7. **Session 3: Applying assessment tools in the context of health systems**

7.1 **Service Availability And Readiness Assessment tool**

Dr Wilson Were presented the Service Availability and Readiness Assessment (SARA) tool for monitoring service delivery at a broader level, collecting data at multiple facility levels including, for example, data in relation to emergency obstetric care, integrated management of childhood illness, medicines, HIV facility survey and service availability mapping.

SARA focuses on so-called availability, that is, physical presence of health infrastructure (facilities, beds, staffing and services); and so-called capacity or readiness of health facilities to deliver a defined package of interventions with a sufficient level of quantity. SARA indicators include service availability, general service readiness and service-specific readiness. SARA is a comprehensive and objective approach for monitoring service delivery based on standard core indicators measured by the presence of a set of tracer items. While the tool does not measure quality per se, it identifies availability of trained staff, and state of basic amenities and resources that are essential for delivering quality services. SARA is a harmonized data collection tool that reduces transaction costs, and reduces the burden of data collection and reporting, and it can be used effectively for country-level planning. It is now also supported by the GAVI Alliance, the Global Fund to fight AIDS, tuberculosis and malaria, and the President's Emergency Plan for AIDS Relief (PEPFAR). SARA collects data through the survey of a sample of health facilities identified through a stratified sampling process, but it can also be used in a baseline complete assessment of health facilities. Information is gathered through key informant interviews and observation. The results are best when the processes are linked to country planning cycle and results are fed into health sector reviews.

7.2 **Quality of care improvement: generic assessment and quality improvement tool for integrated maternal, neonatal, paediatric and adolescent health care**

Dr Martin Weber presented the hospital assessment tool that can be used by everyone who assesses quality of care; it helps to identify areas of care with potential, feasible and cost-effective improvements. Thus, using the tool helps in developing a plan for sustainable improvements and establishing a long-term supportive collaboration between hospitals and the ministry of health. The tool looks at improving quality (defining quality, adherence to minimum standards), assessment (assessment of current quality of care and identifying the gap between standards and actual performance) and finally improvement (what needs to be done to meet the standards). The tool presented focuses on inpatients; the only outpatient module currently included is the one for adolescents. Information is collected from: direct observations; hospital records; interviews with key personnel, mothers, carers and adolescents; and a hospital visit. The five-point scoring method was also explained wherein each section is scored based on standards and criteria to meet these standards, and a summary score is developed at the end of each section. Emphasizing the importance of debriefing and developing an action plan, it was emphasized...
that the findings and the scores should be discussed with the hospital personnel to identify the most important areas that need to be addressed (worst scores) and the possible impact on mortality and morbidity. The team should discuss the feasibility and prioritize interventions in terms of score, impact and feasibility.

Discussion and issues raised

In order to implement SARA and hospital assessment tools the participants expressed a need for greater clarity regarding the level of facility at which the tools are targeted, because preparedness for services depends on the level of facility (primary health centre, district hospital or hospital) being addressed and all check points may not be equally applicable to all facilities. While the current hospital assessment tools are for district hospitals, these can be adapted at country level. While undertaking the assessment, it is important to include a mix of facilities to determine whether or not the level of care it is supposed to provide is provided. The team should ideally comprise a specialist in childcare, an obstetrician and a general health facility person. Ideally, reviews should be done annually but this is neither practical nor feasible. The aim is to identify tracer process indicators through the tool so that information can be collected periodically for corrective action. A self-assessment tool with more items can be used by facilities to guide improvements. Use of these tools goes a long way to building ownership for the services.
8. Session 4: Available methodologies and tools for quality improvement processes in Member States

During a so-called marketplace session, available materials were shared and reviewed, and their usefulness in local or national settings or organizations was considered. Participants had an opportunity to interact and share the materials, hard copies of which had been brought by several Member State teams.

Posters were introduced by the participants – 14 in all – representing different materials used in the context of improvement of care for newborns, children, adolescents and mothers. Details are given in the abstracts of available tools and materials in Annex 4.

Examples included innovative tools, which were shared by Bangladesh, Bhutan, India, Indonesia, Maldives, Sri Lanka, Timor-Leste and Thailand. The tools presented provided an opportunity for participants to learn from each other about a range of topics including improving quality of maternal, newborn and child health services, integrated management of neonatal and childhood illness, youth-friendly services, family planning and a number of assessment tools and checklists for improving quality of care and implementing quality management systems. Bangladesh shared the tools and materials they have adapted and developed, including standard operating procedures for a national maternal health strategy, a national neonatal health strategy etc., which aim to improve quality of services and reduce morbidity and mortality. Value stream mapping has been developed by India to measure and improve critical care in newborns and it helps to reduce lead time by identifying and removing non-value-added activities and in turn improves quality, safety and delivery of services. Smart phone applications on standard treatment protocols for management of common neonatal conditions in small hospitals developed by India were shared.

8.1 Group work 2: How to use the assessment tool in the context of health systems assessment and accreditation

Participants reviewed the Integrated Maternal, Neonatal and Paediatric Assessment and Quality Improvement Tool and Quality assessment guidebook: a guide to assessing health services for adolescent clients and provided inputs into the working draft of the tool. As a specific task, they proposed ways on how to integrate the Quality assessment guidebook: a guide to assessing health services for adolescent clients into the modular approach of the integrated tool. This generic assessment tool is to be used to evaluate the quality of care for mothers, babies and children in hospitals based on standards derived from the WHO Pocket book of hospital care for children and the WHO Integrated Management of Pregnancy and Childbirth. The assessment tool provides some prioritization, recognizing that some aspects of patient care are essential.

The working draft currently includes the following sections:
- Module A: Administration – general hospital information
- Module B: Maternal care
- Module C: Newborn care
- Module D: Paediatric care
- Module E: Adolescent care.

Participants were divided into groups according to this outline to review the specific sections.

**Outcomes of the group work on how to use the assessment tool in the context of health system assessment and accreditation**

The participants found the document useful. They indicated that the document is bulky and lacks clarity on whether the tool is to be used for tertiary or primary level health facilities. Second, sections are segmented and hence it is difficult to undertake a comprehensive assessment in specific areas. It was proposed to have area-wise segregation of the tool to make it user friendly. It was also proposed that checklists be made departmental rather than thematic to make them more effective and efficient for information collection. The participants drew attention to the different terminologies used for health workers in the Region and that this needs to be borne in mind. National guidelines and practices need to be aligned to existing standards in a Member State and the assessor should be thoroughly trained in the guidelines of the Member State. Finally, they suggested that the pocket book document on guidelines, which would provide the standards referred to in an easily accessible format for communication between assessors and the staff of the assessed institution, should be available.

**Module A: Administration – general hospital information**

The participants proposed that the scope of general hospital information should be expanded by adding support services including equipment maintenance services, dietary services etc. Information on telephone numbers and email addresses of the hospital should also be included. Infrastructure needs to be more comprehensive to include maintenance of infrastructure, boundary, ramp wall etc. It was suggested that staffing should be expanded to include anaesthetists, laboratory technicians etc. It is best to include guidelines in the information for a respective department, to make them more available; for example, the protocol for neonatal care or the labour room is relevant in that specific section rather than in the general checklist. Standards and criteria need to be defined more discretely and uniformly. Scoring needs to be more objective, and very precise instructions or descriptions of the scoring system need to be given. It was proposed that public health indicators such as maternal mortality rate and prevalence of anaemia may be removed, as a hospital may not be held responsible for these indicators; only hospital-related mortality should be included. Instead of mentioning specific names of drugs, only categories should be mentioned, and the individual country can decide the drug to be used based on the essential drugs list approved in their country.

**Module B: Maternal care**

Many standards are recommended in the tool. There are some that are so-called must do and these must be indicated. Scoring should not be numerical as this does not give a clear indication of what is there or not there. It was proposed to use alphabetical scoring, where the letter A indicates that criteria have been met, B indicates that criteria have not been met and C indicates that nothing is in place. The participants proposed adding family planning, antenatal care, postpartum care and postpartum visits to the checklist. It was suggested that pictorial
representation of patient flow in an emergency situation rather than a write up would explain the process better.

**Module C: Neonatal care**

This section of the document needs review to make it more user friendly (organization, simplicity) and complete. Layout sections are fragmented and need to be reorganized and reviewed. It was suggested to include standards from international guidelines before each section, as the asessee needs to be aware of existing standards and criteria. Minimum quality of services indicators need to be identified. Protocols and select elements of standard care for sick newborns need to be reviewed and essential newborn care needs to be further expanded. Staffing questions should not only assess numbers but also levels of training and they should specify whether midwives and paediatricians have had specific training (for example, newborn resuscitation, essential newborn care, sick baby care).

**Module D: Paediatric care**

It was proposed to add case management information for emergency care (such as shock, seizure management). Hand washing was described in great detail and this needs to be reduced. It was suggested to revise and adapt drugs and equipment lists locally. It was suggested to add preventive maintenance of equipment. Counselling should be added in all sections.

**Module E: Adolescent care**

Unlike the other assessment tools, this was a proposed module and the participants fleshed out the details to be incorporated. Assessment of adolescent services should be included in the main tool and the document should be renamed to reflect this as: Integrated Reproductive, Maternal, Newborn, Child and Adolescent Assessment and Quality Improvement Tool. Module E should be entitled “Comprehensive adolescent health module for only outpatient care”. Monitoring and supervision indicators for adolescents should be included in Module B, which should be renamed “Paediatric and adolescent inpatient care”.

For adolescent-friendly services, the participants highlighted the importance of maintaining privacy and confidentiality, and ensuring availability of trained providers in delivering services; providers should include a trained paediatrician, gynaecologist, physician, counsellor, nurse and ancillary staff. The facility should have an adolescent-friendly waiting area, and a name board displaying timing and services available, and health education leaflets should be in place. Appropriate equipment and supplies should be available including a self-administered questionnaire for adolescents, a parent questionnaire and referral forms. It was proposed that monitoring and supervision should include administration of a physical and psychosocial health screen, including examination, provision of anticipatory guidance, and appropriate referrals to adolescent-friendly services.

The group identified basic health-care services/common health problems of adolescents to include scholastic problems, conflicts with parents, anaemia, obesity, dental caries, acne, dysmenorrhoea, menorrhoea, premenstrual stress, mental/emotional disorders, infections, pregnancy, abortions, sexually transmitted diseases/HIV, drug abuse and so on.
Discussion and issues raised

The participants reiterated that the tool should be able to answer questions on why, how and what can be done to make services better. The importance of adolescent health was acknowledged by all participants. Considering that adolescents are a unique group, it was felt that one needs to look beyond the facility level because the adolescents are young, live a healthy life and have limited contact with any health service provider. Identifying adolescents is a challenge and hence one may need to locate them in places where one is most like to find them, for example schools or colleges, as well as contact them through outreach workers. Specific standards for adolescents need to be developed. For example, how will adolescent–provider interaction at the level of outpatient department be assessed? It is not sufficient to record the information, as one also needs to understand how the information was delivered as this would indicate quality of care. The current tool is an inpatient module and one needs to see where and how an adolescent fits in different modules and whether there is a need to have a separate inpatient module for adolescents or have only an outpatient department for adolescents.

More generally, the participants felt that there is a need to include the outpatient department in all the modules including antenatal care, postnatal care, family planning and adolescents. Further, it was agreed upon that merely undertaking the assessment is not enough. One needs to follow this through, developing an action plan for both short-term and long-term action that will feed into the Member State’s health management plan and give specific recommendations to management to undertake certain activities.

Keeping in mind the number of technical and clinical aspects in the tool, it was suggested that the assessors need credibility regarding the system and they should be experts in their own area of work, otherwise specialists may not agree with the findings. For example, the paediatric module should be assessed by a paediatrician for credibility of findings.
9. Session 5: The way forward

9.1 The Regional collaborative process and country-specific action plans

9.1.1 Group work 3: Country-specific action plans

Member State representatives developed country-specific action plans for the implementation of the systematic quality improvement process, with activities for the next 12–24 months, including technical assistance needs and monitoring plans.

Each Member State group reflected on existing policies and standards including whether it has in place standards of care for reproductive, maternal, newborn, child and/or adolescent health and whether these need updating; policy and strategy issues that need to be addressed prior to launching the process to improve quality of care were identified and mechanisms that need to be put in place to do so were discussed. While preparing a road map, the Member State groups deliberated on the best way to conduct assessments of quality of care in their country, including by whom, and the steps needed to conduct hospital assessments. Specifically, each Member State developed an action plan for the next 6–12 months, including identifying people responsible for its implementation, time scale for implementation and specific actions to be taken, and the nature of support required from WHO and other partners to improve quality of care. From these country plans, cross-cutting themes were identified as presented in Table 1.

