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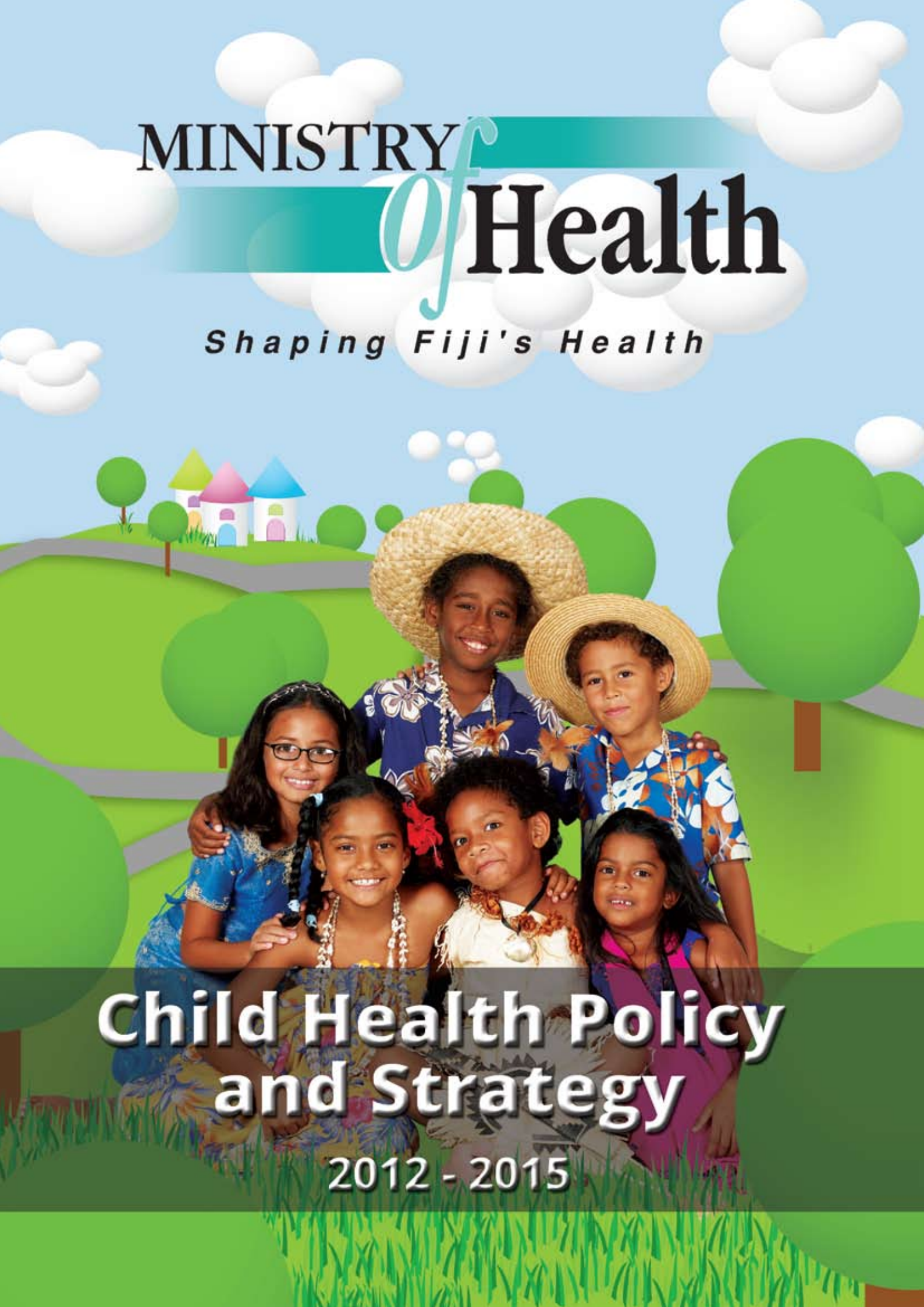

Child Health Policy and Strategy

2012 - 2015


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Acknowlegements

Child health in Fiji has for many years been a priority of both the Public Health Division and Paediatric Department. For decades these two departments have worked in synergy ensuring the health and wellbeing of all children. This synergy is evidenced by the early introduction of new and underutilised vaccines, Integrated Management of Childhood Illness, Prevention of Parent to Child Transmission (PPTCT) as well as adoption and support to breastfeeding and Infant and Young Child Feeding just to name a few.

Over the years the Paediatric and Public Health Departments have worked towards improving Child Health through their core function at the Colonial War Memorial Hospital (CWMH) and other divisional hospitals, while supporting and promoting all other activities outside of the hospital. This is reflected in the paediatric department's goal;

"to provide the services required to meet child health needs to improve and promote the health and welfare of children, through provision of the necessary specific and specialized care and provision and promotion of the preventive aspects of that care, so that the children may reach adulthood in optimum health able to compete at the maximum level of their capabilities."

The Child health Policy and Strategy development followed a comprehensive Child Health Review that identified priority areas that will lead to improvements in child health outcomes and Fiji's ability to meet MDG targets. This innovative Policy has a Strategic Focus and Annual work plans. It has captured the indicators for which divisions could work to in an orchestrated way to meet national targets.

The development of this Child Health Policy and Strategy involved the consultations of many stakeholders involved in the care of infants and children in Fiji. The development of this policy document would not have been possible without the support of Dr Fiona Russell who developed the first draft of the policy before it was edited by the Paediatric (**Headed by Dr Joseph Kado**) and Obstetrics & Gynaecological (**Headed by Dr James Fong**) CSN with the support and help of Dr Frances Bingwor (National Advisor Family Health) and Kylie Jenkins (Technical Facilitator Infant & Child Health, FHSSP) & Dr Rosalina Sa'aga-Banuve, (Program Director, FHSSP).

