World Health Organization
REGIONAL OFFICE FOR Europe

Integrated Management of Childhood Illness

Intercountry Meeting on Improving Paediatric Hospital Care Lessons Learned

Yerevan, Republic of Armenia
19–21 October 2010

Abstract

The purpose of this WHO-Regional Office for Europe *Intercountry Meeting on Improving Paediatric Hospital Care – Lessons Learned* held in October 2010 was to review Member States' experience and progress in improving childcare in hospitals, and to discuss challenges, disseminate technical guidance and decide on the next stage for further improving paediatric hospital care in the European Region. Particular emphasis was on how to strengthen the rights of child-patients to optimal health care. Participants identified options that could possible fill gaps and overcome obstacles at all levels and health providers, from national to community, and came up with recommendations on a specific set of actions. Dissemination of the meeting's outcome could contribute to improve paediatric hospital care in all European Member States.

Keywords

HOSPITALS, PEDIATRIC – standards
QUALITY OF HEALTH CARE
DELIVERY OF HEALTH CARE
PATIENT RIGHTS
CHILD WELFARE
EUROPE

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This publication is based upon the report writer's/editors' interpretations of verbal individual inputs and group discussions at the Meeting for National Focal Points on Improving Hospital Child Care held in Yerevan, Armenia on 19–21 October, screen presentations and written papers prepared as part of the meeting process.

The publication does not necessarily represent the views of the World Health Organization, meeting co-organizers or participants at the meeting (including presenters and group facilitators).

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Acknowledgements

The World Health Organization, Regional Office for Europe expresses appreciation to all those who supported, participated in, and contributed to the achievements of this meeting. We are especially grateful to the Ministry of Health of Armenia and WHO Country office for excellent co-hosting and organizing the event, and for hosting a Ministerial reception for participants.

This publication is a result of hard work and partnerships involving many people at the WHO Regional Office for Europe and WHO headquarters, and in Member States.

Special thanks to Giorgio Tamburlini (MCH Institute Burlo Garafolo, Trieste) for his substantial technical contribution to at all stages of the meeting and to all speakers, group work facilitators and members of the planning group: Fabrizio Simonelli from Meyer University Children Hospital, Florence, Wilson Were from WHO headquarter and Karine Saribekyan from MoH, Armenia.

Abbreviations

BFH	Baby Friendly Hospital
CEE/CIS	central and eastern Europe/Community of Independent States
CME	continuous medical education
CoE	Council of Europe
CRC	Convention on the Rights of a Child
EACH	European Association for Children in Hospital
EBM	evidence based medicine
EPA/UNEPSA	European Paediatric Association/Union of National European Paediatric Societies and Associations
ICATT	Integrated Management of Childhood Illnesses Computerized Adaptation and Training Tool
IMCI	Integrated Management of Childhood Illnesses
IGO	international governmental agencies
IPA	International Paediatric Association
KfW	KfW Entwicklungsbank
MCH	maternal and child health
NGO	nongovernmental organizations
NIS	newly independent states
QoC	quality of care
SEMT	self evaluation model and tool
TF HPH CA	Task Force on Health Promotion for Children and Adolescents in & by Hospitals
ToT	training of trainers
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Development Fund
USAID	United States Agency for International Development
WHO headquarters	World Health Organization, headquarters

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Executive Summary

By Aigul Kuttumuratova[i]

The WHO Regional Office for Europe has been promoting a broad process for improving paediatric hospital care. Better quality of care (QoC) in paediatric hospitals aims at delivering health services to children consistent with best evidence.

WHO has developed, both at global and regional levels, a strategic framework, clinical guidelines and assessment and training tools on strengthening child health services in first level hospitals. Based on these documents, countries have developed their national policies, strategic planning and capacity building for the health workforce.

Over the last years, many countries have re-visited the impact of health systems on health. The WHO European Ministerial Conference on Health Systems – Health Systems, Health and Wealth (Tallinn, June 2008)1 – focused on evidence indicating that the performance of health systems is critical to the health and well-being of the people whom they serve.

Based on this assessment, an Inter country Meeting on Improving Hospital Child Care was held in Yerevan, Armenia, on 19–21 October 2010, organized by the Regional Office, in collaboration with the Ministry of Health of Armenia, Regional office of the United Nations Children's Fund (UNICEF), and European Paediatric Association/Union of National European Paediatric Societies and Associations (EPA/UNEPSA). The objective was to identify and recommend further improvements in paediatric hospital care within a health system framework, with particular emphasis on strengthening child patients' rights in a health care context.

Participants included focal points from twelve European Member States, supported by WHO headquarters (WHO-HQ), the Regional Office and WHO European country offices, United Nations (United Nations) agencies, and international- and partner organizations[ii].

The meeting participants recognized that a number of systematic assessments conducted in central and eastern Europe (CEE)/Community of Independent States (CIS) countries showed that QoC in childcare, both at primary and hospital levels, to be poor or suboptimal. Where high coverage is through primary and hospital care services, such as in CEE/CIS, improving QoC is key for reducing maternal, newborn and child morbidity and mortality.

Participants agreed that, to improve paediatric hospital care, the various partners – Member States, WHO, UNICEF and others should be ready to contribute in their areas of expertise. Each country, according to quality care assessment and health systems and institutional reform context, should identify the best combination of policies and actions, and put in place to ensure quality of care for all children. Best practices believed to improve the quality of maternal and childcare should be evaluated and, if confirmed, disseminated to all health facilities. Partners that can provide support, leadership and professional expertise in implementing guidelines to improve QoC that meet the particular needs of their child population should be identified.

In-depth group discussions facilitated a formulation of different strategies related to i) prioritizing quality improvement methods through standard-based systematic assessments, supportive supervision and peer review; ii) introducing performance-based incentives and child focused criteria for accreditation and licensing of health facilities; iii) strengthening capacity of professional associations; iv) incorporating WHO guidelines for paediatric care and evidence-based medicine (EBM) methodology to guidelines and protocols for both pre-service curricula and Continuous Medical Education (CME).

[i] Medical Officer, Non-communicable Diseases and Health Promotion, WHO Regional Office for Europe
[ii] See List of Participants

1 Introduction

In 2002, the Regional Office started a regional process to support countries in improving quality of paediatric hospital care, triggered by the regional consultations that revealed that a very little evidence on quality of hospital care for children in the WHO European Region exists. Following hospital care assessment in three countries of the Region showed an urgent need for significant improvements in paediatric hospital care in many NIS countries.

The present report highlights outcomes of the Inter country Meeting on *Improving Hospital Child Care* organized by the Regional Office, in collaboration with the Ministry of Health of Armenia, Regional office of UNICEF, and EPA/UNEPSA and held in Yerevan, Armenia, on 19–21 October 2010. The aim of the meeting was to contribute to improving paediatric hospital care in countries by strengthening national health systems.

The aim of this report is to present major issues from plenary sessions, group work and discussions on defining challenges, achievements and developments in context of the meeting's agenda items:

- review of country experiences: establishing standards and guidelines,
- review of country experiences: developing and implementing strategies to improve quality of care for children,
- update on initiatives to support implementation and monitoring of processes aimed at improving hospital care for children, and
- children's rights in hospital settings: assessment and strategies towards child friendly hospitals.

The document provides information, conclusions and recommendations generated during the meeting that can be used by MoHs, national experts and professional associations, international partners for refining the national policies and action plans on improving paediatric care in hospitals.

2 Objectives

- Review of Member States' experiences in:
  - establishing standards and guidelines;
  - developing and implementing strategies to improve QoC for children; and
  - share lessons learned during this processes.
- Update progress of on-going initiatives supporting implementation and monitoring of processes aimed at improving hospital care for children;
- Protect and promote children's rights in hospital settings, and
- Draw up proposals on further strategic actions.

3 Proceedings

3.1 Day 1 – 19 October

3.1.1 Opening session

Dr Harutyun Kushkyan, Minister of Health of the Republic of Armenia, opened the meeting by welcoming participants and expressed his pleasure in seeing so many colleagues, friends, representatives from Member States, United Nations agencies and partner organizations gathered in Yerevan. Dr Kushkyan stressed the importance of children to families and societies. Ensuring the health of children and mothers, Dr Kushkyan continued, is one of the top strategic priorities for every country. Children represent the future and their health and protection is an important issue everywhere.