Table 1. Cross-cutting themes from country-specific action plans

<table>
<thead>
<tr>
<th></th>
<th>Policy and strategy</th>
<th>Standards</th>
<th>Baseline assessment</th>
<th>Improvement: collaborative activity</th>
<th>Monitoring/ repeated assessment</th>
<th>Documenta- tion</th>
<th>Scaling up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>Yes</td>
<td>Yes, but needs review and update</td>
<td>Project specific</td>
<td>Yes, project specific but led by Ministry of Health and Family Welfare (with partners including academia and professional associations)</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Bhutan</td>
<td>No (though may be embedded in other policies)</td>
<td>Yes, but some need to be developed (child health, family planning, adolescent health)</td>
<td>No</td>
<td>Irregular assessment</td>
<td>No</td>
<td>No</td>
<td>…</td>
</tr>
<tr>
<td>Democratic People’s Republic of Korea</td>
<td>Yes</td>
<td>None Propose to adapt framework and tools</td>
<td>None</td>
<td>Requested Establish assessment teams</td>
<td>No</td>
<td>No</td>
<td>…</td>
</tr>
<tr>
<td>Country</td>
<td>Policy and strategy</td>
<td>Standards</td>
<td>Baseline assessment</td>
<td>Improvement: collaborative activity</td>
<td>Monitoring/ repeated assessment</td>
<td>Documentation</td>
<td>Scaling up</td>
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</tr>
<tr>
<td>India</td>
<td>Yes Quality assessment cells merged Focal person</td>
<td>Yes, but needs review and update</td>
<td>National Health Systems Resource Center led some hospital assessment None at national or state level</td>
<td>Yes, but mechanisms need to be developed at state level</td>
<td>Internal assessment Patient satisfaction surveys</td>
<td>Yes Draft QI developed</td>
<td>Proposed</td>
</tr>
<tr>
<td>Indonesia</td>
<td>Yes Nodal person</td>
<td>Yes</td>
<td>Yes</td>
<td>Underway</td>
<td>Ongoing programmes</td>
<td>Yes</td>
<td>Being developed</td>
</tr>
<tr>
<td>Maldives</td>
<td>No (embedded in overall policies)</td>
<td>Maternal and newborn health and family planning available Adolescent-friendly health service finalized</td>
<td>None</td>
<td>Mechanisms being developed QI teams Adaptation of framework and tools</td>
<td>None</td>
<td>None</td>
<td>Proposed</td>
</tr>
<tr>
<td>Myanmar</td>
<td>Yes</td>
<td>Yes, but needs harmonization at different levels</td>
<td>SARA to be conducted</td>
<td>Yes, mechanisms being developed</td>
<td>None</td>
<td>None</td>
<td>Proposed</td>
</tr>
<tr>
<td>Nepal</td>
<td>Yes</td>
<td>Needs revisions and update</td>
<td>Project specific</td>
<td>Yes Adapt framework and tools Dissemination and joint meetings</td>
<td>Proposed</td>
<td>Yes, case study documentation</td>
<td>Pilots and scale up</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>Yes but some needs development (child health)</td>
<td>Emergency and obstetric neonatal care assessment done Adolescent health, reproductive health and child health to be done</td>
<td>Yes, desk review of guidelines, tools, check lists, etc.</td>
<td>Yes</td>
<td>Yes</td>
<td>2015</td>
<td></td>
</tr>
<tr>
<td>Thailand</td>
<td>Yes</td>
<td>Yes (updated in 2012)</td>
<td>Yes</td>
<td>Yes, self assessment Internal/external annually</td>
<td>Reaccreditation 3 years</td>
<td>Yes</td>
<td>Expanding to 90% of hospitals and health facilities by 2014</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>No (needs to be developed)</td>
<td>Adolescent health, not yet Others may need review</td>
<td>QI implemented in referral hospitals</td>
<td>Yes, with partners such as UNICEF, WHO, UNFPA</td>
<td>Needs strengthening</td>
<td>Needs to be done</td>
<td>-</td>
</tr>
</tbody>
</table>
9.1.2 Summary of common themes

Summing up similarities of the country-specific action plans between Member States, the following common or cross-cutting themes emerged.

- All the Member States agreed they need to review, revise, develop or update standards, guidelines, protocols and standard operating procedures for reproductive health, maternal health, newborn care, adolescent health and family planning.
- They need to identify gaps in policies and strategies, undertake policy and strategy reviews, and assess existing infrastructure and human resources.
- They expressed the wish to develop national and subnational level scale-up plans for improving quality of care at hospital level.
- There is a need to create and put in place regulation to endorse standards of care at the national level as a reference for provincial and district levels.
  - Technical resources require strengthening, coordination between health service delivery at all levels and ministry of health needs improvement, and mechanisms for monitoring and evaluation and supportive supervision need to put in place.
  - Capacity of service providers needs to be built at all levels of facility and provider.
  - There should be advocacy with the government to ensure QI processes are put in place.
  - Monitoring mechanisms for a QI system need to be put in place.
  - Technical support from WHO is needed to adapt the tool and framework to country-specific requirements, develop policy/strategy, provide technical assistance including research collaboration to address the current situation, and help with intervention strategies and financial support to implement the tool.

9.2 Round table with partners

Dr Neena Raina facilitated the round table where the participants voiced views on behalf of their organizations. Representatives included UNFPA, United Nations Children's Fund (UNICEF), Japan International Cooperation Agency (JICA), Medical Council Network, obstetrician and gynaecologist associations, and paediatrics and neonatal societies. Reiterating their commitment to improving quality of care, roles of different partner agencies and professional agencies were emphasized. It was agreed that quality of care can be achieved through greater collaboration and with involvement of multiple stakeholders including service providers. Increasing awareness and continued advocacy are essential for bringing the attention that is needed to quality of care. Preservice and inservice education needs to be addressed to build capacity for improving overall quality. Multisectoral support of governments is critical, especially through involvement of other ministries/departments such as child welfare, women's welfare, and education, along with professional bodies, civil societies and NGOs. All the partners agreed that each had a role to play in their respective area, but that the overall concept of QI was a unifying concept under which they could and would be willing to make their contribution.
10. Closing session

10.1 Achievements of the meeting

Dr Martin Weber summarized the key recommendations made by the participants of the meeting. It was acknowledged that quality of care along the life course continuum and across the various levels of the health-care delivery system is crucial, in addition to scaling up the coverage of life-saving evidence-based interventions. There was a consensus that there should be a collaborative and integrated approach to QI of the RMNCAH services, in preference to a component-wise or vertical approach. Participants endorsed the Regional QI framework and the integrated assessment tool as being relevant and applicable in Member States and being feasible to implement following suggested revisions. Delegates commended the Regional Office initiative to bring together Member States, partners and stakeholders to take forward this important agenda for progress towards achieving MDGs and beyond. The conclusions and recommendations made by the participants following the meeting were presented.

Conclusion

The participants were unanimous in their commitment to:

- continue to advocate and provide support and work with partner agencies towards improving quality of services at the local, national and regional levels
- support initiatives for better maternal, neonatal and reproductive health, including family planning, through collaboration with a range of stakeholders including representatives from ministries of health, other ministries, civil societies and NGOs
- support capacity building of different stakeholders including service providers such as doctors, nurses and midwives, and also managers and administrators, in various aspects of quality of care
- provide technical support in improving quality of both preservice and inservice training, capacity building in undertaking assessment and implementing the tools, analysing the information, and developing, implementing and monitoring improvement plans
- acknowledge the importance of putting quality of care into the work plans of respective agencies and facilitate and secure funding for implementing the plans at field level
- provide technical assistance in preparing and finalizing assessment tools and guidelines, and facilitate and provide support where needed in implementing this at the country level.

10.2 Summary of recommendations

The following recommendations were made for Member States.

- An enabling and empowering policy environment with an institutional mechanism, including a dedicated unit with a focal point in the ministry of health, need to be identified to lead and coordinate the activities for the QI process for RMNCAH care, including setting/updating standards of care at different levels of care. Tracking of quality of care fits well into the Commission on Information and Accountability for Women’s and Children’s Health country frameworks and roadmaps in the focus Member States.
• Member States should undertake national adaptation of the Regional QI framework and assessment tools, which would be finalized based on the inputs provided during this meeting.

• A partnership should be developed and strengthened among relevant stakeholders, including professionals and civil societies, to develop a collaborative approach to the QI process.

The following recommendations were made for WHO and partners.

• The inputs provided in this meeting should be incorporated in the revision of the Regional QI framework and assessment tools for hospitals, facilities and communities for RMNCAH, followed by finalization through a consultative process.

• High-level advocacy, capacity building and resource mobilization should be supported to establish/sustain the QI process for RMNCAH.

• There should be facilitation of documentation of experiences/pilots/projects (for example, as case studies) on RMNCAH QI in Member States.

• Support and guidance should be provided to Member States to develop national frameworks and plans for the QI process.

• There should be support for pilot studies and demonstration models for the QI process for RMNCAH care, and opportunities should be created for knowledge and experience sharing, and support of research.
11. References


Annex 1: Agenda
Annex 2: List of participants
Annex 3: Abstracts of country experiences
Annex 4: Abstracts of available tools and materials
Annex 1: Agenda

Inaugural Session
- Welcome and remarks by Director, Department of Family Health and Research (FHR)
- Message from Regional Director, WHO South-East Asia Region
- Objectives of the workshop and introduction to the programme
- Introduction of participants
- Appointment of Chairperson and Rapporteur
- Announcements
- Group photograph

Session 1 – Experiences with the Improvement of Quality of Care
- Quality of care – Background and Rationale
  - Global perspective
  - Quality Improvement in Family Planning services
  - Child and Adolescent health
  - Maternal and Reproductive health
- Country Initiatives
  - Bangladesh adolescent assessment
  - Quality Improvement (RMNCH) in India and development of a national framework
  - Quality Improvement (MNH) in Indonesia
  - Nepal baseline assessment of QOC for NCH
- Situation in and experiences from countries (MoH and partners)
  - Bangladesh
  - Bhutan
  - India
  - Indonesia
  - Maldives
  - Myanmar
  - Nepal
  - Sri Lanka
  - Thailand
  - Timor Leste
Session 2 - Strengthening Regional framework for Improving Quality of Health Care
- Draft Regional framework for improving quality of health care for RMNCAH in South-East-Asia
- Group Work 1 - Regional Framework and collaborative quality improvement process

Session 3 – Applying Assessment Tool in Context of Health System
- Survey Availability and Readiness Assessment Tool
- Quality of Care Improvement - Generic Assessment and Quality Improvement Tool for Integrated Maternal, Neonatal, Paediatric and Adolescent Health care
- Available methodologies and tools for QI in countries
  - Guidelines and Job-Aids
  - Assessment tools (external and self-assessment)
  - Technical training materials
  - QI training materials
  - Monitoring and audit tools
- Group work 2 - How to use the Assessment tool in context of Health System assessment and accreditation

- Group Work 3 - Developing country-specific action plans
# Annex 2: List of participants

Regional Meeting on Improving Quality of Care for Reproductive-Maternal-Newborn-Child-Adolescent Health (RMNCAH), 16 to 18 December 2013, New Delhi

## List of Participants

### Bangladesh

1. Dr Md. Altaf Hossain  
   Programme Manager, IMCI  
   DGHS, Mohakhali  
   Dhaka

2. Ms Shajadi Anjumonowara  
   Joint Secretary (Administrator)  
   BAVS, Mirpur  
   Dhaka

3. Dr Ismail Faruk  
   DPM (Admin & Finance)  
   PHC  
   DGHS, Mohakhali  
   Dhaka

### Bhutan

4. Mr Sonam Wangdi  
   Program Officer  
   Reproductive Health Program  
   Department of Public Health  
   Ministry of Health  
   Thimphu

5. Mr Sonam Zangpo  
   Sr Program Officer  
   Department of Public health  
   Ministry of Health  
   Thimphu

6. Dr Tshering Wangden  
   Gynaecologist  
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### India

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8. Dr R P Meena  
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### Indonesia

9. Dr Gita Maya Koemarasakti  
   Director  
   Maternal Health  
   Ministry of Health  
   Jakarta

10. Dr Riskiyan Sukhandi Putra  
    Deputy Director of Maternity and Post-partum  
    Health Management  
    Directorate of Maternal Health Management  
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11. Drg. Wara Pertiwi  
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12. Dr Marina Damajanti  
    Head of Evaluation Guidance Section  
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13. Dr Jumaile Beygam  
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    Male

14. Ms Moomina Aboobakuru  
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    Male
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   Male

MYANMAR

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   Department of Health
   Naypyitaw

17. Dr Myint Myint Than (Mrs)
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   Department of Health
   Naypyitaw

NEPAL

18. Dr Kiran Regmi
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   Family Health Division
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    Senior Professional Level

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    Dili

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Annex 3: Abstracts of country experiences

Quality Improvement for Maternal, Newborn and Child Health Care in Bangladesh
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Problem and problem analysis
Current health sector program (HPNSDP 2011-2016) of the Ministry of Health and Family Welfare (MoHFW), Bangladesh has taken affirmative actions for instituting a ‘Quality Improvement (QI)’ system for health services. Lack of a comprehensive, inclusive and structured strategic framework and action plan, different directorates are implementing QI and quality assurance(QA) activities in an isolated way leading to system in-efficiency and sub-optimal quality of essential services. Although policy, strategies, regulations, protocols and standard operating procedures (SOPs) have been developed for various programmes following global/international guidelines and trainings have been provided to various categories of health care personnel, optimum quality of health services couldn’t be ensured particularly for the women, children and vulnerable population.

The key bottlenecks in quality of care are lack of effective coordination and integration among different programmes and agencies for QI; absence of a National Strategic-Framework and comprehensive ActionPlan; inadequate capacity at national and sub-national level for QI programme management; shortage of human resources in number and skills; inadequate monitoring & supervision (M&S) system; poor motivation of service providers for compliance of clinical standards and protocols; inadequate budget and timely fund allocation; lack of effective Management Information Systems (MIS) etc.

Objectives of Quality Improvement approach
The objective of the Hospital Service Management (HSM) programme in the HPNSDP is to strengthen health care by providing effective, affordable, and client centred quality care which is accessible to the poor, mothers and children with establishing patients right and community participation.

Strategies/activities undertaken
Strengthening and upgrading of primary, secondary and tertiary level hospitals such as establishment of Special Care Newborn Units (SCANU); capacity development in clinical service delivery and quality improvement; introduction of National Health Care Standards, Quality Assurance programme and Total Quality Management (5S-CQI-TQM); strengthening regulatory framework for the private sector/ NGO hospitals/clinics/laboratories; establishing hospital and laboratory accreditation system; introducing structured referral system; implementation of standard waste management system both in public and private hospitals; Women/Adolescent/Baby Friendly Hospital services and initiatives; development of guidelines and national standards of clinical care following WHO guidelines/protocols; regional quality assurance system for family planning services etc.