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Ms Una Bera
(Acting Deputy Secretary Public Health)

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Chapter 1: Introduction

1.1 Purpose of the Policy Document

The purpose of this Policy & Strategy document is to outline policy statements of the Ministry of Health in support of Infant and Child Health. It outlines a framework of key strategic areas and activities to be implemented and identifies mechanisms for improving the effectiveness and efficiency of programmes and services. The policy document represents national commitments to support child health care at the highest level and calls for responsive action at all levels of the health care delivery.

The development of the Child Health Policy provides an opportunity to redefine common vision and mission, revisit goals and objectives, identify programme priorities, assess emerging issues, reprioritise areas for action; and to establish a roadmap for strengthening the delivery of a results-based programme. The policy reaffirms the need for adequate resources in order to implement an effective programme and deliver quality services. It also emphasizes the importance of strengthening the management and coordinating mechanisms to facilitate the achievement of both curative and preventive aspects of child health as reflected in the vision and mission of the programme.

1.2 Background

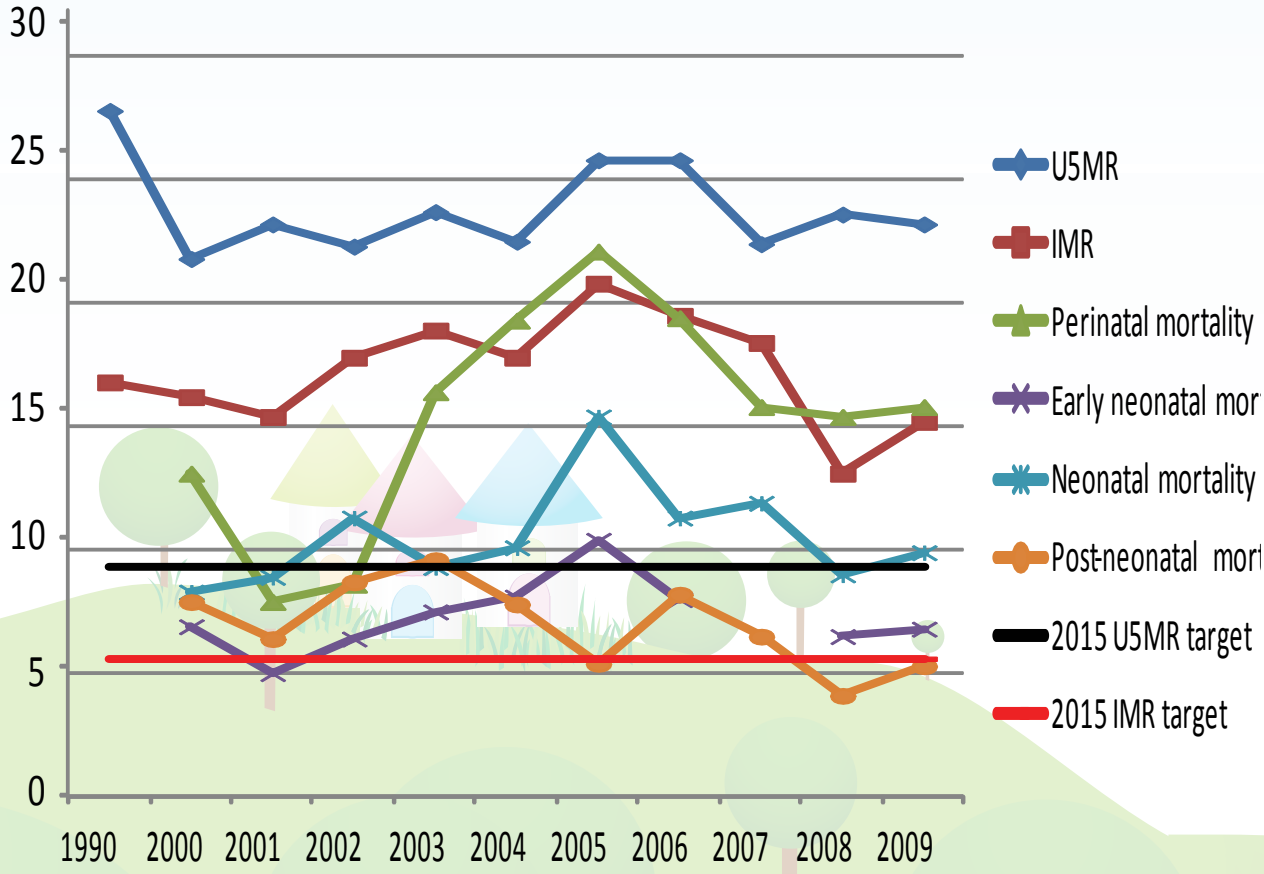
The Republic of Fiji Islands lies within the Pacific Ocean and is currently classified as a lower-middle income country. Fiji's population of 827,900 primarily consists of I Taukei (57%), who are predominantly Melanesian, and Indo-Fijians (38%). Over 75% of the population live on the island of Viti Levu. There has been rapid urbanisation of the Suva peri-urban area, particularly in the area of Nasinu, in the Suva-Nausori corridor. Meanwhile the Northern Division has experienced a very substantial population decrease.

Fiji is party to the Millennium Declaration of 2000 and is committed to achieving the Millennium Development Goals (MDG) targets by the year 2015. The country has incorporated the MDGs in the Strategic Development Plan (SDP) 2011-2015, to ensure that national policies are consistent with the MDGs. The government of Fiji is committed to achieving the child health related MDG targets (MDG 1, 4, and 5) and acknowledges the contribution of reproductive health programme in the achievement of MDGs, in particular the health-related MDGs (MDG 4, 5, 6).

In August 2010 the Ministry of Health undertook a Child Healthcare Review with the aim of evaluating how child health services can make an impact on improving Fiji's MDGs related to child health[1]. The review was based on an analysis of the progress in meeting MDG 4 targets including clinical services for child healthcare, the Integrated Management of Childhood Illness (IMCI), the Expanded Programme of Immunisation (EPI), the Baby Friendly Hospital Initiative (BFHI), child nutrition, health information, research and surveillance, and monitoring and evaluation.

