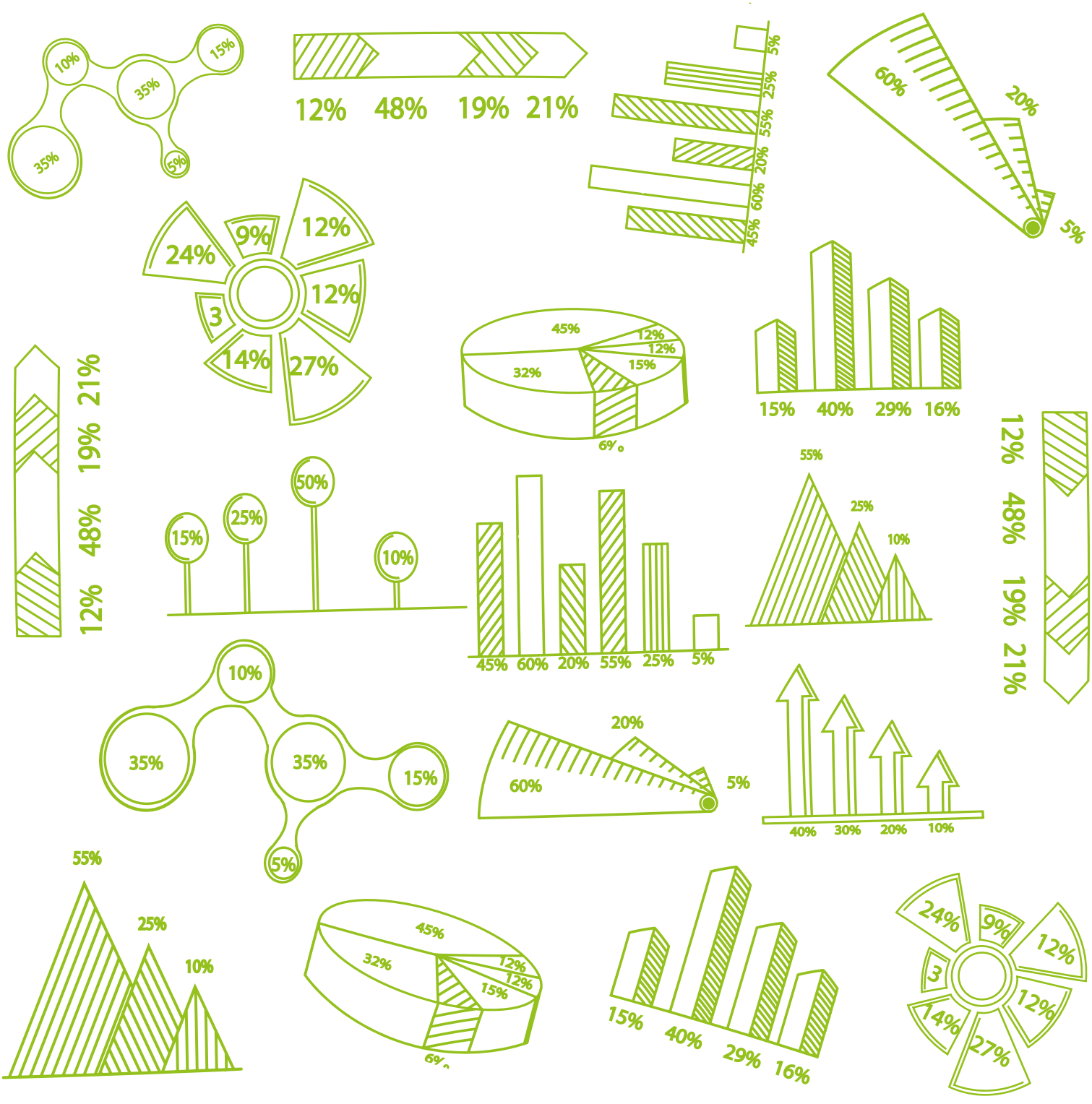


RCPCH Global

Impact Report 2012-2017

www.rcpch.ac.uk/global

This report offers some preliminary evidence and analysis of RCPCH Global programmes supporting stronger paediatric and child healthcare in low-income settings around the world

Contents

BACKGROUND

Since its foundation, the Royal College of Paediatrics and Child Health has embraced a commitment, beyond its work in the UK, to improving child health in the world's poorest countries.

Over the past 20 years, RCPCH Global has worked with local partners, ministries of health and international development agencies in a wide range of low- and middle-income settings, including Kenya, Uganda, Rwanda, Sierra Leone, Ghana, Malawi, Nigeria, Egypt, Jordan, Palestine, Myanmar, India, Sri Lanka and Cambodia.

Our work addresses issues affecting the health and development of newborn infants, children and adolescents, including: maternal and child survival, critical neonatal and paediatric care, integrated management of childhood illnesses, multidisciplinary support for physical and psychosocial disability, and adolescent mental and sexual health.

We focus on improving multidisciplinary clinical care at health facilities, from referral hospitals to primary care centres. We combine course-based training with continuous in-situ mentoring to support doctors, nurses, midwives and other healthworker cadres to improve their practical daily skills in clinical care.

A focus on life-saving paediatric skills

RCPCH Global's programmatic work builds on the WHO-endorsed Emergency Triage Assessment and Treatment Plus (ETAT+) protocol. ETAT+ is designed to strengthen fundamental paediatric life-saving skills and improved management of major childhood diseases.

We view ETAT+ as a philosophy of care – working with doctors, nurses and other cadres to enhance the speed and efficacy of their responses when dealing with sick children in low-resource environments. ETAT+ provides a set of building blocks that can be adapted to local conditions and priorities, and supports health system strengthening.

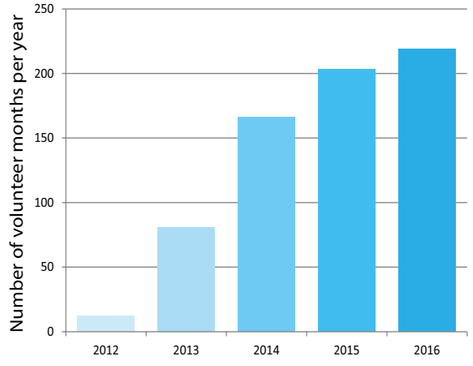
RCPCH GLOBAL IN NUMBERS

RCPCH Global has grown significantly in the last five years. We have expanded the scale of our work, and consolidated our programmes strategy to focus on improving quality of clinical care for children in hospitals and health centres.