QI activities have been implemented by the MoHFW in close collaboration with UN agencies and other development partners. UNICEF, JICA, WHO and icddr:b have been working together with the Director of HSM to support MoHFW in institutionalizing the 5S-CQI-TQM approach through capacity building and developing guidelines and tools along with implementation supports. For implementing QI activities, icddr:b has also conducted baseline assessment of hospital care for children at 18 primary/secondary level hospitals with support from WHO and QI assessment of MNH care in 11 hospitals with support from UNICEF. Academic institutes like BSMMU and professional bodies are also playing critical roles in developing strategies, guidelines/protocols, training and monitoring and mentoring.

Duration July 2011 – June 2016 (5 years)

Tools and materials used
A step-wise approach, 5S-CQI-TQM* has been adopted for quality improvement in the HPNSDP. The Quality Assurance and Improvement Manual for Maternal and Neonatal Health Services at the district level hospitals has been developed and used as guidelines. Based on international standards and WHO guidelines, several SOPs have been developed especially for maternal and newborn clinical care at hospitals. Adapted pocket books of hospital care for children have been distributed to care providers.

Various capacity development trainings such as ‘Emergency Triage and Treatment of Sick newborns’, IMCI, EmOC and TQM have been organised to improve care providers’ skills. The modules for these trainings were modified based on the WHO/UNICEF/global standards.

Results and outcomes
5S-CQI-TQM approach has been introduced at 23 hospitals. To date, 15 hospitals have been upgraded with SCANU. Though it is too early to conclude the outcome of the QI interventions, the facility MIS showed reduction of in-hospital neonatal mortality rate (IH-NMR) at selected hospitals. The average IH-NMR of 6 targeted hospitals has reduced from 11.8% in August 2011 to 8.6% in July 2013.

Lessons learnt and recommendations
• Bring synergy, harmonisation and effective partnership under different programmes and agencies to maximise the efforts for QI.
• Develop a strategic framework and comprehensive action plan for the country on QI
• Develop core sets of quality indicators to monitor the quality of care and strengthen HMIS
• Institute comprehensive QI/QA system at all levels of health facilities leading to formal accreditation and reporting mechanism.

Next steps/Future plan
• Successful models of QI (5S-CQI-TQM) on MNH need to be scaled-up.
• Sustaining and institutionalizing the current activities and expanding the model to more facilities by the MoH&FW.
• Formulate comprehensive strategic framework with time bound costed action plan and M&E framework/ mechanism.
• Strengthen management and coordination through institutional capacity building of MoHFW/ DGHS/ DGFP through functional QI/QA teams at national/sub-national levels.
• Institute ‘Accreditation System’ in phases with clear guidelines, SOP and accountability framework.
Helping Mother Survive (HMS) Program – FOGSI jhipiego Fast Track Initiative in India
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Problem & Problem Analysis
Maternal Mortality is still unacceptably high in India. Postpartum Hemorrhage and Ecclampsia are two major preventable cause of maternal death. Despite good understanding of management of these two condition women are still dying of PPH and Ecclampsia. The causes are multiple but the easy, effective and affordable preventive tools for PPH are strict adherence of Active Management of third Stage of Labor for all women in all setting and Magsulph Pritchard regime and primary health care for eclamptic patient. PATH studies and data from Ecclampsia registry in India reveals that these simple practices are not properly followed in various cadres of health facilities due to various reasons mainly-lack of knowledge and skill in various cadres of obstetric care providers.

Tools & Material Used
FOGSI jhipiego helping mother survive program is simulator (mamanatalle & neonatalle) based drill and skill program emphasizing key message and skills of AMTSL, step wise management of PPH and right Magsulph dosage with essential primary health care in ecclampsia. Pre & Post test questionnaire for participants is given to assess improvement. Participants are encouraged to do role plays to surface local situation and problems.

Objectives of Improvement Approach
The program had the objective of universal adherence to international WHO protocol of active management of third stage of labor, universal work precaution in labor and proper Magnesium sulphate loading dosage administration in Ecclampsia and severe PIH by all cadres of health care provider. Behavior change communication is also considered throughout the program.

Results & Outcome
6000 doctors & paramedical were trained by 200 programs conducted by master trainer. There was marked improvement (30-60%) in knowledge and skill for AMTSL, PPH treatment and primary care in eclamptic patient.

Weakness /Gaps
We have to cover the large part of India especially Govt. women hospitals, nursing staff and Non specialist doctors posted in Primary Health Centers who caters a huge number of obstetric patients. The follow up program for reemphasizing and monitoring the right adherence is also needed.

Links with Other Project
FOGSI has joined with PATH in UP & Karnataka for project Oxytocic initiative which has enforced the right storage, timing, dosage and route of oxytocin in labor.

Lesson Learnt & Recommendation
To fill the large gaps in knowledge as well skill in AMTSL protocol and Magsulph regime such programs are required in large number esp. district hospital, first referral units with follow up monitoring for right change in practice.
Implementing Quality Management System in Public Health Facilities

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Problem and problem analysis
In the past, Public health facilities have been criticized for delivering healthcare of compromised quality, not patient centric, error-prone, and not addressing few critical issues such as patient safety, privacy, dignity, and optimal utilization of available resources.

Objectives of QMS approach
Followings were the objectives of this programme -
• To develop QMS model specific to requirements of Public Health Facilities in India.
• To implement Quality Management System at Public health facilities and use ISO 9001:2008 certification platform for the certification with due emphasis on the process component.
• Improve the effectiveness and efficiency of healthcare facilities.

Strategies/activities undertaken
Initially programme was piloted in 8 District Hospitals of EAG (Empowered Action Group) states i.e. Uttar Pradesh, Bihar, Jharkhand, Rajasthan, Odisha, Uttarakhand, Chhattisgarh and Madhya Pradesh. In second phase, 8 District Hospitals of North East states were also taken in the project. After successful implementation of Pilot project, program was scaled up in 23 states of India at 528 Public Health Facilities ranging including PHCs, CHCs, Sub-district and District Hospitals. This program was implemented in three ways - Full time Support Supportive Supervision, Self-Implementation, as per requirement of states

At the facility level, following activities were taken up-
• Detailed ‘As-Is’ Study and ‘Gap Analysis’.
• Developing time bound Action Plan for traversing of gaps.
• Regular Patient Satisfaction Surveys, their analysis and building action plans to address patients’ concerns..
• Measuring Hospital performance (MIS)
• Developing SOPs for 24 procedures (12 Clinical and 12 Administrative), and Work Instructions.
• Training of all categories of staff on Quality, infection control, biomedical waste management, HMIS, SOPs and Work Instructions.
• Quality assurance activities like calibration of measuring equipment, Microbiological surveillance and external quality assurance program for laboratories.
• Periodic reviews by Internal Audits, Root cause analysis of non-conformities to SOPs observed during internal audits.
• Compliance to regulatory norms like Biomedical waste Management, AERB, PC&PNDT, Fire Safety etc.

Duration
It took 9 months to 20 months for one hospital to get external certification, which depended upon the size of the hospital, mode of implementation and support from top management.

Results and outcomes – what worked?
• Implementation of Quality Management System results in substantial improvement in the quality of services and utilization of OPD and IPD services.
• With implementation of standard operating procedures, variation in the clinical and administrative processes gets reduced and process owners were enabled to perform work more efficiently.
• Patient satisfaction survey results in improvement of service quality of the facility. There was considerable reduction in waiting times and re-dos with process improvement approach.
• Quality assurance activities like internal audits, medical and death audit, and management review meeting were institutionalised in the facilities.

Outcomes
Since initiation of this project in 2008, a total of 147 Public health facilities were certified to ISO 9001 Standards.

Lessons learnt and recommendations
Quality cannot be treated as piece-meal and fragmented approaches to improve. All healthcare facilities need to be scored against uniform criteria across the country.

National Policy on Quality improvement in healthcare is recommended.

Establishment of institutional framework at states and centres for Quality improvement (has been done since then)

Performance based Incentives and disincentives for individuals and teams (included in the revised framework)

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Patient Satisfaction Improvement Programme in Public Health Facilities – An Indian Experience
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Problem and problem analysis
After launch of National Rural Health Mission in India, there has been quantitative jump in the reach of Public Health Services. However, Quality of care remains a cause of concern. Patient perception of quality of the delivered services is important in any effort of the Quality Improvement. There could be many attributes, (as felt by patient), based on which, judgement of satisfaction is made. Due to poor service quality, people often use private healthcare facilities, incurring a high out of pocket expenditure (OOP), a burden, which they are unable to carry through. This leads to compromised access to healthcare by the poors, and low utilization of public hospital

Objectives of improvement approach
The objectives of this improvement program were
- Designing of Patients Satisfaction measurement tools, and scale of measurement, especially keeping the requirement of Public Health Facilities.
- Designing and implementing the methodology for continual measurement and improvement of patient satisfaction.
- Integrate the Patient Satisfaction Improvement Programme with facility level Quality Management System for sustainability.

Strategies/activities undertaken
We developed questionnaires to assess patient satisfaction after understanding the ‘Voice of Customer’ (VOC) through field visits, interviews with patients and service providers and focus group discussions. Attributes distilled though VOC were arranged in an Ishikawa Diagram and converted into a 10-point questionnaire for outpatient, and 20-point questionnaire for the inpatient services. Patient perception was measured on a five-point Likert scale ranging from poor to excellent. We obtained feedback on this questionnaire on a quarterly basis from a sample size calculated for 95% confidence level. Data were analysed and lowest two indicators were identified for root-cause analysis and developing an action plan.

Implementing a collaborative approach?
On identified causes of low satisfaction, a time bound action plan was developed in consultation with hospital staff and members of Rogi Kalyan Samities (Patient Welfare Societies). The results were disseminated through monthly MIS and notice board progress to all stakeholders, so they are part of the ‘solution’.

Links with other initiatives/projects/programmes?
This program was integrated with the Quality Management System being implemented under Quality Improvement Project by National Health Systems at the selected health facilities in 22 states of country.

Tools and materials used
- Plan - Sample size calculator tool
- Do - Patient satisfaction questionnaire

Results and outcomes – what worked?
Data analysis of patient satisfaction survey showed that majority of the OPD patients are most dissatisfied with (a) Non-availability of drugs, and (b) Time-duration for the consultation. For inpatients, cleanliness of toilets mattered most. At the same time, non-availability of drugs is also next dissatisfying factor for inpatients.

Further, it emerges through pareto analysis that enhancement in patients’ satisfaction by more than 60% could be achieved by addressing top three attributes of dissatisfaction. Finally on Kano model, non-availability of drugs and perception of not getting enough consultation time are ‘dissatisfiers’; cleanliness, ready availability of diagnostic services and minimal waiting times as ‘performers’. Nice and courteous behaviour of staff of public hospitals are the ‘delighter’ for the patients. After intervention there has been an substantial increase in utilization OPD and IPD services.

Outcomes
Concerted efforts to address the issues coming out of the findings, has substantially improved the patient satisfaction. While baselines scores at January 2011 varied between 1.5 to 3.5 at most of the facilities, it had improved to being between 3 to 4 on Likert scale in June 2012.

Lessons learnt and recommendations
Patient Satisfaction can be improved by optimizing the processes without increasing the inputs. There may be an initial dip in patient satisfaction level, when baseline is very low because patient expectations tend to increase more rapidly than it can be coped by the facility.
Expectations of patients in public hospitals are quite different from what they used to be in for profit set-ups as most of the clients are poor. So availability of services like consultation, drugs and diagnostics always remains priority. Once this minimum threshold level is met, patient looks for performance factor like be waiting time and information.

Next steps – future
This Patient satisfaction improvement programme has been incorporated in National quality assurance programme, which has been launched by the Ministry of Health & Family Welfare, Government of India

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Assessment of the quality of care for mothers and newborns in 100 health facilities in Indonesia

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Problem and problem analysis

Despite progress, maternal and infant mortality remains high in Indonesia, with an estimated maternal mortality ratio (MMR) of 359 per 100,000 live births and neonatal mortality rate of 19 per 1000 live births (IDHS 2012). The national target for MDG 5 is 102 maternal deaths per 100,000 in 2015. The important factors contributing to mortality and its reduction are quality of obstetric and neonatal emergency care and functioning of referral for complications.

Objectives of improvement approach

Assessment of the quality of maternal and neonatal care is a component of the implementation of Making Pregnancy Safer Strategic Framework to improve Maternal and Newborn Health and to achieve MDGs 4&5.

Strategies/activities undertaken

- MOH, key stakeholders and partners developed the standard assessment tools that can be used country-wide.
- MOH, key stakeholders and partners carried out assessment of the quality of care and services at primary health care level and hospitals throughout the country, to identify challenges.

Implementing a collaborative approach?

The assessment of quality of care in MNH is a collaborative approach between WHO, MOH, professional organizations, UNICEF, UNFPA, and USAID.

Links with other initiatives/projects/programmes?

This initiative can be linked with other quality improvement approaches in MNCH, across the continuum of care and health systems such as accreditation, human resource planning, drug supplies, equipment, and financing.

Duration

The development of assessment tools and pocket book maternal health started in 2010. The assessment was carried out from February to March 2012.

Tools and materials used

The Quality of Care Assessment Tool for Maternal and Neonatal Health, Pocket Book for Maternal Health, CEONC and BEONC standard, Bidan Delima standard, and Facilitative Supervision.

Based on international standards/guidelines?

Making Pregnancy Safer (MPS) assessment tool for the quality hospital care for mothers and newborn babies (WHO Eurotool), WHO IMPAC guidelines.

Results and outcomes – what worked?

Each district was assessed by a team of eight people including obstetricians, midwives, general practitioners, staff of the Ministry of Health and UN agencies (WHO, UNICEF, and UNFPA).

Outcomes

1. Report on assessment of quality of care in maternal and newborn health
2. Indonesian assessment tool for the quality of care for maternal and newborn health
3. Pocket book of maternal health

Self-assessment?