The Minister emphasized that the government of Armenia pays special attention to maternal and child health (MCH) issues, and promotes development and implementation of national strategies on maternal, child and adolescence health. Improving hospital paediatric care is a key priority, as it offers a solid approach to reducing child mortality and meeting the fourth United Nations Millennium Development Goal.[iii]

MCH priorities, continued the Minister, is reflected in Armenia's financial budgets. Despite the financial crisis, the government's allocations for MCH have been steadily increasing. As a result, the Ministry of Health (MoH) has been able to reform obstetric care and has introduced a State Birth Certificate, both having had a positive impact on QoC for mothers and newborns. The MoH is planning to implement a Child Health Certificate to increase access to paediatric hospital care and improve QoC. The MoH has also developed a draft strategy for the improvement of child hospital care, based on WHO recommendation, which will be presented at this meeting.

The Minister expressed his hope that Armenia's experience in MCH, the lessons learned during development of strategies and their implementation will be useful to other Member States and will result in future collaboration between and within countries. The Minister closed by thanking WHO and all those international organizations that are supporting Member States in their efforts to improve children's health.

Dr Ara Babloyan, Chair of the Standing Committee on Health Care, Maternity and Childhood at the National Assembly, Republic of Armenia, greeted participants and emphasized that MCH issues are common to all countries and that protection of MCH is high on the Armenian government political agenda. Dr Babloyan was pleased to announce that this year the government has twice increased financial allocations for paediatric hospital care, an impressive achievement.

Dr Aigul Kuttumuratova, Medical Officer, Integrated Management of Childhood Illnesses (IMCI), the Regional Office, greeted participants and thanked Armenia, as host country, for supporting this WHO Inter Country Meeting. Dr Kuttumuratova then presented the main objectives of the meeting, that have as their basis a the Regional Office survey that showed the need for significant improvements in paediatric hospital care in many newly independent states (NIS) countries. Consequently, participants would discuss such activities they felt might improve services in paediatric hospitals, and define and address major obstacles to optimal care for children.

Dr Kuttumuratova emphasized that special focus will be on monitoring activities that, directly influence quality of paediatric hospital care. At a special session, participants will reflect on ethical and patient rights issues in paediatric hospital settings. The purpose is to help them build capacities in their own facilities, learn from each other's experiences, share tools and documents and strengthen inter country and professional networks. The expected outcome will be agreed-upon concrete steps for improving paediatric hospital care.

[iii] **Reduce by two thirds the mortality rate among children under five**

3.1.2 Introductory Session

➢ **Global status of improving paediatric hospital care**

Dr Wilson Were, Medical Officer, Department of Child and Adolescent Health Development, WHO-HQ , presented the global status of, and lessons learnt from, ongoing activities to improve paediatric hospital care[2]. Dr Were said that the main causes of death of children under five worldwide are neonatal complications (37%), acute respiratory infection (17%) and diarrheal diseases (16%). In the European Region, the neonatal death rate is even higher (53%). Dr Were affirmed that, due to the huge proportion of neonatal deaths among total deaths of children under five, the United Nations MDG 4 could only be achieved if neonatal deaths decrease significantly.

Dr Were explained that child survival depends on disease prevention, proper nutrition, growth and development, early recognition of illness by individuals, families and communities, appropriate case management of sick children, functional referral systems and optimal paediatric care in hospitals. However, paediatric QoC assessments in hospitals worldwide show that up to 75% of hospitalized children receive substandard care because emergency care is poor, staff knowledge and skills in using standard treatment guidelines low, inadequate supply of essential drugs, poor or little monitoring of inpatients and so forth. To remedy this situation, efforts to improve paediatric care in hospitals are on taking place at two levels:

- Global:
  - developing evidence-based guidelines;
  - establishing paediatric standards of hospital care;
  - developing materials and tools to support paediatric care quality improvement processes; and
  - strengthening health systems and clinical skills in management of common illnesses.
- Country:
  - country orientation (identifying leadership and stakeholders);
  - situation analysis, including review of standards, adaptation of hospital care assessment tools, baseline assessment of care against standards, and feedback to national, regional and community counterparts;
  - adaptation of clinical standards;
  - defining interventions and areas for intervention;
  - implementation of standards, QoC mechanisms, links to pre-service training in hospitals;
  - monitoring and evaluation; and
  - dissemination of results and revision of action plans.

At country level, target groups are MoH, stakeholders, policy-makers, programme managers, health professionals and hospital administrators. Current experience shows that different countries are at different stages in the process of improving quality of paediatric hospital care, which requires a systematic approach to addressing gaps in care and involves all stakeholders, so the process may become an integral part of health services. Finally, the introduction of paediatric QoC concepts into pre-service education is key to sustainability of QoC strategies.

➢ **Quality of hospital care for newborns and children – Regional experiences**

Dr Giorgio Tamburlini, WHO consultant, Institute for Maternal and Child Health Burlo Garafolo, Trieste, Italy, made a presentation on the regional experience of improving quality care for children and newborns and its main policy implications. Dr Tamburlini explained that QoC is a multifaceted concept including safety, effectiveness, child centred and continuity of care.

QoC is seen as the key to reducing maternal, newborn and child morbidity and mortality. Low quality care is a drain on both the health system and household finances. Differences in care related to social status, gender and ethnicity are important contributors to inequity in health outcomes. Perceived poor QoC

also harms the system since it may induce caregivers not to seek proper care. Poor quality decreases motivation and places professionals at risk of litigation.

To assess the quality of paediatric, maternal and newborn care in hospitals, WHO has developed specific tools, based on international standards, covering the main clinical aspects of care that help identify areas requiring improvement[3]. The QoC assessment process actively involves both health professionals and users. It has confirmed its potential in improving awareness among health professionals and managers to the shortcomings of the system, their causes and implications, supporting a culture of quality improvement based on peer-to-peer formative assessment rather than on a bureaucracy collecting administrative information that carries a punitive slant towards health professionals.

In 2002, assessments conducted in Moldova, the Russian Federation and Kazakhstan[4] revealed cases of unnecessary admissions, over-diagnosis and over-treatment. Psychological needs of children are often neglected. Recent assessments in Albania (2009) and Kazakhstan (2010) came up with identical shortcomings: QoC is often suboptimal, even when structure, staffing and supplies are not a limiting factor; available resources now used for unnecessary treatments could improve availability and access to essential drugs and effective care elsewhere. More effective and child-friendly care is available within existing structures, staffing and facilities. Dr Tamburlini added that examples of good and even excellent QoC were also observed, confirming that it is possible to ensure quality care in spite of existing deficiencies in health system organization, hospital infrastructure and availability of basic equipment, and essential drugs and supplies.

Dr Tamburlini concluded that it is essential that QoC be improved, the first step should be development of national and/or adoption of international standards, and guidelines (practice guidelines, structural and training standards). Assessment tools and methods should be use to identify critical areas and opportunities for improvement, developing strategies for improving quality, such as motivation, professional development, incentives, accreditation, etc.

Driving force(s) and partners such as MoH, professional societies, international governmental (IGO), nongovernmental organizations (NGO) should be clearly identified at national level.

- **Main discussion points**

  - Participants recognized that the problems set out in both presentations are still common and agreed to the timeliness of this inter country meeting.
  - However, Member States are at different stages of the IMCI guideline implementation process and each faces difficulties and challenges, such as:
    - reluctance of doctors to follow new guidelines;
    - lack of financial resources for MCH (training, essential drugs);
    - lack of incentive mechanisms to encourage providers to use best practices;
    - pressure by pharmaceutical companies in prescribing pharmaceutical products; and
    - poor caretaker knowledge of common symptoms of child illnesses.
  - The closing of paediatric faculties within medical institutes in many Member States has led to a shortage of paediatric cadres, now disproportionally distributed across geographical areas and levels of care, and lack of well-trained health professionals in paediatrics. This is a potential barrier to providing quality of paediatric care in hospitals.
  - Participants emphasized that harnessing the political will to support MCH care, particularly through increased funding, is a key factor for improving QoC.
  - The inter-connection between primary and hospital care means that the quality of one affects that of the other. It is therefore imperative that national health systems improve both holistic and comprehensive approaches, focusing on a full package of paediatric care.