The findings of the review showed that there has been little change in the infant mortality rate (IMR) and under 5 mortality rate (U5MR) for the past 10 years (Figure 1)[1]. The commonest reasons of morbidity and mortality in infants of birthweight >2500g and gestational age ≥34 weeks were perinatal asphyxia, meconium aspiration, and neonatal sepsis. These infants were more frequently admitted to the neonatal intensive care unit (NICU) at CWMH than those that were of low birthweight (<2500g) or <34 weeks gestation.

Figure 1: Child mortality statistics, 2000-2009[2]

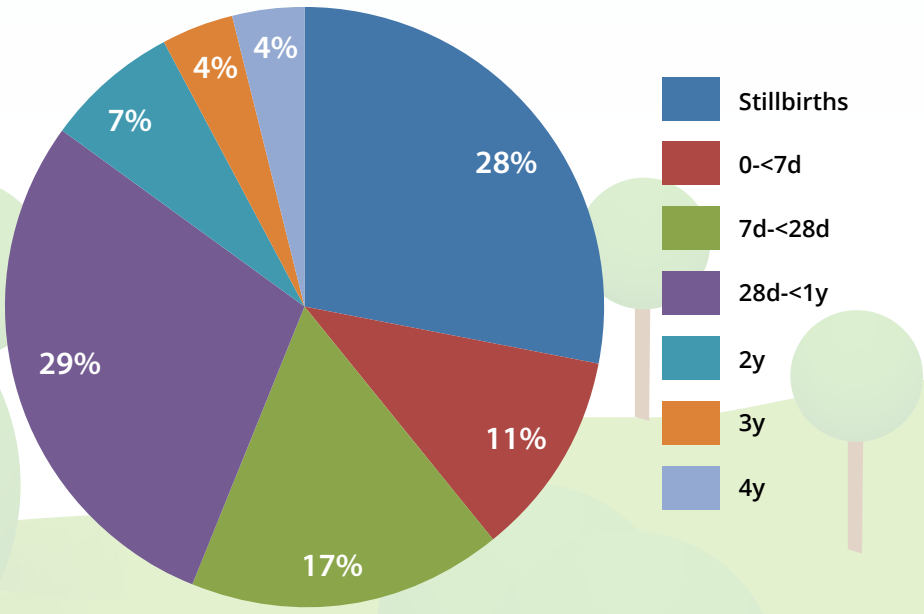


[1] Child healthcare review. Fiji Health Sector Improvement Program, Ministry of Health, 2010.
[2] Vital and Health Statistics, MoH.

Common reasons for admission and mortality in the infants of low birthweight and gestational age <34 weeks were hyaline membrane disease (immature lung), neonatal asphyxia, meconium aspiration syndrome, and neonatal sepsis. Acceleration of MDG4 progress could be made if more attention is given to improving the quality of antenatal and perinatal services as the currently under resourced Obstetric and Antenatal services are significant contributors.

In addition, a sizeable proportion (44%) of all under 5 year old deaths occurred after the neonatal period (Figure 2)[1]. A number of factors including delayed health seeking behaviour due to lack of recognition of illness severity and transportation issues, and delayed referral from subdivisional hospitals were the most frequent factors associated with childhood deaths[1]. The commonest reasons for admission to hospital for children beyond the neonatal period include pneumonia, sepsis (from infected scabies, impetigo, meningitis, pneumococcus, and unknown aetiology), abscess and cellulitis, acute gastroenteritis (with 29% due to rotavirus), congenital heart disease, and injuries. Early detection and treatment of pneumonia and diarrhoea (case management by IMCI trained nurses), in many cases, may prevent the progression to severe disease and hospitalisation. However IMCI is not operational in many of the divisions and shortages of IMCI drugs are common. Severe heart damage from rheumatic heart disease (RHD) following acute rheumatic fever is common and potentially preventable by early detection and good compliance with secondary penicillin prophylaxis.

Figure 2: Contribution of each age group to all U5 year old deaths, 2008



To achieve MDG 4 targets, attention to the continuum of care is paramount. Establishment, promotion of and support for the healthy child is everybody's business. Primary health care is equally as important as curative care. More than 80% of all childhood deaths occur in the three divisional hospitals. Good quality hospital care for children is required to increase the impact of appropriate primary health care interventions on child survival and contribute to achieving MDG 4. Clinical Practice Guidelines (CPGs) are being developed to improve the quality of services delivered.

Many factors contributing to childhood morbidity and mortality need continued programme strengthening. Fiji's progress on core indicators to monitor child survival can be seen in Table 1[1].

Table 1: Fiji's progress on core indicators to monitor child survival

Components of essential package	Core indicators	Percentage (%)
Skilled attendance during pregnancy, delivery, and immediate postpartum	Proportion of births assisted by health personnel	98.8% (2008)[3] 99.8% (2009)
Care of the newborn	Proportion of infants <12 months of age with breastfeeding initiated within one hour of birth	>99%[4]
Breastfeeding and complementary feeding	Proportion of infants <6 months of age exclusively breastfed	40-50%[5]
	Proportion of infants 6-9 months of age receiving breastmilk and complementary food	NA
Micronutrient supplementation	Proportion of children 6-59 months old who have received vitamin A in the past 6 months	Not done
Immunisation of children and mothers against measles	Proportion of one-year-old children immunised	93.9% (2009)[6]
	Proportion of one-year-old children protected against neonatal tetanus through immunisation of their mothers	33%[6]
Integrated management of sick children	Proportion of children 0-59 months of age who had diarrhoea in the past 2 weeks and were treated with oral rehydration solution	NA
	Proportion of children 0-59 months of age who had suspected pneumonia in the past 2 weeks and were taken to an appropriate health care provider	NA

NA: not available

3 Ministry of Health draft Annual Report 2009.
4 PATIS Ministry of Health, average for years 2007-2009.
5 The official rate of 85.5% in the National Dietetic returns, Ministry of Health, 2009, is likely to reflect a substantial degree of double counting.
6 EPI coverage survey, 2008/9.