No

External assessment?

Yes

Results and outcomes – what did not work?

- Difficulties in direct observations for case management in health facilities during data collection period
- Perspective discrepancy among assessors during determining scores for case observations

Weaknesses

No representatives from hospital accreditation commission in the assessor’s team

Gaps

Level of understanding of the assessment methods was low among team members

Lessons learnt and recommendations

- Measuring the quality of care is expensive, and requires constant communication with customers
- Many indicators currently used in global initiatives such as the Countdown 2015 do not contain a quality component, giving false impression about improvement, if interventions coverage increases without quality.

Next steps – future

Framework of MNCH Improvement Quality of Care in Indonesia should be developed in accordance with the Regional and Global Framework.
Quality Improvement of Hospital Care for Children in Indonesia – Experience
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Problem and problem analysis
Reducing child mortality is one of the Millennium Development Goals to be achieved through improving child health services. The Integrated Management of Childhood Illnesses (IMCI) approach was introduced in 1997 at the first level health facilities. Quality of care at the referral health facility is of prime importance for child survival.

Objectives of improvement approach
The objective is to continue the quality of care improvement cycle. The assessment tool should be able to act as a self-assessment tool and integrated in the national hospital accreditation tools. Every hospital is to have an independent team for its quality improvement in a quality improvement network within the district or province. All activities and documents should be integrated with the existing activities and documents.

The Indonesia version “Hospital Care for Children: Guidelines for First Referral Level Hospitals in District or Municipality”, was launched in 2009. The assessment of the quality of hospital care for children was conducted in 2009 in 18 hospitals in 6 different provinces. The report was published in the journal Tropical Medicine and International Health in April 2013.

Strategies/activities undertaken
The Ministry of Health, Indonesian Pediatric Society, key stakeholders and partners, finalized the revised version of the assessment tool having more clinical aspects and could act as a self-assessment tool. A quality improvement plan for nearest provinces (Jakarta, Banten and West Java) as a pilot project would be feasible. However, plan to continue the quality improvement cycle has not yet started.

Implementing a collaborative approach?
Yes, the improvement of quality of care for children is a collaborative approach between WHO, MOH, professional organizations, UNICEF, UNFPA, and USAID.

Links with other initiatives/projects/programmes?
This initiative can be linked with other quality improvement approaches in MNCH across the continuum of care and health system such as accreditation, human resource planning, drug supplies, equipment and financing.

Duration
Two years from finalising the revised self-assessment tool, developing quality improvement team and network, initial assessment for the quality of care for children at selected hospitals in the 3 provinces, followed by quality improvement process.

Tools and materials used
The Indonesia version “Hospital Care for Children: Guidelines for First Referral Level Hospitals in District or Municipality”, the assessment tool for hospital care in children and quality improvement cycle document of WHO.

Based on international standards/guidelines?
Yes. All materials and tools were adapted from WHO documents

Outcomes
1. Indonesia version “Hospital Care for Children: Guidelines for First Referral Level Hospitals in District or Municipality
2. Indonesian assessment tool for hospital care for children – revised version
3. Published article titled “Assessment of the quality of hospital care for children in Indonesia” at journal of Tropical Medicine and International Health, April 2013
4. A plan based on the quality improvement cycle framework

Weaknesses
Changes of staff within the stakeholders. New staff have different points of view and priorities.

Gaps
Low level of understanding of the quality improvement cycle

Lessons learnt and recommendations
Any improvement effort should be linked with the existing program to ensure continuity and effectiveness.

Next steps – future
- To formally complete revision of the assessment tool
- To develop quality improvement team in each hospital and network at district, provincial and national levels
- To start the plan-do-check-action cycle
- To integrate all activities and documents with the related successful programmes and documents.
The Youth Health Café (YHC) Initiative in Male’, Maldives
Maimoona Aboobakur, Population Health Programme, Health Protection Agency, Maldives
Contact E-mail: maimoona.aboobakur@gmail.com

Problem and problem analysis
Maldives is a young population with half of the population below the age 25 years. Adolescents comprise 26% of the total population. Drug abuse and related problems are faced by many of the youth – About 90% convicted offenses on drug abuse are among youth under the age of 26 years. Sexual activity among adolescents is increasingly raising the risk of sexually transmitted diseases and unwanted pregnancy. With this background, the government of Maldives with the support of UNFPA and WHO initiated health and development programs for adolescent and youth.

Objectives of improvement approach
The development of a ‘Youth Health Café’ was a youth friendly initiative undertaken for addressing the health needs specifically focusing on the reproductive health needs. The main objective was to provide specific services to Adolescent/youth population in Male and to improve access to RH information.

Strategies/activities undertaken
Initially the plan was to establish a service delivery component to provide on-site services to the clients and to focus on capacity building of the target group through training and IEC. The on-site services proposed included counseling, health related information and clinical services. Capacity building approach focused on life skills education, thematic education sessions, peer education and a mentoring program

Implementing a collaborative approach?
The Youth Health Café was a collaborative effort of Ministry of Health and Ministry of Youth with the support of UNFPA and WHO. Ministry of Education is also a key partner in reaching out and the implementation of the targeted adolescent life skills development.

Links with other initiatives/projects/programmes?
The adolescent health policy of the ministry of health and relevant strategic plans are aimed to improve the health of young people through research, health promotion, education, training, advocacy and clinical services. The reproductive health strategy and youth health strategy developed have this focus. During the inception of the YHC, an Adolescent Health Clinic in the main hospital (IGMH) in Male’ also went along.

Duration
Youth Health Café’ was started in 2004 as a project under the Ministry of Youth and Sports.

Results and outcomes – what worked?
During 2007 and 2008 the program provided life skills training to 505 adolescents, produced 48 peer educators who in turn reached out to 1901adolescents. Thematic sessions were arranged where 507 couples were informed. YHC was considered a timely and culturally appropriate initiative drawn from a youth accepted contemporary café culture to provide services to the adolescents/youth. At the start of the YHC, it being run in the same premises as the youth centre and youth counselling centre improved access to the service. Open days were used to generate demand for the service. Referrals are done if counseling is needed. As the centre was located close to IGMH and the adolescent health clinic referral from YHC was seen to be quite workable.

Assessment
An assessment was carried out after 5 years of its inception by an international consultant. The assessment looked into a joint evaluation of the YHC and adolescent health clinic of IGMH, for the effectiveness of services, strengths and weakness, constraints and opportunities and to propose recommendation based on findings and prevailing situation

Results and outcomes – what did not work?
The on-site service delivery was restricted to providing brochures of health related information. Arrangement of clinical services proved difficult due to constraints in making medical officers available. With the in administrative set-up that followed with the new government separated the YHC and youth counseling centre were moved to be located at the two ends of the island. Service did not work as planned for several reasons. Mentoring programme did not succeed and was stopped at the initial phase.

Weaknesses
Gaps : Little or no focus was given for capacity building and sustenance of the service. Availability of required human resources was a major gap. Although existence of the YHC is widely known to youth in Male’, very few knows about the services provided. Activities are limited and restricted for demand generation and facilities for attracting females lacked. A café operated by the youth center adjacent to the YHC attracted males as they frequent this café service. Furthermore the presence of youth gangs in the café and surrounding area seems to deter females using both the youth center and the café.

Lessons learnt and recommendations
After 5 years of establishment YHC still functioned as a project funded by a donor agency and did not get internalized into the system as a permanent service delivery point. It was observed that YHC failed to capitalize on the momentum generated in the initial stages mainly due to the nature of administration applied. The inadequacy of proper staff positions to provide the services, high turnover of trained staff, insufficient networking and coordination with relevant agencies, discontinuity of initiatives and lack of medium and long term planning are some of the consequences seen due to the administrative structure of YHC. The following were recommended for improving and sustaining the service:

- YHC to be established as a permanent component in the Ministry of Youth and reorganize the YHC internal structure to be an on-site service delivery center.
- Obtain full time or part time services of health care workers to deliver health services in the YHC
- Establish official and continuous linkages with AHC in IGMH, School health and safety unit in the ME and schools to mutually benefit AHD programmes in all the institutions. Linkages also to provide human resources for clinical services at YHC.
- Demand generation activities of the YHC to be broad based:
collaborating with media channels for advertising the services of YHC; regular school programmes to increase awareness of AHD issues; workplace based activities for awareness and lobbying to direct adolescents/youth to YHC. Target group can also

- Capacity building and refresher training of facilitators

**Next steps – future**

- Establish the YHC in Male’ to a level that it can be used as a model for developing youth and adolescent friendly services in other areas of the country.
- Develop and implement a package of adolescent and youth friendly sexual and reproductive health care service at all levels where health care is provided.
Assessment on Quality of Care for newborn and children in township and station hospitals – Myanmar 2012
Dr Myint Myint Than (dr.myint.m.than@gmail.com); Dr Theingi Myint (theingimyint5@gmail.com)

Objectives of improvement approach

Main objective: Improving quality of care for children and newborn at township and station hospital levels.

Specific objectives: To collect general hospital information about child care including newborn; to obtain baseline information on hospital support system; to assess hospital care (perspective of health workers and care takers); and to explore quality of care for the children including at township and station hospital levels.

Strategies/activities undertaken

An internal assessment of quality of care was conducted in 20 township hospitals and 20 station hospitals (40 altogether).

Methodology: A hospital based cross-sectional descriptive study was conducted. In 20/330 townships randomly selected, the township hospital and one station hospital were selected. Methods of assessment were questionnaires for a) authorized health professionals, b) health professionals and c) caretakers; observations within hospitals; and demonstration of case management with cases or case scenarios.

Results and outcomes

The hospitals were assessed by standards and criteria for: Hospital infrastructure; hospital health statistics; availability of drugs, equipment and supplies; emergency care services; characteristics of the paediatric wards; case management of common conditions; supportive care; monitoring; neonatal care; paediatric surgery and rehabilitation; and hospital administration/access to hospital. Conditions of hospitals were categorized as good, fair or poor.

Main results: The results of the assessment show an extreme variability in the quality of care in the hospitals. Some of the positive findings are: For the summary score for diarrhoea, 72.5% classified as good; for paediatric surgery and rehabilitation, 70% classified as good; for supportive care; none of the hospitals were classified as poor; for laboratory support, 65% were classified as good. Some of the more striking results, however, are as follows: For essential drugs, supplies and equipment, only 20% of the hospitals were classified as good; for emergency care services, only 22.5% were good; conditions in paediatric wards were only classified as good in 20% of the hospitals; the summary score for malnutrition were only good in 12.5% of the hospitals, hospital administration was classified as good in as few as 2.5%; and access to hospitals were only classified as good in 5% of the hospitals.

Lessons learnt and recommendations

Based on the findings of the report, the most important recommendations are:

- All hospitals should be monitored for improving quality of care for newborn and children annually or biannually
- Adequate and updated treatment guidelines need to be available and in use
- Staff needs training in various areas, such as malnutrition, emergency aid/treatment including resuscitation, F-IMNCI, staff attitude
- Management of cough and difficult breathing, diarrhea, fever, malnutrition and use of antibiotics need to be improved
- Patient monitoring and recording need to be ensured and improved, death audits need to be performed
- Need availability of: essential medicines, essential laboratory tests, nutrition supplement, improved infrastructure such as electricity and running water, equipment such as bed sheets and bed nets, improved hygiene
- Need to establish an appropriate financial scheme to improve access and referral

Next steps – future

- To conduct assessment of quality of care for children including newborn at hospital and PHC level
- To train hospital staff with F-IMNCI
- To publish and distribute Standard Treatment Protocol on managing common newborn conditions for hospital staff
- Provision of adequate amount of medicines and pediatric size equipment
Assessment of Quality of Paediatric Care in Referral Hospitals of Nepal
Prof. Dr Shrijana Shrestha, Patan Academy of Health Sciences, Nepal; Contact E-mail: shrijanashrestha@pahs.edu.np

Problem and problem analysis
Integrated Management of Childhood Illness (IMCI) and Community based neonatal care program (CBNCP) are the strategies of Ministry of Health and Population (MOHP) to reduce neonatal and childhood morbidity and mortality in Nepal. Different levels of care and approach based on referral system have been adapted to provide care and treatment of sick children. Regional, Sub-regional and Central hospitals have been envisioned as referral centers. However, the capacity of these referral hospitals to provide quality Paediatric care was largely unknown.

Objectives of improvement approach
A cross sectional descriptive study using both qualitative and quantitative methods was carried out at 4 referral hospitals (1 Central, 2 Regional and 1 Sub-regional) to assess the quality of care, availability of human resources and capacity of hospital support systems (physical structure, laboratory, pharmacy, record section) for providing Paediatric services.

Strategies/activities undertaken
This work was conducted in accordance to an agreement between Child Health Division (CHD), Department of Health Services and World Health Organization (WHO), Country Office for Nepal.

Tools and materials used
The basic tool for the assessment was the adapted version of WHO “Generic tool for the assessment of the quality of care for children in health facilities.” The manual was reviewed by the study team for its consistency with national standards and guidelines, and the finalized tool comprised of 15 sections and additional subsections.

Results and outcomes
• Electricity, provision of backup power and running water were available in all study hospitals
• Laboratory services were reasonably good in all 4 study hospitals.
• Results of the basic tests performed were available within a reasonable time
• Management of malnutrition and measles were reasonably good while management of breathing difficulty, febrile illnesses, diarrhoeal diseases and neonatal conditions were not up to the mark.