3.1.3 Review of country experience: Establishing standards and guidelines

Dr Aigul Kuttumuratova introduced the results of case studies conducted by the Regional Office to assess improvements in paediatric hospital care in Armenia, Kazakhstan, Uzbekistan and Turkmenistan[5], with

support by international partners. A case study questionnaire collected data on issues such as political commitment, adaptation of international clinical guidelines to local conditions, lesson learned, and plans for improving paediatric hospital care.

The study showed that, in general, the political will exists for improving paediatric hospital care through organization of national orientation events and development of national strategies. Countries have set up priorities for improving case management of major childhood illnesses, and some action towards accreditation has started.

Each of the surveyed countries had adapted and disseminated the WHO clinical guidelines on paediatric care; however, no regular monitoring of results for assessing quality assurance carried out. No indicators exist to measure quality of performance nor are there effective incentive mechanisms for care providers. It is urgent that both become available. There are no efficacious information system links between the different levels of care (primary, hospital, tertiary). All countries provide training for medical staff on adapted clinical guidelines, and Uzbekistan and Kazakhstan have integrated these guidelines into the curriculum of medical training institutions. Technical resources for staffing and equipping paediatric hospitals were one of the main obstacles blocking additional improvements. Financial shortages are another obstacle, both at national and local levels.

Dr Kuttumuratova then listed recommendations that could be contributing factors to improving paediatric hospital care under these conditions:

- develop quality improvement strategies and initiatives (accreditation, performance-based incentives, etc.).
- review policies and develop mid- and long-term plans for improving hospital care at both national and facility levels, setting clear priorities;
- increase budget allocations;
- strengthen health systems through better quality manpower, medicines, health information systems, and ensure links between different levels of care;
- provide internal and external audit and regular monitoring to ensure continuous qoc; and
- involve e patients in monitoring quality and equity of care.

Dr Kuttumuratova then gave the floor to representatives from the three countries under consideration.

- **Uzbekistan:**

In 1999–2000, the MoH adapted the WHO IMCI clinical guidelines, and the first countrywide training courses were organized. In 2003, the Rectors' Council integrated IMCI into the pre-service medical curriculum, a training program was developed and a Training of Trainers (TOT) held. In 2009, with the support of UNICEF, courses in paediatric hospital care took place in eight regions. That same year, IMCI principles and guidelines for hospital setting were integrated into the medical education program, and a ToT for 25 instructors held. Clinical IMCI is now part of the curriculum of many medical chairs. Other paediatric chairs, such as emergency care, children's surgery, infectious diseases, etc., should also implement modern principles of paediatric hospital care. Staff trainings and technical resources are available, including computerized educational training courses.

The main lessons learnt from the Uzbekistan IMCI national children's hospital care program include:

- medical educational institutions need to be involved in all stages of program implementation;
- elements of paediatric hospital care should systematically be integrated into medical teaching curricula;
- main decision-makers should be part of the implementation process; and
- strong support from the MoH and international donors is critical.

The major challenges to program implementation are:

- ensuring sustainability; and
- regular updating of protocols and standards.

- **Kazakhstan:**

In 2002, a WHO assessment of the quality of paediatric hospital care showed problems of: unnecessary admissions, over diagnosis of a number of conditions (including neurological diseases), excessive treatment and long hospital stays. To counter these, a strategic plan for national paediatric hospital care was developed, with the following main objectives:

- creation of a national working group;
- adaptation and implementation of WHO-based clinical guidelines and protocols;
- monitoring and evaluation of QoC; and
- implementation of incentive regulations and mechanisms.

An adapted WHO Pocket Book of Hospital Care for Children was piloted in several regions and 4-day training courses organized in three of them. A system for cascade training was developed by national experts and financial resources allocated for countrywide training courses through the 2011–15 State Health Care Development program.

Currently, Kazakhstan is broadening implementation of the WHO assessment tool for quality of paediatric hospital care, to monitor continued quality improvement processes. A set of QoC indicators has been developed, and supportive supervision methodology adapted to assess QoC in hospitals (expert monitoring visits). The main obstacles to implementation of this approach are:

- Insufficient support from medical facilities' administration; and
- Lack of good performance incentive mechanisms, still in the developmental stage.

- **Moldova**

UNICEF-Moldova and the Swiss Development Cooperation Office in Moldova have supported reform of perinatal care in and three national programs have been ongoing since 1998. The programs aim at modernizing perinatal services, improving the quality of MCH care with the ultimate objective of reducing perinatal, infant and maternal mortality. The programs' main activities are:

- Creating a three-level perinatal care regional system (first, second and third);
- Developing a National Policy on Perinatology (national guidelines);
- Establishing a unified system of monitoring and surveillance of perinatal care,
- Developing appropriate information system;
- Developing infrastructure for perinatal centres,
- Training of medical staff;
- Introduction of modern evidence-based technologies; and
- Integration of perinatal care into community and family health.

Implementation has faced obstacles:

- Insufficient funding;
- Lack of organizational and methodical links between first and second referral level perinatal centres;
- Inappropriate use of existing protocol;
- Resistance of doctors against using modern technologies;
- Poor geographical access to the centres; and
- Shortage of medical staff to provide full-time neonatal care.

3.1.4 EBM in NIS

Dr Varsine Jaladyan[iv], WHO consultant, presented experiences in promoting an EBM approach for assessing and managing children with suspected neurological problems. According to a Regional Office

[iv] On behalf of Dr Colin Kennedy, WHO consultant, Southampton University

paediatric hospital care assessment in NIS countries, misdiagnosis and/or mismanagement of infant and child neurological disorders are widespread, caused by, among others, low compliance with international classification systems, lack of evidence-based clinical guidelines, out of date training, and inadequate health system and welfare regulations.

In 2007, at a Regional Office Regional meeting in St Petersburg[6], senior clinicians and MoH representatives agreed that these were priorities problems needing an urgent solution. An effective partnership between clinicians, WHO and the European Paediatric Neurology Society (EPNS) could be instrumental in achieving improvements through:

- Revising the classification of child neurological diseases in harmony with international standards;
- Developing a handbook of EBM approaches;
- Conducting an in-depth assessment and reconsidering present health system regulations to avoid over-diagnosis and overtreatment; and
- Setting up technical collaborations and exchange of experiences between epidemiology and management of child neurological diseases.

One of the activities of the MCH Project in Kazakhstan is to develop clinical guidelines on diagnosing neurological conditions in newborns and children. Review and production of major neurological condition guidelines follow the framework of the *Project on Support for MCH*. A *Handbook of Neurological Assessment in the First Year of Life*, developed on best evidence, will contribute to improving quality of neonatal and childcare lay out proper clinical management of newborns and children, and update knowledge, skills and accountability in clinical practices. The progress achieved by Kazakhstan will benefit other CIS countries.

➢ **Main discussion points**

Participants were very interested in the *Handbook on Children's Neurological Disease Management* and hoped it would soon become available. The Regional Office informed that it is still under production and publication foreseen in the second quarter of 2011. The Handbook will contain algorithms and practical guidelines to assist in development of protocols.

3.1.5 Review of country experiences: Developing and implementing strategies to improve QoC for children

Four presentations were made, as summarized below.

➢ **Armenia**

Armenia's National MCH Strategy for 2003–2015 was approved in 2003. Although infant mortality rates have been declining over the past ten years, the proportion of perinatal, neonatal and infant deaths in the first 24 hours remains high. Mortality rates in hospitals of children and, in particular, during the first 24-hours, have increased, especially in the regions. Most deaths are considered as being preventable.