Maternity Services in Fiji are fairly well developed. While antenatal care coverage has reached more than 95% and many pregnant women receive more than four visits per pregnancy, ensuring better quality antenatal care in terms of early booking (less than 10% of women booking in the first trimester) and more goal oriented antenatal care remains a priority. Most women (>98%) give birth in the three divisional hospitals. However these hospitals are under resourced to provide services for the number of deliveries undertaken. These factors substantially contribute to the perinatal and neonatal mortality rates. Causes of death for many of the stillbirths and neonates appeared potentially preventable.

Breastfeeding rates are low at six months of age despite relatively high levels of early initiation of breastfeeding. Legislation exists to regulate the marketing of infant formulae, all hospitals have been certified Baby Friendly, but few community and workplace supports for breastfeeding are available.

A healthy diet is fundamental in keeping children healthy. There is no data on the rate of complementary food introduction but undernutrition is ~14% in children aged less than five years[7]. Micronutrient deficiencies are common, particularly iron, followed by Vitamin A and zinc. Despite a five year micronutrient supplementation project having commenced the importance of childhood nutrition through a healthy diet, has a relatively low profile. There is a comprehensive Food and Nutrition Policy (2008), and in 2010 the Fiji National Plan of Action on Nutrition (FPAN) was launched. The nutritional aspects of maternal and child health should be integrated into all aspects of training and service provision.

There have been many activities to increase capacity in EPI and therefore increase EPI coverage rates. The coverage rates have improved although in 2009 measles vaccine coverage rates appear to be below target which is thought to be due to a loss in experienced staff following the mandatory retirement of many health workers. The target year for measles elimination is 2012. However, ongoing support is required to achieve this and get MR vaccine coverage rates >95%. The EPI policy has recently been reviewed in 2010. The potential incorporation of new vaccines, pneumococcal conjugate vaccine (to prevent pneumococcal meningitis and pneumonia) and rotavirus vaccine (to prevent one of the commonest causes of childhood diarrhoea) into the EPI schedule requires support and evaluation. Careful planning is required to ensure there is on-going surveillance to detect non-vaccine serotypes. In addition, ongoing support is required to incorporate the planned introduction of Human papillomavirus (HPV) vaccine into the school immunisation schedule.

Primary health care is a key component in the prevention of the many of the childhood illnesses. This includes ongoing support for breastfeeding, nutritional advice, hand washing with soap, minimising the inhalation of indoor air pollution (via cooking smoke or

[7] Consolidated Monthly Returns, 2005-8.

cigarettes), oral health, making a child's home safe, and basic parenting/child care skills. Basic first aid and CPR is also important. In addition the encouragement of food gardens and healthy eating patterns, attendance at antenatal clinic (ANC) and Maternal and Child Health (MCH) clinics, and the ability to identify a sick child needing medical care cannot be overemphasised.

To maximise a child's potential, children need to grow up in a home and community environment that are free from violence, abuse, exploitation and neglect. Fiji ratified the Convention on the Rights of the Child in 1993 and the Child Welfare Decree (which focuses mainly on child abuse, exploitation and neglect) was instituted. When children are abused or neglected there should be guidelines in place to minimise the social, emotional and psychological implications and effects on the child.

Children with disabilities and their families often experience barriers to the enjoyment of their basic human rights and to their inclusion in society. Their abilities are often overlooked, their capacities are underestimated and their needs are given low priority. Early intervention services are required to enhance the child's development, to provide support, assist families, and maximise the child's benefit to society. As neonatal services improve and given that most neonates survive perinatal asphyxia, the need for early intervention and disability services may grow.

Each contact with the health system should be used as an opportunity for health promotion. MCH clinic attendance is an ideal opportunity to give vital health messages as women bring their infants to MCH at least four times in the first year of life.

Collection and collation of data is important for strategic health service delivery and planning. The Public Health Information System (PHIS) and the Patient Information System (PATIS) collect data required for planning. At all levels of the health system, planned activities should be strategic and responsive to the common childhood problems.

1.3 Organisation of Child Health Services

Different levels in the health system are defined in the Clinical Services Planning (CSP) Framework. Basic health care is provided through a hierarchy of VHW (although not formally a MoH service), nursing stations, health centres, subdivisional hospitals, and divisional and specialist hospitals. Divisional hospitals provide tertiary care and subdivisional hospitals provide primary health care and limited secondary health care services. This model has served the country well, but over recent years demographic and social change and improved transport, have meant that the location and size of the buildings require review.

Fiji has a well developed health care system and infrastructure. Newborn and paediatric care have a well-defined clinical/curative component and a public health/preventive component. Linkages and integration between these sections are clearly supported by the Ministry. Health services and programmes are delivered through a decentralised approach through four health divisions Central, Eastern, Northern and Western Divisions.

The types of health facilities comprise the following:

+ Divisional Hospitals - 3
+ Subdivisional Hospitals - 17 (level 1: 4; level 2: 13)
+ Health Centres - 78
+ Nursing Stations - 103

In addition, paediatric services are also provided by the private sector comprising Suva Private Hospital and about 75 registered General Practitioners.

The MoH child health services cover a wide area of health care, with the main ones including:

1. Clinical services for neonatal and child health
2. IMCI
3. MCH checks including EPI
4. BFHI
5. Child nutrition including Infant and Young Child Feeding (IYCF)
6 School health
7. RHD control
8. Adolescent health care
9. HIV-Prevention of Parent to Child Transmission (PPTCT)

1.4 Challenges and the Role of Policy Direction and Support

The move towards decentralisation of programmes and services under the recent health reform aims to build infrastructure, capacity and resources at subdivisional level to be able to deliver a wide spectrum of services as adequately as possible within the constraints of available resources. However these resources have been stretched which often compromises the quality of health services provided. The health sector reforms including the 2009 mandatory retirement of officers reaching the age of 55 years had left a huge gap in senior and middle management [8].