Weaknesses:
- Triage- non existent
- Treatment protocols – non existent
- Hand hygiene not practiced
- Record keeping- very poor; especially in OPD and ER
- Poly pharmacy, overuse of broad spectrum antibiotics

Gaps
- Referral and transport– no proper system in place
- Manpower largely inadequate
- Equipments and supplies inadequate and not well maintained
- No in-hospital pharmacy and government supplied essential drugs largely inadequate

Recommendations
1. Regular supervision from CHD, MOHP
2. Adequate supply of essential drugs, equipments
3. Standard treatment protocols, Job aids
4. Antibiotic protocols
5. Regular trainings and CME for doctors, nurses, paramedics and support staffs

Next steps – future
1. Continuity of periodic ‘Quality care assessment’
2. Expansion of the process to lower level hospitals and health facilities
3. Implementation of the recommendations and follow up
4. Use this ‘Generic Tool’ as a self assessment material for different level Paediatric facilities
5. Promotion of infection control and antibiotic stewardship
Skilled birth Attendant Follow-up Enhancement Program
Dr Kiran Regmi, MD, PHD, Director, Family Health Division
Department of Health Services, Teku
Contact E-mail: regmikiran@gmail.com

Problem and problem analysis
After national Policy on SBA was formulated, short term plan emphasised on SBA training to address equity and access to the maternal & neonatal health. There are 5000 SBAs till date. Even though NHTC mandates 20% of trainees to be followed up the assessment of skill competency is never planned. This program developed a tool to follow up the SBAs and enhance their skills.

Objectives of improvement approach
• Assess the knowledge & skills retained after the SBA training.
• To assess the enabling environment of SBA.
• To assess the attitudes of SBA.
• To provide on site coaching after finding the gap.
• Feed back to DHO/DPHO, NHTC, FHD and related divisions.

Strategies/activities undertaken
• Development of SBA FEP tool.
• Orientation of the trainers for follow up activity.
• Selection of districts to be piloted.
• On site Follow up mentoring visit in health facilities.

Implementing a collaborative approach?
Now this is in pilot phase but this has to be well collaborated between national training centre and Family Health Division

Links with other initiatives/projects/programmes?
It is linked with SBA training program.

Duration-2yrs (2010-2012)
Tools and materials used - SBA FEP tool

Based on international standards/guidelines?
EMoC training manual, Follow up monitoring tool of EmOC service providers developed by JHPIEGO

Results and outcomes – Out of 553 SBA of the area 339 were assessed. Evidence of lack in some of the skills even after training was identified. Necessary of the follow up and mentoring visit has become obvious to government and stake holders.

Results and outcomes – The process becomes expensive as trainers are involved specially for mentoring SBA after assessing them. One site with four SBA needs 2-3 days to complete the process. Linking the finding and recommendation to the responsible department is a challenge.

Weaknesses - this piloting could cover small proportion of SBA. It is expensive.

Lessons learnt and recommendations-
SBA FEP has been one of the ideal program to maintain the quality of service provided by the SBAs. This has to be within the government system.

The partners who supports for SBA training should make financial commitment for follow up too.

MoHP should take initiative to put this in government priority program.

Next steps – To collaborate with partners who are interested to work in QoC.
Lack of a check list for assessment of community based adolescent health services
Dr MN Danansuriya, Consultant Community Physician, National Program Manager –Adolescent Health Family Health Bureau, 231, De Sarem Place, Colombo 10, Sri Lanka
Contact E-mail: manju114c@yahoo.com

Problem and problem analysis
Lack of a check list for assessment of community based adolescent health services

Objectives of improvement approach
To develop a check list for assessment of community based adolescent health services

Strategies/activities undertaken
Conducted several consultative meetings with district & field level health staff, prepared the draft check list based on minimum standards for YFHS for institution based clinics & pilot tested in Kurunegala district

Implementing a collaborative approach?
Efforts had been taken to establish linkages with other government services (Counselling, social services, youth services) at the divisional level

Links with other initiatives/projects/programmes?
Linkages with School health program, Maternal & Child Health Program

Duration
2011-2012

Tools and materials used
National Minimum Standards & guidelines for Youth friendly health services – Sri Lanka (for institution based clinic centers)

Based on international standards/guidelines?

Results and outcomes – what worked?
Draft report prepared awaiting stakeholder consensus
Providing out-reach services were satisfactory but no data on clinic services –as client attendance was not satisfactory.

Outcomes
Self-assessment? By the MOH them selves
External assessment? By -National Level Program Manager

Results and outcomes – what did not work?
Certain parts were not being filled in self assessment due to reasons beyond MOH ‘s capacity.

Weaknesses
Gaps
Tool is comprehensive and possibilities for a short & simplified version has to be sought

Lessons learnt and recommendations
It would be better to focus on assessing out-reach services and exploring other possible service delivery models in reaching adolescents & young persons which can be included in to the checklist later

Next steps – future
Stakeholder meeting to finalize the check list and introduce as a part of existing RH-MIS to be collected on annual basis.
National Emergency Obstetric and Neonatal Care Needs Assessment Survey in Sri Lanka: Do standard indicators help further improve in the quality of care?

Dr. Nilmini Hemachandra, National Programme Manager- Maternal Care, Family Health Bureau, Ministry of Health, Sri Lanka. Contact E-mail: nilmini0822@gmail.com

Other Authors: Dr. Lalini Rajapaksa, Dr. Padmal de Silva, Dr. Dhammica Rowel, Dr. Laxman Senanayake and Dr. Chandani Galwaduge

Starting point:

Sri Lanka has achieved much in terms of reducing maternal and infant mortality. Further improvements in maternal and infant mortality in Sri Lanka will largely depend on the capacity of the health system to respond to obstetric and newborn emergencies and complications. A EmONC needs assessment was planned to examine the ability of the different grades of health institutions at regional and national level to provide necessary life-saving care to pregnant women and their newborns. The EmONC assessment was carried out in all districts including all hospitals where specialist obstetric services are expected to be available sample of non-specialist institutions.

Description of product:

AMDD modules were adapted to suit Sri Lankan context and available in English medium. The data were analysed according to the EmONC indicators described in the manual “Monitoring Emergency Obstetric Care: A handbook” WHO (2009).

Experience, lessons learnt and recommendations:

Standard definitions, Eight standards indicators and cut offs prescribed in the handbook have limited value in Sri Lankan scenario due to delivery pattern, health seeking behaviour and certain policies practicing in Sri Lanka. New definitions were developed for BEmONC facility, institutions that are “potentially able to provide signal functions”, “institutions able to provide CEmONC functions on a 24*7 basis”. New indicators were the area falling outside a defined buffer zone round a CEmONC facility, the percentage of population without CEmONC cover, the accessibility index for a specialized hospital, the accessibility index for a specialized unit and the accessibility index for a specialist obstetrician. The new cut off was developed for Sri Lanka as at least 3 CEmONC facilities per 500,000 population.
The Family Love Bond Project - Project under Royal Patronage of His Royal Highness Crown Prince Maha Vajiralongkorn and Her Royal Highness Princess Srirasmi, Royal Consort. 
Dr. Doughathai Janchua, Health Promotion Centre Region 9 Phitsanulok, Department of Health, Ministry of Public Health, Thailand. Contact E-mail: D_janchua@hotmail.com

Problem and problem analysis
- Discontinuous of quality care monitoring
- Low linkage between hospital to community and household
- Low coverage & accessibility

Objectives of improvement approach
- To strengthen MCH board for quality care monitoring.
- To develop MCH linkage service from excellent hospital to community hospital and sub-district hospital.
- To enhance community care for elementary care coverage.
- To empower household for health care accessibility.

Strategies/activities undertaken
Implementing a collaborative approach
- Enhance quality health care standard for hospital.
- Increase community involvement.
- Encourage self care facilities.

Links with other initiatives/projects/programmes
- Universal Coverage and all rights to free ANC and WCC links with mother and infant smart card.
- Case management for HIV and vulnerable MCH.

Duration: 2012 - 2015

Tools and materials used Based on international standards/guidelines
- Quality care standard on Family love bond hospital and Sub-district family love bond hospital.
  (Leader, Provider, Patient, MCH Club, ANC, LR, PP, WCC, Result)
- Quality care standard on Sub-district of breastfeeding for family love bond.
  (Leader, Community fund-support agreement, Strategic route and linkage map, Data linkage, MCH Club, Child care center, Result)
- Quality care standard on Child care center.
  (Caregiver, Health promotion activities, Early child development and learning, Food sanitation, Environmental health, Security, Result)

Results and outcomes – what worked?
- Quality care monitoring.
  * Declared a national policy and followed by the regional area health service Inspector.
- Linkage between hospital to community and household.
  * Data set, service package for self care, community care linked to the same standard of MCH services in hospital.
  * Sub-district of breastfeeding for Family love bond has been established by community involvement.
- Systematized on health care coverage & accessibility.

Results and outcomes – what did not work?

Weaknesses
- Process of quality care enhancement.
- Concept of community involvement for quality care in hospital.

Gaps
- Perceived role in the development process.
- Human development.

Lessons learnt and recommendations
- Process on improving quality of care should be matched with each context.
- Human have been developing steadily.
- Community has potential to provide MCH health care service linkage to hospital for desirable health status if it is adjusted concepts and understand their roles and given opportunities.

Next steps – future
- Encourage to raise quality standards of family love bond hospital.
- Strengthening of the family love bond hospital evaluation team and providers.
- Training of MCH health promotion personnel in the hospital and in the community.
- Extended sub-district of breastfeeding for family love bond.
Neonatal training programmes to prevent and reduce the infant mortality: Project in Thailand
Suppawat Boonkasidecha, MD, Varaporn Sangtaweessin, MD, Uraiwan Chotigeat, MD
Neonatal Division, Queen Sirikit National Institute of Child Health, Bangkok, Thailand.
Contact E-mail: suppawat_yoo@hotmail.com

Problem and problem analysis
Most of the infant death occurs in newborn period. The preterm delivery and perinatal asphyxia are still the common causes of infants death in Thailand. Proper neonatal care and cardiopulmonary resuscitation are crucial in reduction of complications and mortality.

Objectives of improvement approach
- To improve knowledge and skill in medical personnel that involved the neonatal care and resuscitation, according to the American Academy of Pediatrics (AAP) guideline 2010.
- After 1 year, the infant mortality rate reduce at least 5% from previous mortality rate.

Strategies/activities undertaken
- Neonatal care and resuscitation guideline: Lecture and workshop.
- Training programmes: NCPR training course in every province. Five days course for doctors, four months course for nurses.

Implementing a collaborative approach?
- Collaborate with governmental and private sectors.

Links with other initiatives/projects/programmes?
- Neonatal transportation training programme.

Duration
- 2012-2014

Tools and materials used
- Neonatal CPR handbook and other learning tools: DVD, manikin

Based on international standards/guidelines?
- The neonatal care and resuscitation guideline according to AAP 2010.

Results and outcomes
- The neonatal mortality rate is 8/1000 livebirth.
- The two common causes of neonatal death are prematurity and perinatal asphyxia.

Self-assessment
- The preterm delivery and perinatal asphyxia are still the major causes of infants death in Thailand.

Weaknesses
- Inadequate medical personnel and budget.

Lessons learnt and recommendations
- Another factor that affect the quality of neonatal care is the newborn transportation, especially the very sick babies from the suburban hospitals. The preterm birth and teenage pregnancy rate are increasing. The adequate and proper antenatal care in the mothers and postnatal care in infants are very crucial factors in reduction of complications and mortality.

Next steps – future
- To collaborate with governmental and private sectors to prevent preterm birth and reduce teenage pregnancy.
- To develop the Thai trainers for neonatal transportation by attending the STABLE programme in working group.
Prevention and Teenage Pregnancy Plan
Mrs. Renu Chunin; Bureau of Reproductive Health, Department of Health, Ministry of Public Health, Thailand.
Contact E-mail: renuchunin@hotmail.com

Problem and problem analysis
- Number of population aged 10 – 24 years old = 14 million (of total population of 64 million)
- Adolescent Fertility Rate (number of births per 1,000 women ages 15-19) = 53.8
- Number of teen deliveries aged 20 years old = 133,176 persons
*Number of teen deliveries aged between 15-19 years old = 129,451 persons
*Number of teen deliveries aged below 15 years old = 3,725 persons
*Number of repeat teen deliveries aged under 20 years old = 15,443 persons

Objectives of improvement approach
1. Youth has knowledge to delay sex. At least, youth will be able to have safe sex when they are planned.
2. Youth can assess sexual risk behaviors including unplanned pregnancy – and AIDS and STIs.

Strategies/activities undertaken
- Training programmes: IUD & Implant insertion for nurse, Sex Education for Teacher, peer educator to teach friend
- Youth Friendly Health Services.
- School Campus activities.
- Push the registration of Medical abortion
- Meeting, supervision, M&E

Implementing a collaborative approach?
Collaborate with GOS and NGOs

Links with other initiatives/projects/programmes?
National Strategic Plan on Teenage Pregnancy in Thailand

Duration 2010-2013

Tools and materials used
- WHO Safe abortion guideline and WHO YFHS guideline
- Printed materials for teaching and learning
- Samples of contraceptive methods
- Penis model for condom demonstration

Based on international standards/guidelines?
WHO Safe abortion guideline and WHO YFHS guideline

Results and outcomes
More use of reliable family planning methods in the last sexual intercourse with boy/girl friend or lovers as follows:
- Boys in 5th year of secondary school use more family planning from 51.9% in 2009 to 88.2% in 2012. Also an increase in girls from 44.0% to 80.0%.
- Boys in 2nd year of vocational school use more family planning from 49.9% in 2009 to 87.5% in 2012. Also an increase in girls from 44.2% to 83.9%.

Self-assessment?
Adolescent Fertility Rate (number of births per 1,000 women ages 15-19)

Weaknesses
Budget

Lessons learnt and recommendations
Should collaborate with all stakeholders and involved government and private sectors including mass media to solve this national issue especially mass media since information can be widely distributed to target group.