The 2005 WHO assessment showed that quality of hospital care needs improvement both in urban and rural hospitals. Availability of staff (paediatricians and especially neonatologists), diagnostics, treatment and intensive therapy and other aspects of care need drastic improvements, particularly in regional hospitals. All paediatric hospitals lack continuous monitoring of QoC.[v]

The National Strategy for Paediatric Hospital Care was developed to address these issues and improve paediatric hospital care throughout the country. The priorities at system level are:

- introduce a new financing mechanism – child health state voucher/certificate system – to improve access to and quality of child hospital care services; and

[v] In 2007–2008, the IMCI hospital component was introduced and 73 paediatricians from 10 regional inpatient facilities participated in a 6-day training program. In 2009, assessment of the IMCI program, including the hospital care component, was conducted in two regions.

- develop a program for strengthening regional child/infant hospital services.

The National Strategy also focuses on:

- increasing the number of skilled health staff;
- introducing ebm guidelines;
- improving hospital infrastructure; and
- ensuring availability of basic equipment and essential drugs and supplies.

To improve access to secondary care, particularly at regional level, regional centres will be set up and an effective rapid response referral/transfer system developed. Extra funding will be needed for paediatric hospitals and for introducing incentive mechanisms to reward providers who practice effective care. Other contributing factors for improved quality are:

- community and family involvement;
- education of mothers;
- effective cooperation between stakeholders, resource mobilization; and
- socioeconomic well-being.

➢ Albania

Improving quality of hospital care for newborns and children is an Albanian MoH priority. The 2009 assessment of the quality of paediatric hospital care revealed multiple problems. Most notable were:

- poor infrastructure (lack of running water, heating, inefficient use of space, etc.);
- lack of essential drugs and basic medical equipment;
- shortage and inadequate distribution of staff, especially neonatologists, throughout the levels of care;
- absence of national clinical guidelines and protocols;
- overtreatment and over diagnosis, unnecessary laboratory tests, long hospital stays, poorly developed information and referral systems between primary and secondary levels and between hospitals; and
- violation of mother and child rights.

Improving hospital care in Albania will require a combination of health system reforms and policies (financing, management of resources, service delivery, stewardship issues). However, some short-term activities would not need major system reforms, such as development of guidelines and performance indicators, improving QoC at institutional level, capacity building training courses, etc.

➢ Kyrgyzstan

The Kyrgyz newborn care program now includes emergency and sick newborn care. The MoH has decided to include components of newborn care into programs active in the field of MCH. International donors such as USAID and KfW Entwicklungsbank (KfW), as well as United Nations agencies UNICEF and UNFPA, support implementation of various child health care improvement initiatives (training of medical staff, provision of basic equipment and essential supplies, assessment of QoC etc.).

There have been significant improvements in antenatal care. 90% of neonatologists and 60% of neonatology nurses have been trained in revised neonatal care principles, both at the pre-service and post-diploma level. Fully equipped training centres are available in northern and southern regions. The protocols on newborn care, based on an EBM approach, have been developed and disseminated. In 2008, with the support of KfW, an assessment of neonatal care services was conducted and a tertiary perinatal care program developed.

The next steps to improve the quality of newborn care will be:

- revision of progress indicators;
- financing and certification mechanisms for obstetric facilities based on QoC;
- integration of vertical programs (IMCI);

- establishment of a referral system
- optimization and rational use of obstetric facilities; and
- promotion of monitoring and supervision.

➢ **EPA/UNESPA promotion of EBM and QoC**

Dr Laszlo Szabo, President of the Hungarian Paediatric Association and council member of EPA/ UNEPSA presented this organization's initiatives for promoting evidence-based practice and QoC though education of health specialists, parents and children. The main objectives are to encourage cooperation between national paediatric societies and stimulate collaborative research as a basis for improving quality of paediatric care. At present, EPA/UNEPSA has 38 member countries worldwide and an official journal is available online. The journal contains a debate section to help members express their ideas and propose solutions to common problems. EPA/UNEPSA organizes workshops and scientific meetings where specialists exchange experiences. The Europediatrics Congress, a highlight of EPA/UNEPSA's activities, takes place every two years, with participation of paediatricians from many countries.

Dr Szabo said that EPA/UNEPSA's full membership represents scientific knowledge that could save thousands of European children's lives; however, the organization's activities are hampered by lack of organization, political commitment and resources. Dr Szabo concluded that, working together, countries could achieve greater improvements in their children's health: "Health is a powerful part of all modern economies and this needs to be recognized by governments".

➢ **Main discussion points**

During the plenary session, a number of questions were raised and answered:

- The current role of the paediatrician was deemed to be: family paediatricians working at the primary care level are responsibility for provision of paediatric care; however, general practitioners, re-trained as family paediatricians, often refuse to, or hesitate in, accepting pre-schoolchildren as patients, passing them on to paediatricians.
- The Armenian MoH will be recalculating funding required for implementation of the Child Health State Certificate, as well as allocations for paediatric hospital care. The MoH feels that the introduction of a Child Health Certificate, which is similar to a birth certificate, would improve overall access to medical care.
- With regard to funding of the paediatric associations, Hungarian and European Paediatric Associations are mostly scientific, nongovernmental organizations that are independently funded, mainly by contributions from members and voluntary donations from individual and/or collective members. The European Paediatric Association has links to the European Union.
- The Uzbekistan national experience in monitoring QoC, including supervisory field visits mentored by monitoring teams, shared observed results and recommendations for improvements with the health facility administration. Anonymised results are sent to the MoH and used in developing operational and strategic health policies.

3.1.6 Working in groups: group work 1

During the last session of Day 1, participants were divided into three working groups, each one requested to define the main obstacles for improving adoption of evidence-based guidelines for neonatal and paediatric hospital care, with due consideration to policy, health facility and professional levels. Solutions for overcoming these obstacles should be identified. The groups' results were presented on Day 2.

3.2 Meeting Day 2 – 20 October

Dr Ivan Lejnev, Consultant, UNICEF, opened Day 2 with a presentation on an innovative software application, *Integrated Management of Childhood Illnesses Computerized Adaptation and Training* tool

(ICATT), developed by WHO and the Novartis Foundation as support for the WHO/UNICEF IMCI strategy[7]. ICATT allows adaptation of generic IMCI guidelines at national and subnational levels, translation into various languages, and development of ICATT-based training courses to fit various approaches (pre- and in-service training, self- and distance-learning). Dr Lejnev also presented a new IMCI tool for HIV/AIDS, developed by the Regional Office and the CEE/CIS UNICEF office.

Although educators agree that computers will never totally replace human instructors and other forms of educational delivery, e-learning has proven as effective as traditional training. It reduces classroom time by an average of 45%. It is easy to use in work settings, the technical quality and content is always consistent and it is cheaper than organizing a training course using printed materials. To reflect the dual purpose of ICATT, the tool has two main interfaces: one Open (Builder and Manager) and one Closed (Training Player). Dr Lejnev said that several countries had tested ICATT and the tool was determined to be useful and efficient for adaptation purposes and as a training tool.

3.2.1 Working Groups Day 1: results

➢ Group 1 – Obstacles and strategies to improve adoption of evidence-based guidelines for neonatal and child care

All three groups identified similar obstacles at different levels and proposed strategies interconnecting these. The obstacles were mainly:

- the merely nominal role of professional organizations;
- lack of incentive mechanisms to increase doctors' motivation;
- insufficient practical training;
- insufficient accreditation and certification mechanisms; and
- poor support for, and monitoring of, guideline implementation.

Proposed strategies included:

- improving national policies and harmonizing existing laws;
- establishing incentive mechanisms;
- developing appropriate monitoring and evaluation systems; and
- incorporating guidelines into basic medical education and postgraduate training.[vi]

➢ Main discussion points

- Participants discussed how to increase the role of professional organizations. Some argued that professionals who regularly deal with patient care are more qualified to develop effective clinical guidelines than the MoH. However, in some countries professional organizations are not financially sustainable, operational or proactive. It will require changes in the attitudes of the organizations and this will take time. Georgia shared the positive experience with its Paediatric Association in that its membership is largely made up of highly qualified professionals with both clinical and teaching experience who are actively involved in development of protocols and guidelines.
- Participants agreed that different countries have different socioeconomic and health system structures. However, the overall stewardship role of the MoH is always crucial for legislative and administrative support when implementing protocols and for carrying out monitoring exercises.
- In some countries, there are inconsistencies within existing laws and regulations and adapted guidelines and protocols, a serious obstacle for implementing international guidelines into clinical practice. Appropriate financial allocations and intersectoral collaboration are essential for the implementation process.