[8] MoH draft Annual Report, 2009.

Despite the good intentions of decentralisation, Fiji continues to face significant challenges and constraints that impede the delivery of quality child health services at all levels of the health care system. These are largely related to staffing shortage, inadequately equipped facilities, weak health systems, and inadequate coordination and management of programmes and services. There have been some research activities assisting in providing an evidence-base to programming which assists in informed policy formulation. The recent Child Healthcare Review[1] assisted in identifying priority areas for programming. This policy document calls for action to address these challenges and constraints. Two main action areas for policy direction to support the implementation and delivery of child health programmes and services are highlighted:

1. PROVISION OF ADEQUATE RESOURCES
   In order that resources are adequately mapped out to facilitate delivery of quality services, the following statements apply:

+ The functions of each category of health facility and services to be provided at each level of facility are clearly defined and communicated.
+ The roles of staff assigned to work the facilities are clearly defined and that staff are adequately skilled to deliver these functions and roles.
+ The facilities are adequately equipped with supplies, medicines, commodities and equipment to be able to deliver the functions prescribed for each facility.
+ Mechanisms for ongoing capacity building, continuing education and supportive supervision are established and strengthened to maintain staff morale, upkeep knowledge and skills, and help retain staff.

2. ESTABLISHMENT OF EFFECTIVE MANAGEMENT, COORDINATION AND SUPERVISORY SYSTEMS
   In order to support the functions of each health facility (hospital level to a nursing station), the following need to be established and strengthened:

+ Clearly defined management, coordination and supervisory roles effectively communicated to relevant staff and the health facility team.
+ Staff in position of management and supervision are capable of and accountable for the effective delivery of facility functions.
+ Clearly defined communication lines are in place to enhance coordination.
+ Established patient referral system and continuity of care from one facility to another, and between curative services and preventive/public health services.
+ Mechanisms for ongoing reviews & monitoring and management meetings are in place to support effective programme coordination and health care delivery.

1.5 Structure of the Policy Document

This policy document was drafted following the Child Healthcare Review undertaken over 6 weeks in 2010 in which extensive consultation was undertaken with the senior staff from the Ministry of Health, The United Nations Children's Fund (UNICEF), World Health Organization (WHO), and NGOs. This document overlaps substantially with the Reproductive Health Policy and Strategy 2010 and care was taken to ensure consistency within the two policies and expands on aspects pertaining to child health in this policy.

The following policies and strategies are relevant to child health:

+ Reproductive Health Policy and Strategy 2010
+ 2008 Food and Nutrition Policy
+ Breastfeeding Policy
+ National Food and Nutrition Policy for Schools 2009
+ The Fiji Plan of Action for Nutrition 2010-2014
+ Expanded Programme on Immunisation Policy 2010
+ Fiji PMTCT HIV Policy
+ Rheumatic Heart Disease strategy (under development)
+ Child Welfare Decree 2010

This document includes two component areas aligned to the priority child health action areas for Fiji. Each area has a policy statement which translates into a number of key strategic actions. A number of key activities are outlined under each strategic area. The two component areas include:

1. Newborn Care: This is also contained within the Safe Motherhood – Maternal and Newborn Care in the Reproductive Health Policy and Strategy 2010

2. Infant and Child Health

Chapter 2: Policy Statement for Infant and Child Health

2.1 Vision, Mission and Goal

VISION: The achievement of optimum child health for all children in Fiji

MISSION: To provide comprehensive and integrated health services for all children.

GOALS:

Goal 1: To contribute to the reduction of childhood morbidity and mortality by two thirds between 1990 and 2015, thus contributing to the achievements of MDG 4, specifically:

+ To achieve an IMR of 5.5 per 1,000 live births by 2015
+ To achieve an U5MR of 9.3 per 1,000 live births by 2015

Goal 2: To contribute to the reduction in under five under-nutrition by three quarters between 1990 and 2015, thus contributing to the achievements of MDG 1, specifically:

+ To reduce undernutrition in under 5 years olds to 50% by 2015

2.2 Policy Statement

All infants and children have access to quality curative and preventive paediatric services to protect and safeguard their health, with particular reference to the most common causes of infant and childhood morbidity and mortality including respiratory illness, diarrhoeal disease, and malnutrition.

2.3 Key Policy Areas on Infant and Child Health

Policy Statements On Infant & Child Health

Protecting the health of infants and children from common illnesses will support their survival, growth and development to full potential. The policy calls for action and allocation of necessary resources to provide comprehensive and integrated services for infant and child health. This will help to reduce neonatal, infant and childhood morbidity and mortality thus contributing towards the achievement of MDG 4.

POLICY STATEMENT:	All infants and children have access to both curative and preventive paediatric services to protect and safeguard their health, with particular reference to the most common causes of infant and childhood morbidity and mortality including respiratory illness, diarrhoeal disease and malnutrition
Strategic Area 1:	Development of a well-functional Neonatal Services.
Strategic Area 2:	Development of a well–functional Paediatric Service that provides optimal continuity of care and links in-patient with out-patient paediatric care.
Strategic Area 3:	Development of a well functional Preventive Paediatric Service to protect neonates, infants and young children from common illnesses through the EPI programme and other preventive health programmes such as HIV-PPTCT and RHD.
Strategic Area 4:	Development of a well functional programme on "Integrated Management of Childhood Illnesses (IMCI)" that aims to reduce the incidence and prevalence of the most common causes of childhood illnesses.
Strategic Area 5:	Development of an Infant Nutrition/Feeding programme, including the promotion of Breastfeeding to reduce the incidence and prevalence of nutrition-related causes of childhood illnesses and future non communicable diseases
Strategic Area 6:	Ongoing development and support for operational research.