Between 2012 and 2016, RCPCH Global programmes delivered 12,776 days of training and mentorship in partner countries. This equates to 63.8 years of world-class paediatric expertise transferred to low-income/high child mortality settings. We facilitated 3,090 days (15.4 years) of training with world-leading paediatric institutions in the UK for clinicians from developing regions.

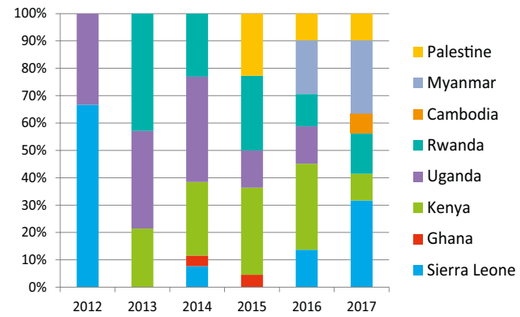
In the last five years, RCPCH Global has seen a substantial increase in numbers of volunteer clinicians working long-term in country programmes (graph 1).

Graph 1: 'Volunteer months' working in RCPCH Global programmes, 2012-2016



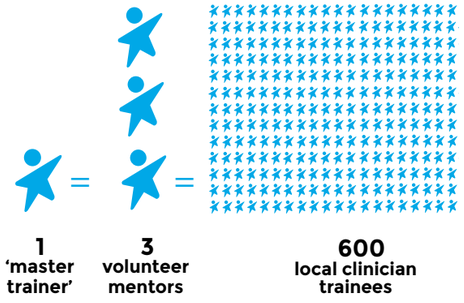
Over the same period, RCPCH Global has diversified and consolidated a portfolio of focus country programmes (graph 2).

Graph 2: RCPCH Global volunteer/mentor programmes, % by country, 2012-17



Our model of long-term volunteer mentors, working directly with clinicians in programme hospitals and health facilities, amplifies the reach and impact of shorter, course-based training (ill. 1).

Illustration 1: Amplifier effect of long-term volunteers



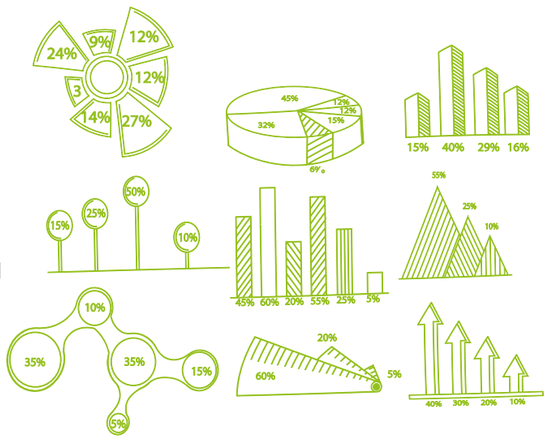
THE CRITICAL ROLE OF EVIDENCE

The need for health practices to be evidence-based is now more or less universally accepted.[1, 2] Generating high-quality evidence about what works to reduce child mortality and improve the efficacy of paediatric care is a priority globally – but a particularly pressing need for low-income countries. Much of the evidence for benchmarking clinical practice is based on research in higher-income settings. There is a critical need to test the efficacy and appropriateness of such practices in resource-poor environments.[3,4]

RCPCH Global is committed to demonstrating the impact of our work. Our process of programme development starts with local consultation and detailed assessment of quality of care in each participating facility, including state of infrastructure, level of clinical capabilities, and morbidity and mortality outcomes. These data form the basis of programme design and evaluation of impact through the life of the implementation. Some examples of this evaluation process are presented in this report.

Credible evaluation is critical not only for external validation, but also to build local and national buy-in for long-term sustainability. Evidence of positive impact can create a virtuous feedback loop showing local clinicians how improvement in their ability to provide care feeds through into better outcomes for their patients; it helps persuade senior managers (often working under considerable pressure) to support their juniors in training, trying out, and applying new skills; it highlights opportunities for health policy and financing at local and national level; and it shows donors the value – whether in terms of lives saved or money spent – of their support.

RCPCH Global uses appropriate research methods in a highly applied form. We aim to feed results from our work into the research literature and academic forums. But the principal focus of our evaluations is to understand what works to reduce child mortality and improve children's health in some of the most challenging environments in the world.



TRAINING CLINICIANS... UNDERSTANDING PEOPLE

The key to improving child health in low-income countries lies in those countries' ability to create and nurture well-trained, high-quality health professionals. Improving the infrastructure of health facilities – from primary healthcare posts to tertiary teaching hospitals – is of course an important dimension of improving care; as is ensuring adequate and sustainable supply of essential medicines and medical equipment. But RCPCH Global believe that it is the people who work within the care system who, ultimately, shape the care that is delivered.

It is estimated that by 2030, there will be a global shortage of 17-18 million healthcare professionals required to meet the health targets of the Sustainable Development Goals.[5,6] The total number of healthcare providers must rise over coming years if we are to see real – and sustainable – continuation of progress on global child health. But it is not solely a question of numbers. We need to find ways to improve the quality of clinical skills among the existing cadres of healthcare workers, to strengthen their management and leadership capabilities, and – critically – to understand what motivates (or stands in the way of) improved practice, from the perspective of the health workers themselves.[7]

RCPCH Global strategy is to support and mentor doctors, nurses and other cadres, working in multidisciplinary teams. We believe that there is already an extraordinary amount of latent value in existing healthworker cadres, which can be released at relatively low cost, through training and mentoring fitted to the realities of healthcare in each programme context.[8,9]

GLOBAL HEALTH AND REVERSE INNOVATION

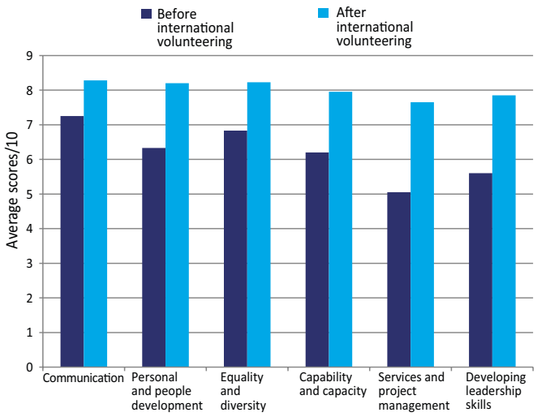
In 2010, USD$6.5 trillion was spent on health worldwide. Only 15% of this was spent in low- and middle-income countries, with 85% of the world's population and 92% of the global disease burden. Per capita spending on health ranges from USD$8,362 per person per year in the United States to USD$12 in Eritrea.[10]

RCPCH Global believe that we should contribute to correcting this global inequity. We, like other Medical Royal Colleges, represent one of the greatest concentrations of health expertise in history. What we can offer is to share that expertise with our colleagues and counterparts in poorer regions, helping to improve the health of infants, children and young people - those children and young people who are the preeminent resource necessary for developing countries to grow their way out of poverty.