[vi] *For further details, see Annex 1*

- All three groups had eventually focused on the health worker who deals directly with children and mothers. Health staff needs adequate support to keep their motivation high. The low remuneration of health professionals and low prestige of paediatricians are a threat to their independence vis-a-vis the pharmaceutical, drug and vaccine industries. The professionals working in rural areas should have increased social protection, adequate working conditions and sufficient resources to allow them to handle their daily work in an effective and efficient manner.

3.2.2 Update on initiatives to support implementation and monitoring of processes aimed at improving hospital care for children

Dr Wilson Were made a presentation on global initiatives for improving paediatric hospital care. Dr Were raised the issue of effective coverage, that is, the cost of services coverage plus QoC; this system would ensure that QoC improvement was an integral part of local and national health systems, providing effective care for children.

Core strategies to improve QoC for children include:

- availability of evidence;
- strengthening staff knowledge and skills; and
- creating an appropriate environment for effective, safe, timely and patient-centred care.

Development of incentive systems, monitoring of performance and coordination with different stakeholders are also key components for improving QoC.

Dr Were stated that WHO's focus in improving quality of children's hospital care is on:

- evidence-based update of clinical guidelines;
- developing training materials for capacity building; and
- developing assessment and monitoring indicators and tools.

To provide continuous quality assurance processes in countries, the WHO assessment tool can be incorporated into a national quality assessment package. Implementation and monitoring of QoC in paediatrics requires support from all stakeholders, an effective and increasing pace of implementation, full integration of paediatric QoC initiatives in national health systems and measurement of outcomes and service delivery performance across all levels of care.

Dr Giorgio Tamburlini presented other initiatives that support implementation and monitoring of processes for improving children's hospital care. Dr Tamburlini reminded participants of basic requirements:

- standards (practice guidelines);
- measurements (assessment tools);
- strategies (motivation, professional development for doctors and nurses, incentives, accreditation); and
- driving forces (MoH, NGOs and professional societies).

Assessment of quality of hospital care includes:

- identification of critical QoC issues and how these can be improved (local teams and national authorities);
- strengthening the use of up-to-date evidence-based guidelines;
- introducing the concept of peer review; and
- incorporation of an assessment tool and monitoring system into the national health structure.

➢ **Tajikistan**

Dr Sabir Kurbanov**,** UNICEF **–**Tajikistan**,** presented the problems in paediatric hospital care and their solutions. The rates of infant and child mortality are falling, both on a sustainable basis. However, compared to the average CEE/CIS national infant and under5 mortality rates, Tajikistan has more than double the number of deaths. The main causes are attributed to:

- perinatal conditions;
- acute respiratory diseases and pneumonia;
- congenital diseases: and
- malnutrition.

An assessment of the quality of paediatric hospital care was conducted in 2006. Data were collected via interviews with staff, mothers, observations of units/wards, and review of medical records. Different blocs of neonatal and paediatric practices, such as neonatal resuscitation, health care for newborns and children, management of common childhood diseases, feeding, infection and thermal control, etc., were evaluated. Problems affecting the quality of paediatric hospital care were shown to be:

- insufficient funding of hospitals and inadequate supply of essential drugs;
- lack of standards and monitoring tools;
- lack of human resources for monitoring, analysis of assessment data, etc;
- reluctance of health care facility staff to use survey/assessment findings; and
- inadequate infrastructure (environment, power supply, water supply etc.).

Almost all neonatal practice units, in particular those caring for sick newborns and newborn feeding, need to be improved.

Based on the recommendations from the assessment, several important activities have been initiated. The WHO pocket book, updated IMCI algorithm and module on management of 0–2 month infants were adapted and disseminated. A ToT on use of the WHO training package for paediatric hospital care was organized. Protocols on the management of key newborn practices are under preparation. A comprehensive child survival monitoring and evaluation framework, and standardized monitoring tools for hospital assessment are being developed. More than two thirds of paediatric hospitals are certified as Baby Friendly Hospitals (BFH).

➢ **Main discussion points**

- The presentations stimulated the interest of participants, who raised issues on availability of the quality assessment tool and comparable statistical data on QoC across countries to define benchmarks.
- Dr Were answered that QoC is a process and the aim of WHO is to support that process. He said that some assessment tools are available online at no cost; others are still in the developmental stage. Assessment tools evaluate the standards of QoC and each country can adapt them based on their priorities and needs. Currently, there are no statistical data for inter country comparisons of the quality of paediatric hospital care, although a list of global indicators has been developed. Quality needs to be seen as the basis of health systems and services.
- Participants agreed that comparisons between country is impossible due to differences in applied indicators; however, comparison between countries could help understanding where each country finds itself in regard to standards, definition of major obstacles and learning from others' experiences. Using assessment tools can help countries identify their critical areas and find solutions at both local and national levels.
- It was unconditionally recognized that introduction of effective incentive mechanisms is important for improving QoC. However, health facility administrators need to use this approach ethically, avoiding any kind of abuse.
- Some countries (for example, Kazakhstan) have built a number of comprehensive approaches to quality assurance based on the successful implementation of the WHO assessment tool. The MoH and local health authorities have chosen QoC experts to carry out internal clinical audits. These experts find the assessment tool extremely useful, as it has helped them gather evidence on the true situation of paediatric hospital care in clinical settings; the tool is applied on a regular basis to help evaluate continuous improvements.

3.2.3 Working in groups: group work 2

Participants were divided into three groups, each requested to propose actions for supporting implementation of WHO guidelines and other approaches to improve childcare in hospitals at policy, facility and professional levels. Their recommendations were presented on Day3.

3.2.4 Children's rights in hospital settings: assessment and strategies towards child friendly hospitals

During a panel session on Day 2, Dr Were introduced the possibility of using children's rights as a tool for improving child health. Dr Were said that the vast majority of the 8 million young children who die each year belong to poor, marginalized and socially excluded population groups. Life saving interventions do not reach most of these children not only due to cost but also because the groups have no political voice or visibility, leading to inequitable allocation and distribution of available resources, limited targeting and increased social exclusion of children and families in most need of assistance. Translating children's health-related needs into health-related legal entitlements – or legal rights – is crucial if all children are to have an equal opportunity to survive. A legal entitlement places legal obligations (rather than moral responsibilities) on decision-makers – legislators, policy-makers, health care providers – establishing a legal framework and mechanisms for monitoring accountability and seeking redress.

The Convention on the Rights of the Child (CRC)[8], adopted by the United Nations General Assembly in 1989, has been ratified by 193 United Nations member countries. The CRC is based on a thorough understanding of the needs of children; it has one primary health article (Article 24) that entitles all children and adolescents up to the age of 18 to health and health care.

Some challenges hamper the use of CRC, such as a persistent low awareness of its value as a framework and tool for child and adolescent health among the health and medical community, lack of ownership by the MoH, and resistance of health care providers to accepting cultural changes based on legal entitlements of children and adolescents.

Dr Were suggested that adopting and using CRC principles in practice would require countries to provide legislative reviews and reforms as integral components of strategic planning for child health, training hospital staff on the relevance of children's rights in practice and monitoring that rights-based standards and indicators as respected during hospital care. Establishing an independent monitoring body, empowered to receive and act upon complaints, will enable an appropriate control over CRC principle implementation in hospitals. As a final step, to ensure sustainability of child rights protection in medical practice (hospitals) by legal means, it is essential that the public is made aware of the rights of child patients and their families.

3.2.5 Council of Europe on child friendly health care

Dr Fabrizio Simonelli, Head, Health Promotion Program, Meyer University Children Hospital, Florence, Italy, stated that, in 2008, the CoE adopted the strategy *Building a Europe for and with children*, with the objective of promoting children's rights and to protect children from violence. A year later, the CoE set up the Expert Committee on Child Friendly Health Care to oversee the program for 2010–2011. The Committee will have two basic remits:

- Identify the needs and problems of children (including provision of child-adapted and child-friendly health care and promotion of children's participation in decision-making); and
- Possible ways and means of responding to the needs and problems of children as patients (for mainstreaming the rights of the child in health policy).