Activities Under Strategic Area 1:

Neonatal Services

1. Assist in the review of the nursing curriculum in newborn care and neonatal resuscitation training.
2. Review current neonatal services in all subdivisional hospitals to harmonise with the CSP.
3. Provide ongoing training for maternal and neonatal care staff in all subdivisional hospitals, including midwife training in foetal monitoring, neonatal resuscitation, and newborn care.
4. Develop/review standard protocols and treatment guidelines for doctors and nurses for the most common neonatal conditions.

5. Establish an effective referral and follow-up system to facilitate continuity of care.
6. Establish a mechanism for on-going Monitoring and Evaluation (M&E) of neonatal services – including a regular analytical review of neonatal service data for informed decisions and evidence-based programming.
7. Confidential inquiry of all neonatal deaths and stillbirths with refinement of the data collected regarding the stillbirths and neonatal deaths to determine whether preventable factors were evident or whether the neonate was incompatible with life.

Activities Under Strategic Area 2:

Clinical Paediatric Services

1. Assist in the review of the nursing curriculum in MCH and child healthcare.
2. Develop specialist paediatric nurses including general paediatrics, PICU and NICU.
3. Review of current Paediatric Services in all hospitals, health centres and facilities; and identify areas for improvement and resources required.
4. All nurses undertaking pre-service, midwifery, and public health nursing to be trained in basic child health (including IMCI, MCH, Paediatric Life Support (PLS), neonatal resuscitation etc) with regular refresher courses.
5. Capacity building and in-service training for clinical staff in all hospitals and clinical settings in the CPGs and other core paediatric skills namely IMCI, PLS, Advanced Paediatric Life Support (APLS), and the WHO Pocket Book for Hospital Care of Children.
6. Provision of a career path for Diploma graduates and revitalisation of the Diploma in District Practice.
7. Review and dissemination of standard protocols and CPGs on the most common Paediatric conditions.
8. Establish an effective referral and follow-up system to enhance continuity of care.
9. Establish mechanisms for on-going M&E of Paediatric services – including a regular analytical review of paediatric service data for informed decisions and evidence-based programming.
10. Confidential inquiry of all under 5 year old deaths.
11. Conduct outreach clinics to sub divisional hospitals.
12. Review of child disability and early intervention services.
13. Review of child and adolescent mental health services.

Activities Under Strategic Area 3:

Preventive Paediatric Service through EPI, HIV-PPTCT, RHD programmes.

1. Specialist input into the revised VHW curriculum.
2. Develop teaching aids and health promotion materials for MCH nurses and VHW.
3. Revise MCH card/booklet.
4. Strengthen partnerships with NGOs and community organisations and offer VHW training to their community health workers.
5. Ongoing support for EPI.
6. Implementation and evaluation of the infant pneumococcal conjugate and rotavirus vaccines, and HPV vaccine into the school health programme.
7. Ongoing support for HIV-PPTCT.
8. Support for the development of the RHD strategy.
9. Ongoing support for the RHD programme for screening and secondary prophylaxis.
10. Review of school health screening and incorporation of RHD screening.
11. Finalise child protection policy.

Activities Under Strategic Area 4:

Integrated Management Of Childhood Illnesses

1. Review/develop policies and guidelines relating to IMCI and wellbeing.
2. Provide ongoing training for health care workers in the delivery of IMCI and wellbeing.
3. Provide access for General Practitioners to ICATT (IMCI) training.
4. Strengthen referral and follow-up system to improve IMCI and wellbeing.
5. Review of medicines and other commodities required for an effective IMCI programme.
6. Establishment of mechanisms for on-going practical M&E.

Activities Under Strategic Area 5:

Infant Feeding And Nutrition, And Breastfeeding

1. Undertake operational research to understand the enablers and disablers of Breastfeeding.
2. Devise evidence based social marketing of Breastfeeding.
3. Review of current Breastfeeding and Infant Feeding/Nutrition policies and practices.
4. Capacity building and in-service training for staff involved in the implementation of the Breastfeeding and Infant Feeding programme.

5. Develop community supports for Breastfeeding with engagement of community groups and agencies.
6. Establish an effective referral and follow-up system to enhance continuity of care and integration of services to support Infant Feeding.
7. Establish mechanisms for on-going practical M&E to support delivery of Infant Feeding and Nutrition to assist in strategic planning at all levels. 8.D e v e l o p guidelines for the management of children with specific nutritional needs, e.g. HIV positive children and HIV negative infants (HIV positive mother).
9. Incorporation of micronutrient supplementation as a routine particularly for under 2 year olds, pregnant women, and girls in their final year of school.
10. Ongoing support and integration with The Fiji Plan of Action for Nutrition 2010-2014.

Activities Under Strategic Area 6:

Ongoing Development And Support For Operational Research

1. Continue partnerships with institutions, agencies, and strengthen links with NGOs to undertake relevant operational research to evaluate the impact of various child health activities and develop the evidence for ongoing strategic planning.

Cross-Cutting Issues

1. Appoint a senior child health officer to co-ordinate and monitor the implementation of the strategy in harmony with other relevant policies and liaise with the divisions on the inclusion of child health activities in annual plans.
2. Regular meetings of the child health committee to guide direction of the implementation of the strategy and monitor progress.
3. Develop a standardised annual child health progress report to assess MDG and other key performance indicator progress.
4. Further training in PHIS and data analysis at all levels of the health system, so activities are strategic and responsive to the common childhood problems.
5. Resources are secured to facilitate the implementation of the activities under each key strategic area in order to operationalise the policy statement. Resources include adequate staffing, facilities and equipment, supplies and commodities.
6. Specialist nurses should be recognised and renumerated with a minimisation of staff movements once staff are trained in a certain area.
7. Plans for integration of Paediatric services into primary health care facilities as a long-term sustainable approach.
8. Integration and linkages for stronger partnership at all levels of implementation and engaging sector-wide approaches.