Next steps – future
Propose the 2nd Draft of National Reproductive Health Policy and Strategies (2014 – 2018)
- Preventing repeat adolescent pregnant Project
- Nurse training on IUD and implant
- NHSO (National Health Security Office) support IUD and implant.
- More collaborate with private sectors including mass media
Quality Improvement for Referral Hospitals in Timor-Leste
Presenter:- Dr Ingrid Bucens, Advisor for Quality Improvement for Paediatric and Neonatal Hospital Care; National Hospital Guido Valadares, Dili, Timor-Leste. Contact E-mail: ingbucens@gmail.com

Problem and problem analysis
There is widespread awareness of the poor quality of care provided at hospitals in Timor-Leste. The population regularly complain to the parliament and the media, about specific clinical incidents and treatments and about the attitudes of health workers. Health professionals and advisors report serious concerns with quality of care, both formally, through assessments, and anecdotally. The situation does not appear to be improving and there is increasing pressure on the government to address the situation.

Objectives of improvement approach
To formally address the quality of clinical care in health facilities the Ministry of Health (MOH) recently established a directorate of quality control, with 3 sub-directorates (ethics, monitoring and evaluation and quality improvement). However the directorate is new and does not yet have a clear scope of work. Concomitantly the MOH appointed an advisor for quality improvement (QI) at the National Hospital Guido Valadares (HNGV), the country’s largest hospital, situated in the capital Dili. There have been occasional appointments of both national and international advisors to this position in recent years however the role has not been sustained and national staff counterparts have dwindled to one. Efforts at QI at primary health care facilities have been initiated and supported by partner agencies, together with local health MOH administration; these efforts have been independent of the hospital improvement process and are not described here.

Strategies/activities undertaken
The newly proposed approach for implementing hospital wide QI process at HNGV operates at two levels, executive and departmental. A central quality committee was established with the following goal “To facilitate the HNGV to achieve its vision of being an institution of highly specialised health care of the best quality”. The objectives of this high level committee were

1. To PROMOTE the integration of QI as an essential component of daily service delivery at HNGV
2. To IDENTIFY priority (cross-cutting) issues for improvement at the HNGV
3. To FACILITATE IMPLEMENTATION of QI activities across departments (“scaling up”)
4. To COORDINATE the QI activities and process within the HNGV
5. To SUPPORT the hospital departments to implement QI activities
6. To MONITOR the implementation of QI activities within HNGV
7. To COMMUNICATE about HNGV QI activities to the MOH, professional associations, partners, donors and the public and
8. To be SOURCE for expansion of QI initiatives to hospitals throughout Timor-Leste (TL)

A decision was made to focus departmental QI interventions in maternal and child health, National Health Service priorities. Socialisation sessions were held with staff to introduce the concept of QI and of improving quality of care (QOC) using basic problem solving techniques. Comprehensive assessments of QOC were conducted in maternity and the neonatal wards in order to identify priority problems for improvement and, equally as importantly, model the first step of the QI problem solving process.

Pilot projects for QI in departments, using the problem-solving cycle to identify, analyse and resolve problems, were attempted in these focus wards. In maternity ward a process was commenced to improve hand-washing / disinfecting rates and in neonatology a process was initiated to improve immediate management of small babies admitted to the ward as part of an objective to reduce mortality in small babies.

Tools and materials used
For the maternity department the assessment was conducted internally with a mixed team of medical and midwifery staff and advisors. The Engender Health / COPE assessment tool for EMOC (http://www.engenderhealth.org/files/pubs/maternal-health/qi-for-emoc-manual.pdf) was used because of its applicability to EMOC (a national standard for maternity care in TL) and the QI process. External assistance was sought from a locally based international health organization (USAID supported project) for the client exit interviews and the client flow analysis.

For the neonatal ward an assessment tool was developed for local / national use. The tool incorporated the neonatal care sections of the earlier WHO Hospital Assessment tool but the content was expanded to comprehensively address all aspects of care relevant to referral level neonatal care in low-resource contexts. A similar tool developed by PAHO together with USAID for use in South America was also used as a reference when developing the TL tool. The tool was based on standards for neonatal care as described in Managing Newborn Problems (WHO), a set of training modules developed for neonatal nurses in referral hospitals in Timor-Leste (WHO / MOH / Health Alliance International, 2005) and the Pocketbook of Hospital Care for Children (WHO).

Results and outcomes
The main problems impacting on the quality of clinical care identified during the assessments were common to the maternity and neonatal ward and common to the earlier assessments conducted at HNGV in paediatric care in emergency (2010) and an earlier assessment of neonatal ward, using the same tool, in 2008. Problems with organisation and management of human personnel were more significant than problems of resource availability. The main problems included:-

- Failing to adhere to national or international standards of care, both medical and nursing / midwifery, in spite of earlier training.
- Inadequate monitoring and supportive care of patients including vital signs monitoring; feeds / fluid administration and monitoring, medication prescription, preparation and administration; procedural care including analgesia; infection prevention and counseling.
• Weak leadership and management of nursing / midwifery staff. Staff to patient ratios frequently inadequate due to inadequate workplace attendance and supervision and, sometimes, due to insufficient staff numbers. Staff are poorly organized (lack of flexibility in rostering, no patient allocation etc)

• Absence of an effective system of accountability (for attendance or performance) and no incentive system. Lack of job descriptions.

• Inefficient system for data collection and failure to use ward data for improvement

• Poor verbal and written communication about patients (lack of common languages, lack of patient handover between shifts and between staff, lack of unit meetings)

Achievements and limitations of QI initiatives at HNGV (why more has not been achieved)

Progress in introducing QI as a key strategy for hospital management at HNGV has been slow because QI is a relatively new concept amongst health staff in TL. Its introduction has been challenged by different cultures in administration and management including a lack of a common understanding of what QI is, what it means and how to begin. Thus, QI is not yet ‘owned’ and promoted by executive staff and it is not yet well integrated into hospital plans and strategies nor yet perceived as a key strategy for service improvement.

At departmental level the assessment process was well understood and promoted a sense of team-work and understanding of the first step of QI (problem identification) as well as reinforcement of the national standards for EMOC and neonatal care. The assessments provided comprehensive descriptions of the issues impacting on quality and have found common themes. As yet there has been minimal follow-on action from the assessments, but this is planned. Pilot projects in QI that were initiated in maternity and neonatal wards have not been sustained, largely due to, again, lack of ownership (local champions) of the work and, importantly, lack of a visible commitment to the process from high level national staff together with the absence of any effective system for performance management.

Next steps / Recommendations

For QI to work better in hospitals in Timor-Leste QI must be prioritised and integrated into hospital strategic plans. QI must be ‘always on the agenda’, a budget and incentives must be allocated and accessible for activities and to reward performance. QI must be integrated into service delivery (not seen as ‘extra work’) and results must be used for ongoing improvement. A performance management system, where staff are held accountable for attendance and performance, and staff are rewarded for good work (and active participation in QI projects) is an important part of the necessary process to shift towards a ‘quality culture’. A workshop at MOH level, to promote a shared understanding of QI and of how QI will be implemented in TL would help to promote the necessary shared understanding and commitment to QI at all levels of the health system. A hospital QI committee could be established in each of the six referral hospitals in Timor-Leste, encouraging a collaborative approach.
Annex 4: Abstracts of available tools and materials

Tools and Materials for Improving Quality of Maternal, Neonatal and Child Health Services in Bangladesh
Md Shahidullah1, Iqbal Arslan2, Parveen Fatima3, Shahjadi Anjumonowara4, Altaf Hossain5, Ismail Faruk6, Dewan Emdadul Hoque1, Sk Masum Billah7, Tajul Islam8, Yukie Yoshimura9, Rabeya Khatoon10, Kie Kanda11, Ziaul Matin12
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Starting point
Bangladesh has achieved remarkable progress in maternal, child health and family planning during the last decade. The maternal mortality and under five mortality has declined by 40% and 44%, respectively but the decline in neonatal mortality is slower (24%). Neonatal mortality contributes more than 70% of the infant deaths. On the other hand delivery by skilled provider is only 31%. There is a wide gap in utilization of services by rural and urban as well as between wealth quintiles. To improve accessibility to quality services and further reduction of morbidity and mortality, attention needs to be given on quality of services. The development partners (DP), UN Agencies and NGOs are supporting the Government to improve quality of services, and in support to this a number of materials and tools have been developed.

Description of product
• National maternal health strategy and Standard Operating Procedures (SOP) (in draft)
• National neonatal health strategy and SOP
• National HIV/AIDS strategy and guidelines for the prevention of parent to child transmission (PPTCT)
• Bangladesh version (adapted) of the Pocket Book of Hospital Care for Children by WHO
• Standard Management Protocols on Emergency Obstetric Care
• Integrated Management of Childhood Illness chart booklet
• Training package on Emergency Triage and Treatment for sick newborns (ETAT)
• Quality assessment and improvement manual on maternal and neonatal health services for district level hospitals
• Hospital assessment and Quality Assurance (QA) monitoring tools
• Total Quality Management (TQM) guidelines and tools
• Women Friendly Hospital Initiative guidelines and tools
• Baby Friendly Hospital Initiative guidelines and tools
• Maternal and prenatal death review system and tool
• SOP for emergency, indoor and housekeeping
• Posters, Videos, e.g., 5S posters
• Exit interview questionnaire
• A number of training materials, such as 5S-CQI-TQM, IPP, safe delivery (including Active Management of Third Stage of Labour, partograph, Antenatal Care, Post-natal Care etc.), essential newborn care, safe blood transfusion, training on obstetric, gynecology and anesthesia, training module and chart booklet for basic health workers

Target audience
The materials are targeted for service providers, managers and policy makers.

Based on international standards/guidelines?
All the materials developed are based on evidence-based global/international guidelines and standards.

Languages available:
Materials are mostly in English. However, some materials especially targeted for care providers are available in Bengali.

Experience
Most of the materials have been distributed to respective target users with effective orientation. Those are also shared with the concerned government officials and other partners. However, it needs a boost to increase the use and application of these materials for better practice and services at all levels.

Links with other tools
All the tools are linked with the program objective and strategies under the government health sector program (HPNSDP 2011–2016). They are also interlinked, for example, the maternal health strategy adapted the national neonatal health strategy and standards. They are also linked with cross-cutting issues such as nutrition, breastfeeding, HIV/AIDS etc.

Where is material available?
The materials are available with the Government, DPs and NGOs. Many of them are also available in the websites.

Lessons learnt and recommendations
Weaknesses:
The major weaknesses are a) some materials are not well disseminated to the target users; b) inadequate monitoring and supervision after dissemination and orientation; c) monitoring findings are not always linked with action; d) weak regulation and accreditation system; e) inadequate quality of training; f) inadequate support to fulfil the standards (e.g., infrastructure, supply of equipment, logistics, drugs and maintenance of equipment).

Gaps:
There is a gap between monitoring findings and linking them with supportive and programmatic action. There are various standards and checklists for a single issue, which need to be integrated.
Recommendations for further development

• Widespread dissemination of materials and their use needs to be enhanced and linked with monitoring and supervision
• The monitoring findings should be linked with the plan of action, especially support from central level
• A comprehensive system and mechanism for QI specifying the person responsible for Quality Assurance at different levels needs to be developed
• Integration of various standards and checklists for a single issue to avoid confusion
• QA steering and technical committees should be reactivated
Departmental Checklists and Score Cards for Improving the Quality: a step towards Certification of District Hospitals

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Starting point

In India, there has been several programme based guidelines, and hospital standards – such as Indian Public Health Standards (IPHS) and NABH (National Accreditation Board for Hospitals & Healthcare Providers) Standards. Though they have their own utility, but have not been able to address the needs of Public Health Facilities. Much of the assessment of Public Health Facilities depended upon the perception of assessor, which could be based upon the interpretation of the standards by assessor. Ministry of Health & Family Government of India has recently revamped National Quality Assurance Programme for Public Health Facilities. Under revised programme, each and every public health facilities is expected to attain compliance to 70 standards (for district hospital). Each standard would have measurable elements and measurable elements (ME) have check-points. For each standard and commensurate ME, the checkpoints as applicable for a department has been collated to arrive at Departmental Check-list. It is expected to reduce operator variability and enable inter comparison of department, hospitals and states based on assessment criteria.

The tools presented here are for the assessment of different department of a district hospital. There are a total 18 such tools in form of Departmental checklists, accompanied by score cards.

Description of product

Each checklist has eighth areas of concern i.e. Service Provision, Patient’s Rights, Inputs, Support Services, Clinical Services, Infection Control, Quality Management. Outcome In the departmental check-lists, under each area of concern, there are relevant standards, measurable elements and Checkpoints that defines requirements and measurable aspect of the check-point. Against each checkpoint, assessment method and support has been given to enable user to decide the extent of Compliance and give scores accordingly. With every departmental checklist, a scorecard has been given that gives departmental as well as ‘area of concern’ wise score. This tool is given on a formula fitted excel sheet, so the scores are automatically calculated and reflected in respective area of scorecard.

Target audience

This assessment tool has been designed taking requirement of an average Indian District Hospital into consideration. The target audiences are members of internal assessment team (facility level), District Quality Assurance Unit, State Quality Assurance Unit and the National Assessors. The programme is being rolled out by the Ministry of Health & Family Welfare and its technical support arm – National Health Systems Resource Centre, New Delhi (NHSRC).

Experience

Before recent roll-out by the Government of India, the tools were extensively field tested at different public hospitals. Though the tool is self-explanatory and user-friendly, it requires an orientation training for first time user, which is intended to be done by NHSRC and the Ministry of Health & Family Welfare. Assessment of a department through the check-list usually takes 2 – 3 manhours of the efforts by trained assessors. The calculation and analysis part requires no additional skills and efforts, as it instantaneously achieved through formula driven excel sheet.

Where is material available?

Electronic version is available at NHSRC official website (www.nhsrcindia.org). These tools have been compiled in form “Assessor’s Guidebook for Quality Assurance in District” (two volumes) along with excel tool in companion CD.