Progress and results from the CoE Expert Committee will be presented and discussed at the 9th CoE Conference of Health Ministers, in September 2011 (Lisbon (Portugal), on the theme of *Child Friendly Health Care*.

As leader of the Task Force on Health Promotion for Children and Adolescents in and by Hospitals (TF HPH-CA), Dr Simonelli also spoke of how implementation of the Self-Evaluation Model and Tool (SEMT) was progressing. The objective of SEMT is ensuring that children's rights in hospitals are upheld.

Established in 2004, TF HPH-CA promotes and applies the Health Promoting Hospitals Network principles and criteria to the specific issues of health promotion for children and adolescents, providing an operational framework for institutions, decision-makers, health care organizations and care professionals. TF HPH-CA recognizes that respecting children's rights is a key-component of health promotion of children and child and family-centred care. The Task Force includes members of Paediatric Associations and Societies, Ministerial and University Institutes, Paediatric Hospitals and Departments.

In 2005, the Task Force conducted a background *Survey on Health Promotion for Children and Adolescents in and by Hospitals and Health Services* in 114 hospitals. Based on results of the survey, in 2008–2009 the Task Force prepared an SEMT assessment on *Respect of Children's Rights in Hospitals and Health Services*[9] and started SEMT implementation in 16 Paediatric Hospital Departments[10].

The model is based on the four main principles of the CRC:

- the right to life, survival, development and protection;
- respecting children's point of view;
- considering the best interests of the child; and
- non-discrimination between children.

The tool aims at assessing the gaps found today between respect of children's rights and hospital practice, and promotes change and improvements, based on a four phase programming cycle:

- mapping reality (self-evaluation);
- planning improvements (set of standards of children's rights in hospital);
- making improvement (implementation of actions); and
- evaluating change (monitoring progress in closing gaps).

The model tool includes 12 Child Rights in hospitals, divided in three main domains (areas):

- 1: right to the highest attainable standard of health care;
- 2: right to information and participation in all decisions involving their health care; and
- 3: right to protection from all forms of violence.

Dr Simonelli briefly presented the main results of the assessment (structured by areas) that included more attention must focus on the needs of adolescents and vulnerable children, understanding culture-specific parenting beliefs and expectations; and respecting the right to information and participation, privacy, etc.

Dr Simonelli emphasized that the tool can contribute to raise awareness to Child Rights and help identify the gaps and what actions are needed for closing them to achieve real improvements and better QoC. Assessments require the participation of children, parents and representatives of associations. Implementation of this tool does not require substantial financial resources and can be used in other settings, such as schools, social organizations, training settings, etc.

➢ **Main points from discussion**

- Participants agreed that child right issues are crucial for overall child health and survival, and that these rights should be incorporated into paediatric hospital care. They felt that, in the first instance, hospital staff and administration should work on safe care provision, respecting patient privacy and other child right issues. BFH may not be able to provide adequate care in terms of safety.
- Participants suggested incorporating SEMT into the quality assessment tool for paediatric hospital care. Some also felt that, since the Child Rights Charter is in legal language and many terms are unknown to health care providers, a simplified version be edited specifically for health care providers, imitating UNICEF's Child Rights protection document that can be understood by doctors and even children.

- It was agreed that QoC and child rights are interconnected. There is no doubt that the first component of children's rights is to safe clinical care, followed by the location where care is provided (counselling rooms to ensure a privacy, etc.). "There are many issues doctors do not consider in actual practice, but that need attention if providers are speaking patients who are familiar with children's rights." There are many practical issues within child rights that, according to clinical and legal components, belong to the 21st century.
- Participants raised the issue of the stress and anxiety children often experience during hospital stays. To minimize these, it is necessary to follow well defined and EBM indications for hospitalization and do away with excessive and unnecessary stays. It is clear that a child has the right to become well, but hospitalization should be avoided if the child can receive care at home. Clinicians should actively consider this right.
- Further, there are cultural peculiarities in child hospitalization. For example, in Armenia, hospital staff who refuse to admit a child who has no clear symptoms requiring hospitalization may be accused of violating the law because some parents believe their children will get better care in the hospital than at home, and may insist on hospitalization and have support in law.
- Participants agreed that people are often unaware of their rights, or their children's rights, as patients. It is therefore important to increase patient awareness to these rights.
- Participants underlined the need for a comprehensive approach to the rights of children in hospitals, which includes safe and quality care. The SEMT should be used as a screening tool in hospitals to identify cases of violation of children's rights and for developing strategies to ensure that these do not occur.

3.3 Meeting Day 3 – 21 October

3.3.1 Working Groups Day 2: results

The three Day 2 working groups presented their results: they proposed action to support implementation of WHO guidelines and approaches in improving childcare in hospitals that can be addressed through a variety of channels, such as policy, facility and professional[vii].

The main actions proposed by participants:

- introduce performance-based incentives and child focused criteria for accreditation and licensing of health facilities;
- disseminate information through the media to foster changes in attitudes among patients and providers;
- promote supportive supervision and peer review standards based on systematic assessments using the WHO tools;
- ensuring appropriate distribution of paediatric professionals across health care levels, including subspecialty care, and standards for basic equipment, essential drugs and supplies by level of care (regionalization);
- introduce innovative training methods, such as ICATT;
- ensure that all hospitals have access to knowledge and to new information technology;
- incorporate EBM approaches and introduce paediatric guidelines based on WHO recommendations in pre-service training and CME;
- promote ToTs on EBM and child focused care;
- foster the role of patient associations in improving QoC; and
- promote clear criteria of a child's rights to hospital care.

Main discussion points.

[vii] *for more detail see Annex 2*

- Participants emphasized the need for promoting and disseminating the supportive supervision concept among all medical communities, since many decision-makers do not have a clear understanding of its purpose.
- It was emphasized that health professional organizations should be involved in QoC initiatives from their inception.
- There is a need in countries for clearly defined services at each level of health care (primary, secondary, tertiary). It would be rational to conduct a situation analysis for setting priorities and defining recommendations appropriate to the different levels of care.
- Participants emphasized that WHO provides significant technical support. Other donor organizations should contribute through provision of essential drugs and basic medical equipment. National health authorities should be more proactive in fund raising and negotiations with donors.
- Participants were introduced to the International Child Health Review Collaboration web site[viii], a multicentre project developed by WHO and partners. The web site is in English and features documents supporting WHO recommendations for paediatric care in hospitals. This web site material should be available also in Russian, so that Russian-speaking health specialists could have access to EBM reviews in hospital paediatrics. Collaboration will be needed with Russian speaking professional centres willing to help with the translation work.
- Countries' legislation on child rights should be reviewed and strengthened, and awareness of child rights during hospital care disseminated to the general population.

3.4 Conclusions and recommendations

The participants of the *First Intercountry Meeting on Hospital Care for Children* recognize that:

1. **Quality care for children means the delivery of safe, effective, equitable and mother and child *friendly* interventions to ensure the best possible health outcomes for all children.**

2. **Health management policy-makers and health professionals should consider quality medical care an ethical imperative. For mothers and children, quality of care is a basic right.**

- QoC for children, both at primary and hospital levels, has proven, during several assessments in CEE/CIS countries, to be poor or even suboptimal. Excessive or ineffective treatments, excessive hospitalization stays, poor implementation of existing guidelines are still common in many countries.
- In countries with a high coverage at primary and hospital care levels, such as in CEE/CIS, QoC is a key issue in reducing maternal, newborn and child morbidity and mortality.
- The lack of quality, besides putting at risk the health of mothers, newborns and children, results in wasting resources, with higher net costs both for the health system and households.
- There are unacceptable differences (social status, gender and ethnicity) in the delivery of QoC, contributing to inequity in health outcomes.
- The assessments also found examples of good and even excellent QoC, showing that providing safe, effective and child-friendly medical care is possible. Good management and professional competence can correct existing deficiencies in health system organization, hospital infrastructure and availability of basic equipment and essential drugs and supplies.