9. Apply the principles of primary health care to engage parent, families and communities in infant and child care.
10. Document lessons learned and best practices as a tool for evidence-based programming.
11. Partner agencies and donor community to engage in more effective coordination at divisional and national level.

Performance Indicators

Input indicators

+ Infant and Child Health is integrated with national Reproductive Health policy and made widely available.
+ Availability of skilled providers – nurses and doctors to provide the services.
+ Availability of VHWs.
+ Availability of medicines, equipment, and drugs.

Process and output indicators

+ Number of hospitals with well-equipped and adequately staffed neonatal units and paediatric wards.
+ Number of health facilities with trained staff to provide IMCI services.
+ Number of health facilities with trained staff to provide Infant Nutrition and Immunisation.
+ Number of health facilities with trained staff to provide PPTCT services.
+ Establishment of referral mechanisms for an integrated program providing continuity of care.
+ Increase in number of trained service providers.
+ Increase in number of health facilities equipped to provide optimal infant and child health.

Outcome indicators

+ Reduction in perinatal mortality rate
+ Reduction in neonatal morbidity and mortality rates
+ Reduction in infant morbidity and mortality rates
+ Reduction in under 5 morbidity and mortality rates
+ Reduction in Paediatric admissions – respiratory, diarrhoeal diseases and malnutrition
+ Increased EPI coverage
+ Reduction in under 5 undernutrition rate

National Child Health Work Plan
Division And Subdivisional Work Plans 2012-2013

ACTIVITIES	PERFORMANCE INDICATORS	TIMELINE	RESPONSIBILITY
STRATEGIC AREA 1: Development of a well-functional Neonatal Services.			
1. Review nursing curriculum in newborn care and neonatal resuscitation training.	Provide specialist input into revision of curriculum	2012-2013	FNU, Paediatric CSN, MoH, Obstetric CSN, FHSSP
2. Review current neonatal services in all subdivisional hospitals to harmonise with CSP.	Review undertaken. Recommendations implemented.	2012 2013	Paediatric CSN, FHSSP
3. Provide ongoing training for maternal and neonatal care staff in all subdivisional hospitals, including midwife training in foetal monitoring, neonatal resuscitation, and newborn care.	Training plan developed & implemented.	2012 & on-going	MoH, FNU, FHSSP, UNICEF, WHO,
4. Develop/review standard protocols and treatment guidelines for the most common neonatal conditions.	Protocols developed and distributed.	2012-2013	Paediatric CSN
5. Establishment of an effective referral and follow-up system to facilitate continuity of care.	Referral and follow up system developed.	2012 & on-going	Paediatric CSN
6. Establishment of mechanisms for on-going Monitoring and Evaluation (M&E) of neonatal services – including a regular analytical review of neonatal service data for informed decisions and evidence-based programming.	Standardisation of the collection of NICU data in 3 divisional hospitals. Annual collation of NICU data.		
7. Confidential inquiry of all neonatal deaths and stillbirths.	Develop review committee and guidelines. 50% of all deaths reviewed by end of 2012. >95% of all deaths reviewed thereafter.	2012	Paediatric CSN, OBSTETRIC CSN
STRATEGIC AREA 2: Development of a well–functional Paediatric Service that provides optimal continuity of care and links in-patient with out-patient paediatric care.			
1. Review nursing curriculum in MCH and child healthcare.	Provide specialist input into revision of curriculum.	2012	FNU, Paediatric CSN, MoH, Obstetric CSN, FHSSP
2. Develop specialist nurses including general paediatrics, PICU and NICU.	Develop paediatric nurse training course. Support for NICU and PICU PACTEM nurses to develop guidelines, training & provide supervision.	2012 & on-going 2012-2013	FNU, Paediatric CSN, MoH, FHSSP,
3. Review current Paediatric Services in all hospitals, health centres and facilities; and identify areas for improvement and resources required.	Recommendations implemented. Review undertaken and completed.	2013 & on-going	Paediatric CSN, MoH, FNU, FHSSP

ACTIVITIES	PERFORMANCE INDICATORS	TIMELINE	RESPONSIBILITY
4. Capacity building and in-service training for CPGs and other core paediatric skills: IMCI, PLS, APLS, WHO Pocket Book, and specialist CPGs.	In-service training plan developed and implemented in each division for: IMCI, neonatal resuscitation, PLS, APLS, WHO Pocket Book.	2013 & on-going	Paediatric CSN, FHSSP, MoH
5. Review and dissemination of standard protocols and CPGs on the most common Paediatric conditions.	IMCI, WHO Pocket Book, & specialist CPG available in all relevant health facilities.	2012	Paediatric CSN, MoH, FHSSP
6. Establishment of an effective referral and follow-up system to enhance continuity of care.	Referral & follow up system established.	2012 & on-going	Paediatric CSN
7. Establishment of mechanisms for on-going M&E of Paediatric services – including a regular analytical review of paediatric service data for informed decisions and evidence-based programming.	Annual national NICU and child health report.	2012 & on-going	Paediatric CSN
8. Confidential inquiry of all under 5 year old deaths.	0% of all deaths reviewed by end of 2012. >95% of all deaths reviewed thereafter.	on-going	Paediatric CSN
9. Conduct outreach clinics to subdivisional hospitals.	9 Outreach clinics performed per year in each division.	2012 & on-going	Paediatric CSN, MoH
10. Review of child disability and early intervention services.	Review undertaken and completed. Recommendations implemented.	2013 & on-going	Paediatric CSN, MoH
11. Review of child and adolescent mental health services.	Review undertaken and completed. Recommendations implemented.	2013 & on-going	Paediatric CSN, St Giles
STRATEGIC AREA 3: Development of a well functional Preventive Paediatric Service to protect neonates, infants and young children from common illnesses through the EPI programme and other preventive health programmes such as HIV-PPTCT and RHD.			
1. Specialist input into the revised VHW curriculum.	VHW curriculum finalised.	2012	MoH, Paediatric CSN
2. Development of teaching aids and health promotion for MCH nurses and VHW.	Materials developed & distributed	2012	MOH, Paediatric CSN
3. Revision of MCH card/booklet.	MCH card/booklet developed & distributed.	2012-2012	Paediatric CSN, MoH, FHSSP
4. Strengthen partnerships with NGOs and community organisations and offer VHW training to their community health workers.	300 community health workers trained per year.	2012 & on-going	MoH, FHSSP, WHO, JICA
5. On-going support for EPI.	MR1 coverage rate.	2012 & on-going	MoH, Paediatric CSN, UNICEF, JICA, WHO, FHSSP,