Lessons learnt and recommendations- While designing and field-testing these tools, many valuable suggestions were given by service provides and experts which made this tool more user-friendly and contextual to Public Health requirement. We recommend that while designing quality assessment tools, specific needs and process of Public Hospitals (as specific to the region and country) should be factored-in to make it more relevant and truly responsive of needs of country’s health system.

Recommendations for further development.

These tools are currently available on MS Excel Platform. These can further into a software application on Microsoft or Android platform that will enable using these tools on portable devices like tablets and smart phones and enable advance level analysis and inter facility/District/State comparison.

*Consultant, ** Advisor, *** Consultant, Quality Improvement Division, NHSRC
Value Stream Mapping (VSM): a tool for measuring efficiency of critical clinical processes in New Born Care

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Starting point

Though there has been many perceptions regarding Quality. One of the practical ways measuring and defining Quality has been as optimal amalgamation of Structure, process and outcome. The there has been quite absolutism in emphasising on structures in prevalent quality improvement paradigms as it is easy to observe, interpret and correct. But, more often essence of Quality improvement lies in improving the processes (more so in health sector). However, it may not always easy to observe process and identify gaps, and even harder to document them and improve them.

Process improvement and reengineering has been “buzz word” in manufacturing industry after the quality revolution pioneered by Toyota formally called as Toyota Production System or Lean Manufacturing. These principle have been incorporated by other industries including service industries like aviation and telecom. Health care has been a late entrant in this domain, and Public health still very new for these terms and principals often rejected as “Management Jargons”.

Here we have tried to use one of lean tool called ‘Value stream maps’ to measure and improve critical care in newborn care. Value stream mapping is method to shows the flow of material and information that helps to complete the process/service.

VSM is a component of lean Management, which helps in waste elimination, standardization of work and reduction in the variability. VSM is an important tool as it helps in reducing lead-time by identifying and removing non value added activities and in turn improves quality, safety and delivery of services.

Description of product

VSM tool consists of a process-mapping tool that has been used extensively in eliciting gaps in Public Health Facilities by National Health Systems Resource Centre India (NHSRC), as a first step in implementing Quality Management System. It enables us to identify value and non-value added activities along with duration taken to perform each activity. This tool capture critical attributes of a process including Process Title, Process Owner, Process Location, Process Description/steps, Time taken, Wastes, Value Adding, Non-Value Adding activities, Bottlenecks and Suggestion for improvement. While capturing information in this tool, process values are represented in a “Value stream map”, where a rectangle represents value adding activities, while an inverted triangle represents non-value adding activities connected by arrows showing the flow of this process. This enables process owners to visually comprehend flow of process and where they have to improve. Value Adding Activities are those activities that add value important for process as such by changing its form and function. Non Value adding Activities are these activities that directly or indirectly not adding any value to the final product.

Waste: There are 7 identified wastes for any healthcare facility. These are Confusion, Motion, Waiting, Over Processing, Inventory, Defect and Over production. Tool identifies the waste as well as Average time taken by particular waste.

Target audience

Service providers, Process owners, Quality professionals, Quality Assessors and Researchers.

Based on international standards/guidelines?

Toyota Production System (TPS), Lean Healthcare/ Kaizen.

Experience

This tool has been used in process intensive areas like Emergencies, Sick new born Care units (SNCU) etc.

One such study was conducted in SNCU of one District hospital in India it was found that an average 35.6 Minutes was taken between from receiving of the patient in the service delivery area (ward/ SNCU/ Emergency room) to administer the first order, advised by the doctor. On average, 41% time was taken in doing non-value adding activities, such as redundant administrative processes like complex documentation, and walking to distant place for hand washing, waiting for availability of drugs and doctors, duplication work like weighing newborn twice. Most prominent waste was waiting (30%). Other wastes e.g. Confusion (9%), Motion (16%), over processing (10%) inventory (12%), defects 3% and over production (20%) was also observed in the processes.

Links with other tools

• Gaps Analysis tools.
• A3 Problem Solving Tool.
• Pareto Charts
• Process Capability Tool
• Failure Mode Effect Analysis (FMEA)

Where is material available?

NHSRC Website: www.nhsrcindia.org

Lessons learnt and recommendations

Value stream mapping is an excellent tool for mapping health care process especially in critical setups like emergency and intensive care. It can be inferred as evidenced in our study that redundant activities like documentation, inadequate information and inventory, Confusion of orders; to & fro movements, etc are leading causes to delay in patient care processes which may contribute to sub optimal clinical outcome of the facility.

Recommendations for further development:

Currently this tool has been used for critical and intensive clinical care settings of District Hospital (India). It can be used for support and administrative processes.

The current tool may be converted into an electronic module.

*Consultant, ** Advisor, *** Consultant
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Guidelines and Tools for Implementing Quality Management System in Public Health facilities: A comprehensive Package

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Starting point
Implementation of Quality Management System at any healthcare facilities require following steps.
- Status assessment through Gap Analysis of facility
- Quality Management System Development
- Process Documentation
- QMS Implementation

In course of designing and implementing Quality Management System at Public Health Facilities NHSRC has developed a package of tools, Guidelines and Standard Operating Procedures which was used for Quality Improvement projects under NRHM

This package provides guideline for all personnel working in the Public Health System and enables them to implement a system of Quality Management System (QMS) at their workplace so that health facilities not only provide a range of services they are supposed to provide but also ensure that services meet defined standards of quality.

Description of product
Package of guidelines and tool contain majorly 5 technical resources named:

a) Quality Management in Public health care facilities- Traversing gaps
b) As Is Studies
c) An Implementation Handbook- Quality Management in Public health care facilities
d) Standard Operating Procedures
c) Quality Management in Public health care facilities- An Implementation Handbook

Target audience
Service providers, Process owners, Quality professionals, Quality Assessors and Researchers.

Experience
The package is tremendously used by Public healthcare facilities undergoing QMS certification program especially working under Self-implementation Model. It is also used as guidebook by states officials and technical support partners for implementation under Supportive supervision and handholding model.

Where is material available?
NHSRC Website: www.nhsrcindia.org

*Consultant, ** Advisor, ***Consultant, Quality Improvement Division, NHSRC
Standard Treatment Protocols for management of common conditions in small hospitals
Dr. A.K. Deorari, Professor, Department of Pediatrics, WHO Collaborating Centre for Training & Research in Newborn Care, All India Institute of Medical Sciences, New Delhi, India
Contact E-mail: ashokdeorari_56@hotmail.com; Website: www.newbornwhocc.org

Background
Newborn mortality remains high in the South-East Region and continues to account for a major proportion of infant mortality. As the institutional deliveries increase and home/community and facility based care gets scaled up referral rates of sick newborns would increase. Such newborns need a good quality care to prevent mortality at the peripheral that would receive a large number of sick newborns. WHO- Collaborating Centre (WHO-CC) at AIIMS, with help from expert neonatologists from South East Asia Region, developed Standard Treatment Protocols (STP’s) based on generic WHO guidelines on management of sick newborn at small hospitals.

Description
- Overview steps
- Triaging – sheet A,B
- History & Examination
- Specific conditions to manage – Hypothermia, Hypoglycemia, Seizures, etc.
- Appendix- Basic resuscitation, fluids, feeds, discharge advise
* Tool will be shared with participants

Process of Development
Draft STPs by WHO-CC Jan-Feb 2011
→ Deliberated in March 2011
Modification done circulated August 2011
→ Reviewed by SEAR experts
Review by WHO HQ’s; Indonesia WHO office Aug-Sep 2012

Target audience
Health professionals working in First Referral Units, Newborn stabilisation units.

Based on international standards/guidelines?

Recommendations for further development
Evaluation of tool in hands of professionals in the field
Creation of new job aids e.g. Antenatal corticosteroids, infection prevention, birth defects, retinopathy of prematurity.

Links with other tools
Value addition to WHO HQ’s ENC package

Where is the material available?
www.newbornwhocc.org
Printed copies of STPs on request SEARO
Apps on Standard Treatment Protocols for management of common conditions in small hospitals
Dr. A.K. Deorari, Professor, Department of Pediatrics, WHO Collaborating Centre for Training & Research in Newborn Care, All India Institute of Medical Sciences, New Delhi, India
Contact E-mail: ashokdeorari_56@hotmail.com; Website: www.newbornwhocc.org

Background
Training health care professionals poses immense challenges in developing countries due to lack of trainers and uniform standardized tools. WHO- Collaborating Centre (WHO-CC) at AIIMS, with help from expert neonatologists from South East Asia Region, developed Standard Treatment Protocols (STP’s) based on generic WHO guidelines on management of sick newborn at small hospitals and produced them as point of care tools on interactive mobile device.

Description
• A user friendly point of care tool using the android developed tools plugging for eclipse based on the STPs. The contents of the tool were validated by five neonatologists
• This application delineates the important steps in the management of sick neonates; and characterizes the cardinal principles of triage and respective neonatal management.
• It teaches an algorithmic approach for the management of common newborn illness including hypothermia, hyperthermia, seizure, respiratory distress, sepsis, jaundice, shock, asphyxia and neonatal transport.
• The appendix includes basic neonatal resuscitation, feeding of low birth weight and sick neonates, administration of intravenous fluid therapy: principles and steps of management and the essential advice which is to be given for the neonate at the time of discharge.
• All the related videos e.g. expression of breast milk and alternative methods of feeding videos and common related equipments as video demonstrations in the appendix of the application.

* Tool will be shared with participants

Target audience
Medical Officers, Trainee Resident Doctors, MSc Nurses

Based on international standards/guidelines?
WHO–HQ’s latest pink & evidence based blue book

Recommendations for further development
Evaluation of tool in hands of professionals in field
Creation of new tools for different cadres
Making available on cheap Tablets

Where is the material available?
On iTune stores - SickNewborn
Android Google play – AIIMS WHO CC STPs

Links with other tools
Add on to ENC package

Weaknesses
Needs device; Training; Connectivity
The Helping Babies Survive Program “Essential Care for Every Baby”: Beta Testing and Evaluation of Educational validity in India
Dr. A.K. Deorari, Professor, Department of Pediatrics, WHO Collaborating Centre for Training & Research in Newborn Care, All India Institute of Medical Sciences, New Delhi, India
Contact E-mail: ashokdeorari_56@hotmail.com; Website: www.newbornwhocc.org

Background

• Low-cost interventions, including training in neonatal resuscitation and other elements of basic newborn care, may effectively reduce neonatal deaths.
• There remains a desperate need for a widely-available, easily-disseminated, simplified program for training birth attendants in resource-limited areas in basic newborn care.
• Helping babies survive (HBS) based on Essential Newborn care (World Health Organization education program) was developed by American Academy of Pediatrics and evaluated.

Description of product

• Action plan
• Facilitator Flip Chart
• Learner workbook
• Simulators for learning water filled manikin, breast model, etc
• Parents guide

Target audience

Birth attendants, Midwives, Nurses

Based on international standards/guidelines?

WHO–ENC Guidelines

Languages available

English

Evaluation-Cross sectional study in two phase

• In phase I testing, master trainers identified 12 experienced teachers (also known as facilitators) in India, and conducted ‘teach-the-teacher’ training.
• In phase II, these 12 facilitators conducted the course for 62 learners at two centres in Hyderabad and Kolkata.

Evaluation of programme

• The facilitators and the learners underwent the objective structured clinical examination (OSCE) and multiple choice question exam (MCQ) for skill and knowledge assessment respectively.
• Focus groups were used to elaborate on the data from the questionnaires and capture more immediate impressions about the course.
• Thirty (30) learners in the Hyderabad group completed the 30-item pre and post Multiple Choice Questionnaires.
• Questionnaires were used to assess facilitator and learner perceptions of the course on Likert’s scale.

*Results of evaluation and tool will be shared with participants

Recommendations for further development

Demonstration course Uganda Jan 2014 for WHO Hq’s
Evaluation of tool in the field

Where is the material available?

Will be dissemination from American Academy of Pediatrics website.
Process for improving hospital care for children
Dr Martin Weber, WHO/SEARO, New Delhi;
Contact E-mail: weberm@who.int

Starting point
About 10% of sick children presenting for illness to a primary care facility require referral to a hospital for inpatient care. These are the most severely ill children, and thus the ones most in danger of dying. Evidence shows that quality of care provided at the hospital is often poor.

Description of product
This proposed process provides policy makers, hospital managers, clinicians and health workers with guidance on how to improve hospital care for children. It describes a sequence of steps to introduce evidence-based guidelines for care. It also introduces the concept of standards and quality of care to achieve the desired standard for clinical and supportive care for children through a continuous quality improvement process.

Target audience
Policy makers, hospital managers, clinicians and health workers

Languages available
English

Experience
The South-East Asian Region has been the champion of this process developing and endorsing this process in 2008. Much work to improve quality of care has been done since then.

Links with other tools
In addition to technical support, a toolkit that includes evidence-based clinical guidelines, the Pocketbook of Hospital Care for Children (2013 2nd edition), as well as teaching materials, assessment and mortality audit tools and general materials for quality improvement are available from WHO.
Indonesian Assessment Tool for the Quality of Care in Maternal and Neonatal Health
Ms Rustini Floranita, WHO-Indonesia;
Contact E-mail: floranitar@who.int

Starting point
The development of Assessment Tool for the Quality of Care in Maternal and Neonatal Health was initiated by Indonesian Ministry of Health (MoH) and WHO in 2010 as one of the attempts to improve the quality of maternal and neonatal health care in Indonesia. The tool was developed in 2011 – 2012 primarily by Social Obstetrics and Gynecology Association of Indonesia - Indonesian Society of Obstetrics and Gynecology (HOGSI-POGI), in coordination with Center for Health Research University of Indonesia (PPK-UI) and Indonesian Midwives Association (IBI). It was also financially supported by UNFPA, UNICEF, and USAID.