1. **Assessments and evaluations show that the main obstacles to delivering safe effective and child friendly care are:**

[viii] http://www.ichrc.org

- **Medical and post-diploma training curricula**: many health professionals do not have the scientific or methodological background to meet international standards in paediatric care, and are unable to continuously update their knowledge and skills, form a positive attitude to collaborative team work or attention or responsiveness to mothers' and children's needs.
- **Incentive systems**: lack of such systems, both in health facilities and for individual professionals, undermines delivery of international standard quality care, resulting in a poor use of resources.
- **Certification and accreditation**: lack of, or an inadequate system not based on QoC criteria, will result in inadequate supplies of essential drugs and basic equipment, poor case management and care that is neither mother nor child friendly.
- **Poor remuneration of health professionals and low prestige of paediatricians:** these factors put at risk providers' independence vis-a-vis the pharmaceutical drug and vaccine industry, increasing the likelihood of informal payments and inappropriate medical interventions.
- WHO has developed a series of tools[ix] as guides to evidence-based hospital care for children at all levels, assessment tools for QoC at hospital level, and software for distance learning (ICATT). WHO, UNICEF, with the assistance and support of other partners, provide technical support to assess and improve QoC in an increasing number of Member States.
- More and more countries are engaged in programmes of assessing and improving QoC for mothers, newborns and children. Preliminary results show these to be effective in raising the level of QoC as well as the knowledge and skills of health managers and staff, particularly when based on participatory peer-review assessments – such as those proposed by WHO – on quality improvement cycles and supportive supervision.
- **Existing gaps in quality of hospital care for newborns and children:** participants call upon MoHs to strengthen their stewardship role in assessing and improving QoC. Options to be considered in addressing gaps and obstacles for reaching this objective, along with the continuum of care for mother, newborn, child and adolescent care from community and primary health care to hospital and referral care, include:
  - prioritizing quality improvement methods based on supportive supervision and peer review standard-based systematic assessments, using WHO tools (assessment tool and "Beyond the Numbers" approaches for maternal health); other approaches should have been validated at the international level;
  - introduction of performance-based financial and non-financial incentives and child focused criteria for certification and accreditation of health facilities, as well as licensing/relicensing mechanisms of health providers;
  - building capacity of professional associations to develop and implement guidelines, local protocols, etc.;
  - empowering patients and patient associations, ensuring that patients' voices are heard by health mangers and health providers, including patients' views on quality assessment and accreditation criteria;
  - incorporating WHO guidelines for paediatric care and EBM methodology to guideline and protocol development in both pre-service curricula and in CME, promoting ToTs to build capacity among faculty members and within professional organizations, introducing innovative training tools and methods, such as ICATT;
  - ensuring appropriate distribution of paediatric professionals across levels of care, including subspecialty care, as well as defining standards and ensuring an adequate supply of essential drugs and basic equipment to all levels of care;
  - eliminating the current fragmentation of referral paediatric care by subspecialty hospitals through comprehensive integrated hospital care for children's medical conditions;
  - ensuring access by all hospitals to new Information Technology;

[ix] IMCI, Paediatric Hospital care Guidelines, relevant training manuals and teaching aids

- promoting a Child Rights-based approach to hospital care by introducing clear criteria, submitted to CRC and the *Charter for Children in Hospital* by EACH (European Association for Children in Hospital); and
- enhancing dissemination by the media to support changes in attitude among health professionals and users for appropriate and child friendly health services.

➢ **Recommended actions**

- Member States
  - each country, according to QoC assessment results of care provided to children, taking into account its health care systems and institutional reforms, should identify an optimal combination of policies and actions, among those mentioned above, to ensure good QoC for all children;
  - best practices for improving quality of mother, newborn and child care should be evaluated, disseminated, brought to scale and incorporated into current QoC development plans; and
  - co-opt partners able to provide support, leadership and professional expertise in the process of implementing guidelines and improving QoC, with emphasis on professional and patient associations.
- WHO and partners:
  - develop concepts, tools and provide supportive supervision;
  - carry out systematic assessments of quality of hospital care;
  - build national capacity in quality assessment and development of practice guidelines;
  - update pre- and in-service training, adopting innovative training methods;
  - explore, with partners, how financial and non-financial incentives and accreditation mechanisms can be used to improve QoC;
  - verify whether child rights are incorporated into national hospital/health systems;
  - identify centres of excellence within the European Region to support dissemination of relevant materials, such as systematic reviews and updates; and
  - continue supporting dissemination of best practices.

Strengthening collaboration with European institutions, in particular the CoE, will facilitate developing synergies in policies and actions aimed at improving QoC in Member States.

- Professional associations: National Paediatric Associations, EPA/UNEPSA and (International Paediatric Association) IPA:
  - provide technical support, model training courses, and include topics related to QoC at meetings and congresses;
  - promote 'twinning' programs, information exchange, professional networking and international benchmarking on quality of referral care by subspecialties; and
  - provide support for development and dissemination of guidelines in specific areas of paediatric care, building on experiences in paediatric neurology, in collaboration with the European Society of Paediatric Neurology.

4 Annexes

Annex 1 – Group work Day 1

Obstacles and strategies to improve adoption of evidence-based guidelines for neonatal and paediatric hospital care

Main obstacles and proposed strategies showed considerable similarities between the three groups and are therefore presented jointly:

- **Obstacles**
  - Policy and strategy:
    - insufficient support for implementation at all levels: national, oblast and facility (common strategy);
    - insufficient harmonization of existent policies;
    - low accessibility in facilities to guidelines, protocols (use of adapted version, printing and dissemination);
    - cascade training has shown limited effectiveness with limited emphasis on supportive supervision and management (policy level);
    - absence of medical care standards at facility level; and
    - insufficient basic equipment, essential drugs and medical supplies.
  - Training of medical staff:
    - insufficient training of health professionals in development of EBM guidelines for neonatal and paediatric hospital care;
    - heads of health facilities insufficiently involved in educational/training process;
    - poor links between EBM guidelines and pre- and in-service training;
    - insufficient supervision, support and follow-up visits to already trained staff;
    - medical education not fully reformed (emphasis on theory without feedback; outdated information, no books); and
    - limited access to EBM materials and sources.
  - Monitoring and evaluation:
    - monitoring and evaluation are inadequate to support interventions;
    - accreditation and certification of organizations not harmonized with new methodologies;
    - entities that need to control QoC sometimes have different goals;
    - no "quick" or "express" indicators to assess QoC at facility level;
    - no internal quality audit of health facility practices; and
    - no mechanisms for providing supportive external supervision.
  - Motivation and systems of incentives and rewards:
    - stereotypes and opposition of medical staff (especially older doctors), pressure from authorities and academic institutions (especially in capital cities);
    - low motivation of medical providers to change clinical practice (low salary, absence of incentive mechanisms);
    - perception by communities on what is "good" quality care (more prescriptions = better care); and
    - low motivation of health care managers for introducing new practices.
  - Use of resources and health care facility organization:

- ineffective use of staff (insufficient delegation of tasks to nurses);
- high migration; staff positions, especially in urban rural areas, not filled; no clear understanding of client-oriented approach;
- insufficient continuity between different levels of care (primary health care and in-patient facilities);
- weak role of professional associations, including capacity to develop and adapt international guidelines due to:
    - lack of financial resources;
    - lack of professional development opportunities;
    - lack of recognition;
    - lack of independence due to scarce financial resources; and
    - weak role of NGOs in general.

The groups proposed the following strategies to improve implementation of EBM guidelines:

- Policy and strategy

There is no "one size that fits all" solution: each country needs to identify key players and their roles in the development of EBM guidelines:

- development of an overall national policy;
- harmonization of existent policies;
- development of standards of care and equipping facilities to meet standards; and
- improving accessibility to protocols and guidelines.