ACTIVITIES	PERFORMANCE INDICATORS	TIMELINE	RESPONSIBILITY
6. Implementation and evaluation of the infant pneumococcal conjugate and rotavirus vaccines, and HPV vaccine into the school health programme.	Development of evaluation plan prior to new vaccine introduction. Implementation of vaccines in 2012. Evaluation of impact.	2012 & on-going	MoH, Paediatric CSN, Mataika house, FHSSP
7. On-going support for HIV-PPTCT.	MTCT rates.	2012 & on-going	MoH, Paediatric CSN,
8. Support for the development of the RHD strategy.	RHD strategy complete.	2012	MoH, Paediatric CSN
9. On-going support for the RHD programme for screening and secondary prophylaxis.	Ongoing RHD programme support.	2012 & on-going	MoH, Paediatric CSN
10. Review of school health screening and incorporation of RHD screening.	Evidence based school based screening programme developed.	2012 & on-going	MoH, Paediatric CSN
11. Finalise child protection policy.	Policy finalised.	2012	MoH, Paediatric CSN,
STRATEGIC AREA 4: Development of a well functional programme on IMCI that aims to reduce the incidence and prevalence of the most common causes of childhood illnesses.			
1. Review/develop policies and guidelines relating to IMCI and wellbeing.	IMCI strategy developed.	2012-2013	MoH, Paediatric CSN
2. Provide on-going training for health care workers in the delivery of IMCI and wellbeing.	In-service training plan developed for each division.	2012 & on-going	MoH, Paediatric CSN, FHSSP, FNU
3. Provide access for General Practitioners to ICATT (IMCI) training.	ICATT part of continuous medical education for GPs.	2012& on-going	MoH, Paediatric CSN
4. Strengthen referral and follow-up system to improve IMCI and wellbeing.	Referral & follow up system established.	2012 & on-going	Divisional IMCI Committee's, MoH, Paediatric CSN
5. Review of medicines and other commodities required for an effective IMCI programme.	All health facilities have IMCI medicines in stock and IMCI equipment available.	2012	Divisional IMCI Committee's, MoH, Paediatric CSN, FPBS
6. Establishment of mechanisms for on-going practical M&E.	M&E plan developed. Each health facility has M&E performed every 6 months.	2012-2013 2013 & on-going	Divisional IMCI Committee's, MoH, Paediatric CSN
STRATEGIC AREA 5: Development of an Infant Nutrition/Feeding programme, including the promotion of Breastfeeding to reduce the incidence and prevalence of nutrition-related causes of childhood illnesses.			
1. Undertake operational research to understand the enablers and disablers of Breastfeeding.	Research undertaken with partners.	2013	MoH, Paediatric CSN, FNU, UNICEF

ACTIVITIES	PERFORMANCE INDICATORS	TIMELINE	RESPONSIBILITY
2. Devise evidence based social marketing of breastfeeding.	Social research undertaken and marketing plan developed.	2012-2013	MoH, Paediatric CSN, FNU, UNICEF, FHSSP
3. Review of current Breastfeeding and Infant Feeding/ Nutrition policies and practices.	Review completed. Revised policies finalised	2012-2013	MoH, Paediatric CSN, FNU, UNICEF, FHSSP
4. Capacity building and in-service training for staff involved in the implementation of the Breastfeeding and Infant Feeding programme.	In-service training plan developed & implemented.	2012 & on-going	MoH, Paediatric CSN, FHSSP, UNICEF
5. Develop community supports for Breastfeeding with engagement of community groups and agencies.	Identify sustainable community support groups particularly in areas where exclusive breastfeeding <30%. Establish support groups in >90% of health facilities	2012 & on-going 2013	MoH, Paediatric CSN, FNU, UNICEF, FHSSP
6. Establish an effective referral and follow-up system to enhance continuity of care and integration of services to support Infant Feeding.	Referral and follow up plan developed.	2012	MoH, Paediatric CSN
7. Establish a mechanism for on-going M&E to support delivery of Infant Feeding and Nutrition to assist in strategic planning at all levels.	M&E plan developed.	2012-2013	MoH, Paediatric CSN
8. Develop guidelines for the management of children with specific nutritional needs, e.g. HIV positive children and HIV negative infants (HIV positive mother).	Guidelines developed and distributed.	2012-2013	MoH, Paediatric CSN
9. Incorporation of micronutrient supplementation as a routine particularly for under 2 year olds, pregnant women, and girls in their final year of school.	>70% of under 2 year olds receiving supplements annually. >90% of pregnant women receiving supplements annually. >80% of final year school girls receiving supplements annually.	Ongoing Ongoing Ongoing	MoH, Paediatric CSN
10. Ongoing support and integration with The Fiji Plan of Action for Nutrition 2010-2014	Membership of FPAN committee.	Ongoing	MoH, Paediatric CSN
11. Establish process for early detection, referral, treatment and feedback for all children failing to thrive or severely malnourished	Reduction in hospitalised cases of severe malnutrition Reduction in mortality from severe malnutrition	2012 & on-going	MoH, Paediatric CSN, FHSSP, UNICEF, FNU
STRATEGIC AREA 6: On-going development and support for operational research.			
1. Continue to partner with institutions, agencies, and strengthen links with the NGOs to undertake relevant operational research.	Develop and implement new research activities in priority areas.	2012 & on-going	MoH, Paediatric CSN, FNU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