But that process of sharing expertise is not one-way. It is increasingly recognised – and borne out by RCPCH Global's experience – that healthcare systems across the world confront a number of common challenges, and that high-income countries have much to gain and learn from genuine partnership with healthcare colleagues in low- and middle-income settings.[11]

With changing patterns of global disease, increasing influence of global determinants of health and renewed commitment to universal healthcare and health equity, health professionals in every country are faced with similar core challenges – how to maximise the health benefits of a limited resource pool through evidence-based use of frugal, appropriate and effective interventions.[12] Working in partnership alongside clinical colleagues in some of the world's most resource-scarce health systems not only builds capacity and improves care for children in those countries. It enhances the skills of UK doctors and nurses, bringing enormous value back to the NHS (graph 3).

Graph 3: Self-reported competency scoring, UK paediatricians pre- and post- international volunteering



RCPCH GLOBAL PROGRAMMES

KENYA AND UGANDA

RCPCH Global built its early programmatic work in East Africa – primarily Kenya, Uganda and Rwanda. Our programme presence was developed through relationships with sister paediatric associations and, through them, ministries of health and leading local child health organisations.

Much of our early growth was supported by grant funding from the UK's Department for International Development (DFID) and the Tropical Health and Education Trust (THET). In Kenya and Uganda, working closely with the Kenyan and Ugandan Paediatric Associations (KPA/UPA), RCPCH co-managed a 3-year programme to deliver ETAT+ training in selected district hospitals. An 18-month ETAT+ intervention package was provided to each hospital including:

- ETAT+ training for doctors, nurses and clinical officers
- Long-term UK 'Global Links' volunteer clinicians deployed to support application of ETAT+ training in practice, and to work with local 'ETAT Champions' within each hospital to develop and implement quality improvement (QI) projects.

QI projects included: improving newborn care; enhanced infection control; development of clinics for conditions such as sickle cell; malnutrition screening referral systems from peripheral health centres; QI projects were accompanied by small-scale programme bursaries to support critical but inexpensive facility infrastructure modifications

Thermoregulation and newborn care

Temperature control of newborns was identified as a common problem amongst participating hospitals, often associated with cold transfer between delivery and neonatal/ paediatric wards.

In Bwindi Community Hospital in Uganda, RCPCH Global Links volunteers and Ugandan counterparts collaborated in a quality improvement project targeting newborn thermoregulation – incorporating refresher training on kangaroo mother care and WHO's 10-step 'warm chain', as well as reminder posters and successful advocacy with the hospital administration to repair damaged radiant warmers. As a result, over the period of intervention, the proportion of newborns registered as hypothermic fell by more than 60% (graph 4).

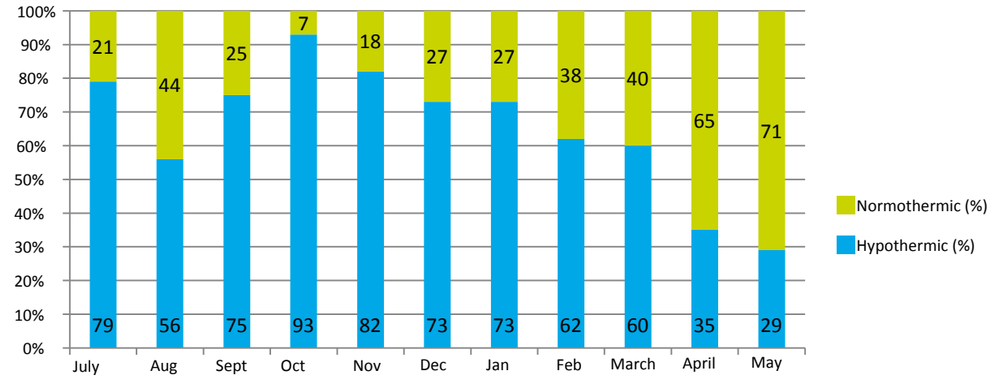
Programmes: Kenya and Uganda

In Kenya, Global Links volunteers and Kenyan counterparts developed a multi-pronged strategy to reduce newborn mortality in Chigoria District Hospital. Intervention included promotion of better thermoregulation, hand-washing and hygiene, regular resuscitation drills, refresher training on use of the two available CPAP machines, and instigation of morbidity and mortality review meetings, with the participation of obstetric staff. Critically, the project focused on encouraging mothers to become actively involved in their babies' care.

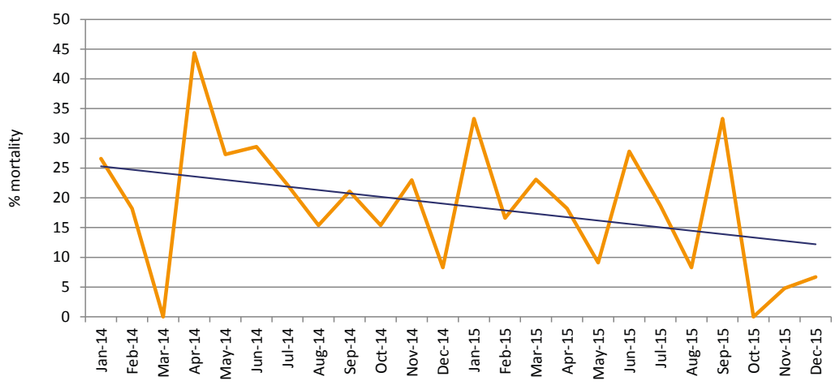
Over the period of the intervention, neonatal mortality fell by almost 50% (graph 5). We know that base mortality data in health systems with weak documentation and information can be problematic. And we are duly cautious in interpreting causation. These effects, for example, are not tested for statistical significance. Notwithstanding, the results point to 'prima facie' evidence of positive impact.

In 2016, RCPCH and KPA agreed a new programme of work, with support from Jersey Overseas Aid, to strengthen referral linkages for sick children between primary care centres in the Kibera slum around Nairobi, and the main Mbagathi Hospital.