Description of product
The tool consists of one manual book and three sets of form book for each type of facility: hospital, health center, and midwifery clinic. Each form book contains: basic data forms, case observation forms, infrastructure forms, and questionnaire forms. Basic data forms are aimed to collect data concerning facility profiles, such as status, case loads, and health indicators. Case observation forms are designed to assess the performance of case management including antenatal care, normal delivery care, and obstetric complications. Infrastructure observation forms mainly assess the availability of drugs, equipment, and supplies. Questionnaire forms are used to obtain feedbacks from patients and health staffs’ perspectives in improving quality of maternal health care.

Target audience
This tool is to be used by health care providers especially OBGYN specialists, general practitioners, and midwives.

Based on international standards/guidelines?
The tool is adapted primarily from WHO materials and adjusted to the existing national/local guidelines based on discussion with experts.

Languages available
The tool is currently in Indonesian (Bahasa). However, we are in the process of making the English version.

Experience
The tool was used for the first time in 2012 to assess 102 facilities in 11 provinces in Indonesia. In early 2013, the tool was revised based on the experience from the first assessment. The tool is now transformed into one module package for independent use. We hope that, in addition to its primary function as the instrument of the MoH in monitoring maternal and neonatal quality health care in Indonesia, the tool can also be used independently by health facilities and health providers nationwide to evaluate themselves and constantly improve their quality of care.

Links with other tools
The development of the tool was synchronized with that of Maternal Health Pocket Book. During the development, we used WHO Europe Making Pregnancy Safer Assessment Tool for the Quality of Hospital Care for Mothers and Newborn Babies (Eurotool), Facility checklist from MoH (Supervisi Fasilitatif), Indonesian BEONC-CEONC training package (PONED-PONEK), and midwife private practice checklist (Bidan Delima guidelines) as the main references. We also supplemented the content with the most recent guidelines from WHO and MoH.

Material availability
The tool is prepared to be mass-printed in January 2014 and will be available online in www.edukia.org.

Lessons learnt and recommendations

Strength:
It combines standard practice guidelines from the existing tools. The forms in this tool are also designed to give comprehensive information on aspect of the quality of care that need to be improved.

Weaknesses:
We still need identify more evidence and strategies in using this tool as an effective self-evaluation instrument.

Gaps:
There are several differences among standards or policies being used in international, national, and local settings. Not all recommendations from WHO guidelines are implementable in Indonesia.

Recommendations for further development:
We recommend international peer review by WHO regional office and headquarter. We also suggest periodic updates of the tool in accordance with the latest guidelines.
The Maternal, Neonatal, and Child Health Pocketbooks
Ms Rustini Floranita, WHO-Indonesia;
Contact E-mail: floranitar@who.int

Starting point
The maternal, neonatal, and Child Health Pocketbooks were developed to respond to the need of manuals that contain guidelines for essential care and management of emergency conditions and complications, for daily practice.
The development of Child Health Pocketbook started in 2006. The Neonatal Health Pocketbook was developed in 2010. In the same year, WHO Indonesia started development of the Maternal Health Pocketbook.

Description of product
The Child Health Pocketbook consists of guidelines for the management of sick children, emergency care, and immunization. The Neonatal Health Pocketbook consists of the essential care for neonates. The Maternal Health Pocketbook consists of guidelines for antenatal care, normal delivery care, postnatal care, family planning, as well as the management of emergency conditions and obstetric complications.

Target audience
The pocketbooks are targeted mainly for doctors, nurses, and midwives working in primary and referral health facilities, particularly health centers and hospitals. Health professional students can also benefit from these pocketbooks.

Standards/guidelines used in developing the materials
The pocketbooks were developed based on international and national guidelines.

Languages available
Except the Child Health Pocketbook, the pocketbooks were developed in Bahasa Indonesia. Translation to English is in the process.

Experience
The Child Health Pocketbook was adapted from the “WHO Pocketbook of Hospital Care for Children”. The adaptation was undertaken with support from IDAI (Indonesian Pediatric Society). The Neonatal Health Pocketbook was developed by the Directorate of Child Health of MoH with the support from WHO Indonesia, UNICEF, Save the Children and IDAI. Within the same year, WHO Indonesia, with the support from UNFPA and UNICEF, appointed HOGSI-POGI (Social Obstetrics and Gynaecology Association of Indonesia) to be the main consultant for development of the Maternal Health Pocketbook. In developing the books, international and national guidelines from various sources were used. The books were reviewed extensively by experts in the respective fields.

Links with other tools
The Neonatal and Maternal Health Pocketbooks were used as references for the development of the Quality of Care Assessment Tool for Maternal and Neonatal Health.

Availability of the material
The pocketbooks have been mass-printed and distributed to primary and referral health facilities Indonesia. Also, they can be accessed at the website www.edukia.org, in which the pocketbooks are available in HTML and downloadable PDF versions.

Lessons learnt and recommendations

Strength:
The pocketbooks provide complete guidelines for daily maternal, neonatal, and child health care.

Weaknesses:
The Neonatal and Maternal Health Pocketbooks have not yet been reviewed by WHO international reviewers.

Gaps:
Challenges are found in implementing the guidelines in the pocketbooks due to inequity among regions, in terms of capacity of facilities and local policies.

Recommendations for further development:
We recommend periodic updates of the pocketbooks in accordance with the latest guidelines.
Indonesia’s Assessment tool for Quality of Hospital Care for Children
Ms Rustini Floranita, WHO-Indonesia;
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Starting point
To improve hospital care for children in Indonesia the Ministry of Health of the Republic of Indonesia, in collaboration with Indonesian Paediatric Society, adapted the pocket book of “Hospital care for children” (WHO 2005) into the Indonesia version "Hospital Care for Children: Guidelines for First Referral Level Hospitals in District or Municipality", which was launched in 2009. In parallel, an assessment tool of hospital care for children were also developed to conduct an assessment which will provide the baseline data for further action on improvement.

Description of product
The Indonesian assessment tool of hospital care for children was first adapted from the WHO assessment tool. The tool covers 3 areas: medical service, nursing service and administration supports. The medical service for children covers emergency service, case management for cough and difficulty in breathing, diarrhea, fever, malnutrition, routine and sick newborn care and HIV/AIDS.

Target audience
First referral hospitals and primary health centers (puskesmas) with beds

Based on international standards/guidelines?
Adapted from WHO assessment tool for hospital care in children

Languages available:
Still in Bahasa Indonesia, waiting for english translation

Experience
The adaptation process was undertaken in accordance with the Indonesian hospital accreditation tool. However, it was still not adequately assessed for clinical problems when it was first used in the national assessment in 2009. Based on this, a revision was done in 2012.

Links with other tools
It is to be linked to the National Hospital Accreditation tool.

Where is material available?
The tool is not yet formally approved by the stakeholders.

Lessons learnt and recommendations
Weaknesses:
The scoring system of the tool was the most difficult one, to be finalized.

Gaps:
Clinical issues should be adequately covered in an assessment tool for hospital care. Moreover, it is not yet a part of the National Hospital Accreditation tool.

Recommendations for further development:
To continue the finalization of the tool and get approval and to link it to the existing national accreditation tool.
Name of material/tool: Decision-Making tool for Family Planning Clients and Providers

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Starting point:
The Government of Maldives adopted a policy to implement Family Planning services in 1986; by 1990 it had reached all islands. However, the use of services has sharply declined since. In an effort to strengthen the service, Decision-Making Tool for family planning clients and providers was adapted in 2006 and translated to Dhivehi in 2011, since then, it has been distributed to all the islands of the country although the usage is still questionable.

Description of product:
It is a comprehensive, user friendly flipchart containing pictures, flow-diagrams and tables which encompasses information segregated into sections that can be conveniently accessed with the use of tabs. The side tabs assists service providers together with the clients to choose a method which is most suited to their needs, while aiding to interact with new and returning clients, as well as clients with special needs. The bottom tabs provide further information on different methodology, its uses, points to remember, and when to seek health care. It also helps to ensure that the client understands the provided information.

Target audience: Reproductive Age Group
This tool is a translation of Decision-Making Tool for family planning Clients and Providers by Department of Reproductive Health and Research, World Health Organization, Geneva and INFO Project at Johns Hopkins Bloomberg School of Public Health; 2004

Languages available:
It has been translated to the National Language of Maldives; Dhivehi which is spoken all around the country.

Experience:
Knowledge of family planning methods were universal among married women, although the usage declined from 42% in 1999 to 35% in 2009. Most widely known method was male condom (98%), followed by pills (96%), and even though, almost all currently married women were aware of a modern method. However, only 1/3 of the married women were using one; with female sterilization being the most popular, followed by male condom use; 10% and 9% respectively. Conversely, in 1999, the pill had the maximum user rates. Highest percentage of use (69%) was seen between the ages of 40-44, with the lowest usage; 42% in the age group 15-19 (MDHS 2009).

Links with other tools:
This tool was developed by WHO in Collaboration with INFO Project at Johns Hopkins Bloomberg School of Public Health; based on Medical Eligibility Criteria for Contraceptive Use (Third Edition, 2004), Selected Practice Recommendations for Contraceptive Use (Second Edition, 2004) and The Essentials of Contraceptive Technology (2003).

Where is material available?:
It has been mandated for use and distributed to all Health Care Facilities across the nation.

Lessons learnt and recommendations:
President’s award was given to islands based on Fertility Rates under population policy instigated in 1986. While it had worked, it resulted in over control of population, adversely affecting the development of smaller islands, subsequently, leading to opposition from the communities, National Planning Division, and change in overall Government Policy over the years. We also learnt that sudden changes in policy and government structure as well as shuffling staff between health facilities and local councils have adversely affected service delivery.

Weaknesses:
Challenges in implementing the family planning programme and in continuing use of the tools, are many. Firstly, our geographical distribution is a crippling factor for development and strengthening Services with 200 inhabited islands, where some communities consist of 200-500 or less people. With the exception of few islands, the rest can only be reached by sea, rendering them unapproachable due to treacherous weather half the year along with concurrent financial constraints. Hence, in-service and refresher training programmes are difficult to conduct. Likewise, resource management, monitoring and supervision have become humonous tasks. Secondly, high turnover of staff and the absence of a proper handing-over system results in new recruits being unaware of existing protocols and tools. Human resource development, retaining and advocacy are areas that need to be focused urgently. Additionally, demotivation leading to reduced commitment among existing staff is another pressing issue. Furthermore, in recent years, mistrust based on social and some religious views have become a challenge among certain groups in society.

Gaps:
While 2/3rd of Married women currently using a family planning method, have availed the service from a government health facility, the primary source of information is the Mass media. Only 9% of the none-users have been reached at home by the outreach workers or health service providers, and an opportunity was missed when 85% of none-users visited a health facility within a 12 month period without having being approached. (MDHS 2009)

Recommendations for further development:
The necessity to change the opinion of public and policy makers have of family planning as means to restrict population growth cannot be over emphasized. Likewise, its role in reducing the number of unwanted pregnancies consequently improving quality of life and in turn reducing the entailing emotional and economic burden requires highlighting. Moving on to the tool, it needs to be made more concise, as well as regularly updated.
Activities of the Sri Lanka College of Paediatricians (SLCP)
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Improving neonatal care -
Since 2007 – Neonatal life support courses – over 3500 persons trained
Since 2008 – neonatal ventilation courses - IPPV, CPAP
Use of surfactant in NICU’s

Promotion of child health –
Since 2009 - Dengue clinical management workshops - trainers trained in Thailand. Regular reviews from expert teams from Thailand
Confidential Dengue Death reviews – in collaboration with Ministry of Health.
2013 – Launch of Guidelines/Handbook and creation of “Safe Houses” for victims of child abuse

In 2007/8, the SLCP has launched several guidelines on management of common paediatric and neonatal conditions in collaboration with Health System Development Project (HSDP) of the government. These are being reviewed and updated at present.

The Perinatal Society of Sri Lanka (PNSSL) has also contributed significantly by conducting ENBC and Promotion of Breast feeding courses for in service staff and guidelines for management of common neonatal conditions.

The latest achievement of the PNSSL is the launching of a “Neonatal Retrieval system” with a fully equipped ambulance and a trained Team. Further training of staff is in progress with the aim of expanding this service islandwide in the future.
Standards for YFHS and Self-Assessment
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Starting point
- Set up various YFHS in the hospital in Thailand.

Description of product
Compose of 4 components as following:
- Management
- Access to the target population and building demand for services
- Services which address the needs of the target group
- Service system that is efficient and youth friendly

Target audience
Administer and Health Provider

Based on international standards/guidelines?
WHO YFHS Guideline

Languages available:
Thai

Experience
Hospitals having staff be trained for YFHS and work together with other agencies in the responsible areas will pass the assessment of YFHS standards.

Links with other tools
- Guidelines for YFHS Assessment
- YFHS Guideline

Where is material available?
Department of Health, Ministry of Public Health / Provincial hospitals/Community hospitals.

Lessons learnt and recommendations
- Evaluate two times in the first year for effectiveness

Weaknesses:
- Some Providers did not attend the YFHS training course.
- Budget

Gaps:
Up to the level of hospital: Regional hospital, Provincial hospital and District hospital.

Recommendations for further development:
Have to adjust YFHS Guideline and Self Assessment according to area context
A regional meeting on improving quality of care for reproductive, maternal, newborn, child and adolescent health (RMNCAH) held from 16 to 18 December 2013 in New Delhi, India provided an opportunity to review the experiences in improving the quality of health care for mothers, newborns, children and adolescents in Member States, and share the available methodologies and tools for improving quality of care. The report outlines a structured framework and assessment tools developed consensually to establish a quality improvement (QI) process with which the Member States could achieve the global standards of RMNCAH care in the Region and matches with the advocacy for concerted efforts to accelerate progress towards achievement of MDGs 4 and 5. This framework will be useful for partner agencies, professional associations and other national stakeholders.