- Training of medical staff:
    - involve health care managers in training programs;
    - develop effective strategies to train medical staff; at least 60% of health care providers should be trained in the use of a new approach;
    - include training courses in pre- and postgraduate medical education;
    - strengthen intersectoral collaboration (Ministry of Economics and MoH);
    - reform medical education systems; and
    - ensure continuous education for high and middle level medical professionals.
- Monitoring and evaluation:
    - develop and introduce monitoring and evaluation system based on WHO tools (including self-assessment, "express" indicators, supportive supervision); and
    - improve accreditation, certification and quality control mechanisms.

- Motivation and system of incentives and rewards:
    - develop methods for providing incentives and rewards supporting new practices;
    - more attention to dissemination of adequate information to the community; and
    - improve skills of health care providers in counselling patients.

- Use of resources and health care facility organization:
    - optimal use of nurses: review their functional responsibilities;
    - technical help needed to introduce client-oriented approaches;
    - improve continuity of care between different health care levels;
    - promote the role of professional associations; and
    - Involve NGOs.

Annex 2 – Group work Day 2

Proposed actions to support implementation of WHO guidelines and approaches in improving child care in hospitals

- **Group 1 – Policy level:**

1. Performance-based incentives and child focused criteria for accreditation and licensing of health facilities:

- Countries:
  - collect information on actual experiences;
  - identify strategy for introduction of performance-based incentives;
  - prioritize action areas; and
  - resolve accreditation and licensing issues (including roles and responsibilities of local players, tools and mechanisms).
- WHO:
  - compile experts' review on performance-based financial and non-financial incentives; and
  - share expert reviews between countries
- Partners:
  - technical and financial support to pilot interventions.

2. Fostering the role of patients' association in improving QoC:

- Countries:
  - identify multiple in-country mechanisms to ensure patients' voices are heard;
  - create conditions for patients' free selection of health care facilities (demand-based finances);
  - develop a mechanism for clear and effective feedback from patients on services received; and
  - involve NGOs and Patient Association in a continuous quality improvement process.
- WHO:
  - provide tools, guidelines, expertise to local NGOs.
- Partners:
  - provide technical and financial support.

3. Promote child rights approach to hospital care by introducing clear criteria.

- Countries:
  - review relevant in-country policies from a child rights perspective;
  - identify gaps in child rights and promote policies to close these;
  - educate health workers in child rights in a clear and comprehensible manner;
  - introduce mechanisms to monitor child rights observance (child medical care all levels); and
  - enhance communications through media to support changes in attitude among care service users and professionals.
- WHO:
  - assist countries in identifying and closing gaps.

- Partners:
  - provide technical and financial support.

➢ **Group 2 – Facility level**

1. Promote supportive supervision and peer review standard-based systematic assessments using WHO tools

- Countries:
  - involve partners, professional associations, NGOs., etc.;
  - adapt WHO assessment tools to national conditions;
  - support training of professionals;
  - support piloting efforts;
  - analyse pilot assessment results; and
  - approve national documents.
- WHO:
  - technical support in adapting WHO instruments and training of specialists.

2. Ensure appropriate distribution of paediatric professionals across levels of care, including subspecialty care, as well as adequate supplies of essential drugs and basic equipment by level of care (regionalization)

- Countries:
  - analysis of current situation and development of strategy:
    - develop health care standards for different levels of health care and scope of practice based on specific national/local health care systems;
    - set up health care facilities based on the level of care, providing adequate resources (human, equipment, drugs); and
    - develop human resource training strategy based on levels of care.
- WHO and other partners
  - technical support for development of standards.

3. Introduce innovative training methods, such as ICATT

- Countries:
  - introduce and adapt ICATT to national conditions (orientation workshop, working groups, etc.);
  - set up ToT program;
  - provide technical support (computers, software); and
  - develop national training strategy.
- WHO and other partners
  - technical support in country orientation, adaptation and ToT program,

4. Ensure knowledge of and access to new information technology in all hospitals

- Countries:
  - develop infrastructure to accept latest information technologies;
  - ensure access to the Internet and EBM literature;
  - provide training courses for medical staff;

  - implement telemedicine;
  - implement e-governance for medical documents; and
  - ensure access to national language version of web pages with systematic reviews of hospital care for children, similar to English-based web-site www.ichrc.org

- WHO and other partners
  - provide information and technical support for training programs.

➢ **Group 3 – Professional level**

1. Incorporate EBM approach and paediatric guidelines (based on WHO guidelines) in both pre-service training and continued medical education:

- orientation workshop for policy-makers (WHO);
- define stewardship body to coordinate process (country); and
- adaptation and development of modules for TOTs (stages to be based on country conditions) (Country, WHO and Partners).

2. Incorporate EBM approach, EBM paediatric guidelines (based on WHO guidelines) in both pre-service training and CME

- train teams of professionals and educators as well as different levels of health care providers in guidelines implementation;
- approve training programs, incorporating them into medical education (Country); and
- continuous supervision and monitoring (Country, with WHO for technical support).

3. Promote supportive supervision and peer review based on systematic assessments using WHO tools

- include team of professionals and educators at all stages of EBM program implementation (Country);
- certification and licensing of professionals to include questions based on EBM (Country); and
- continuous supervision and monitoring (Country).

Annex 3 – Programme

- **Day 1, Wednesday, 19 October 2010**

08:00–09:00	Registration of participants	
09:00–09:20	Welcome	*H Kushkyan, MoH,* A Babloyan *Parliament Armenia, WHO,*
09:20–09:30	Objectives of the Meeting	*A Kuttumuratova*
09:30–10:00	Global status of improving paediatric hospital care and lessons learned	*W Were*
10:00 -10:30	Quality of hospital care for newborns and children–Regional experience: main issues and policy implications	*G Tamburlini*
10.30–11:00	Discussion period	
11:30–13:00	Review of country experiences: 1. Establishing standards and guidelines	*A Kuttumuratova*
	Introducing of WHO Pocket book into pre-service medical training	*Uzbekistan*
	Introducing the WHO Hospital care guidelines into practice	*Kazakhstan*
14:00–15:30	Developing and implementing neonatal care guidelines	*Moldova*
	EBM approach in assessment and management of children with suspected neurological problems	*C Kennedy, V Jaladyan*
	Discussion period	
	Review of country experiences: 2. developing and implementing strategies to improve quality of care for children	
	Developing national strategy on improving paediatric hospital care	*Armenia*
	Strategies on improving quality of neonatal and child care	*Albania*
	Improving quality of neonatal care	*Kyrgyzstan*
	EPA/UNEPSA initiatives to promote evidence based practice and quality of care	*L Szabo*
	Discussion	
16:00–17:30	Group work 1**:** obstacles and strategies to improve the adoption of evidence-based guidelines for neonatal and paediatric hospital care	
19:00	WHO reception	

- **Day 2, Thursday, 20 October 2010**

09:00–09:30	Launch of WHO/UNICEF tool on computerized ICATT training course and "IMCI Complementary Course on HIV/AIDS"	*I Lejnev*

09:30–10:45	Group work 2**:** identify enabling factors, barriers and gaps for effective improvement of clinical care and solutions	
11:15–13:00	Plenary–presentations of group work and discussion	
14:00–14:50	Update on initiatives to support implementation and monitoring of processes aimed at improving hospital care for children	*W Were, G Tamburlini S Kurbanov*
16:00–17:30	Panel session: Children's rights in hospital settings: assessment and strategies towards child friendly hospitals	
	Work in progress of Council of Europe on Child friendly health care	*F Simonelli*
	Observations of international implementation process of self-evaluation model and tool on respecting Children's rights in hospital	*F Simonelli*
	Discussion: Suggestions based on Child rights, for recommendations and guidelines on Child Friendly Hospitals	
	Group work**:** what should be done to support implementation of WHO guidelines and approaches in improving child care in hospitals	
19:00	Reception	

- **Day 3, Friday, 21 October 2010**

09:00–10:30	Group work**:** what should be done to support implementation of WHO guidelines and approaches in improving child care in hospitals
	Plenary: group presentations on proposed activities for countries, WHO and partners
11:00–12:30	Group work: Suggestions for next steps
14:00–15:00	Plenary session: Next steps and recommendations
15:00–15:30	Closing

Annex 4 – List of participants

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Annex 5 – References

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