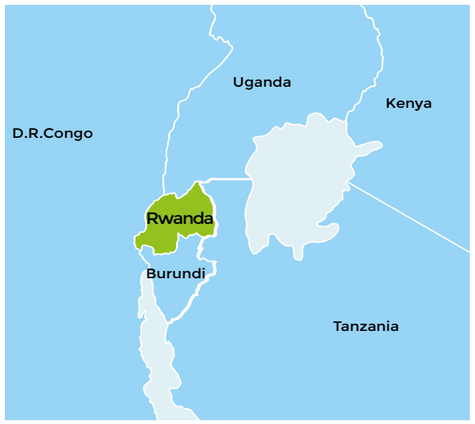
Graph 4: Neonatal hypothermia, Bwindi Community Hospital, Uganda, Jul 2014-May 2015



Graph 5: Mortality rate of neonates admitted to Chogoria NBU, Jan 2014–Dec 2015



RWANDA



After the 1994 genocide, Rwanda has managed an intensive process of reconstruction, strengthening its health system based on a district health model. As a result, significant progress has been made in reducing child mortality. Child health remains, however, one of the major challenges to Rwanda's long-term development.

For the past five years, with financial support from DFID/THET, RCPCH Global has been working in collaboration with the Rwanda Paediatric Association (RPA), under the aegis of the Ministry of Health, to reduce under-5 mortality through ETAT+ courses in 12 district hospitals across the country.

In addition to formal training, the UK team, working with RPA colleagues and hospital 'champions', introduced quality improvement projects targeting critical aspects of clinical care for sick children – including management of major childhood killers such as pneumonia and malaria.

Management of pneumonia

Inaccurate assessment of pneumonia and poorly managed use of antibiotics were identified as a significant issue among programme facilities – a problem seen in many low- and some middle-income countries, presenting a major risk of increasing antimicrobial resistance.

Through a process of training, refresher sessions, quality improvement projects, and periodic audit, clinical performance across the six participating hospitals in the first phase improved substantially. Correct assessment of severity of pneumonia improved from 34% in March 2016 to 58% at the end of programme (graph 6; N.B. small sample size for Nov 15 (n=11) may have distorted results in the initial period). Correct choice of drug improved from 17% in March 2016 to 57% (although the effect was stronger in prescription of ampicillin than gentamicin). Prescription of correct dose per bodyweight of ampicillin improved from 66% to 81%.

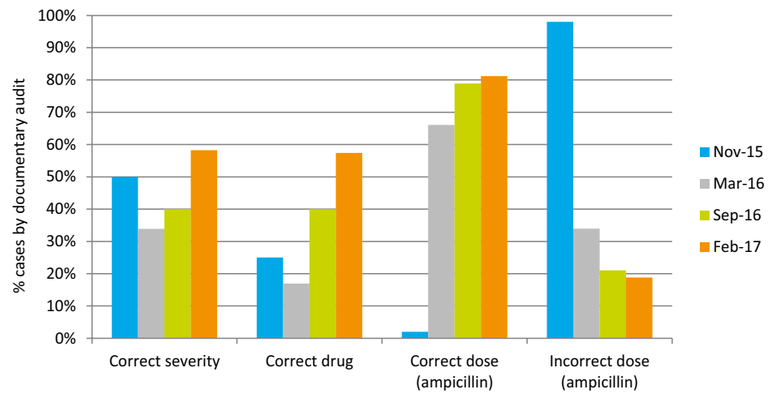
Neonatal and under-five mortality

Improvement in managing pneumonia was one of a range of interventions under the ambit of this progamme. Overall, through intervention, neonatal deaths as a proportion of admissions aggregated across the six hospitals fell from 13.57% to 10.85% (graph 7). The reduction was found to be highly significant (p=0.0092).

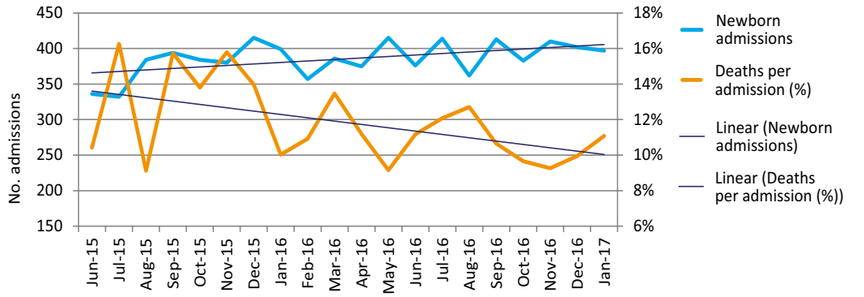
Although under-5 mortality also saw a reduction across the programme hospitals (from 2.6% to 2%), the fall was not found to be significant (graph 8).

A number of RCPCH Global country programmes have found similar effects, where impact on neonatal mortality can be stronger than impact on the rate of paediatric deaths among under-5s. The condition of neonates (especially those in-born to the hospital) may be better, and more directly amenable to controlling intervention, than the range of factors affecting the nature and severity of children under five prior to admission.

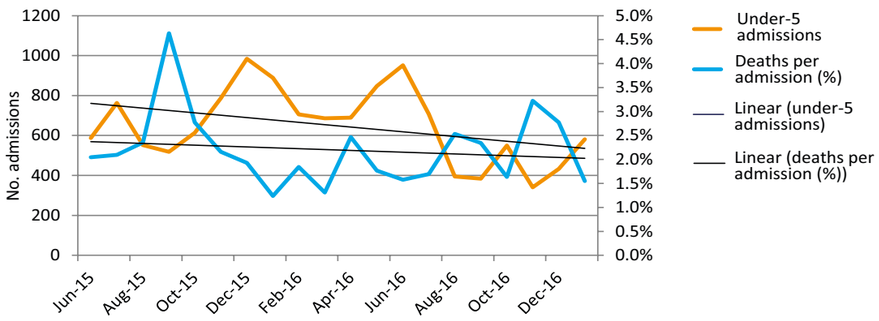
Graph 6: Pneumonia management, 6 hospitals, Nov 2015-Feb 2017



Graph 7: Neonatal mortality as % of admissions, 6 hospitals, Jun 2015-Jan 2017



Graph 8: Under-5 mortality as % of admissions, 6 hospitals, Jun 2015-Jan 2017



SIERRA LEONE

RCPCH Global has worked in Sierra Leone since 2009. Initially through VSO Fellowship placements, RCPCH members focused on support to the only paediatric centre in the country – Ola During Children's Hospital (ODCH) in Freetown. Over time, RCPCH has built strong relationships with the Ministry of Health and Sanitation (MoHS), and with international partners based in-country.

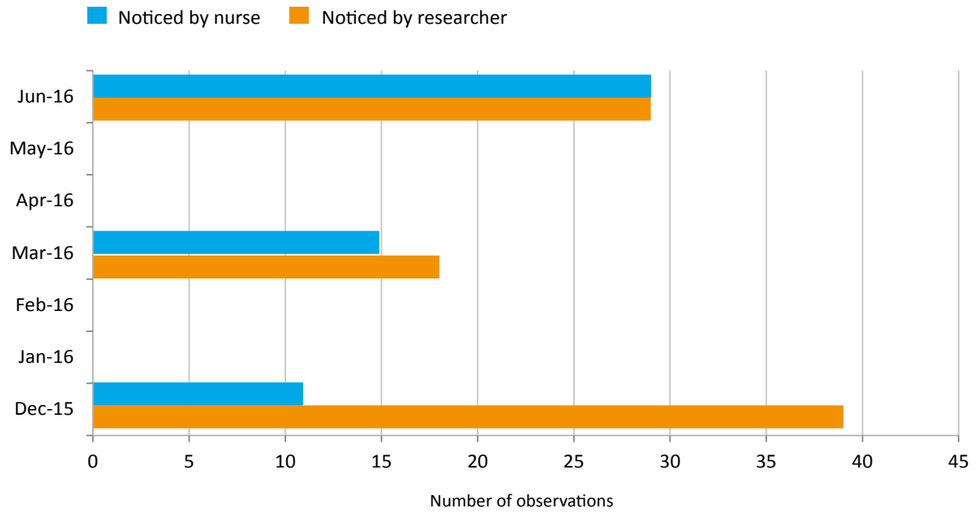
Between 2013 and 2016 RCPCH Global posted 11 Global Links volunteers at ODCH. Alongside ETAT+ training, volunteers and their Sierra Leonean counterparts designed and implemented a range of quality improvement projects, including development of national paediatric guidelines; supporting ODCH to become accredited to deliver postgraduate training in paediatrics; supporting development and pilot of a modular nurse training curriculum; development and delivery of on-the-job training in neonatology and paediatrics; establishment of a cardiac referral system; initial development of oncology diagnosis and treatment capabilities; and nurse-led triage, assessment.

Nurse-led triage and assessment

After the Ebola outbreak in 2014-15, RCPCH Global returned to Sierra Leone in September 2015 to consult on how best to support the post-Ebola process of health system reconstruction. Working under the auspices of the MoHS and the Presidential Recovery Plan, we collaborated with WHO to design and initiate a national ETAT+ training programme extended to all regional and district hospitals in the country. A key modification to this programme was that training was designed to be continuous over 6 months in each participating hospital and to focus on enhancing nurse-led care. Sierra Leonean nurses, teaming up with UK clinician volunteers, were deployed to each hospital to provide continuous mentoring and quality improvement with their district counterparts.

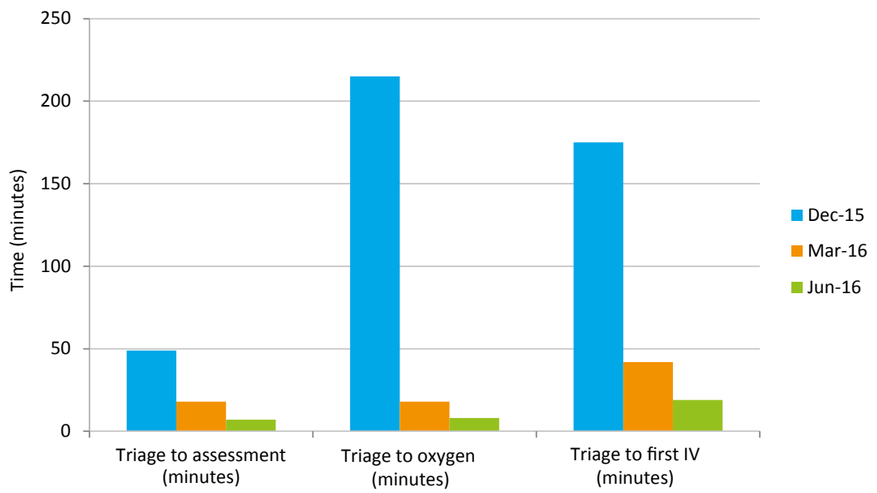
A pilot version of nurse-led training was implemented in ODCH. It was evaluated against baseline immediately after intervention, and three months post-intervention. The ability of nurses to correctly identify children with emergency signs (comparing trainee assessment against that of independent specialists) improved from 30% at the start of the intervention in 2015, to 100% in June 2016 (graph 9).

Graph 9: Emergency signs correctly observed. ODCH, Freetown Dec 2015-Jun 2016



Very significant reductions in the time taken to move from triage to assessment, oxygen and first IV were registered between baseline and end of the training phase of the intervention (Dec 2015- Mar 2016). Equally interesting is that time delays continued to decrease in the three months after the completion of the intervention and cessation of dedicated external support (Mar-Jun 2016). This suggests continuing improvement driven by the nurses themselves, and supported by their hospital administration (graph 10).

Graph 10: Time to assessment treatment, pre-, during and post-mentoring ODCH, Freetown Dec 2015-Jun 2016



MYANMAR

Myanmar has seen promising progress in improving child health in recent years. But maternal, newborn and under-5 mortality remain a national priority. One child in 20 dies before the age of five.

Since 2015, RCPCH and the Myanmar Paediatric Society (MPS) have worked in partnership to deliver an 'Emergency Paediatric Care Programme' (EPCP), supporting enhancement of clinical skills among doctors and nurses in 21 district hospitals across three states, funded by DFID/THET and Unicef. The programme focuses on strengthening not just the clinical capabilities of care providers, but also critical aspects of the physical infrastructure, access to appropriate equipment, and institutional leadership, evaluating change in these interconnected facets of care over time as the programme progresses. EPCP draws on Emergency Triage Assessment and Treatment Plus (ETAT+) but combines it with Integrated Management of Neonatal and Childhood Illnesses (IMNCI), including:

- A one-week course, delivered in each hospital, focusing on in-situ simulation and scenario-based skills training
- Six-month placement of UK volunteer clinicians to mentor, support and advise counterpart doctors and nurses on how to apply EPCP training in daily practice
- Establishment of hospital quality improvement teams, combining UK volunteers and local clinicians, to identify critical changes in the hospital environment that will support EPCP implementation and improve children's outcomes

We used a 5-point Likert scale to gauge quality of clinical performance across a range of areas critical to paediatric emergency care, with assessment at baseline and thereafter at six-month intervals.

Paediatric resuscitation

We assessed quality of paediatric resuscitation across an initial group of 6 participating hospitals, looking for changes to baseline scores after the first six months. We looked at: quality of training uptake, performance of trainees in a simulated environment and in real-time, along with strength of resuscitation system and documentation in each programme hospital.

At baseline (graph 11), performance across categories is clustered to the left, ranging between 'inadequate' and 'adequate'.

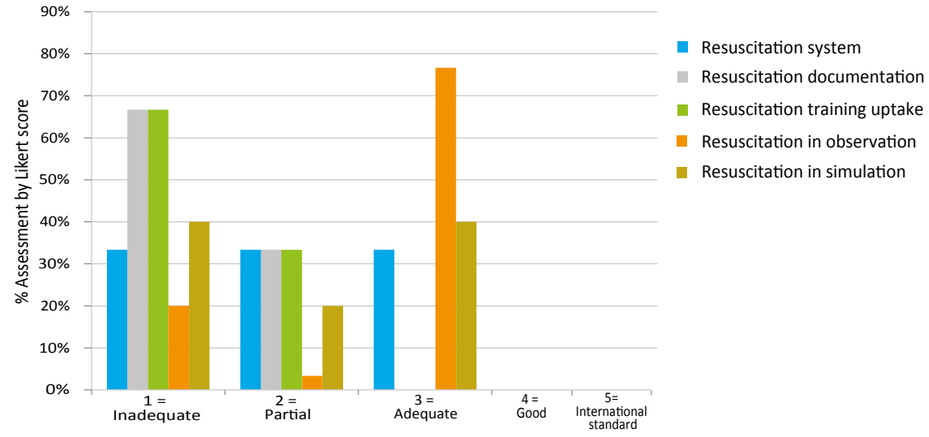
At six months, we can see a distinct shift rightwards in all categories, indicating general improvement in scores (graph 12). 'Uptake of training' has improved from 100% inadequate or partial to 83% good or international standard. This might be expected insofar as training is central to the programme as a whole.

Although clinicians' resuscitation skills improve in both simulation and in real-time observation, performance improves somewhat more slowly in real-time application.

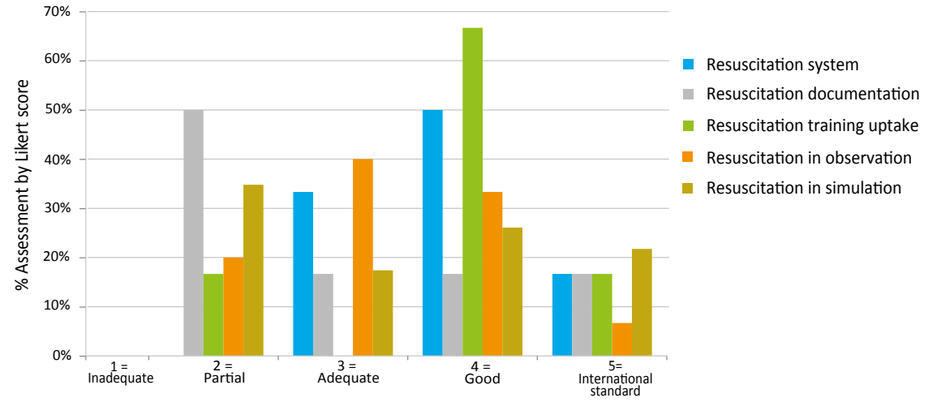
This suggests that longer-term support is required to convert skills in a simulated environment into skills applied in the more hectic context of a real child in need of critical care.

Quality of documentation shows least progress. This is a common finding, suggesting that it can take considerably longer to strengthen the underlying institutional systems supportive of good clinical care.

Graph 11: Paediatric resuscitation, 6 hospitals, baseline



Graph 12: Paediatric resuscitation, 6 hospitals, 6-months follow up



PALESTINE

RCPCH Global has been engaged with partners in Palestine since 1996. We work with the Pediatric Society – Palestine (PSP), as well as the Islamic University of Gaza (IUG). In 2015, with support from DFID and THET, RCPCH, PSP, IUG and Juzoor for Health and Development launched a new programme called 'Maximising Potential' to strengthen understanding of multidisciplinary care for children with disability in the Occupied Territories.

Child disability is under-addressed in health and social care in Palestine. Partly driven by the humanitarian context, in which funding creates fragmented care services, and partly by attitudes to disability which can discourage effective care-seeking, approaches to disability in the region are highly concentrated on diagnosis with much more limited effective referral onward to specialist forms of treatment, as well as psychosocial support for families. Independent charitable and NGO bodies often provide such care, often with a specific focus on one type of disability. As a result, few children with multiple disabilities, or with a disability leading to multiple developmental deficits, receive genuinely multidisciplinary, joined-up care planning and treatment.

Families, who are the main providers of care over the long term, are not well supported in understanding the needs or the positive capabilities of their disabled children.

"Maximizing Potential" was designed to address the lack of multidisciplinary working in the field of child disability. Through a process of skills and knowledge transfer and health systems strengthening, the programme incorporated several sequenced components, starting with a training of trainers supported by a small team of UK paediatric and disability specialists.

This was designed to build a local 'faculty' who went on to work with and coach peer practitioners, drawn from a wide range of government and non-government disability agencies, across a range of disability fields, building multidisciplinary collaborations. Using a standardised child disability 'patient profile' and care pathway planning tools, practitioners were encouraged to work more closely together to provide better integrated support.

"We have been able to accomplish more, faster, with the children. We began coordinating with each other, and at times reinforcing each other or coming in to help during our colleague's sessions. I am in favour of implementing this approach."

Towards the end of the programme period, trainers and practitioners were brought together in workshops in the West Bank and Gaza to review progress and explore potential for sustaining gains made. During the same period, RCPCH engaged external evaluators to assess both the clinical impact of multidisciplinary approaches on a sample of documented cases, as well as the efficacy of the programme in addressing child disability in the wider Palestinian context. Both evaluations were primarily qualitative in nature.

Evaluators found that case management of children improved with adoption of programme protocols, and that there was significant evidence of willingness to build further collaboration among and between disability organisations (though with some differences in the supporting environment between West Bank and Gaza).

A key limiting factor on programme impact was the extent of uptake of multidisciplinary working at organisational (as opposed to individual practitioner) level. It became clear that gaining buy-in from senior organisational leadership was critical to enabling practitioners within those organisations to commit time and resources to multidisciplinary working.

Palestine programme in numbers (Gaza and West Bank)

- 19 trainers trained in training others in the multi-disciplinary method
- 58 local practitioners trained by local trainers in using MDT approaches and developed tools
- 29 coaching sessions attended
- 221 cases reviewed using MDT approaches across West Bank and Gaza
- 33 local organisations involved

OUR WORK IN THE UK

Advocacy

RCPCH Global collaborates with a wide range of partner institutions to advocate for global child health. We assess and encourage the UK Government's role in global child health, including through maintaining efficient and effective use of UK aid. We join with colleagues and partner organisations to demand protection for children caught up in crises, and promotion of humanitarian principles banning attack on medical facilities and health workers in situations of conflict. RCPCH Global continues to call for a more humane approach to the issue of child refugees, as they have emerged as a new and distinct priority in the global landscape.

Visiting Fellowship scheme

Since 1996, with the generous support of RCPCH members, the Visiting Fellows programme has provided specialist UK-based placements for more than 250 paediatricians from over 30 countries in Africa, Asia and the Middle East. To align with the College's mission and values, applicants in a competitive process are assessed on their contribution to child health in their respective countries and globally.

By matching overseas paediatricians and health workers to leading specialist units in the UK, the Visiting Fellows programme aims to improve their capacity for prevention, diagnosis, and treatment across a full range of child health conditions, advancing the genuinely global transfer of clinical knowledge, research and practice.

RCPCH Global Programme Development Small Grants Scheme

The college launched its Global Programme Development Grant in 2016. The grants aim to provide seed funding to RCPCH members who have established or plan to establish a child health intervention in the global space, with potential for development at larger scale in low-resource settings.

Pilot interventions competing for a grant can focus on any aspects of paediatric and child health with applicability in low-income and middle-income countries. The grants are particularly oriented to development of interventions which enhance the clinical capability and impact of health workers.

Each £5000 grant supports a pilot project that may be scaled up to a longer-term and/or more extensive programme. The first grant focused on neurodisability in rural Uganda. Following early intervention infants at high-risk of neurodevelopmental impairment showed significant improvements in family quality of life scores. The second grant was awarded to the 'NeoTree' mobile app which supports clinical staff treating neonates in Malawi. Early results show it has become firmly imbedded in clinical practice and is showing signs of improving the quality of care delivered.

UK-based training

Child Health in Low-resource Settings

RCPCH Global runs a three-day Child Health in Low-resource Settings (CHiLS) course aimed at paediatricians and other child health practitioners with an interest in global child health or who intend to work in low-income countries.

The course equips clinicians to manage the most common childhood presentations assuming operation in a resource-scarce setting, as well as providing insights into the characteristics of public health and health care systems in poorer regions and an understanding of the realities of working overseas.

"Immeasurably helpful both for my work in the UK and overseas...inspiring and interesting"

ETAT+ training in the UK

RCPCH Global trains UK clinicians to become instructors qualified to deliver Emergency Triage, Assessment and Treatment (ETAT+) courses in resource poor-settings across the world.

ETAT+ was developed specifically for implementation in resource-poor settings and provides a comprehensive package of training in treating common neonatal and paediatric presentations within a resource-poor healthcare setting.

The intervention package provides hands-on training to healthcare workers using evidence- based and up-to-date clinical protocols for identifying and managing the most common threats to newborn and child survival. The training approach:

- Reviews simulated practice and monitors outcomes to improve quality
- Promotes teamwork and the integration of new skills and knowledge into everyday practice
- Produces a core of trainers and mentors to build a sustainable UK-based and international capacity

VALUE FOR MONEY

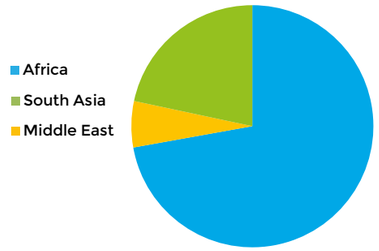
RCPCH Global is committed to ensuring that its programmes represent efficient and effective use of resources. We know from econometric research that health gains from investment in facility-based care are likely to be comparatively very high.[13]

We know that community and primary care interventions have made significant inroads into maternal, newborn and child mortality in low-income countries over the last quarter century. But we know too that the efficiency and effectiveness of care in these settings is significantly enhanced by improved institutional capacity for quality clinical care at secondary and referral hospital levels.[14,15]

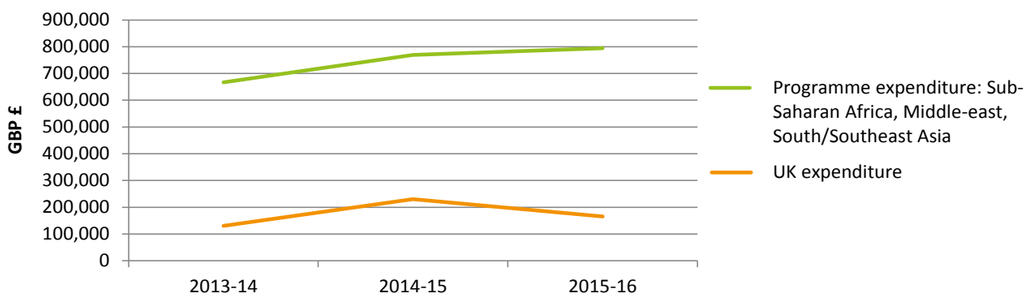
Our programmes focus on least-developed countries and regions (see pie chart) and in the often under-invested secondary level of care. Over the last four years, RCPCH Global has increased programmatic activity whilst bringing down cost (graph 13).

RCPCH Global operates mainly through grants from bilateral and multilateral donors. A small proportion (2%) of the RCPCH membership fee is allocated to our international work, supporting fellowships for paediatric clinicians from low-and middle-income countries to train with senior counterparts in the NHS, and supporting programmes development and management. In FY2016-17, RCPCH Global held grants with a total value of GBP£1.8m; every pound of membership support is used to leverage grant income by a factor of 30.

RCPCH Global programmes 2015-16



Graph 13: Global programmes expenditure and cost, 2013-16



OUR PARTNERS

RCPCH Global works with and through its members. It is their willingness to support a global role, and to commit to working overseas – almost invariably without remuneration, often in challenging contexts – that underpins our ability to operate.

We owe a huge debt of thanks to all those College members who have worked with us and those who continue to support our work. That work would not be possible without the continuing commitment of our partners: government leaders and ministries of health under whose aegis we operate; district health managers, hospital and health centre staff on whose knowledge and energy we depend; leaders in paediatric health whose influence paves the way for effective working; civil society partners whose work we support and who facilitate ours; donors who provide the financial lifeblood of our endeavours; and, finally, the families and children who seek the quality of care our partners aspire to provide.

Our thanks go to:

- The Academy of Medical Royal Colleges
- Al Quds University
- The British High Commission India
- The UK Department for International Development (DFID)
- The Department of Paediatrics & Child Health, Makerere University
- Global Health Uganda (GHU)
- Health Education England
- The Islamic University Gaza (IUG)
- Jersey Overseas Aid Commission (JOAC)
- Juzoor for Health and Development
- The Indian High Commission (UK)
- The Kenyan Ministry of Health
- The Kenya Paediatric Association (KPA)
- The King's-Sierra Leone Partnership
- The Liverpool School of Tropical Medicine (LSTM)
- The London School of Hygiene and Tropical Medicine (LSHTM)
- Medial Aid for Palestinians (MAP)
- The Myanmar Paediatric Society (MPS)
- The Myanmar Ministry of Health and Sport
- Ola During Children's Hospital
- The Paediatric Society – Palestine (PSP)
- Public Health England
- The Royal College of Midwives (RCM)
- The Royal College of Nursing (RCN)
- The Royal College of Obstetricians and Gynaecologists (RCOG)
- The Royal College of Physicians (RCP)
- The Royal College of Surgeons of England (RCS)
- The Royal College of Surgeons (Edinburgh)
- The Royal College of Pathologists
- The Royal College of Psychiatrists
- The Rwandan Ministry of Health
- The Rwanda Paediatric Association
- The Sierra Leone Ministry of Health and Sanitation
- The Sri Lankan College of Paediatricians
- The Tropical Health and Education Trust (THET)
- The Faculty of Public Health (UK)
- The National Health Service (NHS, UK)
- The Ugandan Ministry of Health
- UNICEF
- The UN Relief and Works Agency (UNRWA)
- The Welbodi Partnership
- The West African Colleges of Physicians and Surgeons
- The World Health Organisation

REFERENCES

1. Flenady et al. Stillbirths: recall to action in high-income countries. Lancet, Volume 387, Issue 10019, 13–19 February 2016, Pages 691–702.
2. Ralston et al. Global paediatric advanced life support: improving child survival in limited-resource settings. Lancet, Volume 381, Issue 9862, 19–25 January 2013, Pages 256–265.
3. Mason et al. From evidence to action to deliver a healthy start for the next generation. Lancet, Volume 384, Issue 9941, 2–8 August 2014, Pages 455–467.
4. Mangham-Jefferies et al. Cost-effectiveness of strategies to improve the utilization and provision of maternal and newborn health care in low-income and lower-middle-income countries: a systematic review. BMC Pregnancy and Childbirth2014 14:243 DOI: 10.1186/1471-2393-14-243.
5. Magidson et al. Task Shifting and Delivery of Behavioral Medicine Interventions in Resource-Poor Global Settings: HIV/AIDS Treatment in sub-Saharan Africa. The Massachusetts General Hospital Handbook of Behavioral Medicine; Current Clinical Psychiatry pp 297-320.
6. Scheffler et al. The deepening global health workforce crisis: Forecasting needs, shortages, and costs for the global strategy on human resources for health (2013-2030). Annals of Global Health, May-June, 2016, Volume 82, Issue 3, p510.
7. Bhutta, Z.A., et al. Education of health professionals for the 21st century: a global independent Commission. Lancet, 375 (9721), 1137–1138, 2010.
8. Gimbel et al. Creating academic structures to promote nursing's role in global health policy. International Nursing Review, January 2017, DOI: 10.1111/inr.12338.
9. Mandeville et al. Human resources for health: time to move out of crisis mode. Lancet, Vol 388 July 16, 2016.
10. Revill et al. Using cost-effectiveness thresholds to determine value for money in low- and middle-income country healthcare systems. CHE Research Paper 98, University of York, May 2014.
11. DePasse & Lee. A model for 'reverse innovation' in health care. Globalization and Health 2013 9:40 DOI: 10.1186/1744-8603-9-40.
12. Crisp N. Mutual learning and reverse innovation–where next? Globalization and Health 2014 10:14 DOI: 10.1186/1744-8603-10-14.
13. Revill et al., 2014.
14. Darmstadt et al. Evidence-based, cost-effective interventions: how many newborn babies can we save? Lancet, Volume 365, Issue 9463, 12–18 March 2005, Pages 977–988.
15. Adam et al. Cost effectiveness analysis of strategies for maternal and neonatal health in developing countries. BMJ 2005; 331 doi: http://dx.doi.org/10.1136/bmj.331.7525.1107.

SUMMARY

WHAT WE HAVE LEARNED

- In many low-resource health systems, there is a large volume of untapped value latent within the existing workforce – particularly among nurses; improving the quality of basic clinical capabilities among these cadres is a cost-efficient way of strengthening the health system, improving health outcomes, and reducing maternal and child mortality
- Although child mortality and morbidity are the ultimate indicators of positive health system change, they are influenced by many intermediating factors; improvement in clinicians' knowledge and practice, and in the operating environment of the health facility as a whole, are themselves important outcomes of our programme work
- Improvement in clinical knowledge does not automatically translate into better clinical practice; large numbers of formal training courses have had little impact on health outcomes; formal training has greater and more sustained impact when accompanied by long-term mentoring to support trainees embedding new skills in daily practice
- Inexpensive improvements in the operating environment (critical aspects of hospital layout, equipment and systems) can significantly improve the effective translation of training into better clinical practice
- Health systems and facilities work in quite rigid hierarchies – improving team working between doctors, nurses, midwives, medical officers and health assistants can substantially improve overall performance; but challenging hierarchy requires strong leadership
- Changing systems in healthcare generally takes longer than training clinical skills; changing systems requires institutional and clinical leadership from national policy to hospital administration.

"RCPCH Global... sharing skills and knowledge to improve global child health"

If you are interested in taking part in our programmes email: global@rcpch.ac.uk or register with the Global Health Consultancy at ghc@rcpch.ac.uk

RCPCH 2017
The Royal College of Paediatrics and Child Health (RCPCH) is a registered charity in England and Wales (1057744) and in Scotland (SC038299).

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